The Clatterbridge Cancer Centre NHS Foundation Trust

Agenda: Trust Board Part 1
Date/Time of Meeting: 26th April 2023, 09:30

	Standard Business		Lead	Time
1-23/24	Welcome, Introduction, Apologies and Quoracy	v	Chair	09:30
2-23/24	Declarations of Interest	v	Chair	
3-23/24	Minutes of the Last Meeting – 29th March 2023	p	Chair	
4-23/24	Matters Arising / Action Log	p	Chair	
5-23/24	Cycle of Business	p	Chair	
6-23/24	Chair's Report to the Board	v	Chair	
	Reports and Action Plans			
7-23/24	Board Assurance Framework	p	Chief Exec	09:40
8-23/24	BAF Refresh	p	Chief Exec	09:50
9-23/24	Staff Story – Springboard Development Programme	v	Director of Workforce	10:00
10-23/24	Quality Committee Chair's Report including Terms of Reference	p	NED - TJ	10:10
11-23/24	Audit Committee Chair's Report	p	NED - MT	10:20
12-23/24	People Committee Chair's Report including Terms of Reference	p	NED - AR	10:30
13-23/24	Integrated Performance Report	p	Exec Leads	10:40
14-23/24	Finance Report	p	DoF	10:55
15-23/24	2023/24 Operational and Financial Planning Update	v	DoF	11:05
16-23/24	NED & Governor Engagement Walk-round	p	Chief Nurse	11:15
17-23/24	NED & Governor Engagement Walk-round Annual Report	p	Chief Nurse	11:25
18-23/24	Risk Management Strategy	p	Chief Nurse	11:35
19-23/24	Mortality Report (Learning from Deaths)	p	Medical Director	11:45
20-23/24	Use of Trust Seal Report	p	ADoCG	11:55
	Any Other Business			
21-23/24		v	Chair	12:05
	Date and time of next meeting hybrid MS Teams and Boardrooms CCC-L: 31st May 2023 at 09:30			
	Resolution: *"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*			
	Close			

p paper
***** presentation
v verbal report

WE ARE...
KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOAGEND
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

Draft Minutes of Trust Board Part 1
29th March 2023, 09:30

Title / Department	Name	Initials	Present / Apols	Attendance Record	Deputy
Core members (as per ToR)		P:Present A:Apologies 0:No apologies			
Chair	Kathy Doran	KD	P	10/10	☐
Non-Executive Director (NED)	Mark Tattersall	MT	P	10/10	☐
Non-Executive Director (NED)	Geoff Broadhead	GB	P	8/10	☐
Non-Executive Director (NED)	Elkan Abrahamson	EA	P	9/10	☐
Non-Executive Director (NED)	Terry Jones	TJ	A	8/10	☐
Non-Executive Director (NED)	Anna Rothery	AR	P	7/10	☐
Non-Executive Director (NED)	Asutosh Yagnik	AY	P	7/10	☐
Chief Executive	Liz Bishop	LB	P	10/10	☐
Director of Workforce & Organisational Development	Jayne Shaw	JSh	P	10/10	☐
Medical Director	Sheena Khanduri	SK	P	9/10	☐
Chief Nurse	Julie Gray	JG	P	10/10	☐
Chief Operating Officer	Joan Spencer	JSp	A	10/10	☐
Director of Finance	James Thomson	JT	P	10/10	☐
Chief Information Officer	Sarah Barr (NV)	SB	P	10/10	☐
Director of Strategy	Tom Pharaoh (NV)	TP	P	10/10	☐

Also in attendance		
Title	**Name**	**Initials**
Corporate Governance Manager (minutes)	Skye Thomson	ST
Interim Associate Director of Corporate Governance	Paul Buckingham	PB
Communications Manager	Susan King	SK

Item No.	Standard Business
38-23	**Welcome, Introduction, Apologies & Quoracy:** The Chair welcomed the Board and observing Governors and noted there were apologies for absence from Terry Jones, Non-Executive Director and Joan Spencer, Chief Operating Officer. The Chair confirmed the meeting was quorate.
39-23	**Declarations of Interest:** There were no declarations made in relation to any of the agenda items.
40-23	**Minutes of Previous Meeting**

V2

	The minutes of the meeting held on 1st March 2023 were approved as a true and accurate record subject to the following amendments: NED AY queried his attendance record and agreed to pick this up with the Corporate Governance Manager outside of the meeting. NED EA noted a typo in the minutes and agreed to send details through to the Corporate Governance Manager	
41-23	**Matters Arising / Action Log** There were no matters arising. The Board noted that the following updates regarding the action log: P1-013-23 – The data on the VTE assessments due at Quality Committee had been deferred from the March meeting to the June meeting. P1-033-23 – The Director of Strategy provided NED AR with an update on the hot water systems on the 28 March. This action is complete. P1-36-23 – The Chief Executive provided confirmation on Endoscopy wait list figures in the private meeting on the 1st March. The Chief Exec noted one section of the report didn't include added surveillance figures. NED MT noted this was also the case in the 29 March report.	
42-23	**Cycle of Business** The Board received and noted the cycle of business	
	Reports and Action Plans	**Action Lead**
43-23	**Chair's Report to the Board** The Chair informed the Board she had met with senior representatives from NHS England regarding the Liverpool Clinical Services Review. The meeting was positive and they were keen for Trusts to move ahead with the agenda. The first joint committee meeting with Liverpool University Hospitals NHS FT (LUHFT) took place on 15 March. The Committee discussed its terms of reference, developing the current collaborative work plan and will look at reporting to each Trust's Board. The Committee were pleased to see there were already joint work streams in place. The Chair noted she had showed the Chair of Liverpool Women's Hospital around the CCC-Liverpool hospital. She also met the new Interim Chair at LUHFT who is keen to come round soon. The Chair attended a Cheshire and Merseyside Acute and Specialist Trust (CMAST) Chairs' meeting where updates were provided on the work plans. Two Consultants have been appointed in the breast service and a Nominations Committee took place in month looking at the terms of reference and NED appraisals. The Board **noted** the updates.	
44-23	**Patient Story** The Chief Nurse introduced the patient story report which detailed the actions to be taken following the story of a sarcoma patient. The Board had received a video of the story prior to the meeting. The Chief Nurse noted the feedback was very positive with a few areas for action.	

	There are improvements to be made around patients feeling isolated, which is difficult with the single room model. The volunteers will be introducing a buddy system and the team are creating a job description for a volunteer dining companion. The team also aim to use shared spaces in wards for patients to eat together. This ties in with the biosecurity work, the infection prevention and control team are working with other cancer centres to ensure guidance is the same across the board. From Monday 3rd April 2023, staff, patients and visitors will no longer be required to wear masks within The Clatterbridge Cancer Centre. With regards to action 3 around temperature control, the team are doing a piece of work, which will report through Acute Division Board. NED AR queried if temperature control was linked to drafts around doors and windows. The Director of Strategy noted it is more likely linked to the way the air circulates in the room. The Board noted the positive testimony to services and discussed potential action around information on nursing roles. The Medical Director suggested the Trust promote the huge skill mix in the nursing staff. The Board discussed putting biographies on the website, staff pictures on the Wards, and videos of 'who you might see at CCC'. The Chief Nurse noted that at the year-end, the team will do a close down report from actions from all 2022/23 patient stories which will go to the Patient Experience and Inclusion Committee. All patients will be sent a thank you card and going forward this will be done straight after their story is received. An example of the card was shared around the Board room. The Chair noted that the feedback from the patient stories is consistent with that from the NED and Governor Engagement Walk-rounds. The Board **noted** the report.	
45-23	**Integrated Performance Report** The Chief Operating Officer introduced the Month 11 Integrated Performance Report and each Executive Lead briefed on highlights in the SPC Charts and exception reporting for the following areas: Access, Efficiency, Quality, Research & Innovation and Workforce. <u>Access and efficiency</u> The Chief Nurse noted that the report had been reviewed at Quality Committee in detail the week before and highlighted the following: There were two avoidable breaches by 3-4 days due to pressure with capacity and out patients. The importance of mitigating challenges from industrial action and bank holidays was noted. There was a fall in compliance in month for turnaround for inpatient imaging. The team have done a deep dive and this is now resolved. This was due to a combination of annual leave, unexpected sickness and training regarding marking cases as urgent. NED MT noted that pg 6 of the report refers to category 1 patients always starting treatment on a Monday and queried why this is and if this was being reviewed. The Medical Director noted that the Category 1 patients is not a simple departmental change but a Royal College set standard.	

	ACTION: The Chief Operating Officer to provide further detail on Category 1 patients starting treatment on a Monday and if this is being reviewed.	JSp
	NED MT noted the reference to the CT machine breakdown on pg 16 and that it was out of action for a week. He queried if this was common and why it occurs.	
	ACTION: The Chief Operating Officer to provide an update on how often the CT machine breaks down and the impact of this.	JSp
	NED AY, queried on pg 5 of the report, CW07 31 Day subsequent chemotherapy, the narrative states that the nature of variation indicates that achievement of the target is likely to be inconsistent, however the figures have been green for 12 months. CW08 31 day subsequent Radiotherapy states the target is outside SPC limits and is therefore likely to be achieved consistently. AY queried this.	
	ACTION: Chief Nurse and Chief Information Officer to provide clarification to the Board on the narrative for the SPC charts for CW07 and CW08.	JG / SB
	<u>Quality</u> The Chief Nurse noted there was an Information Commissioner's Office (ICO) breach marked as red on the report. The case was investigated and it was agreed there was no breach. How this is reported in the IPR needs to be reviewed. The Interim Associate Director of Corporate Governance noted that ICO reporting is included in the annual governance statement and this red reporting could give a misleading position. It was suggested the wording from the Annual Governance Statement could be included in the report.	
	A review process is underway on policy management, to ensure policies are required, up to date and assigned to a committee or group rather than an individual person.	
	NED MT noted this work ties in with CQC preparedness and queried when it would be completed. The Chief Nurse noted there was a lot of work to do on assigning policies to committees and streamlining those in place. The assigning is aimed for completion at the end of May. The Information Governance Manager is working with divisions to see what support they need for streamlining.	
	NED AR asked how many FOI requests (Freedom of Information) are submitted by patients. The Director of Finance noted that the team wouldn't necessarily know as there is anonymity	
	ACTION: Director of Finance to determine if it is possible to find out how many FOIs are submitted by patients.	JT
	<u>R&I</u> The Medical Director noted that recruitment levels had been achieved in month. The majority of studies currently in set-up are complex, supporting the BRC and ECMC strands of the research portfolio.	
	<u>Workforce</u> The Director of Workforce and Organisational Development (WOD) highlighted that sickness absence was the same as last month, above target with the 3 usual reasons.	

	There is manager training underway for assurance on policy procedures for short-term sickness absence recording. This will be monitored through Workforce Advisory Group and People Committee. Staff turnover was discussed, and it was noted an increase has been seen across Cheshire and Merseyside, a focus on exit interviews is underway to support staff retention. The People Committee will monitor deep dives into themes and trends. The Director of WOD noted the need to look into the high sickness absence due to gastro illness. The Board **noted** and **approved** the Integrated Performance Report	
46-23	**Finance Report** The Director of Finance presented the finance report, which detailed the Trust's financial performance for February 2023. The Director of Finance highlighted the following: • The team are closing the final position, the Trust submitted a plan to NHSE/I showing a £1.621m surplus for 2022/23 • With regards to recruitment the variance from actual to establishment is reducing • The reclassification of bank and agency spend has caused a spike in agency reporting • The Trust closed the CIP programme after hitting the target for the year. However, £2.3m was met non recurrently. • Capital committee are confident the Trust will hit the spend target; high value items are being worked through at the moment. NED MT noted section 5.1 of the report regarding £9m from NHSE for ERF>104% performance and the £5.5m repay to the ICB. NED MT requested this be discussed at the Audit Committee on 31 March to understand it from an audit perspective. The Board discussed the position and the Director of Finance confirmed the Trust would spend the £200k extra capital this year. The position doesn't include any backdated pay award, the assumption is that this would be covered nationally. There is still uncertainty around what this will look like. The Trust have included 2% which is the current guidance for planning next year. The Board **noted** the finance report.	
47-23	**2023/24 Operational and Financial Planning** The Director of Finance presented an update on the 2023/24 Operational and Financial Planning, providing detail on: 1. Cancer Planning Context – Cancer Alliance 2. Planning Timeline 3. Activity 4. Workforce 5. Finance 6. Next steps The Director of Finance noted that NHS England will make an assessment of all Trust and ICB plans following submission by 31st March. It is expected that if a Trust, or ICB, plan does not meet NHSE requirements the planning process will continue until plans	

	are able to be approved. If the Trust plan needed to be revised there could be a need for an extra-ordinary Board meeting in April. The Board **noted** the update.	
48-23	**Gender Pay Gap** The Director of WOD introduced the report, which provides details of the Trust's gender pay gap in line with the statutory requirements. The report was prepared by the Head of Equality Diversity and Inclusion who started in January. The Director of WOD highlighted the following: • The Head of EDI is keen to understand the data in more detail and to understand differences to inform next steps. • The Trust will look at benchmarking data (although it is always a bit out of date) to learn from organisations that do better. • The Head of EDI works across Alderhey and CCC and a collaborative approach can be taken as plans develop forward. • A six monthly update report will go to People Committee demonstrating the work done. NED EA queried the reporting format noting the importance of reporting against all protected characteristics. The reports for the workforce race equality standard and the workforce disability equality standard are on the cycle of business for later in the year and EA queried having consistent joined up reporting. The Director of WOD noted the Trust are required to report on each area in isolation. NED EA suggested that there should be consistency of approach, for example a pay gap report on race, disability. EA noted that the report doesn't show what the Trust has done in year. The Director of WOD agreed to look into this. The Board discussed the report and highlighted the following • The importance of understanding comparative gender pay gap differences in each band • The significant difference in bonus pay • The importance of understanding the impact of ethnicity within the gender pay gap. • Triangulating this information with Trust performance, looking at the impact this has on other areas; turnover, sickness absence, vacancy etc. The Director of WOD noted that the March People Committee meeting was rescheduled to April due to industrial action and the report will go there on the 18 April. She agreed to tweak the report following the Board feedback prior to People Committee. NED AR noted the equality impact assessment on the report should show impact on other areas not just gender and noted work was needed on ensuring EIA's are complete. The Board **noted** the mandatory reporting to be open and transparent about gaps. The Board **agreed** for the report to be approved at People Committee prior to publication following amendments from the discussion.	
49-23	**Staff Survey Results** The Director of WOD introduced the staff survey results published on 9 March 2023 and highlighted the following:	

	• The increase to a 65% response rate which was above the 52% average. Thanks were given to staff for completing the survey and the results were published at a 'CCC live' event and shared with divisions. • Section 3.3 shows scores increased in 6/9 themes and 3 stayed same • Sections 4, 5, 6 show performance against the sector (Acute and Specialist Trust) • In previous years the Board asked for additional detail on divisional performance, this has been included in the report • The next steps are to agree areas for action and hold listening events like last year. • Progress will be monitored through Performance Review Groups and Workforce Advisory Group. NED AY noted the scores against appraisals and queried if this was due to them not happening or not going the way staff want. The Director of WOD confirmed they are happening but the quality of conversations is not always the way it should be. The team are looking at updating the PADR process, making it less repetitive and more intuitive. There is a concern that in pushing compliance, the quality of conversations could be compromised. NED EA queried if the stats were broken down via site. It was confirmed that stats are broken down by Division and Staff group and themes in each looked at. The Director of WOD was unsure is stats could be broken down by site and will look into it. The Director of Finance noted that the listening events give the opportunity for site specific feedback. The Chair noted the positive results and thanked the team for their work. The Board **noted** the staff survey results	
50-23	**NED and Governor Walkround** The Chair introduced the report as the Non-Executive Director representative on the February walk-round on Chemotherapy Treatment Unit and the Clinical Trials Unit both on floor 6, CCC Liverpool. The Chair informed the Board that this was a very positive visit with great feedback from patients and staff. The clinical trials unit staff were very passionate about their mission and were keen for more space. The Chair noted it was great to hear from staff in both areas how they have been supported by CCC to develop their careers. One member of staff joined as admin support, and then worked as a HCA and now a qualified nurse. The Board **noted** the positive report.	
51-23	**Guardian of Safe Working Report Q3** The Medical Director introduced the report containing details of exception reports, rotas, staffing and vacancies across the junior doctors. There were 4 exception reports all related to hours worked beyond contracted hours. All doctors received time off in lieu or payment and were responded to in 7 days. The Medical Director noted that haematology doctors in training come under The Clatterbridge Cancer Centre NHS Trust when on placement at the Trust. In the period of the report, Haematology trainees/junior doctors made 11 exception reports on the Royal Liverpool exception report system. The reports were done due to regional service demands within haematology and not directly caused by CCC acuity. The Medical	

	Director confirmed she was assured that these exceptions were not impacted by work related to CCC. The Board discussed the impact of additional training positions on safe working reporting. The Board **noted** the report.	
52-23	**NED Independence & Board Register of Interests** The Interim Associate Director of Corporate Governance introduced the report aimed to facilitate a decision by the Board of Directors relating to the independence of Non-Executive Directors. Each of the NEDs completed a declaration confirming if they meet the independence criteria. Since the report was distributed, NED AR has completed a declaration and doesn't meet any of the criteria. With the exception of NED TJ (due to his role in at Liverpool University and LUHFT) all NEDs declared independence. The Board **endorsed** this position to include in the annual report. The IADoCG noted since the distribution of the report, NED AY submitted an updated declaration of interest advising his role as Transformation Director is no longer applicable. The Chief Executive submitted an additional hospitality declaration for attendance at the HSJ Partnership Awards. The Corporate Governance Manager noted she had been informed that the following Executive Directors have roles in the private practice joint venture which will be declared following the meeting: Sheena Khanduri, Julie Gray and Joan Spencer. The Board **confirmed** a positive conclusion on the independence of the Chair and the other Non-Executive Directors. The Board **confirmed** that the content of the register of interests are accurate and up to date subject to the addition of the PPJV declarations.	
	System Working	
53-23	**Cheshire and Merseyside Cancer Alliance Performance Report** The Chief Executive presented the Cheshire and Merseyside Cancer Alliance (CMCA) Performance Report and noted this was the last of this kind of report. The Chief Executive highlighted the following: • Treatments remain high, as does endoscopy activity but the standard faster diagnostic figures have been slipping over a number of months - more information has been requested on performance by tumour type and provider. • A focused piece of work will be done to bring together the diagnostic team and CMCA to see if more can be done for GI and Urology. • Going forward the CMCA will report to Board quarterly. The team have been asked to develop SPC charts so the Board can see statistical trends and get into the detail. Reporting on transformation programmes will also be included • The new report will be sent out to all provider Boards and PLACE directors to report to their Boards. • There is a 6 week lag on the information for the report. This means that the Q1 report would not be ready until August. As the Board doesn't meet then, this would come to Board in September.	

The Clatterbridge Cancer Centre NHS Foundation Trust

	ACTION: The Chief Executive and Chair to agree CMCA reporting for July/September The Chief Executive confirmed that the report will be transparent showing outliers and trends. CMCA also report to the Provider Collaborative, ICB and Nationally. The Board **noted** the report and agreed the amended reporting frequency going forwards.	LB
	Any Other Business	
54-23	There was no additional business	
	Date and time of next meeting: 26th April 2023, 09:30	

						4-23-24
TRUST BOARD ACTION LOG PART 1						
KEY: BLUE = COMPLETE / GREEN = ON TRACK / AMBER = AT RISK / RED = LATE						
Item No.	**Date of Meeting**	**Item**	**Action(s)**	**Action by**	**Date to complete by**	**Date Completed / update**
P1-160-22	28-Sep-22	Formal Review of the Board Committee Governance Structure	The Board agreed to continue on this Committee governance model and review again in 6 months	**JG**	Mar-23	Included on cycle of business Deferred - Awaiting new ADoCG starting
P1-013-23	26-Jan-23	Integrated Perfromance Review	The Medical Director to take data on VTE incidents to Quality Committee	**SK**	Mar-23	Added to Quality Committee Cycle of Business for March 23 Deferred until June 23
P1-045-23	29-Mar-23	Integrated Performance Report	The Chief Operating Officer to provide further detail on Category 1 patients starting treatment on a Monday and if this is being reviewed	**JSp**	Apr-23	Verbal update to be given 26 April
P1-045-23	29-Mar-23	Integrated Performance Report	The Chief Operating Officer to provide an update on how often the CT machine breaks down and the impact of this	**JSp**	Apr-23	Verbal update to be given 26 April
P1-045-23	29-Mar-23	Integrated Performance Report	Chief Nurse and Chief Information Officer to provide clarification to the Board on the narrative for the SPC charts for CW07 and CW08	**JG / SB**	Apr-23	Verbal update to be given 26 April
P1-045-23	29-Mar-23	Integrated Performance Report	Director of Finance to determine if it is possible to find out how many FOIs are submitted by patients	**JT**	Apr-23	Verbal update to be given 26 April
P1-053-23	29-Mar-23	Cheshire and Merseyside Cancer Alliance Performance Report	The Chief Executive and Chair to agree CMCA reporting for July/September	**LB**	Apr-23	Verbal update to be given 26 April

Trust Board Annual Work Plan 2023/24																
Item	**Lead**	**Frequency**	**Item For**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**2024**	**Jan-24**	**Feb-24**	**Mar-24**
Standard Items																
Welcome, Introductions, Apologies and Quoracy	Chair	Monthly	Standard Business	√	√	√	√		√	√	√			√	√	√
Declarations of Interest	Chair	Monthly	Standard Business	√	√	√	√		√	√	√			√	√	√
Matters Arising / Action Log	Chair	Monthly	Standard Business	√	√	√	√		√	√	√			√	√	√
Cycle of Business	Chair	Monthly	Standard Business	√	√	√	√		√	√	√			√	√	√
Strategy & Planning																
Progress against 5 Year Strategy	Director of Strategy	6 monthly	For information/noting		√						√					
Annual Financial/Operational Planning Guidance	Director of Finance	Q3 and Q4	For information/noting							√				√	√ Draft	√ Submission
Progress against Innovation Strategy (Inc. Bright Ideas) Annual Report	Medical Director	Annually	For information/noting											√		
Progress against Research Strategy Annual Report	Medical Director	Annually	For information/noting							√						
Progress against Green Plan Annual Report	Director of Strategy	Annually	For information/noting												√	
Digital Strategy	Chief Information Officer	Annually	For Approval	√												
Quality Strategy	Chief Nurse	Annually -tbc	For Approval													
Risk Management Strategy	Chief Nurse	Annually	For Approval	√												
Assurance: Quality, Performance																
Patient Story	Chief Nurse	Every other meeting	For information/noting		√		√			√				√		√
Staff Story	Director of WOD	Every other meeting	For information/noting	√		√			√		√				√	
Quality Committee Chair Report	NED TJ	Quarterly	For information/noting	√			√			√				√		√ Inc. ToR
Performance Committee Chair Report	NED GB	Quarterly	For information/noting		√				√		√				√ Inc. ToR	
Audit Committee Chair Report	NED MT	6 times a year	For information/noting	√	√	√	√			√				√ Inc. ToR		
Charitable Funds Committee Chair Report	NED EA	adhoc	For information/noting	√	√ (deferred to May 23)											
People Committee Chairs report	NED AR	Quarterly	For information/noting	√ (inc ToR - deferred from Mar 23)		√				√				√		√ Inc. ToR
Integrated Performance Report	Exec Leads	Monthly	For discussion For approval	√	√	√	√		√	√	√			√	√	√
Finance Report	Director of Finance	Monthly	For information/noting	√	√	√	√		√	√	√			√	√	√
Safer Staffing Report	Chief Nurse	6 monthly	For approval			√								√		
Gender Pay Gap	Director of WOD	Annually	For discussion For approval													√
Workforce Race Equality Standard Data	Director of WOD	Annually	For information/noting							√						
Workforce Disability Equality Standard Data	Director of WOD	Annually	For information/noting							√						
Equality Diversity & Inclusion Annual Report	Director of WOD	Annually	For approval				√									
In-Patient Survey	Chief Nurse	Annually	For information/noting				√									
NED and Governor Engagement Walk round	NED attended	Monthly	For information/noting	√	√	√	√		√	√	√			√	√	√
Actions from NED and Governor Engagement Walk-rounds Annual Report	Chief Nurse	Annually	For information/noting	√												
New Consultant Appointments	Medical Director	Adhoc	For information/noting	√	√	√	√		√	√	√			√	√	√
Caldicott Guardian Annual Report	Medical Director	Annually	For approval						√							
Staff Survey Results	Director of Workforce	Annually	For information/noting													√
Statutory Reporting/Compliance																
Annual Report & Accounts including the Annual Governance Statement	Associate Director of Corporate Governance	Annually	For approval			√- extra ordinary										
External Audit Findings Report and Letter of Representation	Associate Director of Corporate Governance	Annually	For information/noting			√ extra ordinary										
Self-Certification against the Provider Licence	Associate Director of Corporate Governance	Annually	For approval		√											
Regulation 5 Declarations (Fit and Proper)	Associate Director of Corporate Governance	Annually	For approval				√									
Emergency Preparedness Resilience and Response (EPRR) Annual Report and core standards	Chief Operating Officer	Annually	For approval						√							
Mortality Report (Learning from Deaths)	Medical Director	Quarterly	For information/noting	√			√				√			√		
Mortality Annual report	Medical Director	Annually	For approval				√									
Revalidation Annual Report	Medical Director	Annually	For approval						√							
Guardian of Safe Working Report (quarterly)	Medical Director	Quarterly	For information/noting			√			√		√					√
Guardian of safe working annual report	Medical Director	Annually	For approval			√										
Infection Prevention and Control Annual Report	Chief Nurse	Annually	For approval				√									
Freedom to Speak Up Annual Report	Associate Director of Corporate Governance	Annually	For approval				√									
Health and Safety Annual Report	Chief Operating Officer	Annually	For approval						√							
Safeguarding Annual report	Chief Nurse	Annually	For approval						√							
Collaboration																
CMCA Report	Chief Executive		For information/noting				3 month report		Q1		Q2				Q3	
Joint Committee - LUHFT and CCC Chair's Report	Chair	(tbc)	For information/noting		√											
Board Governance																
Review of Constitution (ADHOC)	Associate Director of Corporate Governance	adhoc	For discussion For information/noting For approval													
Board Assurance Framework	Associate Director of Corporate Governance	Quarterly	For information/noting For approval	√			√			√				√		
BAF Refresh	Associate Director of Corporate Governance	Annually	For approval	√												
Audit Committee Annual Report	Associate Director of Corporate Governance	Annually	For discussion For information/noting				√									
Annual Review of Board Effectiveness	Associate Director of Corporate Governance	Annually	For discussion For approval		√											
Trust Board Annual Reporting Cycle 2024/25	Associate Director of Corporate Governance	Annually	For discussion For approval													√
NED independence & Board register of interest	Associate Director of Corporate Governance	Annually	For information/noting													√
Use of Trust Seal Report	Associate Director of Corporate Governance	Annually	For information/noting	√												
Adhoc / Committee Requested																
Formal Review of the Board Committee Governance Structure	Associate Director of Corporate Governance	Adhoc	For discussion				√ (deferred from March 22)									√
Freedom to Speak Up Reflections and Planning Tool	Associate Director of Corporate Governance	One-off	For information/noting			√										
Freedom to Speak Up Policy	Associate Director of Corporate Governance	One-off	For information/noting			√										

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Board of Directors
Date of meeting: 26 April 2023

Report lead	Liz Bishop, Chief Executive				
Paper prepared by	Skye Thomson, Corporate Governance Manager Updates to strategic risks provided by the Executive Risk Leads				
Report subject/title	Board Assurance Framework (BAF) updates				
Purpose of paper	To provide an update on the sections of the BAF under direct oversight of the Board (strategic risks BAF4 and BAF6)				
Background papers	Q3 BAF report presented to January Board of Directors; BAF update reports to Performance Committee (February), Quality Committee (March), People Committee (April) and Audit Committee (April)				
Action required	Confirm level of assurance provided about key controls for BAF4 and BAF6. Note the current risk exposure across the set of strategic risks (Appendix 1).				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work		
	Be Collaborative	x	Be Digital		
	Be Research Leaders		Be Innovative		

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

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

The Clatterbridge Cancer Centre NHS Foundation Trust

1.0 Introduction

1.1 This report provides key updates about the Trust's strategic risks. It includes key highlights about strategic risks under direct oversight of the Board: BAF4 and BAF6 relating to Board governance and system working. A one-page summary of risk levels aligned to the Trust's strategic priorities is provided in Appendix 1, and the full BAF detailing risks, controls, assurances and actions is provided in Appendix 2 for reference.

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

- BAF2, 3, 5, 8 and 15 reviewed by the Performance Committee 15 February;
- BAF9, 10, 11 and 12 reviewed by the People Committee 18 April;
- BAF1, 7 and 13 reviewed by the Quality Committee 23 March;
- BAF14 reviewed by the Audit Committee 19 April.

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

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

2.0 Key highlights

2.1 Highlights from committees

2.1.1 Performance Committee

The Committee reviewed the BAF risks aligned to Performance Committee and approved the requested revised scores for BAF 8 from (3 x 4) 12 to (2 x 4) 8 and BAF 15 from (4 x 3) 12 to (3 x 3) 9. The Committee challenged the difference between BAF 2 – Demand Exceeds Resource scoring 12 and BAF 3 – Insufficient Funding scoring 16. It was noted that the BAF 2 score may increase, however for 2022/23 the Trust has managed capacity and demand well.

2.1.2 People Committee

The Committee reviewed the BAF risks aligned to People Committee and noted the requested revised scores for BAF 9 from (3 x 4) 12 to (3 x 3) 9 and BAF 11 from (4 x 4) 16 to (3 x 4) 12. The Committee discussed both decreases and did not approve the decrease for BAF 9 from 12 to 9, this was due to many of the actions still requiring time to be embedded. BAF 11 will remain at a score of (4 x 4) 16. The Committee approved the reduction of BAF 9 but noted that whilst a range of courses had been set up, the Committee didn't have figures on attendance and impact, this will be built into annual reports going forward.

2.1.3 Quality Committee

The Clatterbridge Cancer Centre NHS Foundation Trust

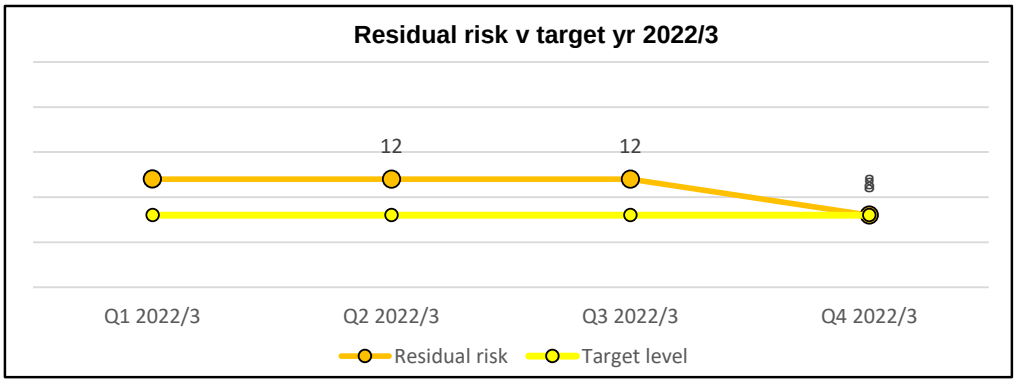
The Committee reviewed the BAF risks aligned to Quality Committee and approved the BAF 13 requested revised score from (3 x 4) 12 to a (3 x 3) 9. The Committee noted BAF 1 and BAF 7 had remained static and were keen to meet to look at these issues. The risk appetite for BAF 1 is low and the Committee noted there are deadlines for the end of March 2023 with actions in place but it will take time to bring the risk down. The Committee were satisfied with the direction of travel.

2.1.4 Audit Committee

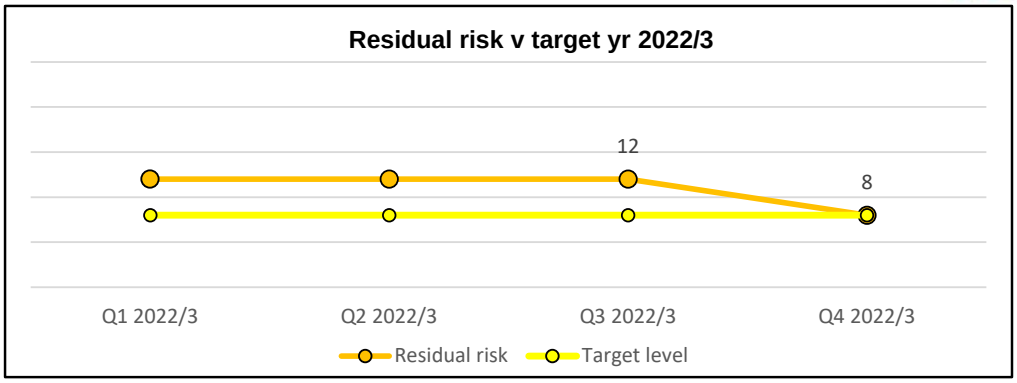
The Committee reviewed BAF entry 14 Cyber Security and noted that the residual risk score remains at 12, which is the target score to be achieved by 31 March 2023. The Committee also noted that the residual risk score was not likely to reduce further given the changing nature of cyber threats.

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

Summary table: BAF4 Board Governance				
Risk appetite: low				
Risk title	**Residual risk**	**Assurance ratings**	**Actions**	**Target 31/03/23**
There is a risk that **corporate and clinical governance arrangements** do not provide comprehensive **Board oversight and assurance**, leading to inadequate visibility of critical issues and failure to meet regulatory expectations **Executive Risk Lead**: Liz Bishop Chief Executive **Last Updated:** 5 April 2023	**8** ⬇	**ACCEPTABLE** 5 controls (1 increased in Q4) **PARTIAL** 2 controls	Completed Q4 -Cover for Governance gaps - Review CCC corporate governance Revised Due Date -Audit improvement plan and risk management strategy review (Now 31/04/23) --Development of Quality Improvement Strategy (Now 30/09/23) New Action - Close gaps identifies from the code of governance review	**8**
Commentary Good progress has been made in terms of streamlining corporate governance processes and an assessment of compliance against the new Code of Governance for NHS Provider Trusts, which comes into effect from 1 April 2023, has been completed by the Interim Associate Director of Corporate Governance (ADoCG) with outcomes forming the basis of an action plan to address any gaps in compliance. There is further work to be undertaken on the development of the Quality Strategy in 2022-23 but there has been significant improvement in the management of clinical risk. The Risk Management Strategy has progressed and due to be approved by the Board in April 2023. A substantive Associate Director of Corporate Governance is in place and she will lead the review of compliance against the Code of Governance which will be monitored through Audit Committee. Since the last report the residual risk score has decreased from (3 x 4) 12 to (2 x 4) 8.				



Summary table: BAF6 ICS				
Risk appetite: moderate				
Risk title	**Residual risk**	**Assurance ratings**	**Actions**	**Target 31/03/23**
There is a risk that the Trust fails to achieve sufficient **strategic influence within the ICS** to maximise collaboration around cancer prevention, early diagnosis, care and treatment **Executive Risk Lead**: Liz Bishop Chief Executive **Last Updated:** 5 April 2023	**8** ⬇	ACCEPTABLE 4 controls PARTIAL 1 control	Completed Q4 -Complete CMCA business plans for 2023-24 -Development of diagnostic business plans Revised Due Date -Risk sharing agreement with ICB (Now July 2023)	**8**
Commentary This risk is largely mitigated through the CCC hosting of the Cheshire & Merseyside Cancer Alliance, to enable CCC to influence prevention, early diagnosis and cancer surgery. The leadership role and hosting of the Cheshire & Merseyside Diagnostics Programme on behalf of the ICB, gives greater influence over cancer diagnostics. Work has been to broaden executive directors' stakeholder engagement, and raise the profile of CCC's brand and senior leaders. Since the last report the residual risk score has decreased from (3 x 4) 12 to (2 x 4) 8.				



3.0 Recommendations

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

Appendix 1: Strategic risk heatmap showing initial, residual and target risk scores Q4 2022-23

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

Key

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

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

BAF1. Quality governance systems

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

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23
BAF1 There is a risk that **quality governance systems fail to drive improvements in patient safety and experience and the effectiveness of care**, which would negatively affect the CQC's assessment of the Trust's services **Executive Risk Lead:** Julie Gray, Chief Nurse **Board Committee**: Quality **Last Update:** 13 March 2023	**Causes** 1. Insufficient and ineffective clinical governance processes 2. Failure to learn from patient feedback 3. Exceeding thresholds for harm free care indicators (falls, pressure ulcers, health care associated infections (HCAIs)) 4. Lack of coherent and sustained focus on Quality 5. National Patient Safety new ways of working 6. Nosocomial outbreaks 7. Increased patient dependency and acuity **Consequences** 1. Increased levels of patient harm 2. Negative impact on patient experience 3. Quality standards not met 4. Poorer outcomes for patients 5. Lower CQC rating 6. Reputational damage	5 x 5 = 25	C1) Risk Management Strategy 2022. Incident reporting and investigation policies. Dedicated Clinical Governance and Safety Team. **Control Owner**: Chief Nurse	Risk management strategy annual update report - Quality Committee and Board Annual Clinical Audit Report, reviewed by Quality Committee.	Audited Quality Account, reviewed by Quality Committee, June 22 MIAA audits of key systems: Risk Management, Substantial Assurance March 22; Incident reporting, Limited Assurance April 22; Claims, Substantial Assurance, 2021/22	Partial	3 x 5 = 15	No	G1) Requirement for further development of clinical audit programme. Patient Safety Strategy Framework (PSIRF) workstream MIAA recommendations for incident reporting and risk management process.	1. Develop the clinical audit programme and align to clinical governance structures and processes 2. MIAA audit improvement plan 3. Review risk management strategy **Action Owner**: Chief Nurse **Due date**: 31/03/23	Strategy workshops completed in Q4.2023-26 Risk Management Strategy to be approved at Board April. Participation in regional PSIRF collaborative.	2 x 5 = 10
			C2) Patient Experience & Inclusion Strategy. Established Patient Experience & Inclusion Committee and dedicated Head of Patient Experience Role. Action plans developed and monitored from national surveys. Complaints and PALs procedures in place. **Control Owner**: Chief Nurse	Patient Experience and Inclusion Annual Report to Quality Committee. Complaints, PALS & Claims reports, reviewed by Risk & Quality Governance Committee monthly and quarterly by Quality Committee.	National Cancer Patient Experience Survey results, reviewed by Quality Committee, September 22 showed Trust in top decile. MIAA Sustantial Assurance for Patient Experience, 2020/21 MIAA Moderate Assurance for Complaints March 2022.	Partial			G2) Number of complaints and PALs contacts exceeds tolerance level	1. Review and restructure of complaints process 2. Quarterly (Aggregated) Patient Safety and Experience Report **Action Owner**: Chief Nurse **Due date**: 31/03/23	Complaints process review led by Associate Chief Nurse diuscssed at Quality Committee Q4. Quarter 3 - Patient Safety & Experience Report published.	
			C3) All falls, Pressure Ulcers and HCAIs are reviewed via Harm Free Care group. Call don't fall initiative & falling leaf symbol in place. Ramble guard TAB system in place. Waterlow system for assessment of risk used. NHSI criteria for assessment & expectations around pressure ulcers internal review undertaken. Maintain low rates of catheter associated UTIs and maintain 95%+ VTE assessments. **Control Owner**: Chief Nurse	Harms Free Care Committee Data reported to Board of Directors via Integrated Performance and Quality Report	Model Hospital Data	Partial			G3) Training data, appropriateness of Waterlow Risk assessment for Oncology patients. Risk of a single room facility not adequately understood. No tangible impact for learning for improvement evident from Harms Free Care Group	Collaborative improvement projects for Falls reduction and Pressure Ulcers. Identify/gather 12 months of baseline data in order to set improvement targets. Reveiw effectiveness of Harms Free Care Group **Action Owner**: Chief Nurse **Due date**: 31/03/23	Pressure Ulcer Collaborative supported by AQuA commenced 7/09/22 Falls/Manual Handling Lead commenced in post, scoping requirements and updating policy. Wholesale review of harm free care process during Q4.	
			C4) Investment - Access to AQuA Expertise in PMO. Data expertise in BI/Digital/CNIO 'Bright Ideas' and Innovation Centre to capture areas for improvement. Dedicated Quality Improvement Nurse and investment in Tendable - formerly Perfect Ward **Control Owner**: Chief Nurse	Integrated performance and quality report. Bright Ideas report to Board of Directors.	Care Quality Commission (CQC) rating. Specialist commissioners oversight. Good Governance Institute Review 2022.	Partial			G4) Lack of up to date Quality Strategy. No clear system to demonstrate and celebrate quality improvement activity	Trustwide engagement and development of a Quality Improvement Strategy, including agreed prefered methodology and improvement programme **Action Owner**: Chief Nurse **Due date**: 31/03/23	Early scoping underway. Tendable functionality and efficiency options appraisal underway.	
			C5) Dedicated role - Associate Director of Clinical Governance and Patient Safety. Patient Safety champions. Newly established Executive Review Group and Patient Safety Committee with Consutant leadership. Learning from incidents internal wepage. Incident investigation training in line with the Patient Safety Syllabus published May 2021 **Control Owner**: Chief Nurse	Improvement actions from incident investigations report to Risk and Quality Governance committee monthly. Quarterly patient safety and experience report to Quality Committee	MIAA Quality spot checks to start Q2 and updates provided to Quality Committee	Low			G5) Patient Safety Strategy due a refresh. Newly introduced and not yet embeded incident reporting system. Limited accurate safety data to inform trends and targeted improvements. Variable levels of demonstrable risk and patient safety knowledge across the Trust	Undertake trust-wide safety culture survey and associated action plans. Foster clinical leadership in patient safety initiatives. **Action Owner**: Chief Nurse **Due date**:31/03/23	New Associate Director of Clinical Governance and Patient Safety post commenced in post November 22. Patient Safety Committee refreshed - Consultant chair appointed. Patient Safety Incident Response Framework (PSIRF) initial implementation plan drafted, participation in regional PSIRF collaborative and benchmarking to commence with The Royal Marsden Hospital and The Christie.	
			C6) Single room occupancy so all patients are isolated. Antimicrobial prescribing policy and lead pharmacist. Post infection review (PIR) undertaken for each known case. **Control Owner:** Chief Nurse	Established IPC Team Weekly data reported via Silver Command meeting Monthly IPC Committee Established PIR process in place with expert microbiology/virology support Antimicrobial pharmacist	Quality Accounts. ICNet benchmarking data. Monthly C&M and NW nosocomial benchmarking report with oversight from regional IPC team. Collaboration/peer scrutiny with other specialist oncology centres	Acceptable			G6) Monthly scrutiny panel with specialist commissioner input	Establish monthly Nosocomial Infection Performance Review meeting **Action Owner**: Chief Nurse **Due date**: 31/03/23 (revised from 30/09/22)	IPC strategy day Q1 203/24.	
			C7) Twice daily patient flow meetings. Utilisation of the safer Nursing Care assessment Tool. Bi-annual Safer Staffing Report to Board of Directors. Visible leadership at ward level from Matrons. **Control Owner**: Chief Nurse	Patient Flow Report Bi-annual safer staffing report to Quality Committee and Board		Acceptable (Improved from partial)			G7) Variable levels of demonstrable patient accuity assessment knowledge across the Trust	Targeted training for inpatient service staff on the use of safer nursing care tool **Action Owner**: Chief Nurse **Due date**: 31/03/23	Data collection tool refined and data validation completed. Task & finish group estabilised to optimise use of digital solution.	

Additional narrative

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

BAF2. Demand exceeds resources

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

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF2 There is a risk of **demand exceeding available resources**, that could impact the quality and safety of services and patient outcomes **Executive Risk Lead:** Joan Spencer, Chief Operating Officer **Board Committee:** Performance **Last Update:** 2 February 2023	**Causes** 1. Changing patterns of demand 2. Workforce gaps 3. Covid threat alters the operating environment indefinitely 4. Waiting list backlogs at referring Trusts 5. Population health needs change due to long-term effects of Covid **Consequences** 1. Ineffective restoration of services 2. Detrimental impact on patient care and experience 3. Poorer outcomes for patients 4. Regulatory and reputational impact	4 x 5 = 20	C1) Planning process based on Cheshire & Merseyside Cancer Alliance weekly cancer waiting time reports **Control Owner**: COO	C&MCA waiting time report monthly to Board and CCC CWT performance discussed at Trust Board via IPR	MIAA programme includes review of cancer waiting times systems and processes	Acceptable	4 x 3 = 12	No	G1) CCC has no control over the impact of the pandemic on activity flows from referring Trusts	Capacity & Demand monitored daily. Weekly monitoring of CMCA data **Action Owner**: COO **Due date**: 31 March 2023	Currently delivering capacity to meet demand. Weekly monitoring of activity. Late referral data shared with referring trust on a monthly basis	4 x 3 = 12 ⬆
			C2) C&MCA activity plan cascaded to all senior managers to aid planning **Control Owner:** COO	C&MCA waiting time report is a standing agenda item at Trust Operational Group		Acceptable			G2) Referring Trusts may increase their recovery activity without understanding impact on CCC	Request to COOs at referring Trust for updates on planned increases/ changes to recovery plans **Action Owner:** COO **(Complete)**	Ongoing discussions with COOs across C&M via weekly COOs meetings	
			C3) Cancer Waiting Times Dashboard updated daily, CWT team alert senior managers to any issues with flow of referrals **Control Owner:** COO	Oversight & utilisation of escalation processes demonstrated at Divisional Performance Review Groups (PRGs) and reported via COO's report to Performance Committee	C&MCA activity plans monitored by ICS, monthly reporting back to Trusts across C&M via hospital cell	Acceptable			G3) Further waves of increases in Covid incidence may affect workforce and therefore reduce capacity to deliver the Trust recovery plan	Monitor Trust recovery plan via Trust Operational Group. Staff sickness absence monitored via PRGs. Escalation plans for high sickness absence and business continuity plans in place. **Action Owner**: COO **(Complete)**	Trust recovery Plan now monitored via TOG from 1.7.22	
			C4) Recovery and escalation plan to meet NHS System Oversight Framework Metrics **Control Owner**: COO	Progress reported monthly via Finance update at Trust Board and quarterly to Performance Committee. Activity monitored via PRGs.	Trust activity plans monitored by ICS, monthly reporting back to Trust via hospital cell. ERP activity reports indicate CCC is delivering according to plan.	Acceptable			G4) High number of late referrals to CCC due to delays in diagnostic capacity, this is creating challenge to delivery of the 62 day target for C&M	1. Refer to C&M diagnostics delivery plan **Action Owner**: CEO **Due date**: April 2023. 2. CCC to work with referring trusts with highest number of late referrals **Action Owner**: COO **Due date**: April 2023	CCC CEO is the SRO for C&M Diagnostics recovery programme, clear improvement programme in place. Monitored at ICS and via national cancer Team. Diagnostic work completed by C&MCA Oct 2022, CCC Team now engaged with LUHFT to improve most challenged pathways by March 2023.	
			C5) Live dashboard of new referrals & SACT activity available to Divisional Teams **Control Owner**: COO	Divisional Performance Review meetings held monthly and/or quarterly with outcomes reported to Performance Committee	Trust performance and activity against CWTs monitored by CMCA	Acceptable			G5) Referral numbers continue to rise, highest on record in Sept 2022	Site Reference Groups (SRGs) monitoring activity, capacity challenges escalated to managers daily. Additional clinics in place across a number of tumour groups. **Action Owner:** COO **(Complete)**	Daily escalation supporting early intervention	
			C6) Daily & weekly flow monitoring via registrations team and Trust Operational Group **Control Owner**: COO	Reported and monitored via weekly Trust Operational Group (TOG)	MIAA review cancer waiting times	Acceptable			G6) Clinicians not always able to accommodate additional activity	SRGs working as one to offer patients an appointment with alternative clinician who may have capacity within the specialist area. **Action Owner:** COO **(Complete)**	This is now an ongoing action, patients routinely offered an alternative appointment with another clinician whenever possible	
			C7) Flexible Consultant job plans that enable additional Waiting List Initiative clinics to be held at short notice **Control Owner**: COO	Job plans are agreed and signed off by Divisional Teams		Acceptable			G7) Late referrals to CCC make it difficult for CCC to consistently achieve 62 day target	CCC Team now engaged with all referring trusts to improve timeliness of referrals **Action Owner:** COO **Due date:** 31 March 2023	Referral data to be shared at Cheshire and Mersey Cancer Managers Group Nov 2022. Late referral activity data shared with all referring trusts monthly , challenged pathways identified to enable focused mitigation plans	
			C8) Weekly activity monitoring and escalation via Trust Operational Group and PTL meetings **Control Owner**: COO	IPR to Performance Committee quarterly and Board (monthly), Divisional PRGs		Acceptable						
			C9) Allocation of first appointments monitored by registrations team. Lack of capacity escalated to relevant senior manager **Control Owner:** COO	Capacity monitored via weekly TOG		Acceptable						
			C10) WLI clinic can be expanded to meet demand **Control Owner:** COO	Capacity monitored via weekly TOG		Acceptable						
			C11) CCC monitoring internal 24 day target **Control Owner**: COO	Weekly at TOG, monthly IPR to Trust Board and quarterly to Performance Committee, PRGs		Acceptable						
			C12) 62 day target to be performance managed alongside 78ww **Control Owner**: COO	Weekly TOG, Monthly IPR to Trust Board and quarterly to Performance Committee. CCC CEO is SRO for diagnostics for C&M	Weekly Monitoring via C&MCA, ICS & National Cancer Team	Partial						
			C13) Divisional business plans detailing response to increased demand via expansion of the workforce & changes to operational hours across a number of services **Control Owner**: COO	Work programmes to improve service delivery (detailed in Business plans) are reviewed at Trust Transformation and Improvement committee. Divisional BPs to be presented at Trust Performance Committee via a rolling programme.		Acceptable						

Additional narrative

Despite multiple mitigations, the risk score cannot currently be reduced below 12. Uncertainty regarding future waves of the Covid pandemic and the uncertain financial environment maintains the likelihood score as 4, however, there are sufficient controls in place to ensure that the predicted impact would be 'moderate' rather than 'catastrophic' as indicated by the inherent risk level. Further to discussions regarding the likelihood of ongoing financial uncertainty at Performance Committee in August 2022, the target score has been increased from 6 to 12 to reflect this.

BAF3. Insufficient funding												
RISK APPETITE: Financial LOW (4-8)												
STRATEGIC OBJECTIVE:	Be Outstanding											
Risk description & information	**Causes & consequences**	**Initial (inherent) risk score L x C**	**Key controls** *(what is in place to manage the risk?)*	**Board Assurance** **Internal assurance** *What/where reported/when?*	**External assurance** *What/where reported/when?*	**Overall assurance level**	**Residual (current) risk score L x C**	**Within risk tolerance?**	**Gaps in Control / Assurance**	**Actions** **Planned action**	**Progress update**	**Target risk score by 31/03/23 L x C**
BAF3 There is a risk of **available funding being insufficient** to deliver the Trust's strategic priorities **Executive Risk Lead:** James Thomson, Director of Finance **Board Committee**: Performance **Last Update:** 2 February 2023	**Causes** 1. Changes to the commissioning regime and funding process 2. Inability to meet patient demand without further investment 3. Inability to deliver further efficiencies 4. Inflationary pressure 5. Management of the ICB financial position (deficit) might negatively impact funding position or efficiency requirement **Consequences** 1. Re-evaluate cost base and resource levels 2. Review strategic ambitions if additional resource required 3. Increased performance management from NHSE/I and ICB 4. Reduced Trust board risk appetite 5. Reduced ability to invest in capital infrastructure and staff	4 x 5 = 20	C1) Divisional and departmental budget setting process **Control Owner**: DoF	Planning process managed through Finance Committee and reported quarterly to Performance Committee. Budgets approved by lead managers.	External Audit includes assessment of plan though VFM testing (reported to Audit Committee). National Financial Sustainability exercise by MIAA (HFMA checklist) - Q3 22/23.	Acceptable	4 x 4 = 16	No	G1) None identified at this stage.	Start budget setting cycle in Q3 2022/23 - in line with national financial guidance publication. Take complete budget plan to Trust Board by March 2023. **Action Owner**: DoF **Due Date**: 31/03/23	Not applicable at this stage in the financial year. Trust submitted HFMA checklist, which was accepted by MIAA, with no further actions.	2 x 4 = 8 ⬇
			C2) Contract position agreed and managed with commissioners **Control Owner**: DoF	Monthly formal contract meetings with commissioners. Annual planning process, with rebasing exercise.	Commissioner (NHSE/ICB) review of contract performance - quality and commercial. Commissioner 2023/5 contract planning reviews, and ICB planning reviews.	Partial (Changed from Acceptable)			G2) Impact of 23/25 API funding methodology and contracting round to be determined.	Trust reviewing its funding position with regard to 2023/5 NHSE guidance. And will submit 23/24 plan on this basis. **Action Owner:** DoF **Due Date:** 31/3/23	Trust working with ICB and Specialised Commissioning teams to understand and agree contracting mechanisms and funding position. A series of national, system and individual meetings is in place.	
			C3) Efficiency (CIP) and productivity plan in place - with clear cash releasing schemes **Control Owner**: DoF	Performance managed through Finance Committee (total) and Performance Review Groups (PRGs) and reported via Finance Report to Performance Committee and Board. Dedicated finance lead. Process for MD and CNO review.	External Audit includes assessment of plan though VFM testing. Efficiency programme monitored monthly by NHSE/I. National Financial Sustainability exercise by MIAA (HFMA checklist) - Q3	Acceptable			G3) Assurance on recurrent CIP delivery pipeline to be confirmed. Productivity analysis of core services to be complete	1. Escalate CIP non-delivery as required through Performance Committee. **(complete)** 2. Produce productivity analysis for Performance Committee. 3. Deep dive requested by Performance Committee. **(complete)** **Action Owner:** DoF **Due date:** 31/05/23 (revised from 31/03/23)	CIP profiles agreed with operational divisions and departments. Quantum of CIP included in ICB planning. Trust provided Deep Dive report to November Performance Committee. Trust has achieved 100% CIP target, reported to January Trust Board. However, level of recurrent CIP not achieved.	
			C4) Trust Board approved financial plan, and ICB approved target financial position **Control Owner**: DoF	Finance report quarterly to Performance Committee and monthly to Trust Board	Audited accounts annually. Financial performance managed by ICB and NHSE/I. ICB receives governance score through Strategic Outcomes Framework rating.	Acceptable			G4) Impact of system financial position and risk management approach to be established	Trust is developing its financial plan for 2023/5. It is in active discussions with partners in the ICS to identify approach to organisational finance risk for 2023/5. **Action Owner:** DoF **Due date:** 31/12/22	Draft financial principles for the ICS have been shared. Trust likely to agree, and same as 2022/23 period. Trust has submitted draft finance plans that show a level of risk. (06/02/23)	
			C5) Trust included in emerging system financial planning **Control Owner:** DoF	DoF updates through Financial Planning Reports to Performance Committee and Trust Board. Chair and Executives included in ICB peer networks.	ICB receives governance score through Strategic Outcomes Framework rating.	Partial			G5) ICB financial governance and programme structures in development.	Trust participating in finance system governance development - through DoF and senior finance teams interactions with peers. **Action Owner:** DoF **Due date:** 31/03/23	Executives participate in peer ICB networks. Trust working with partners in Liverpool health system to support, following Carnal Farrar report - November 22	
			C6) Trust 5 year capital plan identifies capital and cash requirement **Control Owner:** DoF	Capital plan managed through Capital Committee. Input from divisions and departments.	Audited accounts annually. Financial performance managed by ICB and NHSE/I	Acceptable			G6) Capital decision making governance for C&M ICB not established	Trust to review multi-year capital programme quarterly, and escalate to ICB capital governance system as required. **Action Owner:** DoF **Due date:** 31/03/23	Trust capital plan for 2022/23 agreed with ICB. 5 year capital plan submitted as part of ICB planning exercise. Trust Capital Committee reviewed draft capital plan - 31/01/23.	

Additional narrative

The financial system for 2022/23 is a transition period. This is because of structural change of ICB/system working and establishing financial income flows for the Trust. Key risks include securing sufficient funding through contractual mechanisms, including ERF, and delivering the efficiency programme.
The Target Risk Score has been increased from 4 (2x2) to 8 (2x4). The Trust recognises that 23/24 will be a further transition year regarding commissioner process and relationships. On this basis the impact assessment has been increased, as the funding impact could relate to elective and non-elective income streams. The probability remains at 2, as it remains highly likely that a financial planning process will be required, which provides a framework for managing this risk.
The Trust is actively developing its financial plan, with reference to emerging NHS England guidance. As at 03/02/2023 Trust and the ICS continues to work through the new funding mechanisms for 2023/5. There is a level of uncertainty regarding the funding methodology, and the impact of the changes remain unclear.
Until there has been further clarification and analysis of the funding position, the Trust is not proposing to change the BAF risk score.

BAF4. Board governance

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

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF4 There is a risk that **corporate and clinical governance arrangements** do not provide comprehensive **Board oversight and assurance**, leading to inadequate visibility of critical issues and failure to meet regulatory expectations **Executive Risk Lead:** Liz Bishop, Chief Executive **Board Committee**: Board **Last Update:** 5 April 2023	**Causes** 1. Development areas identified in WLDR 2. Increased complexity in operating environment and system context 3. Governance models including risk management need to take account of ICS developments **Consequences** 1. Poor decision making 2. Failure to manage key risks 3. Failure to improve CQC well-led rating	4 x 4 = 16	C1) Risk management strategy 2022 (RMS) and risk registers **Control Owner**: Chief Nurse	Risk management strategy annual update report - Quality Committee and Board Annual Clinical Audit Report, reviewed by Quality Committee Risks monitored through monthly Risk and Quality Governance Committee; operational risk reports to Board Committees with escalation route to Board via Chairs' reports. Annual Risk Management Report to Quality Committee and Board	Audited Quality Account, reviewed by Quality Committee, June 22 MIAA audits of key systems: Risk Management, Substantial Assurance March 22; Incident reporting, Limited Assurance April 22; Claims, Substantial Assurance, 2021/22	Partial (improved from partial)	2 x 4 = 8 ⬇	No	G1) Requirement for further development of clinical audit programme. MIAA recommendations for incident reporting and risk management process.	1. Develop the clinical audit programme and align to clinical governance structures and processes 2. MIAA audit improvement plan 3. Review risk management strategy **Action Owner**: Chief Nurse **Due date**: 31/04/23 (revised from 31/03/23)	Review of Risk Management Strategy underway. Awaiting publication of Patient Safety Strategy Framework national documentatin in order to align Incident Reporting Processes. Risk Management Strategy to go to Trust Board fro approval April 2023 Clinical audit programme and acations against quality spot checks in place	2 x 4 = 8
			C2) Revised governance structure approved by Board April 2022; Board and Committees keep their workplans under regular review **Control Owner**: Ass Dir of Corp Gov	Committee effectiveness evaluations reported to Board annually via Audit Committee Annual Report	New structure aligns with the reccomendations made in the Well Led Development Review (WLDR)	Acceptable			G2) Potential gap in Corporate Governance Team whilst recruiting substantive post	Interim plans to cover governance gaps (gaps in clinical governance closed) **Action Owner**: CEO **Due date**: March 2023 **(complete)**	Additional support for corporate governance confirmed until end of the financial year. Recruitment of substantive Associate Director of Corporate Governance underway. ADOCG in post from April	
			C3) Corporate Governance framework **Control Owner**: Ass Dir of Corp Gov	Annual Governance Statement approved by the Board	Well Led Development Review report to Board March 2022 with a number of recommendations	Partial			G3) NHSE draft Guidance on Good Governance and Collaboration (May 2022) sets out expectations for Trusts under the Provider Licence to reflect 5 key characteristics in their governance arrangements	Review CCC corporate governance in light of new guidance **Action Owner**: CEO **Due date**: March 2023 (revised from 31 July 2022)- **(Complete)** Close gaps identifies from the code of governance review Action Owner: ADoCG Due Date: 31/10/23	An assessment of compliance against the new Code of Governance for NHS Provider Trusts, which comes into effect from 1 April 2023, has been completed by the Interim Associate Director of Corporate Governance (ADoCG) with outcomes scheduled to be reviewed by the Audit Committee on 12 January 2023. Outcomes will form the basis of an action plan coordinated by the ADoCG to address any gaps in compliance. Ongoing compliance will be monitored by the Audit Committee on a six-monthly basis. Board recived compliance against new Code of Governance and agreed actions. Progress to be reviewed by Audit Committee quarterly	
			C4) Trust Strategy implementation plans **Control Owner:** Director of Strategy	Progress updates 6 monthly to Board	WLDR report highlighted the robustness of strategic planning and strength of engagement with plans	Acceptable						
			C5) Delegated authority for oversight of quality care by the quality committee **Control Owner:** Chief Nurse	Quality reporting to Quality Committee and Board via IPR and quality reports to monthly Risk and Quality Governance Committee. Quality and Safety oversight at Divisional PRGs. NED and Governor Engagement Walk-rounds with action plans monitored through PEIG and oversight at Trust Board.	WLDR report to Board March 2022 with a number of recommendations	Partial			G4) Lack of up to date Quality Strategy. No clear system to demonstrate and celebrate quality improvement activity	Trust wide engagement and development of a Quality Improvement Strategy, including agreed preferred methodology and improvement programme **Action Owner**: Chief Nurse **Due date**: 30/09/2023	Early scoping underway. Quality Improvement Board Development Session planned for July	
			C6) Board Assurance Framework (BAF) - strategic risks assigned to Board/Committees for oversight **Control Owner:** Ass Dir of Corp Gov	Quarterly reporting cycle at Committees and Board	MIAA annual review of BAF, small number of recommendations; WLDR review highlighted improvements to be made	Acceptable			G6) BAF improvements	Revised BAF 2022-23 to be drafted and embedded to direct the agendas and work programmes for Board and Sub-Committees **Action owner:** CEO **Due date:** 31 July 2022 (**Complete**)	Handover of ongoing management and reporting of the BAF from external support to Corporate Governance team in progress.	
			C7) Performance management arrangements - IPR refresh completed May 2022 to include SPC charts	Oversight at Performance Committee and Board	MIAA IPR audit 2021 gave substantial assurance	Acceptable						

Additional narrative

Significant change has been made to both the corporate and clinical governance processes and teams in recent months. Good progress has been made in terms of streamlining corporate governance processes and the Well Led Development Review was largely positive with an action plan in place to close any gaps. The 2022-3 BAF is complete with clearer description of assurances, controls, gaps and actions. There is further work to be undertaken on the development of the Quality Strategy but there has been significant improvement in the management of clinical risk.The Risk Management Strategy has progressed and due to be approved by the Board in April 2023. A substantive Associate Director of Corporate Governance is in place and she will lead the review of compliance against the Code of Governance which will be monitored through Audit Committee.

BAF5. Environmental sustainability

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

STRATEGIC OBJECTIVE: 8a Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Board Assurance: Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF5 If the **Trust does not integrate environmental sustainability considerations into delivery of its strategic priorities**, it will fail to realise the potential benefits and contribute to the NHS Net 0 target **Executive Risk Lead:** Tom Pharaoh, Director of Strategy **Board Committee**: Performance **Last Update:** 2 February 2023	**Causes** 1. Lack of environmental sustainability strategy/plan 2. Environmental considerations not embedded in policy and decision-making processes 3. Limited understanding of the potential benefits 4. Up-front investment required **Consequences** 1. Failure to reduce waste and realise efficiencies 2. Failure to contribute toward improving local environment, e.g. air quality 3. Failure to meet public, staff and regulatory expectations as a responsible healthcare provider	5 x 3 = 15	C1) Green Plan approved by Board and summary version published. Board-level sustainability lead identified. **Control Owner**: Director of Strategy	First annual report on Green Plan delivery due to be presented to Performance Committee February 2023 and to Board March 2023	Quarterly national 'Greener NHS' NHS England data collection exercise	**Partial**	4 x 3 = 12	No	G1) Substantive Green Plan programme management arrangements not yet in place	1. Source interim Sustainability Programme Manager resource **Action Owner**: DoS **Due date**: 14th July 2022 **(Complete)** 2. Develop short-term action plan with programme manager to deliver early priorities **Action Owner**: DoS **Due date**: 31st July 2022 **(Complete)** 3. Recruit substantive Sustainability Programme Manager **Action Owner:** DoS **Due date:** 31st March 2023 (Revised from 31st Jan 2023)	Control gap partially addressed through completion of actions 1 and 2.	3 x 3 = 9
			C2) Multidisciplinary Sustainability Action Group formed to support delivery of the Green Plan action plan - supported by interim Sustainability Manager for 6 months. **Control Owner**: Director of Strategy	Programme reports to be reviewed quarterly at Sustainability Action Group following first annual report in February 2023. Escalation of relevant issues will be through chair's report to Performance Committee.		**Partial**			G2.1) Sustainability Action Group not yet fully functioning	1. Engage with current members to ensure engagement and participation 2. Review terms of reference including membership, accountabilities **Action Owner**: DoS **Due date**: 5th September 2022 **(Complete)**	Additional members invited. Existing members encouraged to prioritise and engage in delivery of the action plan. Terms of reference reviewed. Group now functioning well with good engagement and work progressing. Substantive Programme Manager appointment vital to maintain progress.	
									G2.3) Sustainability Action Group does not have programme management support to fully function	3. Establish substantive Sustainability Programme Manager as lead officer for the Sustainability Action Group Action Owner: DoS Due date: 31st April 2023	Group now functioning well with good engagement and work progressing. Substantive Programme Manager appointment vital to maintain progress. Recruitment plan as above.	
			C3) Build specification of CCC-L supports Trust's environmental sustainability commitments, with potential to improve further. **Control Owner**: PropCare Managing Director	Monitoring of CCC-L building management system (BMS)		**Partial**			G3) Development of the delivery mechanisms for key workstreams identified in the Green Plan	1. Develop and publish green travel plan **Action Owner**: DoS **Due date**: 31st March 2023 (date specified) 2. Develop and deliver sustainability staff engagement programme **Action Owner**: DoS **Due date**: 31st March 2023 ((date specified) 3. Communicate to staff and stakeholders the current waste management arrangements and rates of recycling - using comms to outline further plans and seek staff behaviour change **Action Owner**: DoS **Due date**: 1st April 2023 (revised from 31 January 2023, revised from 31 October 2022)	Green travel plan drafted by interim sustainability manager following successful green travel survey with staff. To be refined by DoS for launch early 2023. Action date changed. Staff engagement programme deferred to link with staff health and wellbeing engagement programme in 2023. Action date changed. Current waste management processes under review. Results to be set out in Green Plan annual report.	
									G4) CCC-W redevelopment plans not yet developed	1. Creation of new projects division in PropCare **Action Owner**: PropCare MD **Due date**: 31st July 2022 **(Complete)** 2. Development of detailed proposals for redevelopment of CCC-W to include sustainability considerations **Action Owner**: DoS/PropCare MD **Due date**: 30th September 2023 (revised from 31st Dec 2022)	PropCare Projects now in place. Architects engaged to develop high level options over 3-week period of Nov/Dec 2022. Results presented to Trust Board and CCC-W redevelopment group formed.	

Additional narrative

The Trust has previously promoted sustainability in certain areas, for example cycle to work schemes and active travel facilities. The newly-approved Green Plan clarifies the Trust's overarching aims and states key targets to be achieved. The Green Plan also sets out the early, short-term priorities and the main initiatives that will be implemented in the longer term. The current risk score reflects the opening of the new, modern CCC-L building which marks a milestone in upgrading the Trust's estate.
A key part of future delivery depends on establishing effective programme management arrangements. Two unsuccessful attempts to appoint substantively to Sustainability Programme Manager role (12 months fixed term) has necessitated consideration of interim solution. The interim sustainability manager (part time) was in post for 6 months from July to December 2022. Following a further unsuccessful attempt to recruit to the post on a fixed term basis it was advertised as a permanent role in January 2023. PropCare projects division has also been formed to support PropCare's significant contribution to green agenda, including through progressing CCC-W redevelopment.

BAF6. Strategic influence within ICS

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

STRATEGIC OBJECTIVE: Be Collaborative

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Board Assurance: Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF6 There is a risk that **the Trust fails to achieve sufficient strategic influence within the ICS** to maximise collaboration around cancer prevention, early diagnosis, care and treatment **Executive Risk Lead:** Liz Bishop, Chief Executive **Board Committee**: Board **Last Update:** 5 April 2023	**Causes** 1. Organisational politics 2. Senior capacity and relevant experience 3. Shared goals and plans still in development 4. Lack of single data sources across the system 5. Immature ICS **Consequences** 1. Failure to improve population health and cancer outcomes 2. Disjointed care pathways 3. Failure to realise efficiencies 4. Failure to innovate at scale 5. Reduced CQC rating 6. Reputational damage	**3 x 4 = 12**	C1) Trust hosting the Cheshire and Merseyside Cancer Alliance (CMCA) with CEO as SRO **Control Owner**: CCC CEO	Board oversight of CMCA employee contracts becoming substantive (last reported to Board June 2022) Overview of business plans approval for 23/24 by National Cancer Team and NHS England included in Chief Executive report to Trust Board (April 2023) Business Plan approved at CMCA Board (March 2023)		**Acceptable**	**2 x 4 = 8** ⬇	**Yes**				**2 x 4 = 8**
			C2) CMCA Business Plan 2022-23 submitted and approved December 2022 by National Cancer Team; funding confirmed for 2023-25 **Control Owner**: Managing Director, CMCA	CMCA performance reports to Board monthly Overview of business plans approval for 23/24 by National Cancer Team and NHS England included in Chief Executive report to Trust Board (April 2023)	Weekly sit reps produced by CMCA for COOs. Monthly CMCA performance reports are circulated to acute/ST providers CEO,COOs and Place Leads and reported fortnightly to CMAST	**Acceptable**		G2) Lack of clarity about cancer reporting to ICB (control gap closed July 2022) Additional: CMCA plans for 2023-24 to be developed and submitted by end of Q4	New action: Complete bsuiness plans for 2023-24 Action Owner: CEO Due date: March 2023 **(Complete)**	Monthly CMCA cancer performance reports are incorporated into the ICB monthly Integrated Performance Report with bi-annual deeper dive report. Weekly tier 1/2 meetings continue. CMCA also report on monthly KLOEs ahead of the Regional Elective Oversight Meeting and fortnightly to CMAST. CMCA paper went to ICB 30 March 2023 Business Plan approved by CMCA	
			C3) Trust CEO is ICS System Lead for all diagnostics; governance and management arrangements established and delivered via bi-monthly Diagnostic Delivery Board **Control Owner**: CEO	Update to CCC Board at Strategy Away Day 28 July 2022	Diagnostic Delivery Board established and diagnostic performance reports into CMAST (fortnightly) and ICB Integrated Performance Report (monthly)	**Partial**		G3) Risk sharing agreement with ICB not in place	Finance Manager and HR manager to be appointed for the Diagnostic Programme **Action Owner:** CEO **Due date:** 30 November 2022 (revised from July 2022) **(complete)** Complete risk sharing agreement with ICB	Recruitment/ interims in place. Contracts to be held by CCC and risk sharing agreement in progress with ICB (led by ICB DoW) CCC DoW following up with ICB DoW	
			C4) Funding to 2024 to deliver CDCs and C&M Diagnostics Recovery Plan **Control Owner**: CEO	Update to CCC Board at Strategy Away Day 28 July 2022	Diagnostic Delivery Board established and diagnostic performance reports into CMAST (fortnightly) and ICB Integrated Performance Report (monthly)	**Acceptable**		G4) No confirmation for funding of diagnostic programmes other than CDCs, but will be overseen by Diagnostic Delivery Board.	Business plan being developed in order to bid to both national and ICB teams **Action Owner**: CEO **Due date**: 31 March 2023	By 1 April 7 CDCs will be opened, and national funding secured ICB Transformation Board approved the ICB funding for the diagnostic programme 9th March 2023. Acquired Paddington CDC - implementation planning underwas - 1st patient due in June	
			C5) Trust involvement with CMAST Provider Collaborative and ICS **Control Owner**: CEO	Update to CCC Board at Strategy Away Day 28 July 2022. Chair and CEO updates at monthly Board meetings. NED involvement and oversight at CMAST level via quarterly NED CMAST events. CEO and Chair attendance at CMAST Leadership Board		**Acceptable**		G1) WLDR report highlighted need to increase senior capacity and visibility in ICS to take on greater leadership role	1. Broaden executive directors' stakeholder engagement in ICS **(complete)** 2. Develop marketing plan to strengthen CCC brand and raise profile of senior leaders **Action Owner:** Dir of Strategy **Due date:** April 2023 **(Complete)**	1. Executive directors attending respective C&M leadership fora 2.Comms and Marketing Strategy in progress, preferred marketing provider engaged Communications Strategy approved at TEG. Marketing strategy complete and implemntation commenced eg. Media training April	

Additional narrative

This risk is largely mitigated through the CCC hosting of the Cheshire & Merseyside Cancer Alliance, to enable CCC to influence prevention, early diagnosis and cancer surgery. The recent leadership role and hosting of the Cheshire & Merseyside Diagnostics Programme on behalf of the ICB, gives greater influence over cancer diagnostics, although it is appreciated the diagnostics programme covers non cancer work. Formal channels through the CMAST/ICB governance and reporting arrangements are established.

BAF7. Research portfolio

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

STRATEGIC OBJECTIVE: Be Research Leaders

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF7 If the **Trust is unable to increase the breadth and depth of research**, it will not achieve its research ambitions as a specialist cancer centre **Executive Risk Lead:** Sheena Khanduri, Medical Director **Board Committee**: Quality **Last Update:** 13 March 2023	**Causes** 1. Reliance on partners to maintain Experimental Cancer Medicine Center (ECMC) status 2. Liverpool unsuccessful for BRC and CRUK 3. Service pressures impact upon research capacity **Consequences** 1. Failure to achieve status as a leading cancer research centre 2. Insufficient future funding to sustain planned research programmes 3. Failure to develop new treatments for patients 4. Reputational damage	**3 x 5 = 15**	C1) Research Strategy 2021-2026, approved by Trust Board **Control Owner**: Medical Director	Research Strategy Business Plan updates reported quarterly to Performance Committee		**Acceptable**	**3 x 4 = 12**	**Yes**	G1) ECMC status requires renewal from April 2023	Development and submission of ECMC application **Action Owner**: Medical Director **Due date**: 30 June 2022 **(Complete)**	Complete. Bid successfully submitted 30 June 2022. Outcome successful.	**2 x 4 = 8**
			C2) Dedicated Early Phase Trials Unit at CCC operational from 5 April 2022 **Control Owner**: Medical Director	Occupancy is reported monthly through R&I Directorate Board and to Risk & Quality Governance Committee		**Acceptable**			G2) Early Phase Trials Unit Operational Policy required and recruitment of support staff	1. Policy to be developed and approved by TIC **(Complete)** 2. Recruitment of Early Phase Clinical Research Fellow **(Complete)** **Action Owner**: Medical Director **Due date**: 31 March 2023	1. Policy approved at July 2022 TIC. 2. Two candidates appointed, anticipated start date August 2023.	
			C3) ECMC clinical trials open **Control Owner**: Medical Director	Quarterly ECMC updates to Research Strategy Committee reporting to Quality Committee		**Acceptable**			G3) Clinical trial pharmacy staffing capacity	Appointment of Deputy Clinical Trials Pharmacist **Action Owner**: Medical Director **Due date**: 30 June 2022 **(Complete)**	Deputy Clinical Trials Pharmacist appointed. Started in post July 2022. Advanced Pharmacist (0.4WTE) started August 2022.	
			C4) Successful collaborative bid securing funding as an NIHR Clinical Research Facility 2022 for 5 years **Control Owner: Medical Director**	Quarterly CRF updates to Research Strategy Committee reporting to Quality Committee		**Acceptable**			G4) CRF governance arrangements	Governance structure to be established for September Action Owner: Medical Director **Due date**: 14 October 2022 (original 31 August 2022) **(Complete)**	CRF meeting held between LUHFT and CCC CRFs June 2022. Governance structure agreed with LUHFT October 2022.	
			C5) Collaboration with major cancer centre for Biomedical Research Centre bid 2022 **Control Owner**: Medical Director	Quarterly BRC updates to Research Strategy Committee reporting to Quality Committee		**Acceptable**			G5) BRC bid outcome awaited May 2022	Report outcome to Research Strategy Committee when received **Action Owner**: Medical Director **Due date**: 31 October 2022 (original 31 May 2022) **(Complete)**	Successful outcome - CCC in collaboration with Royal Marsden Hospital Biomedical research centre; steering committee estabilshed and workstreams identified.	
			C6) Research Activity Policies **Control Owner**: Medical Director	Internal audit plan monitored at monthly R&I Directorate Board through to Risk and Quality Governance	Regulatory compliance evidenced external audit MIAA	**Acceptable**			G6) Aseptic Unit recovery reliant on Pharmacy staffing	Appointment of aseptic pharmacy staff **Action Owner**: Medical Director **Due date**: 31 October 2022 **(Complete)**	Aseptic services staffing is at establishment for current delivery model.	
			C7) Pharmacy Aseptic Unit recovery plan in place since 30 August 2021 **Control Owner**: Medical Director	Monitored monthly by Performance Review Group with exceptions only escalated to Quality Committee		**Partial**			G7) Study opening reliance on pharmacy staffing plan	See G3		
			C8) Study Prioritisation Committee meets monthly **Control Owner**: Medical Director	Monthly updates to R&I Directorate Board; studies opening in month included in Trust Board IPR with exception report		**Partial**			G8) Internal and external service pressures impacting on trials opening	1. Monitor progress against plan with Pharmacy. **Due date**: June 2023 2. Revised clinical trial portfolio leading to additional service requirements eg Interventional Radiology (IR), see below action. **Due date**: June 2023 (original date April 2023) 3. Develop Research vision for the CCC IR Service to remove dependance on third party providers. **Due date**: June 2023	1. Weekly and Monthly operational meetings in place. 2. Research Priority meeting held 14/11/22 to propose priorities for CCC. Follow-up meeting January 2023 (delayed to April 2023 due to investigator availability) followed by wider engagement. 3. Meeting held 19/12/22. Conributing to IR Business Case led by Radiology.	

Additional narrative

ECMC bid renewal was successful and will be renewed in April 2023 for a further 5 years ; the ability of CCC to continue to deliver high quality research will be strengthened, providing access to novel treatments and enhancing reputation through increased capacity and capability. Likelihood of future successful bids will be increased. Gaining Clinical Research Facilites status with a collaborative bid involving CCC and 2 other Trusts within the region secured £5.3m for local regional facilities. The successful outcome of the BRC bid will help demonstrate further research capability and ensure access to high quality research.

BAF8. Research resourcing

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

STRATEGIC OBJECTIVE: Be Research Leaders

Risk description & information	Causes & consequences	Initial (inherent) risk score	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23
BAF8 Competition for talent and research sponsorship means that **the research programme is at risk of being under-resourced**, which would hinder the Trust's ambition to be research leaders **Executive Risk Lead:** Sheena Khanduri, Medical Director **Board Committee**: Performance **Last Update:** 2 February 2023	**Causes** 1. International competition for specialist research skills 2. Reliance on partners to secure major sources of funding 3. Current vacancies 4. Funding shortfall following the Covid pandemic **Consequences** 1. Failure to develop new treatments for patients 2. Failure to achieve status as a leading cancer research centre 3. Loss of status and influence 4.Inability to deliver planned research programmes	3 x 5 = 15	C1) Research Strategy Funding ring-fenced to support Early Phase Clinical Trial Infrastructure and future growth in capacity **Control Owner**: Medical Director	Research Strategy Business Plan update reported quarterly to Performance Committee from January 2021		**Acceptable (changed from partial)**	2 x 4 = 8 ⬇	Yes	G1) Early Phase staffing capacity	Recruitment of Early Phase staff **Action Owner**: Director of Clinical Research **Due date**: March 2023 (revised from 31 December 2022)	Staffing gaps identified. Financial resource agreed. Recruitment process underway and interviews in place. Workforce plan agreed in-line with ECMC and Research Strategy funding.	2 x 4 = 8
			C2) Monitoring of use of funding (£2M allocated to the Research Strategy for year 2) **Control Owner:** Medical Director	Monthly reporting to R&I Directorate Board; Business Plan update quarterly report to Performance Committee	MIAA R&I Audit of finance and governance arrangements 2022 - substantial assurance received	**Acceptable**			G2) ECMC funding until March 2023	ECMC bid submission 2023-27 **Action Owner**: Medical Director **Due date**: 30 June 2022 **(Complete)**	**Bid submitted** within due date with CCC and UoL oversight; funding contribution from CCC identified from R&I envelope; outcome due December 2022 Confirmed successful bid in collaboration with University of Liverpool, secured ~£1.5M.	
			C3) Required research establishment is set out in Board approved Research Strategy **Control Owner**: Medical Director	Quarterly updates to Research Strategy Committee and Trust Executive Group; Business Plan update quarterly report to Performance Committee		**Acceptable (Changed from partial)**			G3) Recruitment required to reach full establishment in line with approved Research Strategy	Identify funding sources to recruit academic posts in line with Research Strategy **Action Owner**: Medical Director **Due date**: September 2023 (revised from 31 March 2023)	Recruitment of a Chair in Radiation Oncology is in progress. Date amended to September 2023	
			C4) Successful collaborative bid securing funding as an NIHR Clinical Research Facility 2022 for 5 years **Control Owner:** Medical Director	Quarterly monitoring of use of funding via Research Strategy Committee. Operational Oversight through new joint ECMC/CRF Operational meeting.		**Acceptable**			G4) CRF governance arrangements	Governance structure to be established for September **Action Owner**: Medical Director **Due date**: 14 October 2022 (Original 31 August 2022) **(Complete)**	CRF meeting between LUHFT and CCC CRFs June 2022; launch meeting scheduled September 2022 moved (national mourning) to November 2022. Now complete. Governance structure agreed with LUHFT October 2022.	
			C5) Major bid development - Biomedical Research Centre **Control Owner:** Medical Director	Bid development monitored via Research Strategy Committee		**Acceptable (Changed from partial**			G5) BRC bid outcome awaited May 2022	Report outcome to Research Strategy Committee when received **Action Owner**: Medical Director **Due date**: 31 May 2022 **(Complete)**	Outcome previously under embargo; embargo lifted October 2022 and confirmed successful bid in collaboration with Royal Marsden Hospital	
									G6) Contribution from Clatterbridge Cancer Charity in line with the Research Strategy	Delivery of 1st year fundraising activity **Action Owner:** Medical Director **Due date**: 31 March 2023	Annual activity plan in place; additional contribution to support BRC confirmed; Clatterbridge Research Funding Scheme 2022 announced closing March 2023; successful application from Professor Ottensmeier to enhance research into cancer and immune system	

Additional narrative

The Research Strategy has a fully costed Business Plan (Research Strategy Business Plan 2021-2026) which is monitored at Performance Committee; the Business Plan outlines bid developments, commercial funding opportunities and charitable funding to deliver the strategy.

BAF9. Leadership capacity and capability

RISK APPETITE: Workforce LOW (tolerance 4-8)

STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Overall assurance level	Residual risk (current) score	Within risk tolerance ?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF9 There is a risk that **leadership capacity and capability at the Trust is insufficient** to drive the changes required to achieve its strategic ambitions **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 4 April 2023	**Causes** 1. Leadership development required to adapt to system reforms and strategic ambitions 2. Multiple changes in the operating environment divert leadership capacity **Consequences** 1. Inability to adapt quickly enough to keep pace with system changes 2. Inability to manage competing priorities 3. Ineffective decision-making 4. Insufficient leadership visibility to drive change and right culture 5. Reduced health, wellbeing and morale for senior staff 6. Reputational damage	4 x 4 = 16	C1) Leadership passport programme **Control Owner**: Director of WOD	Bi annual updates to Workforce Assurance Group (September) Annual Learning and Organisational Development Report People Committee (March)	National Staff Survey Report People Committee (April) and Board (March) Improvement in national staff survey scores 2022 show improvements in Leadership scores	Acceptable	3 x 3 = 9 ⬇	No	G1) Lack systematic processes throughout the Trust to support leadership development	Further refine and enhance the leadership and development on offer, ensuring its accessibility to all staff **Action Owner**: Director of WOD **Due date**: 30/11/22 (original date 30/06/22) **Complete**	Learning and Development prospectus developed, alongside the Leadership and Management passport. Leadership masterclasses in place Leadership toolkit launched and available on the intranet Increased offering of national recognised leadership programmes via the Trust apprenticeship levy and short personal development programmes developed Review of findings of the Messenger Review completed and reported to WAG in September 22 and awaiting next steps from ICB Leadership 360 readily available to all staff Coaching offer increased BI Dashboard developed for monitoring and auctioning staff development requests from PADR Leadership programme for middle managers developed and will be rolled out from January 2023 Manager induction programme launching April 2023 Improvements to staff survey scores for inclusive leadership and team working	3 x 3 = 9
			C2) Leadership programme for Divisional Triumvirates - Team at the Top Control Owner: Director of WOD	Bi annual updates to Workforce Assurance Group (September). Annual Learning and Organisational Development Report People Committee (April).	National Staff Survey Report People Committee (April) and Board (March).	Acceptable (improved from partial)						
			C3) Coaching programme (all levels) **Control Owner**: Head of Learning and OD	Bi annual updates to Workforce Assurance Group (September) Annual Learning and Organisational Development Report People Committee (March)	National Staff Survey Report People Committee (April) and Board (March)	Acceptable			G1) Lack systematic processes throughout the Trust to support leadership development	Design and implement a range of leadership development programmes for senior leadership, ensuring they have the skills and knowledge to effectively lead and transformation services **Action Owner**: Director of WOD **Due date**: 30/06/2023 (revised from 30/06/22, 31/12/2022)	Team at the Team programme completed Coaching support provide to senior leader Head of L&OD developing a senior leaders programme for band 8a and above for implementation from June 2023	
			C4) Medical Leadership development programme of work **Control Owner**: Director of WOD	Bi annual updates to Workforce Assurance Group (September) Annual Learning and Organisational Development Report People Committee (March) National Staff Survey Report People Committee and Board (March)	National Staff Survey Report People Committee (April) and Board (March).	Partial			G3) Lack of leadership development approach specific to medical staff	Develop a programme of work that increases medical leadership awareness and engagement **Action Owner**: Director of WOD **Due date**: 30/06/23 (revised from 31/03/23, 30/04/22)	Working with external company to develop framework to support medical leadership development including coaching offer. Appraisal processes for medical leaders developed. Engagement with the NW Emerging clinical leaders programme. OD diagnostic undertaken as part of Medical Leadership and Engagement review and roll out of deliver against actions to commence in 2023. Appraisal processes for medical leaders being developed to be implemented by Q2 Continuous engagement with the NW Emerging clinical leaders programme OD diagnostic undertaken as part of Medical Leadership and Engagement review and roll out of deliver against actions to commence in 2023	
			C5) Shadow Board programme to develop future leaders Control Owner: Director of WOD	Shadow Board Programme completion reported to Trust Board Bi annual updates to Workforce Assurance Group (September) Annual Learning and Organisational Development Report People Committee (March)	National Staff Survey Report People Committee (April) and Board (March).	Partial			G2) No systematic process throughout the Trust to support Talent management	Design and implementation of a systematic approach to Talent Management **Action Owner:** Director of WOD **Due date:** 30/06/23 (revised from 31/03/23)	Shadow Board cohort 1 programme completed, with review paper provided to Trust Board. A further funding application for a 2023 cohort will be submitted in April 2023. Cohort 1 will continue to meet and work through specific Trust challenges and projects. Appraisal system redesigned to support talent management conversations and BI dashboard developed to enable ease access to talent/career ambitions data - to be launched by Q2 In-house coaching network in place to support career coaching Work on developing talent management programme delayed due to staffing shortages in L&OD Team. This will form part of the year 2 people commitment implementation plan Year 2 People Implementation Plan will include programme of work on succession planning	
			C6) People Commitment outlines our plans for the next five years to build an inclusive and compassionate culture and enhance our leadership skills and capacity **Control Owner**: Director of WOD	Bi monthly reports to People Committee outlining progress against plan Quarterly updates to be linked to the strategic themes 'Be a great place to work'	National Staff Survey Report People Committee (April) and Board (March).	Partial					Year 1 implementation plan completed. Improvements seen in staff survey scores linked to compassionate leadership and culture	

Additional narrative

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

BAF10. Skilled and diverse workforce

RISK APPETITE: Workforce LOW (tolerance 4-8)

STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Overall assurance level	Residual risk (current) score	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23
BAF10 There is a risk of being **unable to attract and develop a diverse and highly skilled workforce**, which could limit the Trust's capacity to deliver and develop further its specialist services **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 4 April 2023	**Causes** 1. Different expectations of younger people entering the workforce 2. Perceived or real cultural barriers for BAME staff 3. Poor perception of NHS as a place to work 4. Competition within NHS and from private sector **Consequences** 1. Failure to improve services 2. Widening vacancy gaps 3. Inability to plan capacity effectively 4. Reduced workforce morale 5. Damage to reputation as an employer 6. Failure to maintain CQC ratings	4 x 4 = 16	C1) Equality, Diversity and Inclusion action plans (WRES/WDES/ EDS2) **Control Owner**: Director of WOD	Action plan updates through EDI group and People Committee Results and action plan reported to Trust Board and People Committee	WRES & WDES Annual Reports incl external benchmarking data, reviewed at Trust Board in October 2021 and showed improvements	Acceptable	3 x 4 = 12	No	G1) No dedicated group for EDI	EDI lead to be appointed and service agreement to be developed **Action Owner**: Director of WOD **Due date**: 30/04/22 **(Complete)**	Head of EDI commenced employment in January 2023 and will develop a EDI work plan to be reported to People Committee In April 2023.	3 x 3 = 9
			C2) Inclusive Recruitment processes **Control Owner**: Director of WOD	Managed through EDI group and assurance reported quarterly though People Committee	WRES & WDES Annual Reports incl external benchmarking data, reviewed at Trust Board in October 2021 and showed improvements	Acceptable			G2) Revised Recruitment policy	Full scale review of policy underway to support the NHSIE 6 Actions for Inclusive recruitment **Action Owner**: Director of WOD **Due date**: 31/05/23 (revised from 31/10/22, 31/08/22)	Review underway, WRES/ WDES annual reports published in October 2022 which outlines plans for next 12 months. Submitted Gender Pay Gap Report. Submitted EDS 2 Report work underway for EDS 22. New Head of EDI now in post. Approval to carry over from the year 1 People Commitment Implementation Plan included in April's People Commitment Report	
			C3) Retention plans of critical staff groups **Control Owner**: Director of WOD	Turnover KPIs monitored month through IPR and through Trust sub-committee structure	National Staff Survey Report People Committee (April) and Board (March).	Partial			G3) Robust clinical skills/ development programme for clinical staff	Review of clinical skills offer to ensure clinical staff have access to relevant clinical training and development opportunities Action Owner: Chief Nurse Due date: 30/09/2023 (Revised from 31/03/2023 31/07/22, 31/11/22, 29/02/2023).	Task and finish group established to review all role essential and clinical skills training. Further work needed to develop clinical competency pathways to support the removal of some role essential training programmes. Review of RET completed and development of a digital competency passport in progress. New Clinical Competency documents developed	
			C4) Revised Values Framework launched February 2022 **Control Owner**: Director of WOD		National Staff Survey Report People Committee (April) and Board (March).	Acceptable			G4) Values based recruitment framework	Embed a model of values based recruitment **Action Owner**: Director of WOD **Due date**: 30/06/2023 (revised from 31/03/23, 30/11/2022)	New values embedded into recruitment literature Work commenced on developing a new vales based recruitment training programme, but implementation delayed and will now be included as a key priority in the year 2 People Commitment implementation plan National Staff Survey 2022 took place between September and November. Increase in completion rates. Results from the 2022 survey show positive increases across 6 out of the 9 People Promise themes. Values embedded into recruitment literature. Next steps are to communicate and educate leaders to ensure the recruitment process is values based at all stages - part of the year 2 People Commitment	
			C5) Recruitment and Retention Plans **Control Owner**: Director of WOD	Update to Workforce Assurance Group bi-monthly Updates to People Committee		Partial			G5) Digitally streamlined recruitment and on boarding processes	Streamline transactional processes for recruitment to ensure we adopt digital solutions **Action Owner**: Director of WOD **Due date**: 30/09/2023 (original date 30/09/22, 30/10/22)	Recruitment Improvement Plan approved and new divisional model implemented Proposal approved RPA/ SharePoint operational group to identify areas of WOD transactional processes that can be digitised. Good progress has been made on scoping and developing blue prints for the automation of HR processes and testing is underway. There have been some delays due to vacancy gaps and absences within the Workforce Systems Team.	
			C6) Participation in ICS international recruitment campaigns for Nursing and (AHP's) **Control Owner**: Chief Nurse	Update to Workforce Assurance Group bi-monthly. AHP recruitment strategy in place		Partial			G6) Clinical Education Strategy requires updating for 2023 onwards	New strategy to be developed in partnership with key stakeholders **Action Owner**: Chief Nurse **Due date**: 01/10/2023 (original date 30/09/22)	A new Multi-professional Education Strategy is in development and currently at coproduction phase, with key stakeholders focus groups being held. Final approved strategy and implementation plan for launch Q3 2023.	
			C7) Clinical Education strategy **Control Owner**: Chief Nurse	Monitored through Education Governance committee, WAG and People committee		Partial			G7) Formal KPIs for Clinical Education to be developed	KPIs to be developed for 2023/4 reporting **Action Owner:** Chief Nurse **Due date:** 01/10/2023 (original date 30/09/22)	Clinical Education KPIs, to include mandated compliance targets for Resuscitation and Manual Handling, are reported via the EGC, Patient Safety Committee, People Committee and at PRGs. Additional KPIs to be developed as part of the Clinical Education strategy	
			C9) Appraisal and personal development process **Control Owner**: Director of WOD	PADR compliance reviewed monthly through IPR, People Committee, WAG and PRGS Monthly compliance data issued to divisions KPI for appraisal being achieved	MIAA Staff Appraisals & Mandatory Training audit Q1 2022/23 - Substantial assurance received	Acceptable						

Additional narrative

Recruitment challenges exist across the NHS and challenges are significant for some hard to recruit to posts.

BAF11. Staffing levels

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

STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Board Assurance: Overall assurance level	Residual risk (current) score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 (L x C)
BAF11 There is a risk of **insufficient staffing levels in some areas of the Trust**, which could result in disruption to services and jeopardise the quality of care **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 4 April 2023	**Causes** 1. Short-term and long-term staff absences 2. Vacancies 3. Misalignment of workforce planning, activity and finance 4. Lack of accurate and up-to-date workforce information and data **Consequences** 1. Inability to plan capacity effectively 2. Disruption to service delivery 3. Poorer patient care and experience 4. Failure to maintain CQC ratings 5. Reputational damage	4 x 4 = 16	C1) Targeted recruitment campaigns for hard to recruit roles (Nurses/ Radiographers/ Pham) **Control Owner**: Director of WOD	Reported quarterly through people committee and monitored through recruitment and retention focus group		Acceptable	4 x 4 = 16	No	G1) Dedicated lead for recruitment for Nursing and AHP	Establish Recruitment and Retention focus group with key stakeholders **Action Owner**: Director of WOD **Due date**: (Originally 30/06/2022 then TBC) **Complete**	Internal WOD scoping meeting taking place 27/09/2022. Timescale to be revised subsequently. Working in partnership with Liverpool City Region Employment and Skills Team to promote roles and opportunities to local community groups Develop and implement Career Insight Days, focusing on Nursing, AHP, Medical and Support Services Careers from April 2023 Actively work alongside schools, colleges, universities and local communities to attract a more diverse workforce. NHSE Nurse Retention return submitted in March 2023 Divisional Focus groups in place for areas with the highest turnover. Groups analyse KPIs and develop action plans which are reviewed monthly by divisions. Stay and grow conversations taking place - Team working to deliver a programme of work that will establish and embed stay and grow conversations in high turnover areas.	3 x 3 = 9
			C2) E-roster implemented in all clinical areas in line with NHSIE Levels of Attainment Implement plan for development and project team for development **Control Owner**: Director of WOD	Reported bi-monthly through Workforce Assurance Group and monitored monthly through Systems Utilisation Group	MIAA E-Roster audit 2021/22, substantial assurance	Acceptable			G2) An E-Roster work plan is in place to support the achievement of NHSIE Levels of Attainment. Work is in progress but not complete	Detailed actions plans to be developed and implemented for each clinical are to address gaps/areas of focus **Action Owner**: Director of WOD **Due date**: 30/08/23 (revised from 31/03/2023)	Audit completed in Dec 2021 that identified number of key actions. Refreshed Trust-wide project plan agreed to support Level of Attainment. Divisional work groups identified to address specific gaps/areas of focus for each area. Audit actions completed Q3 22-23. Ward Walkabouts taking place to support the utilisation of eroster consistently. Significant work undertaken and the team are continuing to support e-roster users.	
			C3) Implementation of E-job planning for medics and advance practice roles **Control Owner**: Director of WOD	Reported bi-monthly through Workforce Assurance Group and monitored monthly through Systems Utilisation Group	MIAA Medical Job Planning audit planned Q3 2022/23	Acceptable			G3) Procurement of new E-job planning system	Procure new system to support e-job planning **Action Owner:** Director of WOD **Due date**: 30/06/2022 **(Complete)**	Procurement process concluded Sept 2022. Workforce systems team developing implementation plans for the transition of systems. New system to go live January 2023. Backup of current system procured to support transition.	
			C4) Bank framework to support temporary gaps in the workforce **Control Owner**: Director of WOD	Reported bi-monthly through Workforce Assurance Group and Divisional Performance reports		Acceptable			G4) Implementation workforce planning model and tools for the Trust	Development and implementation of workforce planning tools **Action Owner**: Director of WOD **Due date**:31/03/2024 (revised from 31/03/2023)	National guidance received and being reviewed by WOD and finance . Draft workforce plan submitted in March 2023 to Cheshire and Mersey ICB. On year 2 People Implementation plan- continue to deliver workforce planning model aligned to 2023-28 plan	
			C5) Robust workforce plans for all clinical areas **Control owner:** Director of WOD	Workforce Planning updates reported quarterly to People Committee		Acceptable			G5) Automation of ESR reporting	1. Joint working between WOD and BI to automate current reporting processes 2. Validation of data 3. Build of WOD metrics and PowerBI dashboard **Action Owner**: CIO and Director of WOD **Due date**: 30/09/23 (revised from 31/03/2023)	Member of WOD team working with BI to support automation of ESR reporting 1 day a week. ESR data is data warehouse- validation in progress. WOD metrics built - work progressing well for BI dashboard	
			C6) Real time reporting of workforce metrics including turnover and sickness **Control Owner**: Chief Information Officer	Reported bi-monthly through Workforce Assurance Group and monitored monthly through Systems Utilisation Group		Low			G6) Utilisation of Safe Care as the tool for reporting safe staffing levels at ward level	Joint working between WOD/ Digital/ Nursing teams to embed systems and ensure fit for purpose **Action Owner**: Chief nurse and Director of WOD **Due date**: 30/06/2023 (revised from 31/03/2023)	SafeCare reporting tool has been implemented ine ach of the ward areas and work is underway to embed the utilisation to support workforce deployment WOD metrics built - work progressing well for BI dashboard	

Additional narrative

BAF12. Staff health and wellbeing												
RISK APPETITE: Workforce LOW (tolerance 4-8)												
STRATEGIC OBJECTIVE:	Be a Great Place to Work											
Risk description & information	**Causes & consequences**	**Initial (inherent) risk score L x C**	**Key controls** *(what is in place to manage the risk?)*	**Board Assurance** **Internal assurance** *What/where reported/when?*	**External assurance** *What/where reported/when?*	**Overall assurance level**	**Residual risk (current) score**	**Within risk tolerance?**	**Gaps in Control / Assurance**	**Planned action**	**Actions** **Progress update**	**Target risk score by 31/03/23**
BAF12 There is a risk of **decline in the health and wellbeing of staff**, which may result in increased absence and turnover, affect the Trust's ability to deliver services, and damage its reputation as an employer **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 4 April 2023	**Causes** 1. Increase in mental health issues in the wake of the initial waves of Covid 2. Staff with 'long Covid' 3. Staff burn-out 4. Covid part of long-term operating environment **Consequences** 1. Loss of goodwill and staff engagement 2. Fluctuating capacity 3. Increase in long-term sickness 4. Increased staff turnover 5. Disruption to services 6. Reputational damage	**4 x 4 = 16**	C1) Occupational Health Service for staff **Control Owner**: Director of WOD	OH contract performance monitored quarterly and reported to Workforce Advisory Group annually (exceptions escalated to People Committee)	2022 National NHS Staff survey Results show improvements in staff wellbeing scores	**Acceptable**	**3 x 3 = 9**	**No**	G1) Staff survey results state that only 55% of staff believe we take positive action on H&WB as a Trust	Review H&WB offer to staff **Action Owner**: Director of WOD **Due date**: 30/06/22 **(Complete)**	Review of offer complete and to be monitored on an ongoing basis. Recruited H&WB co-ordinator role. Successfully secured funding from the Charity to support Staff Wellbeing and Engagement. Developing role profile for a H&WB lead. Next step is to undertake NHSIE Health and Wellbeing Framework Diagnostic Tool by December.2022 National NHS Staff survey Results show improvements in staff wellbeing scores	**2 x 3 = 6**
			C2) Employee Assistance Programme, including counselling, available for all staff **Control Owner**: Director of WOD	OH contract performance monitored quarterly and reported to Workforce Advisory Group annually Staff Survey results reported annually to People Committee		**Acceptable**			G2) MHFA are not embedded into the organisation/ routinely accesses for support	Implement Wellbeing Champions and a H&WB Champions group **Action Owner**: Director of WOD **Due date**: 30/04/2023 (Revised from 30/02/2023, 30/09/22)	Commencement of this work delayed. New Engagement and Wellbeing coordinator to scope Wellbeing champion training offer and develop a proposal for recruitment Role description designed and approved for champion role and will be advertised across the Trust in January 2023. New Engagement and Wellbeing Group to be set up by April 2023 to provide oversight on wellbeing activities. New Engagement and Wellbeing Group to be set up by May 2023 to provide oversight on wellbeing activities. Review of Health and Wellbeing Guardian role completed . Reports from the Health and Wellbeing will now form part of the CoB for People Committee	
			C3) Mental Health First Aiders **Control Owner**: Director of WOD	Heath and Wellbeing Guardian meetings quarterly and annual Health & Wellbeing report to People Committee (December)		**Acceptable (improved from partial)**			G3) Plan required to fulfil the Board's commitment to the NW Wellbeing Pledge	Develop NW Wellbeing Pledge Action Plan **Action Owner**: Director of WOD **Due date**: 30/09/2023 (revised from - on hold)	Update provided to Workforce Advisory Group on progress of the regional projects in partnership with NW Trusts. Further update provided to WAG in January in relation to a regional sickness policy. This has now been shared with provider organisation for consideration for local agreement and implementation monitored through WAG	
			C4) Health & Wellbeing objectives for line managers and all staff **Control Owner**: Director of WOD	PADR compliance data monitored monthly by Workforce Advisory Group and People Committee via IPR		**Acceptable (improved from partial)**			G4) Diagnostic assessment against New NHS Health and Wellbeing Framework	Undertake assessment and identify gaps in provision **Action Owner**: Director of WOD **Due date**: 30/05/23.	Based line assessment completed. 2023/24 Live well Work Well programme in development. Updated provided to Aprils People Committee	
			C5) Resilience modules in Leadership Masterclass modules **Control Owner**: Director of WOD	Bi annual updates to Workforce Assurance Group (September) Annual Learning and Organisational Development Report People Committee (March)		**Acceptable**						
			C6) Culture and Engagement Groups in each Division and for Corporate Services **Control Owner**: Director of WOD	Staff Culture and Engagement Pulse results, reviewed quarterly by People Committee as part of wellbeing and engagement update		**Partial**						
			C7) Health and Wellbeing activities and interventions in place for 2022 **Control Owner**: Director of WOD	Quarterly Guardian meetings. Annual Health & Wellbeing report to People Committee.		**Acceptable**						
			C8) Non-Executive Health & Wellbeing Guardian to hold Trust to account on ensuring H&WB is an organisational priority **Control Owner**: Director of WOD	Quarterly Guardian meetings. Annual Health & Wellbeing report to People Committee.		**Acceptable**						

Additional narrative

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

BAF13. Development and adoption of digitisation

RISK APPETITE: Digital MODERATE (tolerance 8-12)

STRATEGIC OBJECTIVE: Be Digital

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF13 There is a risk of **limited development and adoption of digitisation across the Trust**, which would constrain service improvements and reduce the benefits for patients **Executive Risk Lead:** Sarah Barr, Chief Information Officer **Board Committee**: Quality **Last Update:** 13 March 2023	**Causes** 1. Lack of local published Digital Strategy. 2. Unknown national funding arrangements for Digital. 3.Lack of operational and clinical workforce digital capabability. 4.Emerging Integrated care System (ICS) and Places across Cheshire & Merseyside and developing Digital and Data strategies. 5. Inconsistent and unreliable data recording at source. **Consequences** 1. Inability to achieve intended benefits for patient care and safety 2. Inability to ensure data-driven decision making 3. Lost opportunity to modernise 4. Inefficient use of resources 5. Unsustainable operating costs 6. Reputational damage	**4 x 4 = 16**	C1) Digital Board established with Medical Director as Senior Responsible Owner (SRO). Digital Board is the single governance for Trust wide Digital assurance **Control Owner**: CIO	Digital Board ensures the Trust's strategic and operational plans are supported by Digital Technology. The Digital Board will report quarterly to Quality Committee.		**Acceptable**	**3x 3 = 9** ⬇	**YES**	G1) Digital Strategy required to set long term direction of travel	Digital Strategy to be developed and approved by Trust Board. Iterative approach planned with content to be completed by end of September 2022. Establishing a reporting cycle into Quality Committee. **Action Owner**: CIO **Due date**: April 2023 (Launched in January 2023, initial vision presented 30 September 2022)	Themes and vision of the Digital Strategy presented at Trust Board Development day 28th September. Themes presented to Digital Board in October. Engagement of mission and vision is ongoing with clinical divisions between December 22 and Jan 23 to ensure strong foundational partnership ready for launch end of January 23. Digital Strategy has been prepared and shared at Digital Board in January 23. The strategy was endorsed by Digital Board and has been shared at TEG in early March 2023. Teg approved for the strategy to be shared with Quality Committee in March 23. Trust Board April	**3 x 3 = 9**
			C2) Clinical System Transformation Programme to ensure clinical systems are operationalised and embedded to improve quality and safety **Control Owner**: CIO	Digital Board signed off the workstream approach and proposed Governance to take forward the findings from the review of clinical systems optimisation	CCC nationally ranked within group 3 for Electronic Patient Record (EPR) Capability Levels as part of the work undertaken by National Frontline Digitisation Team. Group 3 classifies as an EPR that "already meets the national core capabilities"	**Acceptable**			G2) Operational ownership for embedding technical change within clinical divisions	Agreement of roles and responsibilities of Governance between Digital Board and Transformation Improvement Committee. Additional Key Performance Indicators to be monitored via divisional performance review Groups **Action Owner**: COO **Due date**: 30 July 2022 **(Complete)**	A full governance review has taken place and governance arrangements are in place for Clinical Systems optimisation with Executive oversight from Medical Director. Workstreams will have Executive Oversight from Chief Nurse and COO. Governance approach between programme and TIC signed off at Digital Board in August 22. (Complete) There is strong leadership from operational and clinical teams in the EPR optimisation workstreams	
			C3) Digital Programme plan **Control Owner**: CIO	Full Digital Programme plan is monitored monthly through Digital Board. Monitoring a broad range of projects across all disciplines within the Digital Services function.	Number of work streams in line with national initiatives and reported to Integrated care System or NHS Transformation Team.	**Acceptable**			G3) Full overview of all digital programmes ensuring capture of new and emerging programmes	Review of Digital Programme reporting dashboard to be undertaken by the Head of Digital programmes **Action Owner**: CIO **Due date**: 31 October 2022 **(Complete)**	Review of digital programme reporting completed to ensure regular reporting of projects such as Robotic Process Automation (RPA), Remote Monitoring and Clinical Transformation programme work streams are captured within the reporting cycle. Reporting will continue to be monitored through the BAF as the governance processes are embedded with Transformation Improvement Commitee and Clinical Optimisation Group. (Complete) A further review will be understken in April once the Digital startegy is launched.	
			C4) Data Warehouse and Interactive Power Bi Dashboards in place **Control Owner**: CIO	Data Management Group chaired by the Director of Finance monitors progress and feeds into Digital Board		**Acceptable**			G3.1) Resource and capacity to deliver the clinical systems transformation programme of work	Recruitment of Project Manager **Action Owner**: CIO **Due date**: 04 July 2022 **(Complete)**	Member of staff in post and inaugural Clinical System Optimisation Group took place 1 September 2022. This group is operting effectively with strong project management leadership and strong clinical and operational commitment.	
			C5) Strong Clinical Leadership and Engagement through Chief Clinical Information Officer (CCIO) and Chief Nursing Information Officer (CNIO) **Control Owner**: Medical Director	N/A		**N/A**			G3.2) Clinical Documentation work stream programme	Clinical Documentation work stream to be launched with Chief Nurse as Clinical Lead **Action Owner**: Chief Nurse **Due date**: 30 June 2022 **(Complete)**	Chief Nursing Information Officer presented programme of work to Risk &Quality Committee June 2022. Work is underway and the programme fits into the overarching governance. Inaugural workstream meeting arranged for 26th September. CNIO having bi-weekly operational meetings with Nursing teams to start to review the nursing documentation. The action is complete and the workstream continues to be effective with strong clinical leadership, reporting into Digital Board	
			C6) Progress against Digital Maturity Model using the Internationally recognised tool Healthcare Information and Management Systems Society (HIMSS) approach **Control Owner**: CIO	HIMSS assessment report taken through Digital Board	HIMSS level 5 achieved (externally verified via an onsite assessment by the Regional Director HIMSS-Europe) - findings report reviewed by Digital board and NHS Digital. Level 5 was a requirement of the GDE programme.	**Acceptable**			G3.3) Pharmacy Digital work stream	Digital Pharmacy work stream led by Chief Medicines Information Officer (CMIO) with Chief Operating Officer (COO) as Operational Lead **Action Owner**: COO **Due date**: 31 August 2022 **(Complete)**	Workstream is underway, led by the COO. This action is complete and is led by the Director of Pharmacy. The workstream is operating effectively and reports into Digital Board	
									G4) Completion of National "What Good Looks Like Framework for Nursing" (WGLL) to be undertaken	National "What Good Looks Like Framework for Nursing" (WGLL) to be undertaken by CNIO and a baseline assessment undertaken **Action Owner**: Chief Nurse **Due date**: 31 October 2022 **(Complete)**	WGLL framework assessment completed with a wide range of stakeholders across the Trust November 21 and submitted to ICS. Action plan monitored through Digital Board. The WGLL framework has now been incorporated in the new Digital Maturity Assessment (DMA). The new DMA was launched on 6/2/23 ands the Trust's initial submission will be submitted 19/3/23. The DMA is based on the WGLL framework	
									G5) Education in use of BI Dashboards and monitoring of usage through Divisional Performance Review Groups (PRGs)	Further 1-1 training planned on request. Head of Performance and Planning to include within performance reviews with divisional and operational teams **Action Owner**: COO **Due date**: 30 September 2022 **(Complete)**	Training video available on intranet, face to face sessions held at divisional cabinet meetings. Head of Planning to incorporate additional divisional data into PRG as new data feeds become available at the end of Jan 23. Training with staff and teams continually offered and delivered. Continual revision of training is underway. A new BI Training plan was sharedw ith Data management Group in March. Weekly targeted dashboard training sessions have been launched commencing 13/4/23	
									G6) HIMMS level 6 gaps identified	Plan in place to review and close level 6 gaps is being led by the Head of Digital Programmes. **Action Owner**: CIO **Due Date**: December 2023 (Previously December 2022 in error)	Nationally, Level 5 HIMSS is the standardised requirement for Digital Maturity which we have met. Level 7 is the highest. Level 6 assessment undertaken at CCC and a plan to close gaps in progress. Key work required to meet level 6 is Closed Loop Prescribing for Non-Sact Medicines, to be managed within the Medicines workstream of the Clinical Systems Optimisation Programme. NHSE launching new national digital maturity tool, expected in December 2022. The new national Digital maturity Assessment will incorporate the WGLL framework and Trusts are expected to complete their first assesment Jan/Feb 23.. We will complete new DMA and continue with HIMMs once closed loop is progressing	

Additional narrative

The Organisation is developing it's levels of digital maturity through use of digital systems. It is essential that the addition of any new technologies is embedded for the right reasons and to support clinical and operational processes to its best effect. It is essential that process change and embedding of new ways of working is owned operationally. The Inherent risk score is high as, if uncontrolled there is a risk the organisation could fall behind. There is considerable change management aspect of the work required in the development and adoption of digitisation which is cross-cutting and requires different parts of the organisation to own and lead alongside the Digital services team. A number of actions have been completed. The clinical optimisation programme continues to be well led, with strong clinical and operational buy-in for transformational change. The workstreams now report into Digital Board and there is strong commitment from the clinical leads to lead this. Following engagement work around the digital strategy, the draft versions have been approved by Digital Board and Trust Executive Group. A version will be shared with Quality Committee in March with the recommendation to share at Trust Board in April. Nationally, NHSE have now launched the new digital maturity assessment tool which is currently not factoring in HIMMS. The toolkit is based on the What Good Looks Like Framework and was launched in February 22. A collaborative approach has been taken with the self assesment elements and will be submitted on time by 19/3/23. Actions around G4 and G6 will change in the next review of the BAF. The work of the Clinical Optimisation programme is starting to embed a change in culture. Progress is strong around the digital strategy and the committee is asked to consider a reduction of the residual risk score from a 12 to 9 (3x3).

BAF14. Cyber security

RISK APPETITE: Digital MODERATE (tolerance 8-12)

STRATEGIC OBJECTIVE: Be Digital

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF14 There is a risk of **major security breach** arising from increasing digitisation and cyber threats, which could disable the Trust's systems, disrupt services and result in data loss **Executive Risk Lead:** Sarah Barr, Chief Information Officer **Board Committee**: Audit **Last Update:** 11 April 2023	**Causes** 1. Increasing sophistication and variety of malicious attacks 2. Integration of networks across the ICS 3. Increased reliance on digitised processes 4. Legacy infrastructure requiring modernization 5. Heightened national threat from Russia **Consequences** 1. Disruption to services 2. Loss of data 3. ICO fines (Highest maximum amount is £17.5m or 4% of the annual turnover in preceding year- whichever is highest) 4. Fraud/theft 5. Reputational damage	4 x 5 = 20	C1) Anti-virus software up to date across server and PC estate, regularly monitored and maintained **Control Owner**: CIO	Anti-virus posture reported monthly to Digital Security Committee (DSC). Forms part of the Triple A Chairs report to Digital Board. Regular quarterly report starting January 2023 to include Anti Virus posture.	NHS Digital receive real-time telemetry from Windows devices, which feeds national dashboards and triggers alerting.	Acceptable	4 x 3 = 12	Yes	G4) Adoption of enhanced standards via Cyber Essentials Plus and ISO27001	Plan in place for progress towards Cyber Essentials Plus and ISO27001 implementation **Action Owner**: CIO **Due date**: July 2023 (revised from March 2023	ISO27001 - remains in progress and on track. Several divisions have now had preliminary audits. Physical audits for ISO have taken place at CCC-w and CCC_A with CCC-L planned for. Phase one audits underway in April with phase two expecting completion at the end of July 2023. Cyber Essentials Plus certification action complete. Certification awarded in December 2022. Reaccreditation due in Dec 23	4 x 3 = 12
			C2) Enterprise Backup Solution **Control Owner**: CIO	Backups checked daily. Reported monthly to Digital Security Committee. Restores tested on a quarterly basis. All backups are immutable and can not be altered.	MIAA , substantial assurance for Cyber Security Audit. (12th March 2022) NHSD/MTI - Full backup review performed in Feb 2021. All recommendations now in place.	Acceptable			G5) Cyber incident response in-house skills - details SOC 24/7 monitoring not available	Digital Security Team taking Cyber Incident Response exams Cheshire& Merseyside Regional 24/7 Security Operations Centre (SOC) being developed. CCC Leading on this. **Action Owner**: CIO **Due date**: March 2024 (revised from November 2022)	Digital Security Team have undertaken Cyber Incident response courses. ICS working with external supplier and NHS England to develop a regional Cyber Security Strategy and a Regional Security Operations Centre (SOC) Roadmap for C&M. It is anticipated this will include an underpinning Blueprint to support the procurement of a SOC during 23/24- subject to regional funding.	
			C3) Windows Advanced Threat Protection (ATP) **Control Owner**: CIO	ATP deployed to all applicable assets.	All CCC devices have Windows ATP and are continuously monitored by NHSD Security Operations Centre (SoC)	Acceptable			G9) Training and development for Information Asset Owners (IAOs) and Information Asset Assistants (IAAs)	Information Governance Team to develop awareness and understanding Programme for IAOs and IAAs to be developed ready for 2024 submission of DSPT **Action Owner**: Director of Finance (SIRO) **Due date**: April 2023 (revised from March 2023)	New action added Jan 2023. A new Information Asset Owner (IAO) and Information Asset Administrator (IAA) training programme is underway to support understanding, awareness and the submission of the toolkit	
			C4) Adherence to Cyber Essentials standard **Control Owner**: CIO	CE & CE+ accreditations and compliance progress tracked via Digital Security Committee. Quarterly reporting to Audit Committee starting Jan 2023.	Cyber Essentials Plus certification awarded December 2022. Engaged with Greater Manchester Shared Services for ISO27001 compliance.	Acceptable						
			C5) Network vulnerability Monitoring **Control Owner**: CIO	Security posture dashboards presented to Digital Security Committee on a monthly basis. Quarterly reporting to Audit Committee to starting Jan 2023.	External audits take place to provide independent assurance on posture. Annual external Penetration Testing is undertaken by PH Consulting (16/6/22). Plans to move to Quarterly Pen Testing	Acceptable						

Additional narrative

Cyber is a risk that will always score high on a Trust Risk Register due to the fluctuating nature of this type of risk and new and emerging risks to Cyber Security happening at all times. There are a number of national approaches to control Cyber Risks which this Trust is fully immersed in.The Trust has been awarded Cyber Essentials + certification in December 2022. This is a significant achievement for the organisation. The Trust continues with plans for ISO27001 accreditation, a number of preliminary audits and physical audits have already been completed and accreditation is expected in July 23. Operational level cyber risks and progress with the toolkit continue to be managed through monthly Data Security Committee Meetings and IG Board. The following control gaps have been closed to date: G1 security threat due to use of Russian software; G2 Corporate back-ups to be air-gapped; G3 Global Log4j vulnerability; G7 Devices up to date using VPN, G8 Process for Joiners, Movers and Leavers. For the remaining Gaps in control: G4 accreditation is expected in July 23, G5- Regional Security Operations Centre is dependant on regional commitment and is expected to continue into 2023/24. G9: IAO and IAA training is expected to be completed in April 23

BAF15. Subsidiary Companies and Joint Venture

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

STRATEGIC OBJECTIVE: Be Innovative

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF15 There is a risk of **inadequate governance of the Trust's Subsidiary Companies and Joint Venture**, which would result in failure to maximise the potential commercial and efficiency benefits **Executive Risk Lead:** James Thomson, Director of Finance **Board Committee**: Performance **Last Update:** 2 February 2023	**Causes** 1. Lack of clear strategy for subsidiaries 2. Lack of governance and assurance interfaces with Trust 3. Lack of signed SLA/contract agreements **Consequences** 1. Failure to realise efficiencies 2. Failure to maximise commercial income 3. Subsidiaries and JV do not invest in business and reduce growth/market share	5 x 3 = 15	C1) Limited Liability Partnership agreement with the Mater Private Healthcare. Renewed by both parties 2020. **Control Owner: DoF**	Contract format and agreement reviewed by Trust Board. Also managed through joint venture Board.	Legal advice taken on initial structuring and renewal agreement.	**Acceptable**	3 x 3 = 9 ⬇	**Yes**	G1) Annual review of budgets to support SLA relationship to complete before Trust financial plan for year.	Commence SLA discussion in Q4 22/23 **Action Owner:** DoF **Due date:** 31/03/23 (Revised from 31/1222)	Agreed SLA position for 2022/23. Budget for JV approved by JV Board in June 2022.	2 x 2 = 4
			C2) Financial plan set by The Mater and approved by Trust **Control Owner: DoF**	JV performance reports and finance results reported to Performance Committee - twice per year.	External audit required annually	**Partial**			G2) Revised multi-year marketing and growth plan to be developed and approved.	JV producing revised multi-year strategy for growth. **Action Owner:** DoF **Due date**: 30/06/22 (revised from 30/11/22, revised from 30/09/22)	Standing item on JV Board. Separate strategy session planned July 2022. Budget approved by JV Board in June 2022. Marketing and engagement plan revised and being implemented by JV Manager. New JV Manager to start April 23.	
			C3) Separate governance and Board arrangements for CPL and PropCare **Control Owner: DoF**	Internal SLA and financial reporting process managed through Finance Committee and Divisional Boards (monthly).	Governance arrangements included in MIAA audit plan Both subsidiaries subject to external audit, and for CPL professional regulatory licensing.	**Acceptable**			G3) Governance process impacted by absence of Company Secretary. Final revised SLA with CPL, not signed. **(closed)**	Temporary Company Secretary to be engaged. Trust/CPL to sign SLA following review. **Action Owner:** CEO **Due date**: 30/11/22 (revised from 30/09/22) **(closed)**	Trust engaged with experienced governance lead for temporary contract. Substantive recruitment process in train. Revised CPL SLA signed January 2023. New Chair of CPL appointed by Trust Board.	
			C4) PropCare approved business strategy and medium term plans March 2022 **Control Owner**: **DoF**	PropCare performance reports to Performance Committee and Trust Board - bi-annually. Trust Board Non Executive Directors named as Directors of subsidiaries.	PropCare subject to external audit.	**Partial**			G4) PropCare have developed strategy (March 2022) and required to translate into full business plan.	Trust to receive full business plan Quarter 4. **Action Owner**: DoF **Due date**: 31/03/23 (revised from 30/11/22, revised from 31/09/22)	PropCare have started to implement the strategy, making key appointments as planned.	
			C5) CPL approved business strategy and medium term plans March 2022 **Control Owner**: DoF	CPL performance reports to Performance Committee and Trust Board - bi-annually. Trust Board Non Executive Directors named as Directors of subsidiaries.	Subsidiaries subject to external audit. CPL corporate tax structure advised by KPMG.	**Acceptable (changed from partial)**			G5) CPL to develop and present 5 year strategy to Trust Board for approval.	CPL to finalise 5 year strategy at CPL July Board. To present to Trust Board at next update. **Action Owner:** DoF **Due date:** 31/10/22 (closed)	CPL Board Strategy session complete. CPL presenting 23/24 plan at CPL Board October 2022 CPL 5 year strategy presented to Trust Board November 2022	

Additional narrative

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

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Title of meeting: Trust Board
Date of meeting: 26 April 2023

Report lead	Liz Bishop, Chief Executive			
Paper prepared by	Skye Thomson, Corporate Governance Manager Recommendations provided by the Executive Risk Leads and Board Committees			
Report subject/title	Board Assurance Framework (BAF) Refresh 2023/24			
Purpose of paper	To present recommendations to the Board for the risk wording, and 2023/24 target scores for the BAF.			
Background papers	Q4 BAF report presented to April Board of Directors; BAF update reports to Performance Committee (February), Quality Committee (March), People Committee (April) and Audit Committee (April)			
Action required	Approve the recommended risk wording and 2023/24 target scores			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work	
	Be Collaborative	x	Be Digital	
	Be Research Leaders		Be Innovative	

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

The Clatterbridge Cancer Centre NHS Foundation Trust

1.0 Introduction

1.1 This report is to provide recommendations to the Board for any changes to the BAF wording, and 2023/24 target scores for the BAF.

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

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

1.3 Each BAF risk has been reviewed by the Executive Risk Lead who proposed any wording changes to the risk title suggested (in red below) and a target score for 31st March 2023. In quarter 4 reports, committees were requested to consider the BAF risks' position at the end of 2022/23 and discuss the 2023/24 gaps and potential target scores, which would support the Executive Risk Leads.

2.0 2023/24 BAF Refresh

BAF1 Quality governance systems				
Risk appetite: Low (exceeded)				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/24**	**Commentary**
~~There is a risk that **quality governance systems fail to drive improvements in patient safety and experience and the effectiveness of care**, which would negatively affect the CQC's assessment of the Trust's services~~ There is a risk that a lack of organisational focus on patient safety and quality of care will lead to an increased incidence of avoidable harm, higher than expected mortality, and significant reduction in patient satisfaction **Executive Risk Lead**: Julie Gray Chief Nurse	**15**	**10**	**10**	During 2022/23 existing governance systems and processes where reviewed and refreshed to ensure they meet the requirements to evidence a safe, caring, responsive, effective and Well-led organisation. A new governance committee structure with clinical leadership, clearer lines of responsibility and mechanisms to ensure accountability was introduced and aggregated data/thematic reports were developed. During 2023/24 these processes will begin to embed and once consistent data is available to demonstrate sustained improvement the target risk score will be achieved. Vacancies/investment in key posts has remains a limiting factor.

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BAF2 Demand exceeds resources				
Risk appetite: Low (exceeded)				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/24**	**Commentary**
There is a risk of **demand exceeding available resources**, that could impact the quality and safety of services and patient outcomes **Executive Risk Lead**: Joan Spencer Chief Operating Officer	**12**	**12**	**12**	The target needs to remain at 12 as there are a number of external factors affecting our activity including; 1. All referring trusts have a target recovery plan over 104% of 19-20 activity, increased throughput at referring trust will increase referrals to CCC 2. CDCs are supporting high volumes of diagnostics that will increase the number of patients diagnosed with cancer and therefore require SACT treatment. 3.The allocation of funding for the delivery of SACT does not cover all costs associated with a SACT Pathway 4. The majority of CCCs activity is codes as an OPD procedure, there is a national drive to reduce OPD activity by25% and therefore any OPD activity we deliver is capped at 75%

BAF3 Insufficient funding				
Risk appetite: Low (exceeded)				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/24**	**Commentary**
There is a risk of **available funding being insufficient** to deliver the Trust's strategic priorities **Executive Risk Lead**: James Thomson Director of Finance	**16**	**8**	**8**	The funding and contracting system for 2023/24 and 2024/25 has changed, with funding based on population allocations and elective activity. The transition to devolved specialised commissioning is ongoing, and further governance structures are expected to be set-up in the year. The Trust has agreed an increase to its contract for 2023/24. It is recognised that the Cheshire and Merseyside ICS is subject to financial challenge, and a level of 5% efficiency is expected by NHS England in 2023/24. This is an historic high level of savings for the Trust. The transition to devolved specialised commissioning is ongoing, and further governance structures are expected to be set-up in the year. The Trust have agreed an improved contract offer for 2023/24. Overall, the risk of insufficient funding remains high, and the establishment of new funding mechanisms and system working will continue to present challenges.

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BAF4 Board Governance				
Risk appetite: low				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/24**	**Commentary**
There is a risk that **corporate and clinical governance arrangements** do not provide comprehensive **Board oversight and assurance**, leading to inadequate visibility of critical issues and failure to meet regulatory expectations **Executive Risk Lead**: Liz Bishop Chief Executive	**8**	**8**	**4** ↓	During 2022/23 many of the actions addressing gaps in controls have been closed. The key areas of focus for 2023/24 are the completion of the quality strategy and the work against the Code of Governance, identified in the compliance assessment. The plan is to close these actions in the first half 2023/34.

BAF 5 Environmental sustainability				
Risk appetite: low (exceeded)				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/24**	**Commentary**
If the **Trust does not integrate environmental sustainability considerations into delivery of its strategic priorities**, it will fail to realise the potential benefits and contribute to the NHS Net 0 target **Executive Risk Lead**: Tom Pharaoh Director of Strategy	**12**	**9**	**9**	Good progress has been made in 2022/23 as set out in the first Green Plan annual report (presented to Board in February); however, the BAF5 target score for 2022/23 (3 x 3 = 9) was not achieved. This is in large part due to the challenges in appointing a substantive Sustainability Manager resource during 2022/23. An appointment has now been made and the successful candidate begins in post in June 2023. The Sustainability Manager will lead and drive as a priority the delivery of the planned actions to address the gaps in controls. It is anticipated that the target risk score for 2023/24 (3 x 3 = 9) will be achieved by the end of Q2.

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BAF6 ICS				
Risk appetite: moderate				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/23**	**Commentary**
There is a risk that the Trust fails to achieve sufficient **strategic influence within the ICS** to maximise collaboration around cancer prevention, early diagnosis, care and treatment **Executive Risk Lead**: Liz Bishop Chief Executive	**8**	**8**	**8**	During 2022/23 many of the actions addressing gaps in controls have been closed. However, risk still remains around external funding and the Trust is still following up on the completion of the risk sharing agreement with the ICB.

BAF 7 Research portfolio				
Risk appetite: moderate				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/24**	**Commentary**
If the **Trust is unable to increase the breadth and depth of research**, it will not achieve its research ambitions as a specialist cancer centre **Executive Risk Lead**: Sheena Khanduri Medical Director	**12**	**8**	**8**	There is still work to get studies open with the following actions due for completion in quarter one which should support the reduction of the risk score: 1. Monitor progress against plan with Pharmacy. 2. Revised clinical trial portfolio leading to additional service requirements e.g. Interventional Radiology (IR), see below action. 3. Develop Research vision for the CCC IR Service to remove dependence on third party providers.

BAF 8 Research programme under-resourced				
Risk appetite: moderate				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/24**	**Commentary**
Competition for talent and research sponsorship means that the **research programme is at risk of being under-resourced**, which would hinder the Trust's ambition to be research leaders **Executive Risk Lead**: Sheena Khanduri, Medical Director	**8**	**8**	**6** ↓	The Trust has funding for ECMC, BRC and CRF. However there is short fall in ECMC funding and more BRC funding needed. Additional work will take place in 2023/24 to close funding gaps.

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BAF9 Leadership capacity and capability				
Risk appetite: Low (exceeded)				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/24**	**Commentary**
There is a risk that **leadership capacity and capability at the Trust is insufficient** to drive the changes required to achieve its strategic ambitions **Executive Risk Lead**: Jayne Shaw Director of Workforce & OD	**9**	**9**	**9**	The work from the actions addressing the gaps in controls will take time to deliver and be fully embed for the Trust to see the benefits of the programmes.

BAF 10 Skilled and diverse workforce				
Risk appetite: Low (exceeded)				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/24**	**Commentary**
There is a risk of being **unable to attract and develop a diverse and highly skilled workforce**, which could limit the Trust's capacity to deliver and develop further its specialist services **Executive Risk Lead**: Jayne Shaw Director of Workforce & OD	**12**	**9**	**9**	This BAF risk contains actions with revised implementation dates for 2023/24. The work from the actions addressing the gaps in controls will take time to deliver and be fully embed for the Trust to see the benefits of the programmes

BAF 11 Staffing levels				
Risk appetite: Low (exceeded)				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/23**	**Commentary**
There is a risk of **insufficient staffing levels in some areas of the Trust**, which could result in disruption to services and jeopardise the quality of care **Executive Risk Lead**: Jayne Shaw Director of Workforce & OD	**16**	**9**	**12** ↑	There has been a national increase in staff turnover which is reflected regionally. We need to understand the local position. The work from the actions addressing the gaps in controls will take time to deliver and be fully embed for the Trust to see the benefits of the programmes.

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BAF 12 Staff health and wellbeing				
Risk appetite: Low (exceeded)				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/23**	**Commentary**
There is a risk of **decline in the health and wellbeing of staff**, which may result in increased absence and turnover, affect the Trust's ability to deliver services, and damage its reputation as ~~an employer~~ a great place to work **Executive Risk Lead**: Jayne Shaw Director of Workforce & OD	**9**	**6**	**6**	The work from the actions addressing the gaps in controls will take time to deliver and be fully embed for the Trust to see the benefits of the programmes.

BAF 13 Digitisation				
Risk appetite: moderate				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/24**	**Commentary**
There is a risk of **limited development and adoption of digitisation across the Trust**, which would constrain service improvements and reduce the benefits for patients **Executive Risk Lead**: Sarah Barr Chief Information Officer	**9** ⬇	**9**	**9**	During 22/23 There have been a number of gaps in control closed throughout the year and the risk has reached its target grade of 9 for March 2023. There is still ongoing work required to embed digititisation and it is proposed that the target grade remains as 9 for 23/24. Gaps in control will be reviewed for this BAF in 23/24 and closed gaps will be removed or added as controls where appropriate.

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BAF14 Cyber security				
Risk appetite: Moderate				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/24**	**Commentary**
There is a risk of **major security breach** arising from increasing digitisation and cyber threats, which could disable the Trust's systems, disrupt services and result in data loss **Executive Risk Lead**: Sarah Barr, Chief Information Officer	**12**	**12**	**12**	During 22/23 There have been a number of gaps in control closed throughout the year and the risk has moved from 16 to 12. Due to the fluctuating nature of Cyber risk, it is proposed the target remains as 12 for 23/24. Gaps in control will be reviewed for this BAF in 23/24 and closed gaps will be removed or added as controls where appropriate.

BAF 15 Subsidiary companies and Joint Venture				
Risk appetite: moderate				
Risk title	**Residual risk**	**Target 31/03/23**	**Target 31/03/24**	**Commentary**
There is a risk of **inadequate governance** management **of the Trust's Subsidiary Companies and Joint Venture**, which would result in failure to maximise the potential commercial and efficiency benefits **Executive Risk Lead**: James Thomson Director of Finance	**9**	**4**	**4**	The Trust recognises the value that its subsidiaries and private patient joint venture continue to represent. The management structures for the subsidiary companies are stable, after some senior changes in 2022/23. Both companies have strategies that have been reviewed by the Trust. Governance and management process are established. The private patient joint venture has delivered its targets for 2022/23, and is looking to develop further in 2023/24. A new clinic manager has been appointed and will be pivotal in the clinic achieving its financial and operational objectives. Governance and management process are established.

3.0 Risk Appetite Statement

3.1 The Trust's 2023-2026 Risk Management Strategy will go to the Board of Directors for approval on 26th April 2023. This includes the Trust's risk appetite statement for approval.

4.0 Recommendations

4.1 The Board is requested to approve the recommended risk wording and 2023/24 target scores

Appendix 1: Strategic risk heatmap showing initial, residual and target risk scores for Q4 2022/23 and Q4 2023/24

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

Key

⊗	Initial (inherent)
Ⓡ	Residual (current)
★	2022/23 Target
★	2023/24 Target
→	Distance to target

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

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Trust Board Part 1 – 26 April 2023

Chair's Report for: Quality Committee

Date/Time of meeting: 23 March 2023: 09.30-12.30

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

General items to note to the Board	<u>Terms of Reference</u> The Committee completed the annual review of its Terms Reference. Following discussion, the Committee endorsed a number of proposed amendments which aimed to provide clarity on the Committee's functions and membership. The proposed amendments included deletion of functions relating to monitoring of the Freedom to Speak Up Policy and ensuring that robust arrangements are in place for Emergency Planning as these functions are undertaken by the People Committee and Performance Committee respectively. The Committee recommended the revised Terms of Reference included at Annex A to this report to the Board of Directors for approval. <u>Digital</u> The Committee approved the Digital Strategy and requested annual updates to come to the Committee. <u>Board Assurance Framework</u> The Committee reviewed the BAF risks aligned to Quality Committee and approved the BAF 13 requested revised score from (3 x 4) 12 to a (3 x 3) 9. The Committee noted BAF 1 and BAF 7 had remained static and were keen to meet to look at these issues. The risk appetite for BAF 1 (quality governance systems) is low and the Committee noted there are deadlines for the end of March 2023 for the Risk Management Strategy, Complaints process review, falls and pressure ulcers, Quality Improvement strategy, culture survey, nosocomial infection performance review meeting and safer nursing care tool training. The Committee noted that some of these actions will need revised targets and it will take time to bring the risk down. The Committee were satisfied with the direction of travel.

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	MIAA Quality Spot Checks The Committee received a detailed update on the actions taken following the limited assurance MIAA Quality Spot Checks. The Committee interrogated the update and were pleased with the progress made against the recommendations and requested a further update at the next meeting in June. Draft Risk Management Strategy The Committee approved the draft Risk Management Strategy subject to inclusion of more detail regarding risk appetite which outlines the approach to risk appetite for the Board.
Items of concern for escalation to the Board	Safeguarding The Committee received an update on Safeguarding following a request to follow up in 6 months made at the September 2022 meeting. This request was made as the Committee raised concerns from the Annual Safeguarding Report on the learning disability standard outcome which has now improved from 57.9% of patients surveyed agree that they were given a choice about their care, to 100%. However the number of staff that agreed that there was a clear policy in regards to DNACPR had decreased from 36.8% in September to 17% in March. There is work underway to increase staff awareness of this process in partnership with Palliative Care Team and the recent publication `Do not attempt cardiopulmonary resuscitation (DNACPR) and people with a learning disability and or autism` which will provide focus of awareness. The team will use champion roles to support awareness raising. The Committee discussed this in detail and requested an update on the planned work in the Safeguarding Annual Report in September.
Items of achievement for escalation to the Board	Ward to Board Presentation The Board received a presentation from Kate Parker, Macmillan Metastatic Spinal Cord Compression Service Lead, which provided an overview of the current Metastatic Spinal Cord Compression (MSCC) Service and the transformational plans to move towards the provision of an emergency and Network wide spinal oncology service. The Committee were pleased to see the excellent work being done by the team.
Items for shared learning	No items for shared learning were identified.

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Quality Committee Terms of Reference

ToR Reference	(To be provided by DCO)
Version	V.6
Name and designation of ToR author(s)	Paul Buckingham, Interim Associate Director of Corporate Governance
Approved by (committee, group, manager)	Board of Directors – Draft for review
Approval evidence received (minutes of meeting, electronic approval)	
Date approved	
Review date	
Review type (annual, three yearly)	Annual
Target audience	Board of Directors and Board Committees
Links to other strategies, policies, procedures	
Protective Marking Classification	Internal
This document replaces	V.5
Date added into Q-Pulse	For completion by DCO
Date document posted on the Intranet	For completion by DCO

Date	Version	Author name and designation	Summary of main changes
February 2019	V.2.0	Angela Wendzicha, Associate Director Corporate Governance	Full review of current Terms of Reference with additional strengthening of: • Membership • Roles and responsibilities • Reporting arrangements
April 2019	V.3.0	Angela Wendzicha, Associate Director Corporate Governance	
June 2022	V.4.0	Skye Thomson, Corporate Governance Manager	• Updated into new template • Removed items now going to the People Committee • Updated job titles in membership section
June 2022	V.5.0	Skye Thomson, Corporate Governance Manager	• Completed updates requested at June 2022 Quality Committee meeting regarding Membership, Freedom to Speak Up and R&I Board
February 2023	V.6.0	Interim Associate Director of Corporate Governance	Annual Review

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NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Quality Committee – Terms of Reference	
Authority	1.1 The Quality Committee ("the Committee") is constituted as a standing committee of The Clatterbridge Cancer Centre NHS Foundation Trust's Board of Directors ("the Board"). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings. 1.2 The Committee is authorised by the Board to act and investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee. 1.3 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. 1.4 The Committee is authorised to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to exercise its functions. 1.5 The Committee is authorised to establish time limited working groups from time to time on specific subjects requiring detailed review. 1.6 The Committee is authorized to meet via a virtual/remote meeting. For the purposes of such meetings, 'communication' and 'electronic communication' shall have the meanings, as set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.
Specific work areas	Role **2. On behalf of the Board obtain 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 to:** 2.1 Promote continuous improvement in patient safety, effectiveness and excellence in patient care. 2.2 Ensure the effective and efficient use of resources through evidence-based clinical practice. 2.3 Ensure compliance with legal, regulatory and other obligations, including national quality standards, National Institute for Clinical Excellence and National Service Frameworks. 2.4 Promote visible leadership with regard to quality and risk management. 2.5 Ensure that appropriate arrangements and responsibilities are in place from 'Board to Ward'. Duties

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	The Committee will ensure that the Board is assured in relation to quality (patient experience, safety and outcomes) and workforce which will include but not limited to: **3. In respect of general governance arrangements:** 3.1 To ensure that all statutory elements of governance are adhered to within the Trust. 3.2 Develop and recommend for approval by the Board, Trust-wide quality priorities to form the basis of the Trust Quality Strategy and provide direction to the clinical governance activities of the Trust's services and Directorates. ~~through routine consideration of the Trust's Annual Integrated Governance Report.~~ 3.5 To consider matters escalated to the Committee by its own sub-committees. 3.6 To approve the annual Clinical Audit Programme on behalf of the Board, ensuring it is consistent with the audit requirements of the Trust. 3.7 To make recommendations to the Audit Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference. 3.8 To ensure the Trust complies with any NHS Resolution requirements. 3.9 To ensure the registration criteria of the Care Quality Commission continue to be met. 3.10 To review the Trust against the national standards of quality and safety of the Care Quality Commission and Foundation Trust Licence conditions that are relevant to the Committee's area of responsibility; subsequently receive advice regarding remedial action being taken as necessary by the Executive Team and provide assurance to the Board. 3.11 To receive and review the Trust's Annual Quality Report and make recommendations as appropriate for Board approval. **4. In respect of safety and excellence in patient care:** 4.1 To commission the setting of quality standards and ensure that a mechanism exists for these standards to be monitored. 4.2 To oversee the system within the Trust for obtaining and maintaining licences or accreditation relevant to clinical activity in the Trust, receiving such reports as the Committee considers necessary. 4.3 To seek assurance through review of the Legal Report that the Trust incorporates any recommendations from external bodies e.g. National Confidential Enquiry into Patient Outcomes and Death, Care Quality Commission. 4.4 To ensure that robust arrangements are in place for the review of patient safety incidents (including near misses), complaints, claims

	and reports from HM Coroner from within the Trust and the wider NHS to identify similarities or trends and areas for focused or organisation-wide learning. 4.5 To identify areas for improvement in respect of complaints / PALS / Friends and Family Test and ensure appropriate action is taken. 4.6 To support the Board in promoting within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care. ~~in accordance with the Trust Freedom to Speak Up Policy in addition to the monitoring of that policy.~~ 4.7 To ensure the Trust has a robust system in place for the management of national patient safety alerts and ensure that appropriate action is taken in respect of these. 4.8 To escalate to the Audit Committee any identified unresolved risks arising within the scope of these terms of reference that require Executive action or that pose a significant threat to the operation, resources or reputation of the Trust. 4.9 Ensure that any areas of concern identified from the Committee's review of clinical quality are entered onto the Trust risk register as appropriate and any identified gaps in controls in relation to delivery of relevant Trust strategic objectives are reflected and escalated to the Board Assurance Framework. 4.10 To ensure that robust processes are in place for the review of any proposals for cost improvement programmes and other significant service changes and the effect of those on the Trust's quality of care (ensuring there is a clear process for staff to raise any concern and for these to be escalated to the Committee) and report any concern relating to an adverse impact on quality to the Board. 4.11 To ensure that care is based on evidence of best practice / national guidance. ~~4.12 To assure the implementation of all new procedures and technologies according to Trust policies.~~ ~~4.14 Ensure robust arrangements are in place in relation to Emergency Planning and Business Continuity.~~ 4.16 To ensure that where practice is of high quality, that practice is recognised and propagated across the Trust. 4.17 To ensure the Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.
Reporting arrangements	5.1 The minutes of all meetings of the Quality Committee shall be formally recorded by a member of the Corporate Governance Team. ~~Office or their nominee.~~ 5.2 The Committee will report to the Board following each meeting and the Chair of the Committee will bring to the attention of the Board any items that the Committee feels that the Board should be aware of in addition to any issues that require disclosure to any regulatory

	authority. The Chair's report to the Board of Directors will also be presented to the Council of Governors for information. 5.3 The Committee will carry out an annual review of its effectiveness and provide an annual report to the Audit Committee on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference.~~the effectiveness of its work and its findings.~~ This will assist the Audit Committee in discharging its responsibility for providing assurance to the Board in relation to all aspects of governance, risk management and internal control. ~~5.4 The Quality Committee will report to the Council of Governors generally and on any matters which it considers that action or improvement is required and making recommendations as to the steps to be taken.~~ • ~~Integrated Governance Committee~~ • ~~Research & Innovation Board.~~
Membership	6.1 The Committee will be appointed by the Board and will consist of: • Three Non-Executive Directors • Chief Nurse • Medical Director • Director of Workforce and OD • Chief Operating Officer • Chief Information Officer 6.2 A Non-Executive Director shall be appointed Chair of the Committee with a second Non-Executive appointed as Deputy Chair. 6.3 The following will routinely be in attendance at Committee meetings: • Associate Director of Corporate Governance • Head of Planning and Performance • Risk Manager • ~~Associate~~ Director of Research & Innovation Operations • Deputy Director of Nursing 6.4 Members are required to attend at least 75% of the meetings in any one financial year. 6.5 The Trust Chair and Chief Executive may attend any or all meetings but are not designated as members of the Committee. The Committee may invite other persons to attend the meeting from time to time so as to assist in discussions and the Chair will be notified in advance of attendees. 6.6 Membership of the Committee will include at least one common Non-Executive member of the Audit Committee. This member will act as a conduit of information and assurance across the two Committees in support of the Trust's Integrated Governance approach.
Quorate	The Committee will be deemed quorate to the extent that the following members are present:

	• At least two Non-Executive Directors, one of whom shall Chair the Committee • The Chief Nurse or the Medical Director.		
Notice of meetings	An agenda of items to be discussed and supporting papers will be forwarded to each member of the Committee and any other attendees no later than 4 working days before the date of the meeting.		
Standard items	Standard Agenda items will fall under the headings: 1. Reports and Action Plans 2. For consultation / approval 3. For information 4. Items for shared learning 5. Items for Escalation to Trust Board 6. Any Other Business		
Frequency	The Committee will meet quarterly.		
Date Approved:		**Review Date:**	

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1 – 26 April 2023

Chair's report for: Audit Committee

Date/Time of meeting: 19 April 2023: 09.30-12.30

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

General items to note to the Board	• The Committee reviewed BAF entry 14 Cyber Security and noted that the residual risk score at the end of quarter 4 remains at 12 in line with the target score. The Committee was satisfied that the controls, gaps in controls and assurance were accurately captured and supported retaining a target risk score of 12 for 2023/24.
	• The Committee received an Internal Audit Progress Report covering the period 1st Jan to 31st March, which detailed the following audits:
	  • Quality Spot Checks (Limited Assurance)
	  • Recruitment and Retention (Substantial Assurance)
	  • Data Quality (Substantial Assurance)
	
	The audit of Quality Spot Checks identified 4 high and 2 medium recommendations. Work to address the issues identified has been reviewed by Quality Committee and progress will continue to be monitored.
	
	• The Committee also received the Head of Internal Audit Opinion (HOIA) for the period 1st April 2022 to 31st March 2023 which provides **Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.**
	
	• The Committee approved the Internal Audit Plan for 2023/24 noting the planned reviews align to the the Trust's BAF risks and comply with the Public Sector Internal Audit Standards.
	
	• The Committee noted the Internal Audit Follow-Up Report and the progress made on completing management actions arising from earlier audits. The Committee agreed to request attendance by lead Directors where progress

	against rescheduled actions cannot be evidenced when the Committee meets in July. • The Committee approved the Annual Anti-Fraud Plan for 2023/24 which is based on a robust strategic risk assessment of the organisation and the wider NHS. • The Committee noted the Anti-Fraud Annual Report for 2022/23 which included the self-assessment of compliance against the Government Functional Standard 013 for Counter Fraud. The assessment demonstrated compliance against all 12 components. The Committee thanked the Corporate Governance team for all their efforts which enabled the Trust to declare compliance for component 12-Policies and Registers for Gifts and Hospitality and Conflicts Of Interest-which was previously rated as amber. • The Committee received the Annual Audit Plan from the External Auditor which outlined the proposed approach/scope for the audit of the financial statements and the value for money review for the year ended 31 March 2023. • The Committee reviewed an early draft of the Annual Report including the Annual Governance Statement (AGS). The Committee requested that the Executive should include additional narrative in the AGS to highlight the achievement of Cyber Essentials accreditation and to describe the scope and breadth of partnership working. In addition, the Committee highlighted that the narrative/table in the draft AGS relating to the Internal Audit activity in 2023/24 needed to be consistent with the information included in the Head of Internal Audit's Opinion. The draft Annual Report was supported by a self-assessment of the Trust's compliance with the NHS Foundation Trust Code of Governance. The assessment evidenced compliance against the main principles of the Code. • Following the publication by NHS England of model accounting policies in early March 2023 a review was undertaken by the Finance Team to ensure appropriate adjustments were made to Trust policies to reflect the amended model policies. The Committee considered and approved the amended Trust accounting policies.
Items of concern for escalation to the Board	• The Director of Finance provided an update to the Committee regarding financial planning for 2023/24. Following recent Board approval the Trust submitted a plan projecting a £54k surplus for the year. However, as the

	overall plan submitted to NHSE by Cheshire and Merseyside delivered a significant deficit then the ICB's plan was not accepted by NHSE. NHSE are now engaging directly with the Cheshire and Merseyside ICB to explore what actions could be taken to enable the ICS to resubmit a break-even plan. Consequently, at this point in time we have not had confirmation that the plan submitted by the Trust has been accepted by the ICB. The Director of Finance agreed to provide an update to the Board regarding this matter at the forthcoming Board meeting.
Items of achievement for escalation to the Board	• The Committee reviewed a report which detailed performance against a range of Key Financial Assurance Indicators and noted positive performance against the range of indicators. The Committee thanked the Finance team for their efforts and noted a letter received in March from Julian Kelly, Chief Finance Officer, NHS England congratulating the Trust on it's performance in relation to the Better Payment Practice Code for the year to month 10. The national standard requires that the NHS pays at least 95% of all invoices in line with contract terms, typically 30 days. The Trust's performance all year by value and by number has been over 95%. The Trust were one of only 27 Trusts in the country and of only two in the North West to receive a letter. • In addition to recognition from NHSE the Finance Department have been awarded Level 1 towards Excellence Accreditation. This demonstrates that the Department is meeting key requirements for staff development and levels of professional conduct.
Items for shared learning	No items for shared learning were identified.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1 – 26 April 2023

Chairs report for: People Committee
Date/Time of meeting: 18 April 2023

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

Items of concern for escalation to the Board	**Board Assurance Framework** The Committee agreed that whilst BAF 11 had a reduced score from 16 to 12 due to ongoing plans to mitigate the risk, it was agreed that the plans need to be monitored over the next few months to be able to measure their impact on the risk, and therefore a score of 16 will be reinstated until the plans have been implemented and reviewed. **Mandatory Training and PADR Performance Report** ILS and BLS training remain under target, despite additional training opportunities that have been offered, including late night training sessions, weekend's and one-to-one training. The Committee noted that the team are now focussing on those individuals who are consistently non-compliant for a 6-month period, who will be receiving escalation letters with a focus on completing the training. **Guardian of Safe Working Report** The Committee noted that agency staff were brought in to cover three new junior doctor trainees/fellows due to not having up to date ALS training upon recruitment, however this has now been addressed and will be included as part of the pre-employment checks. The Committee noted that Board had reviewed this report in full at its meeting on 29 March 2023. **Industrial Action Update** The Committee noted the recent end to the 96-hour junior doctor strike on 15th April but with the recent news regarding the rejected pay offer by the RCN, more strikes are scheduled to take place amongst nursing staff between 30th April – 2nd May 2023. Planning continues, to ensure safe staffing levels and safe patient care during the strike action, whilst also supporting the staff to take part.

The Clatterbridge Cancer Centre NHS Foundation Trust

Items of achievement for escalation to the Board	**Staff Story – Menopause Staff Network** The Committee noted the creation of the new Menopause Network, led by staff, which welcomes all attendees, and provides education around the impact of menopause and the support that is available. The Committee commended the 6 staff champions for the progress that has been made in such a short space of time, with the opening of a Menopause Microsoft Teams channel, Menopause Café, and a Menopause email box. The plan for 2023 includes close working with the Occupational Health Teams, Learning and OD, and Workforce teams, to continue to raise awareness and provide advice on the support that is available. **Leadership and Organisational Development** The Committee noted the high level of learning and development activities, and work streams that have taken place over the past 12-months in relation to leadership and management programmes including, Teams at the Top, Leadership Masterclasses for all staff, and the Springboard Programme, aimed at career development for female colleagues across the organisation. The development programme also incorporates the Apprenticeship Programme and the NHS Leadership Academy Programmes. All programmes have been well received and attended, and link in with the Trusts five workforce pillars within the People Commitment. **NED Wellbeing Guardian** The Committee noted the outline responsibilities for the Wellbeing Guardian whose purpose is to seek out and provide assurance around workforce wellbeing. The Guardian will be supported to do this by the Workforce and Organisational Development Teams. **People Risks** The Committee noted that there are currently no specific people risks with a score of 15 or above. **Workforce Planning** The Committee received an update regarding workforce planning and noted that a revised submission date of 28th April has been agreed. The next stps include finalising 2023/24 workforce investments by staff group and occupational code and Support Divisions/Departments to develop and achieve recruitment plans. **Committee Governance** The Committee review its Cycle of Business for 2023/24 and agreed to the proposed revisions to its Terms of Reference. **The People Commitment Report** The Committee received an update on the progress of the implementation of

	the Trust's 5-year People Commitment. Key achievements in q4 include: • 2023/24 Live Well Work Well interventions and priorities developed • 2023 Leadership Passport launched • Project plan and funding for new My Appraisal process and system approved • Continued work with LRC to offer apprenticeships and work placements The Committee approved the areas to be carried forward to the year 2 People Committee implementation plan. **Recruitment Update** An Open Evening supporting Administration and Clerical recruitment was held on 6th April 2023 and the Committee noted over 70 applicants had been interviewed. Work is progressing around the next international nurse cohort with 4 WTE commencing April 2023 **Equality, Diversity & Inclusion Report** The Committee noted that the focus for 2023 will be on improving and enhancing the experiences of our staff and to ensure that the deeper detail, behind the data is understood. **Gender Pay Gap Report** The Committee noted the gender pay gap of 23.8% but are confident that the gender pay gap is not as a result of paying men and women differently for the same or equivalent job role however, more work is to be carried out to attain gender balance across the workforce. The Committee noted that Board had reviewed this report in full at its meeting on 29 March 2023. **Staff Wellbeing** The Committee noted the progress that has been made against the priorities identified in the People Commitment and ongoing intelligence received through the NHS Staff Survey, Culture and Engagement Pulse and staff engagement events. The Committee noted the further work involved with embedding cultural change programmes and time required to measure the results.
Items for shared learning	No Shared Learning was identified

The Clatterbridge Cancer Centre NHS Foundation Trust

Performance Committee Terms of Reference

ToR Reference	(To be provided by DCO)
Version	V.3
Name and designation of ToR author(s)	Paul Buckingham, Interim Associate Director of Corporate Governance
Approved by (committee, group, manager)	Board of Directors – Draft for review
Approval evidence received (minutes of meeting, electronic approval)	
Date approved	
Review date	
Review type (annual, three yearly)	Annual
Target audience	Board of Directors and Board Committees
Links to other strategies, policies, procedures	Trust Strategy 2021-2026 Our People Commitment 2021-2026
Protective Marking Classification	Internal
This document replaces	V.2
Date added into Q-Pulse	For completion by DCO
Date document posted on the Intranet	For completion by DCO

Date	Version	Author name and designation	Summary of main changes
June 2022	V.1.0	Zoe Hatch, Deputy Director of Workforce	Committee formed and document created.
September 2022	V.2.0	Zoe Hatch, Deputy Director of Workforce	:Updated to incorporate feedback from June 2022 Trust Board.
February 2023	V.3.0	Interim Associate Director of Corporate Governance	Periodic Review.

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The Clatterbridge Cancer Centre NHS Foundation Trust

People Committee – Terms of Reference	
Authority	1.1 The People Committee is constituted as a standing committee of The Clatterbridge Cancer Centre NHS Foundation Trust's Board of Directors ("the Board"). The constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings. 1.2 The People Committee is authorised by the Board to act and investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the People Committee. 1.3 The People Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to exercise its functions. 1.4 The People Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. This may include establishing task and finish groups as required to assist in discharging its responsibilities. 1.5 The People Committee is authorized to meet via a virtual / remote meeting. For the purposes of such meetings, 'communication' and 'electronic communication' shall have the meanings as set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.
Specific work areas	**2. Purpose of the People Committee** 2.1 The purpose of the People Committee is to provide assurance to the Board on the quality, delivery and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. This includes, but is not limited to: • Employee health and wellbeing • Organisational culture • Equality, diversity and inclusion • Employee engagement • Leadership • Organisational values and behaviours • Education and training • Learning and development • Organisational development • Workforce development

	• Workforce planning • Recruitment and retention. 2.2 The People Committee will assure the Board of the achievement of the objectives set out in the Trust's 5-year strategy, Our People Commitment and NHS People Promise. 2.3 The People Committee is responsible for providing assurance to the Board in relation to the delivery of the Trust's People Commitment, ensuring that the cultural identity, values and behaviours framework is aligned to the delivery of corporate objectives and compliance with legislation. 2.4 The Committee will ensure that the Trust's workforce has the capacity and capability to deliver the Trust's objectives through effective leadership and development, workforce planning and organisation development. 2.54 The Committee will ensure that risks relevant to the Committee's purpose are minimised through the application of the Trust's risk management system. This will include, but not be restricted to, the consideration of significant risks to the delivery of the Trust's strategic objectives, through review and scrutiny of the relevant risks from the Board Assurance Framework (BAF) and the division/corporate risk registers requiring consideration in accordance with the risk management policy. **3. Specific Functions of the People Committee** 3.1 Review and recommend to the Board workforce key performance indicators and targets. 3.2 Monitor and review performance against key performance indicators and any action plans to deliver improved performance. 3.3 Ensure that the Trust's people policies and procedures are prepared in accordance with legislation, NHS Guidelines and requirements and are operating within the Trust's overall assurance framework. 3.4 Ensure that all staff are receiving an effective annual appraisal and that robust succession plans and talent management processes are in place. 3.5 Receive and consider the national Staff Survey and Culture and Engagement survey results for the Trust and oversee the implementation and effectiveness of improvement plans on staff experience and engagement. 3.6 Ensure that the Trust has adequate staff with the necessary skills and competencies to meet the current and future needs of patients and service users. 3.7 Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics (i.e. Workforce Race Equality Standards, Workforce Disability Equality Standards and Gender Pay Gap reporting). 3.8 Monitor the effectiveness of staff engagement processes.

	3.9 Monitor and review the effectiveness of the Freedom to Speak Up service in the Trust. 3.10 Oversee the development and delivery of a workforce education and development plan. 3.11 Oversee the development of leadership skills and capacity across all levels of the Trust. 3.12 Oversee the development and implementation of new roles and career pathways that support the sustainable provision of services within the Trust. 3.13 Ensure the Trust fosters an open, transparent and high-performing culture, where staff feel valued and recognised and feel empowered to raise concern. 3.14 Oversee the development of the cultural identity, values and behaviours of the Trust, seeking assurance on the alignment with the delivery of workforce improvements. 3.15 To review progress being made to establish the Trust as an Anchor Institution in terms of workforce and education. 3.16 Oversee, review and ensure all aspects of staff health and wellbeing. 3.17 Monitor and oversee other relevant items as identified on the Committee's Cycle of Business~~Forward Plan~~ (agreed annually by the Committee).
Reporting arrangements	4.1 The minutes of all meetings of the People Committee shall be formally recorded by a member of the Corporate Governance Team~~Office or their nominee~~. 4.2 The People Committee will report to the Board following each meeting and the Chair of the People Committee will bring to the attention of the Board any items that the People Committee feels that the Board should be aware of in addition to any issues that require disclosure to external bodies or authorities. 4.3 The following sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, the Committee and any report or briefing requested by the Committee: • Education Governance Committee • Workforce Advisory Group 4.4 The Committee will carry out an annual review of its effectiveness and provide an annual report to the Audit Committee on its work in discharging its responsibilities, delivering its objectives and complying with its Terms of Reference. The review of effectiveness will specifically comment on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

Membership	5.1 Members of the People Committee will be appointed by the Board and membership will comprise: • Three Non-Executive Directors (one of whom must have relevant and current financial experience) • Director of Workforce and OD • Chief Nurse • Medical Director • Chief Operating Officer • Chief Information Officer 5.2 A Non-Executive Director shall be appointed Chair of the People Committee with a second Non-Executive Director appointed as Deputy Chair. 5.3 The following will routinely be in attendance at People Committee meetings: • Deputy Director of Workforce and OD • Head of Learning and Organisational Development • Head of Workforce Transformation • 1 x Workforce Business Partner • Director of Pharmacy • Associate Director of Education • Associate Director of Communications • Head of Equality, Diversity and Inclusion • Associate Director of Corporate Governance • Staff Side Chair 9.4 Members are required to attend at least 75% of the meetings in one financial year. 9.5 The Trust Chair and Chief Executive may attend any or all meetings but are not designated as members of the People Committee. The Committee may invite other persons to attend the meeting from time to time to assist in discussions and the Chair will be notified in advance of attendees. 9.6 Membership of the People Committee will include at least one common Non-Executive member of the Audit Committee. This member will act as a conduit of information and assurance across the two Committees in support of the Trust's Integrated Governance approach.
Quorate	The People Committee will be quorate to the extent that the following members are present:

	• Two Non-Executive Directors, one of whom shall Chair the Committee • The Director of Workforce and OD • One other Executive Director.		
Notice of meetings	An agenda of items to be discussed and supporting papers will be forwarded to each member of the Committee and any other attendees no later than 5 working days before the date of the meeting.		
Standard items	Standard Agenda items will fall under the headings: 1. ~~Workforce Performance and Risk~~ Standard Business 2. ~~Reports and Presentations~~ Be a Great Place to Work 3. ~~Annual Reports~~ Valuing our People 4. ~~Delegations from the Trust Board~~ Looking after our People 5. ~~Approvals~~ Digital Workforce 6. ~~Committee Report to the Trust Board of Directors~~ Developing our People 7. ~~Any Other Business~~ Workforce for the Future 8. Governance 9. Items for Shared Learning ~~7.~~10. Any other Business The business of the People Committee will take into account the relevant risks on the Board Assurance Framework.		
Frequency	The People Committee will meet quarterly.		
Date Approved:		**Review Date:**	

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board
Date of meeting: 26th April 2023

Report lead	Joan Spencer, Chief Operating Officer					
Paper prepared by	Hannah Gray, Head of Performance and Planning					
Report subject/title	Integrated Performance Report M12 2022 / 2023					
Purpose of paper	This report provides an update on performance for month 12 2022/23 (March 2023). This report provides an update on performance in the categories of access, efficiency, quality, workforce, research and innovation and finance. RAG rated data and statistical process control (SPC) charts (with associated variation and assurance icons) are presented for each KPI. Exception reports are presented below the relevant KPI against which the Trust is not compliant / alerting on SPC charts.					
Background papers						
Action required	For discussion and approval.					
Link to: Strategic Direction Corporate Objectives	Be Outstanding	Y	Be a great place to work	Y		
	Be Collaborative	Y	Be Digital	Y		
	Be Research Leaders	Y	Be Innovative	Y		
Equality & Diversity Impact Assessment						
The content of this paper could have an adverse impact on:	Age	~~Yes~~/No	Disability	~~Yes~~/No	Sexual Orientation	~~Yes~~/No
	Race	~~Yes~~/No	Pregnancy/Maternity	~~Yes~~/No	Gender Reassignment	~~Yes~~/No
	Gender	~~Yes~~/No	Religious Belief	~~Yes~~/No		

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Ref: FCGOREPO
Review: July 2025
Version: 2.0

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Integrated Performance Report
(Month 12 2022/23)

Hannah Gray: Head of Performance and Planning

Joan Spencer: Chief Operating Officer

Introduction

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

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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Interpretation of Statistical Process Control Charts

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

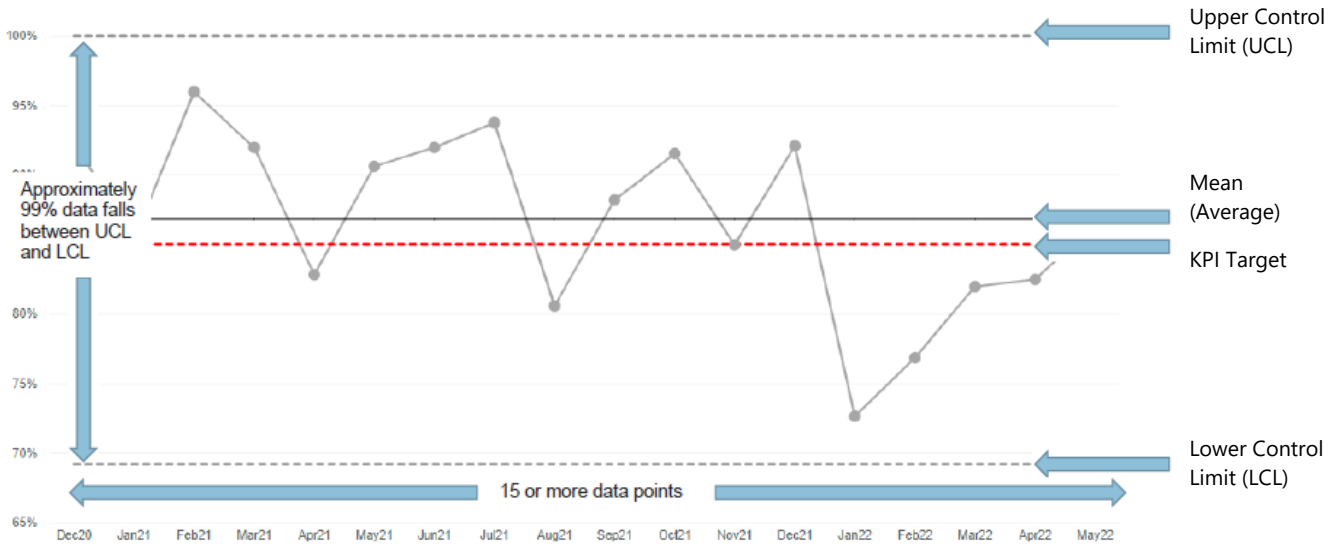
Are we improving, declining or staying the same? (Variation)			
Icon	**Variation**	Definition	Action
	Special Cause Improving Variation	Unexpected variation that results from unusual circumstances in a system or process i.e. assignable. (Blue = significant improvement/low pressure, H = high numbers,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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Anatomy of the SPC Chart



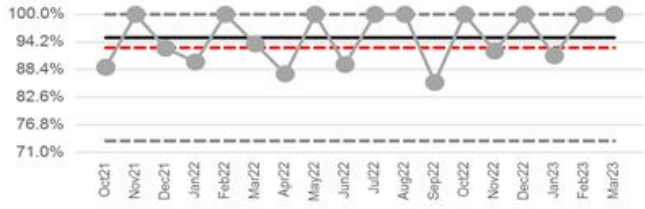
Integrated Performance Report (April 22 - Mar 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

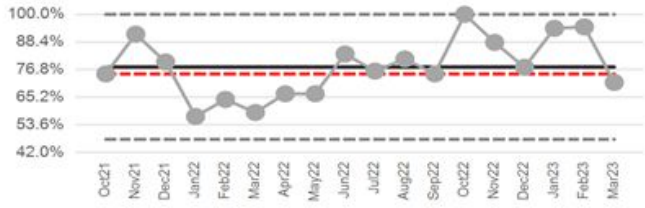
Access

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW10	2 Week Wait From GP Referral to 1st Appointment	Green ≥93% Red <93%	Contractual / Statutory		87.5%	100.0%	89.5%	100.0%	100.0%	85.7%	100.0%	92.3%	100.0%	91.3%	100.0%	100.0%		
				Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW00	28 Day Faster Diagnosis - (Referral to Diagnosis)	Green ≥75% Red <75%	Contractual / Statutory		66.7%	66.7%	83.3%	76.2%	81.3%	75.0%	100.0%	88.2%	77.8%	94.1%	94.7%	71.4%		
				Narrative	This national target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
6 patients breached the 28 Day FDS target in March. 5 of the breaches were unavoidable to CCC; 1 patient had a complex pathway, 1 patient required further investigation at other trust, 1 patient required investigation for another primary, 1 patient requested further investigation and 1 patient DNA'd their diagnostic test and then a sample was inadequate for diagnosis and required further analysis. The avoidable breach was due to an administration error, with the patient not downgraded correctly on triage.	The relevant standard operating procedure (SOP) has been circulated to all triage staff and discussed at the SRG meeting, to prevent further occurrence of this error.

Escalation Route & Expected Date of Compliance
Trust Operational Group, Divisional Quality and Safety Meetings, Divisional Performance Reviews, Performance Committee, Trust Board April 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW47	28 Day Faster Diagnosis - (Screening)	Green ≥75% Red <75%	To Be Confirmed		-	100%	-	-	-	-	-	-	-	-	-	-		
				Narrative	There were no 28 day faster diagnosis screening patients this month.													

Data Not Applicable for SPC

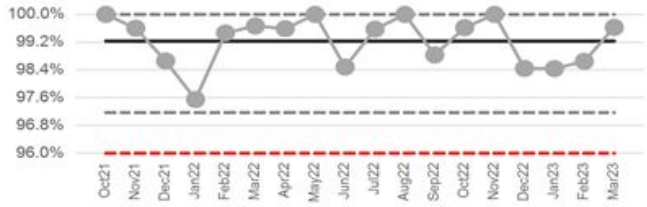
Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

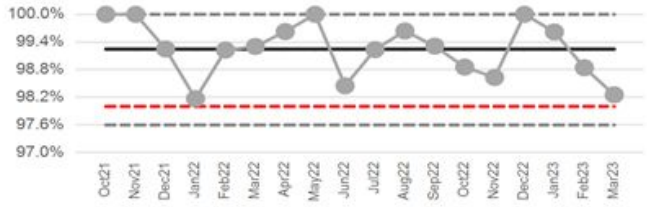
Access

Responsible Forum: Performance Committee

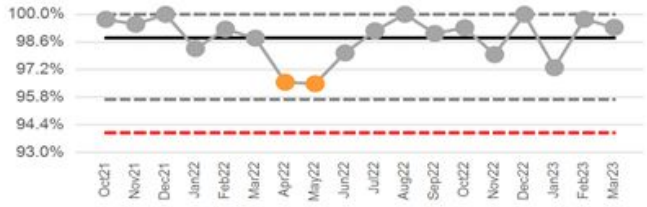
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW09	31 Day Firsts	Green ≥96% Red <96%	Contractual / Statutory		99.6%	100.0%	98.5%	99.6%	100.0%	98.8%	99.6%	100.0%	98.4%	98.4%	98.6%	99.6%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW07	31 Day Subsequent Chemotherapy	Green ≥98% Red <98%	Contractual / Statutory		99.6%	100.0%	98.4%	99.2%	99.6%	99.3%	98.9%	98.6%	100.0%	99.6%	98.8%	98.3%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW08	31 Day Subsequent Radiotherapy	Green ≥94% Red <94%	Contractual / Statutory		96.6%	96.5%	98.0%	99.2%	100.0%	99.0%	99.3%	98.0%	100.0%	97.3%	99.7%	99.3%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW40	Number of 31 Day Patients Treated ≥ Day 73	Green 0 Red >0	Contractual / Statutory		0	0	0	0	0	0	0	1	0	0	0	0		
			Narrative	This month, there were no 31 day patients treated on or after day 73.														

Data Not Applicable for SPC

Integrated Performance Report (April 22 - Mar 23)

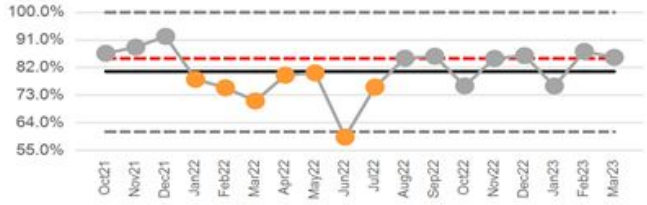
The Clatterbridge Cancer Centre NHS Foundation Trust

Access

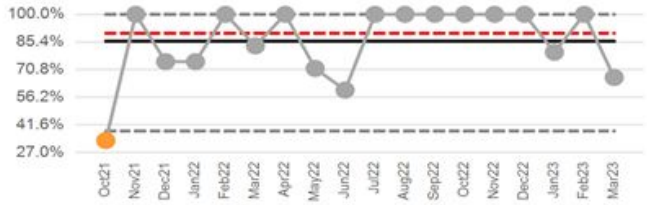
Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW90	24 Day Wait Target - Referral Received to First Treatment (62 Day Classics Only)	Green >85% Amber 80-84.9% Red <80%			82.5%	86.7%	85.5%	83.0%	86.9%	89.1%	84.4%	86.0%	86.7%	82.3%	90.5%	87.1%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW03	62 Day Classic	Green ≥85% Red <85%	Contractual / Statutory		79.5%	80.3%	59.4%	75.7%	85.1%	85.7%	76.1%	85.0%	85.9%	76.0%	87.3%	85.3%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW05	62 Day Screening	Green ≥90% Red <90%	Contractual / Statutory		100.0%	71.4%	60.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	66.7%		
			Narrative	This national target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
1 patient breached this target in March. This was a Lower GI patient; treated on day 28. The breach was avoidable, with the delay due to an administration reason, with the patient not being identified as a screening patient.	The Access Team have been reminded how to identify screening patients on the IPT form and a refresher training session will be given at the next team meeting.

Escalation Route & Expected Date of Compliance
Trust Operational Group, Divisional Quality and Safety Meetings, Divisional Performance Reviews, Performance Committee, Trust Board April 2023

Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Responsible Forum: Performance Committee

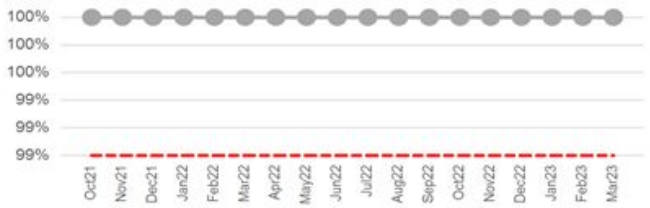
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW43	Number of Avoidable Breaches, Treated ≥ 104 Days and at CCC For Over 24 Days	Green 0 Amber 1 Red >1	Contractual / Statutory		0	1	1	3	0	1	0	0	1	5	2	1		
			Narrative	This month, there was 1 patient treated on or after day 104, at CCC for more than 24 days and with an avoidable breach to CCC. An exception report is provided.														

Data Not Applicable for SPC

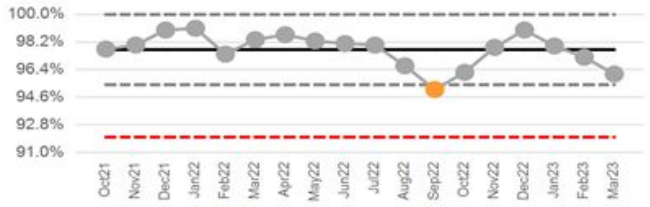
Reason for Non-Compliance	Action Taken to Improve Compliance
1 patient was treated => 104 days AND at CCC for over 24 days, with an avoidable breach. This urology patient was at CCC for 29 days. There was a delay to their follow up appointment due to capacity.	Out patient capacity, activity and demand is being reviewed in detail by each SRG, with plans continually being developed to maximise capacity.

Escalation Route & Expected Date of Compliance
Trust Operational Group, Divisional Quality and Safety Meetings, Divisional Performance Reviews, Performance Committee, Trust Board April 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
DI01	Diagnostic Imaging Waitlist - Within 6 Weeks	Green ≥99% Red <99%	Contractual / Statutory		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
RT03	RTT Incomplete	Green ≥92% Red <92%	Contractual / Statutory		98.7%	98.3%	98.1%	98.0%	96.6%	95.1%	96.2%	97.8%	99.0%	97.9%	97.2%	96.1%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



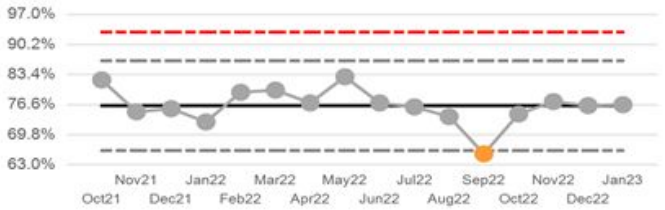
Integrated Performance Report (April 22 - Mar 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access: Cheshire and Merseyside

Responsible Forum: Acute and Specialist Trust Provider Collaborative

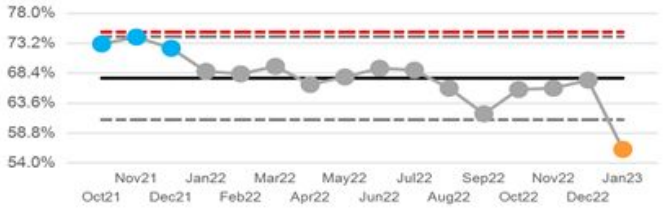
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW44	2 Week Wait From GP Referral to 1st Appointment (Cheshire and Merseyside)	Green ≥93% Red <93%	Contractual / Statutory		77.0%	82.9%	77.0%	76.1%	73.9%	65.5%	74.5%	77.3%	76.4%	76.6%	-	-		
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that the target is unlikely to be achieved without this change.														



Reason for Non-Compliance	Action Taken to Improve Compliance
Non-compliance with this standard was largely driven by underperformance in the following tumour groups: Suspected brain/central nervous system tumours 50% (1 breaches) Suspected breast cancer 64.8% (778 breaches) Suspected upper gastrointestinal cancer 72.8% (324 breaches) Suspected head and neck cancer 73.2% (301 breaches) Suspected skin cancer 75% (600 breaches) Suspected lower gastrointestinal cancer 78.3% (563 breaches) Suspected sarcoma 83.7% (7 breaches) Suspected gynaecological cancer 87.9% (134 breaches) Suspected haematological malignancies (excluding acute leukaemia) 91.6% (7 breaches) Suspected children's cancer 91.7% (3 breaches) Suspected urological malignancies (excluding testicular) 92.5% (66 breaches) Providers not achieving the national standard were: Liverpool University Hospitals 51% (1535 breaches) Countess Of Chester Hospital 64.3% (429 breaches) Warrington And Halton Hospitals 83.6% (182 breaches) East Cheshire 85.2% (89 breaches) Wirral University Teaching Hospital 86.9% (221 breaches) St Helens And Knowsley Hospitals 88.6% (197 breaches) The Clatterbridge Cancer Centre 91.3% (2 breaches) Southport And Ormskirk Hospital 91.7% (87 breaches) Mid Cheshire Hospitals 92.4% (103 breaches) Liverpool Women's 92.6% (22 breaches)	• CMCA primary care programme – improvement team established including investment in GP clinical leadership for each of the nine places in Cheshire and Merseyside. • The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group to identify areas of service pressure. • Increased use of appropriate filter tests in primary care including FIT.

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

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
CW45	28 Day Faster Diagnosis - (Referral to Diagnosis) (Cheshire and Merseyside)	Green ≥75% Red <75%	Contractual / Statutory		66.6%	67.8%	69.2%	68.9%	66.0%	61.9%	65.8%	66.0%	67.3%	56.2%	-	-		
			Narrative	The target has not been achieved and an exception report is provided. Performacne is lower than expected and the nature of variation indicates that the target is unlikely to be achieved without significant change.														



Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

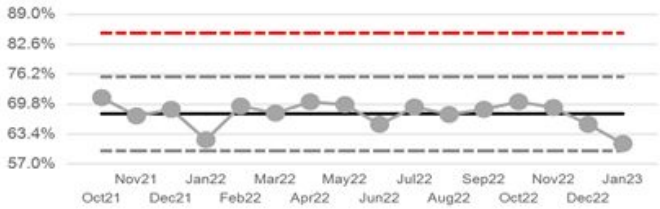
Access: Cheshire and Merseyside

Responsible Forum: Acute and Specialist Trust Provider Collaborative

Reason for Non-Compliance	Action Taken to Improve Compliance
Non-compliance with this standard was largely driven by underperformance in the following tumour groups: Suspected lower gastrointestinal cancer 33.7% (1786 breaches) Suspected urological malignancies (excluding testicular) 35.8% (522 breaches) Referral from a National Screening Programme: Unknown Cancer Report Category 37.4% (139 breaches) Suspected haematological malignancies (excluding acute leukaemia) 43.5% (48 breaches) Suspected gynaecological cancer 54.7% (532 breaches) Suspected upper gastrointestinal cancer 57.9% (497 breaches) Other suspected cancer (not listed) 60% (10 breaches) Suspected sarcoma 66.7% (16 breaches) Suspected testicular cancer 67.6% (11 breaches) Suspected head and neck cancer 69.1% (274 breaches) Suspected lung cancer 69.1% (54 breaches) Providers not achieving the national standard were: Liverpool Women's 42% (185 breaches) Liverpool Heart And Chest 50% (2 breaches) Liverpool University Hospitals 50.5% (1384 breaches) East Cheshire 56% (328 breaches) Countess Of Chester Hospital 63.2% (456 breaches) Warrington And Halton Hospitals 63.6% (399 breaches) St Helens And Knowsley Hospitals 64.3% (656 breaches) Southport And Ormskirk Hospital 65.3% (360 breaches) Mid Cheshire Hospitals 66.3% (423 breaches) Wirral University Teaching Hospital 72.8% (468 breaches)	• Continuation of surgical and diagnostics hubs as part of CMCA's response to Covid-19. • The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group. • Alignment with the C&M diagnostic programme with a clear, prioritised plan to increase capacity. • CMCA primary care programme – improvement team established including investment in GP clinical leadership for each of the nine places in Cheshire and Merseyside. • Increased use of appropriate filter tests in primary care including FIT.

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

Metric ID	Metric Name	Target	Metric Type	Year & Month												V	A
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23		
CW46	62 Day Classic (Cheshire and Merseyside)	Green ≥85% Red <85%	Contractual / Statutory	70.3%	69.7%	65.5%	69.2%	67.6%	68.7%	70.3%	69.1%	65.5%	61.4%	-	-		
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that the target is unlikely to be achieved without this change.													



Integrated Performance Report (April 22 - Mar 23)

Access: Cheshire and Merseyside

Responsible Forum: Acute and Specialist Trust Provider Collaborative

Reason for Non-Compliance	Action Taken to Improve Compliance
Non-compliance with this standard was largely driven by underperformance in the following tumour groups: Gynaecological 26.3% (28 breaches) Head & Neck 32.4% (25 breaches) Other 33.3% (4 breaches),Lower Gastrointestinal 34.8% (45 breaches) Urological (Excluding Testicular) 43.5% (95 breaches) Lung 53.2% (22 breaches) Sarcoma 55.6% (4 breaches) Haematological (Excluding Acute Leukaemia) 57.7% (11 breaches) Upper Gastrointestinal 68.2% (14 breaches) Breast 70% (24 breaches) Skin 84.5% (23 breaches) Providers not achieving the national standard were: Liverpool Women's 0% (13 breaches) Liverpool Heart And Chest 15.8% (8 breaches) Liverpool University Hospitals 41.1% (84 breaches) East Cheshire 43.7% (20 breaches) Southport And Ormskirk Hospital 44% (32.5 breaches) Countess Of Chester Hospital 45.8% (38.5 breaches) Warrington And Halton Hospitals 57.3% (20.5 breaches) Mid Cheshire Hospitals 60.6% (30.5 breaches) Wirral University Teaching Hospital 69.6% (25.5 breaches) The Clatterbridge Cancer Centre 75.7% (9 breaches) Bridgewater Community Healthcare 77.8% (2 breaches) St Helens And Knowsley Hospitals 79% (21 breaches)	• Continuation of surgical and diagnostics hubs as part of CMCA's response to Covid-19. • The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group. • Alignment with the C&M diagnostic programme with a clear, prioritised plan to increase capacity. • CMCA primary care programme – improvement team established including investment in GP clinical leadership for each of the nine places in Cheshire and Merseyside. • Increased use of appropriate filter tests in primary care including FIT. Patient and public communications to improve patient confidence to attend for appointments.

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

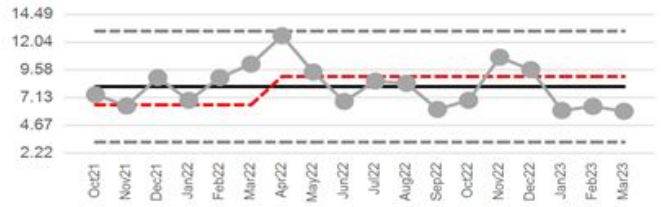
Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

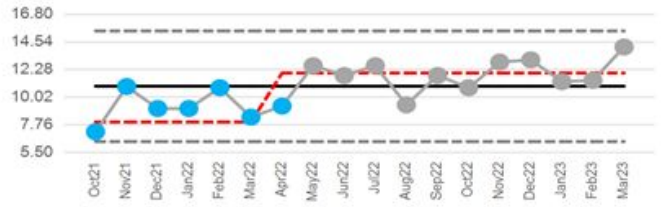
Efficiency

Responsible Forum: Performance Committee

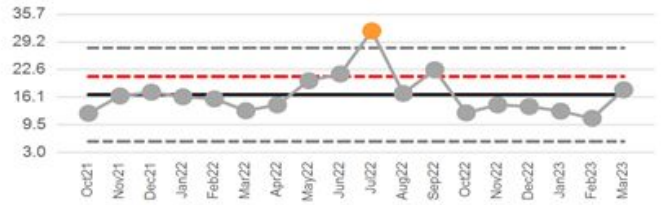
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP05-ST	Length of Stay Elective Care: Solid Tumour Wards (Average Number of Days On Discharge)	Green ≤9 Amber 9.1 -10.7 Red >10.7	Statutory		12.60	9.40	6.80	8.60	8.40	6.10	6.90	10.70	9.61	6.00	6.36	5.93		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



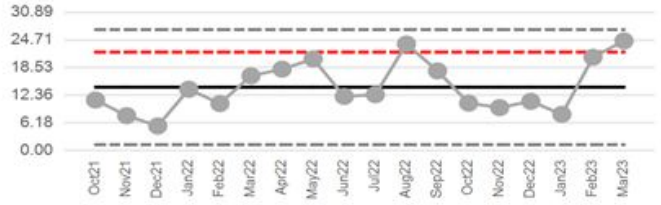
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP06-ST	Length of Stay Emergency Care: Solid Tumour Wards (Average Number of Days On Discharge)	Green ≤12 Amber 12.1-14.3 Red >14.3	Statutory		9.30	12.60	11.80	12.60	9.40	11.80	10.80	12.90	13.08	11.30	11.40	14.13		
			Narrative	This internal target has not been achieved, however there is no significant change. The nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP05-4	Length of Stay Elective Care: HO Ward 4 (Average Number of Days On Discharge)	Green ≤21 Amber 21.1-22.1 Red >22.1	Statutory		14.3	20.0	21.6	31.8	17.0	22.6	12.4	14.3	13.9	12.8	11.1	17.9		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP06-4	Length of Stay Emergency Care: HO Ward 4 (Average Number of Days On Discharge)	Green ≤22 Amber 22.1-23.1 Red >23.1	Statutory		18.20	20.50	12.10	12.50	23.80	17.80	10.60	9.60	11.00	8.10	20.86	24.50		
			Narrative	This internal target has not been achieved, however there is no significant change. The nature of variation indicates that achievement of the target is likely to be inconsistent.														



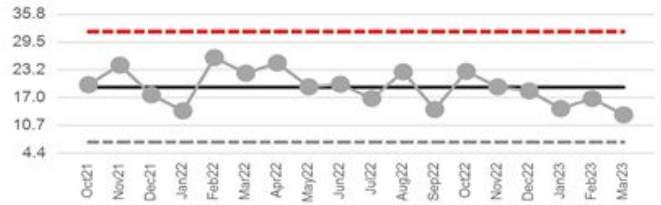
Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

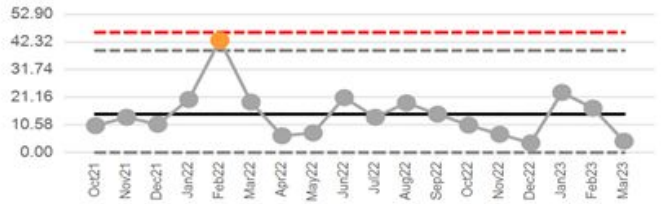
Efficiency

Responsible Forum: Performance Committee

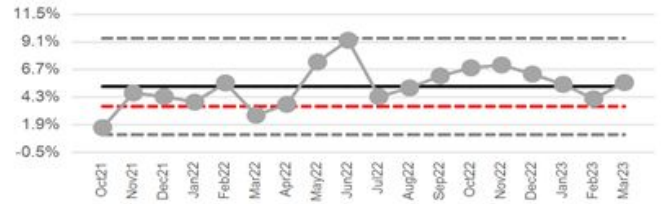
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP05-5	Length of Stay Elective Care: HO Ward 5 (Average Number of Days On Discharge)	Green ≤32 Amber 32.1-33.6 Red >33.6	Statutory		24.8	19.4	20.0	16.8	22.8	14.3	22.9	19.4	18.5	14.5	16.8	13.1		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP06-5	Length of Stay Emergency Care: HO Ward 5 (Average Number of Days On Discharge)	Green ≤46 Amber 46.1-48.3 Red >48.3	Statutory		6.40	7.50	21.00	13.50	19.00	14.70	10.50	7.00	3.67	23.00	17.00	4.33		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP22	Delayed Transfers of Care As % of Occupied Bed Days	Green ≤3.5% Red >3.5%	Statutory		3.7%	7.4%	9.2%	4.4%	5.1%	6.1%	6.9%	7.1%	6.3%	5.4%	4.2%	5.6%		
			Narrative	The nationally set target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

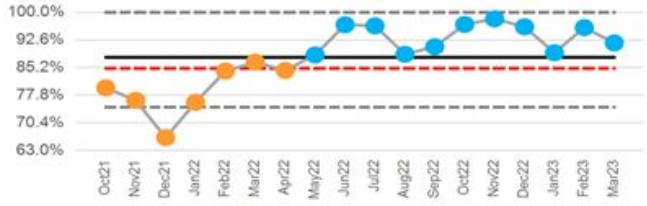
Efficiency

Responsible Forum: Performance Committee

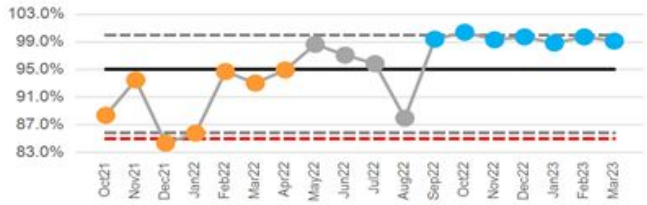
Reason for Non-Compliance	Action Taken to Improve Compliance
Delayed Transfers of Care (DTOC) as a % of occupied bed days for the month of March was above the Trust target of <= 3.5%, with 5.6% reported this month. This is a 1.4% increase on February 2023. There were 155 extra bed days in March. The average length of DTOC was 10.3 days. There were 15 DTOCs in March 2023, which is 1 less than in February 2023. 5 Patients awaited Fast Track Packages of care (46 extra bed days). Covid continues to impact community services, which has increased the length of time to commission a POC across all areas. 2 Patients awaited Fast Track Nursing Home placement (25 extra bed days). 3 Patients awaited hospice placement (10 extra bed days). One hospice has reduced bed capacity due to being unable to recruit staff. 3 Patients awaited a Social Package of Care (36 extra bed days). 2 Patients awaited a Social Service Nursing home (38 extra bed days).	Weekly 'Lengthened Length of Stay' meetings have continued with attendance of Matron and the Business Services Manager to ensure the flow of patients continues and any concerns can be escalated. The outcome of these meetings are forwarded to the General Manager for review. The Patient Flow Team continue to work with wider MDT to aid discharge planning, ensuring patients are discharged safely home or to a suitable care setting. Weekly complex discharge meetings occur with the MDT. Consultant of the week (COW) MDT meetings continue, to allow discussion of all inpatients so that there is a clear plan for each patient. CHC (NHS Continuing Healthcare) are being contacted daily for an update on the availability of beds. The Trust Operational Group ToR is under review and likely to be extended to incorporate wider operational performance including inpatient flow.

Escalation Route & Expected Date of Compliance
Divisional Quality, Safety and Performance Meeting, Divisional Performance Review, Performance Committee, Trust Board August 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP20-4	Average Bed Occupancy at 12 Midday: Ward 4	Green ≥85% Amber 81-84.9% Red <81%	Statutory		84.4%	88.6%	96.7%	96.4%	88.8%	90.8%	96.8%	98.3%	96.1%	89.2%	95.9%	91.8%		
			Narrative	The target has been achieved. Bed occupancy is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP21-4	Average Bed Occupancy at Midnight: Ward 4	Green ≥85% Amber 81-84.9% Red <81%	Statutory		95.0%	98.7%	97.1%	95.9%	88.0%	99.4%	100.4%	99.3%	99.7%	98.9%	99.7%	99.1%		
			Narrative	The target has been achieved. Bed occupancy is higher than expected and the target is outside SPC limits and therefore likely to be achieved consistently.														



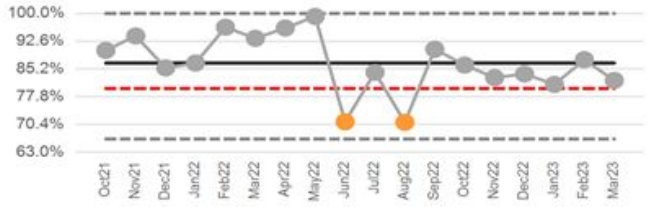
Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

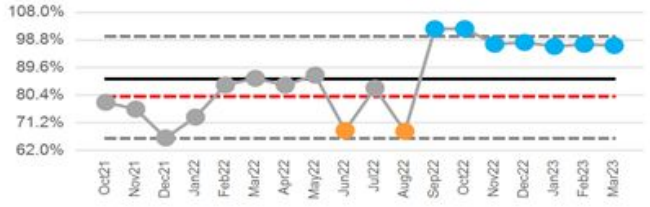
Efficiency

Responsible Forum: Performance Committee

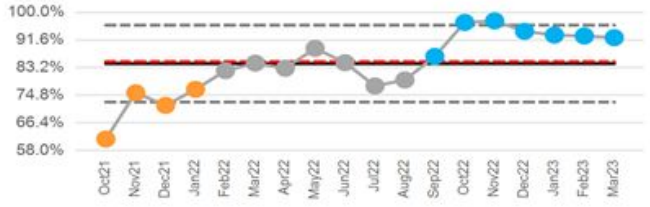
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP20-5	Average Bed Occupancy at 12 Midday: Ward 5	Green ≥80% Amber 76%-79.9% Red <76%	Statutory		96.1%	99.2%	71.1%	84.3%	71.0%	90.4%	86.2%	82.9%	83.9%	81.1%	87.7%	82.2%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



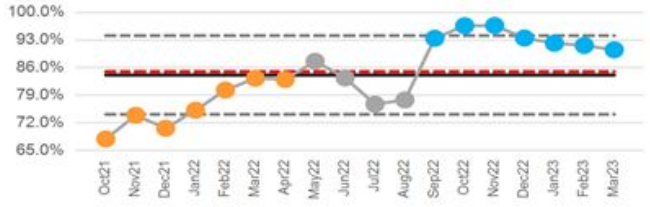
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP21-5	Average Bed Occupancy at Midnight: Ward 5	Green ≥80% Amber 76%-79.9% Red <76%	Statutory		83.8%	87.1%	68.7%	82.8%	68.4%	102.5%	102.6%	97.4%	98.0%	96.7%	97.4%	97.0%		
			Narrative	The target has been achieved. Bed occupancy is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP20-ST	Average Bed Occupancy at 12 Midday: ST Wards	Green ≥85% Amber 81-84.9% Red <81%	Statutory		83.0%	89.1%	84.7%	77.6%	79.5%	86.6%	96.9%	97.4%	94.2%	93.1%	92.8%	92.3%		
			Narrative	The target has been achieved. Bed occupancy is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP21-ST	Average Bed Occupancy at Midnight: ST Wards	Green ≥85% Amber 81-84.9% Red <81%	Statutory		83.0%	87.6%	83.4%	76.7%	77.8%	93.4%	96.6%	96.7%	93.5%	92.2%	91.6%	90.5%		
			Narrative	The target has been achieved. Bed occupancy is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



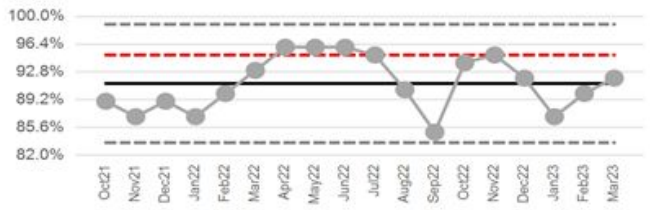
Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP23	% of Expected Discharge Dates Completed	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		96.0%	96.0%	96.0%	95.0%	90.5%	85.0%	94.0%	95.0%	92.0%	87.0%	90.0%	92.0%		
			Narrative	Despite improvement in the last 2 months, this internal target has not been achieved this month. There is however no significant change. The nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP24	% of Elective Procedures Cancelled On or After The Day of Admission	Green 0% Red >0%	Contractual		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
			Narrative	No procedures have been cancelled on or after the day of admission.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
IP25	% of Cancelled Elective Procedures (On or After The Day of Admission) Rebooked Within 28 Days of Cancellation	Green 100% Red <100%	Contractual		-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	There is no data to display, as no procedures were cancelled.														

Data Not Applicable for SPC

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

Data Not Applicable for SPC

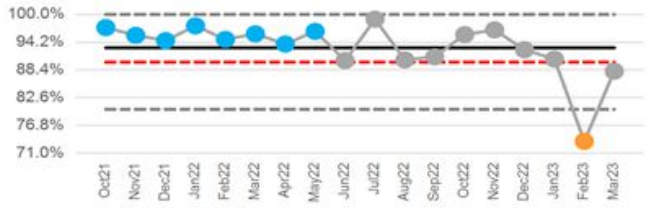
Integrated Performance Report (April 22 - Mar 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

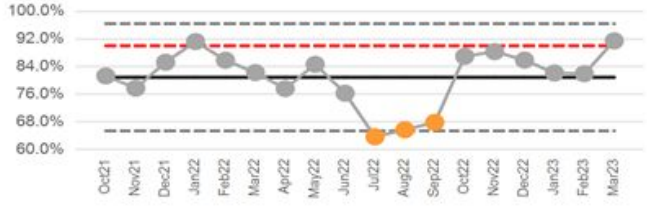
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
EF10	Imaging Reporting Turnaround (Inpatients)	Green >90% Amber 80-89.9% Red <80%			93.8%	96.5%	90.4%	99.0%	90.5%	91.1%	95.8%	96.8%	92.6%	90.7%	73.5%	88.1%		
			Narrative	The target has not been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. Although the target figure is internally created and performance is within normal variation, CCC is keen to provide regular updates on this issue and therefore an exception report is provided.														



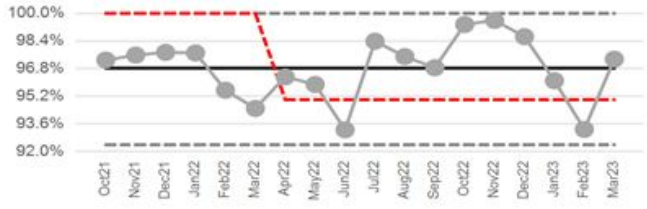
Reason for Non-Compliance	Action Taken to Improve Compliance
There has been a significant improvement from 73.5 % in February 2023, to 88.1% in March 2023. There is still sickness absence in the radiologist team, as well as planned absence and annual leave in March which has created capacity pressure in this group. These scans are not outsourced to Medica as the turnaround time is too long.	Recruitment is underway for 2 Radiologist posts. Following on from the identification of the issue regarding inaccurate grading of the urgency of reports, the X-ray team lead is monitoring this on a daily basis and turnaround times are closely monitored.

Escalation Route & Expected Date of Compliance
Divisional Quality, Safety and Performance Meeting, Divisional Performance Review, Performance Committee, Trust Board April 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
EF11	Imaging Reporting Turnaround (Outpatients)	Green >90% Amber 80-89.9% Red <80%			77.7%	84.7%	76.3%	63.7%	65.7%	67.9%	87.0%	88.3%	85.9%	82.2%	82.0%	91.5%		
			Narrative	The target has now been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
DQ01	Data Quality - % Ethnicity That is Complete (or Patient Declined to Answer)	Green ≥95% Amber 90-94.9% Red <90%	Covid-19 Recovery		96.3%	95.9%	93.3%	98.4%	97.5%	96.9%	99.4%	99.6%	98.7%	96.1%	93.3%	97.3%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



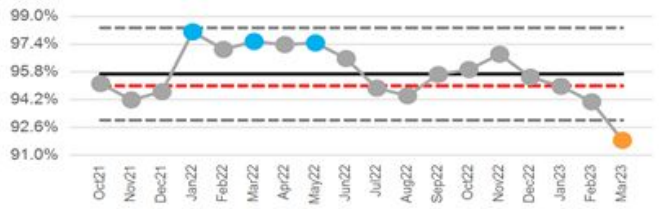
Integrated Performance Report (April 22 - Mar 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
DQ02	Data Quality - % of Outpatients With an Outcome	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		97.4%	97.5%	96.6%	94.9%	94.4%	95.6%	95.9%	96.8%	95.5%	95.0%	94.1%	91.9%		
			Narrative	The target has not been achieved and performance is lower than expected, triggering the inclusion of an exception report. The nature of variation indicates that achievement of the target is likely to be inconsistent.														

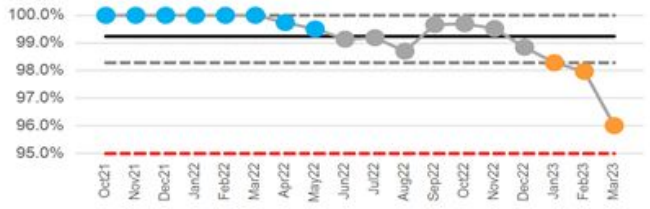


Reason for Non-Compliance	Action Taken to Improve Compliance
The Administration Services team has activated their Business continuity plan due to a high number of vacancies and sickness within the team. Whilst in this position there has been some delay with the disposal of appointments.	A successful recruitment evening was held, with appointments being made to vacant posts. Clinics are being prioritised to ensure patients continue to receive timely care and treatment.

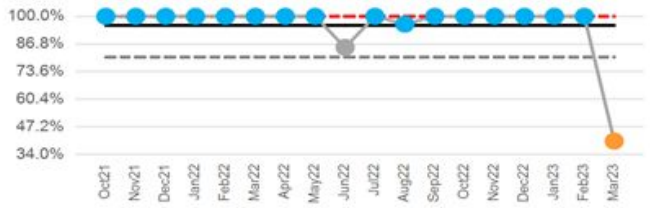
Escalation Route & Expected Date of Compliance

Divisional Quality and Safety Meetings, Divisional Performance Reviews, Performance Committee, Trust Board
May 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
DQ03	Data Quality - % of Outpatients With an Attend Status	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		99.7%	99.5%	99.1%	99.2%	98.7%	99.7%	99.7%	99.5%	98.8%	98.3%	98.0%	96.0%		
			Narrative	The target has been achieved. Although performance is lower than expected, the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
EF01	Percentage of Subject Access Requests Responded to Within 1 Month	Green 100% Red <100%	Contractual		100.0%	100.0%	85.2%	100.0%	96.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	40.4%		
			Narrative	This national target has not been achieved and an exception report is provided. Performance is lower than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
The Administration Services team has activated their Business continuity plan due to a high number of vacancies and sickness within the team. The responsible person allocated to SARS was absent for a period and unfortunately this was not escalated.	This role is being transferred to another team within Admin Services and multiple staff will be trained to perform this function, This will provide cover at all times.

Escalation Route & Expected Date of Compliance

Divisional Quality, Safety and Performance Group, Divisional Performance Review, Performance Committee, Trust Board
April 2023

Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
EF02	% of Overdue ISN (Information Standard Notices)	Green 0% Red >0%	Contractual		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
			Narrative	The target continues to be achieved.														

Data Not Applicable for SPC

Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU17	Never Events	Green 0 Red >0	Contractual / Statutory		0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target continues to be achieved, with no never events this month.														

Data Not Applicable for SPC

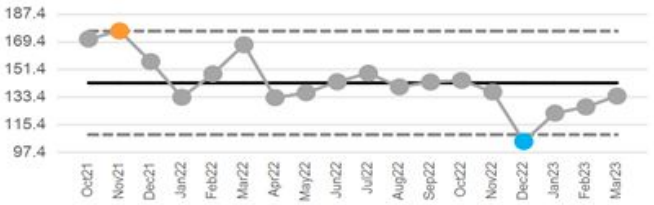
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU04	Serious Incidents (SIs)	No Target	Contractual / Statutory		0	0	0	2	0	1	0	0	0	1	0	0		
			Narrative	No SIs were reported this month.														

Data Not Applicable for SPC

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

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU03	Incidents /1,000 Bed Days	No Target	Statutory		133.1	136.3	143.5	149.1	140.1	143.3	144.4	136.9	104.6	123.0	127.1	134.2		
			Narrative	Incident numbers are as expected. Incidents are reviewed at Divisional Quality and Safety meetings and Divisional Performance Review meetings. This focus promotes a good reporting culture and analysis of themes and trends to drive improvement.														



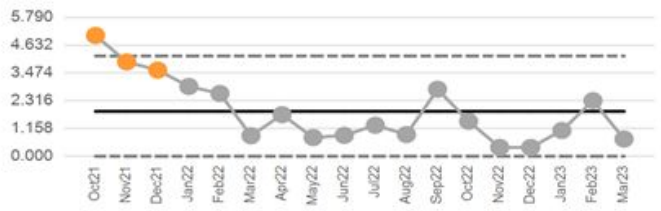
Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU05	All Incidents Resulting in Moderate Harm and Above /1,000 Bed Days	No Target	Local		1.735	0.779	0.872	1.293	0.904	2.794	1.458	0.370	0.367	1.076	2.318	0.719		
			Narrative	Numbers of incidents of this severity are as expected. Incidents are reviewed at Divisional Quality and Safety meetings and Divisional Performance Review meetings. This focus promotes a good reporting culture and analysis of themes and trends to drive improvement.															



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU06	Inpatient Falls Resulting in Harm Due to Lapse in Care	Green 0 Red >0	Contractual		0	1	0	0	0	0	0	0	0	0	0	0		
			Narrative	There were no falls resulting in harm due to a lapse in care. The harm review process has been amended and therefore figures may change retrospectively, following review.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU07	Inpatient Falls Resulting in Harm Due to Lapse in Care /1,000 Bed Days	Green 0 Red >0	Contractual		0.000	0.390	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000		
			Narrative	There were no falls resulting in harm due to a lapse in care. The harm review process has been amended and therefore figures may change retrospectively, following review.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU08	Pressure Ulcers (Hospital Acquired Grade 3/4, With a Lapse in Care)	Green 0 Red >0	Contractual		0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target continues to be achieved, with no such pressure ulcers this month. The harm review process has been amended and therefore figures may change retrospectively, following review.														

Data Not Applicable for SPC

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NHS The Clatterbridge Cancer Centre NHS Foundation Trust

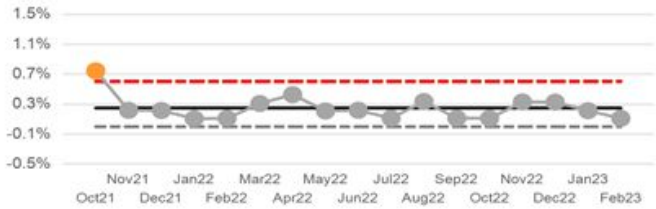
Quality

Responsible Forum: Quality Committee

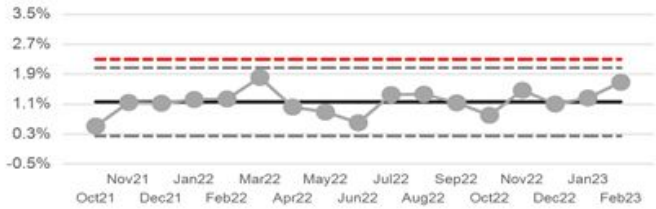
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU09	Pressure Ulcers (Hospital Acquired Grade 3/4, With a Lapse in Care) /1,000 Bed Days	Green 0 Red >0	Contractual		0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target continues to be achieved, with no such pressure ulcers this month. The harm review process has been amended and therefore figures may change retrospectively, following review.														

Data Not Applicable for SPC

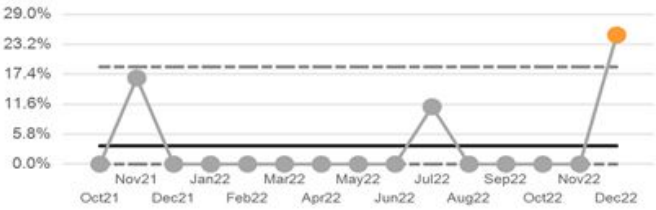
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU10	30 Day Mortality (Radical Chemotherapy)	Green ≤0.6% Amber 0.61% - 0.7% Red >0.7%	SOF		0.4%	0.2%	0.2%	0.1%	0.3%	0.1%	0.1%	0.3%	0.3%	0.2%	0.1%	-		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU12	30 Day Mortality (Palliative Chemotherapy)	Green ≤2.3% Amber 2.31% - 2.5% Red >2.5%	SOF		1.0%	0.9%	0.6%	1.4%	1.4%	1.1%	0.8%	1.5%	1.1%	1.3%	1.7%	-		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that the target is likely to be achieved.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU13	100 Day Mortality (Bone Marrow Transplant)	To Be Confirmed	SOF / NR		0.0%	0.0%	0.0%	11.1%	0.0%	0.0%	0.0%	0.0%	25.0%	-	-	-		
			Narrative	2 out of 8 patients who had transplants in December 2022, died within 100 days of the transplant. The outcomes of the mortality review for these patients, will be described in the IPR following discussion at the Mortality Review Group.														



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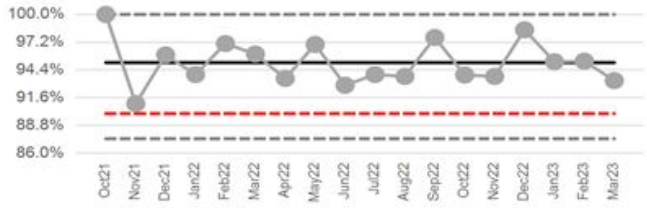
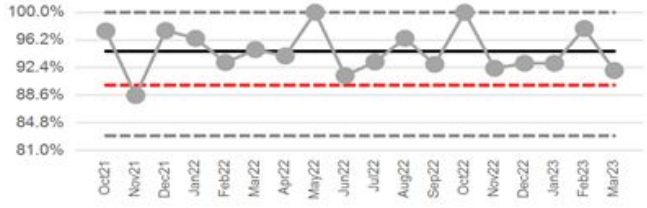
Quality

Responsible Forum: Quality Committee

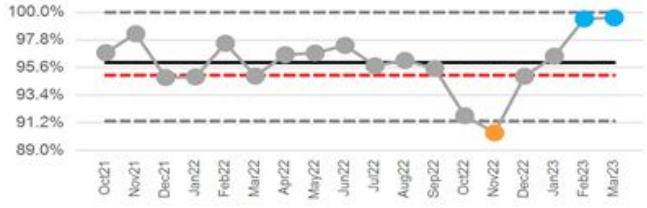
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU62	Consultant Review Within 14 Hours	Green ≥90% Red <90%	Contractual		93.5%	97.0%	92.9%	93.9%	93.8%	97.7%	93.9%	93.8%	98.4%	95.2%	95.3%	93.3%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



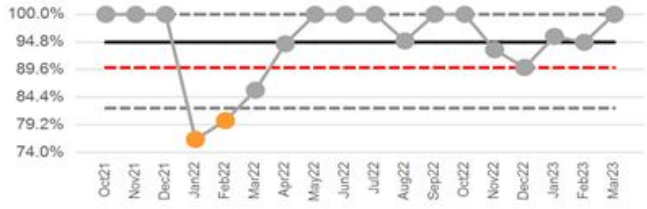
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU48	Sepsis IV Antibiotics Within an Hour	Green ≥90% Red <90%	Contractual		94.0%	100.0%	91.3%	93.2%	96.4%	92.9%	100.0%	92.3%	93.0%	93.0%	97.8%	92.0%		
			Narrative	The target has been achieved (subject to validation). There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU31	Percentage of Adult Admissions With VTE Risk Assessment	Green ≥95% Red <95%	Contractual / Statutory		96.6%	96.8%	97.4%	95.7%	96.2%	95.5%	91.8%	90.4%	94.9%	96.5%	99.5%	99.6%		
			Narrative	The target has been achieved. Performance is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU14	Dementia: Percentage to Whom Case Finding is Applied	Green ≥90% Red <90%	Contractual		94.4%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	93.3%	90.0%	95.8%	94.7%	100.0%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



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Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU15	Dementia: Percentage With a Diagnostic Assessment	Green ≥90% Red <90%	Contractual		-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	No patients have required a diagnostic assessment.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU16	Dementia: Percentage of Cases Referred	Green ≥90% Red <90%	Contractual / Statutory		-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	No patients have required a referral.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU34	Clostridium Difficile Infections (HOHA and COHA)	Green ≤17 per year Red >17 per year	Contractual / Statutory		2	2	1	1	2	2	0	1	0	1	0	0		
			Narrative	There were no such infections this month and the chart shows that the annual target was achieved.														

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU40	E. Coli Bacteraemia (HOHA and COHA)	Green ≤11 per year Red >11 per year	Contractual / Statutory		2	0	2	1	1	4	1	4	0	1	1	4		
			Narrative	There were 4 such infections this month and an exception report is provided. The chart shows that the annual threshold of 11 was exceeded in November.														

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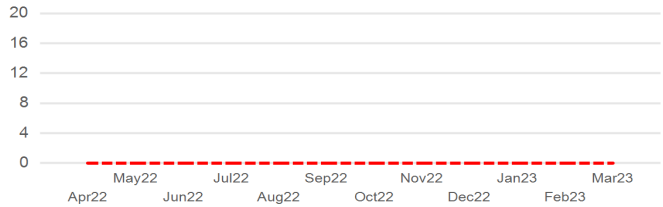
Quality

Responsible Forum: Quality Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
Four E.coli HOHA infections were identified in March 2023. One is likely to be intra-abdominal in origin. No lapses in care were identified from this episode of infection. The remaining 3 cases were urinary in origin: • 1 is a likely Catheter Associated Urinary Tract Infection, the patient had 6 urinary catheters inserted during admission and also developed an Acute Kidney Injury. • In the remaining 2 cases, delays in obtaining urine samples were identified. Whilst this did not contribute to the development of infection, it was been raised as a learning point with the clinical team.	The increase in the number of Gram negative infections has been escalated to the Chief Nurse. This has resulted in the establishment of an 'IPC Masterclass' to be held in April in collaboration with Clinical Education to offer an opportunity for competency assessments relating to the fundamentals of practice.

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

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU36	MRSA Infections (HOHA and COHA)	Green 0 per year Red >0 per year	Contractual / Statutory		0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	There were no such infections this month and the chart shows that the annual target was achieved.														



Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU38	MSSA Bacteraemia (HOHA and COHA)	Green ≤4 per year Amber 5 Red >5 per year	Contractual / Statutory		1	0	0	1	0	3	0	1	5	0	0	1		
			Narrative	There was 1 such infection this month. The chart shows that the annual threshold of 4 was exceeded in September.														

Reason for Non-Compliance	Action Taken to Improve Compliance
1 HOHA MSSA bloodstream infection was identified in March 2023. The source is likely to be intra-abdominal as the patient also has an E.coli infection. No learning points identified.	N/A

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

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Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU43	Klebsiella (HOHA and COHA)	Green ≤8 per year Red >8 per year	Contractual / Statutory		3	1	0	1	1	1	0	3	2	1	2	1		
			Narrative	There was 1 such infection this month and an exception report is provided. The chart shows that the annual threshold of 8 was exceeded in November.														

Reason for Non-Compliance	Action Taken to Improve Compliance
One Hospital Onset Hospital Acquired (HOHA) Klebsiella pneumoniae bloodstream infection was identified in March 2023. This is most likely intra-abdominal. No lapses in care were identified.	N/A

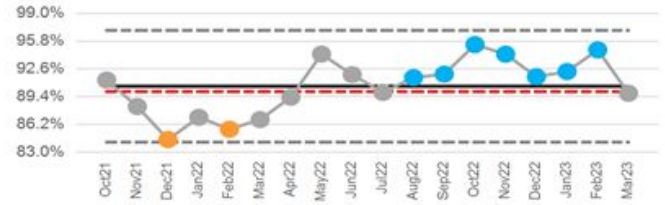
Escalation Route & Expected Date of Compliance
Harm Free Care Meeting, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board April 2023

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU45	Pseudomonas (HOHA and COHA)	Green ≤1 per year Red >1 per year	Contractual / Statutory		2	0	1	2	0	0	1	2	0	1	0	1		
			Narrative	There was 1 such infection this month and an exception report is provided. The chart shows that the annual threshold of 1 was exceeded in April.														

Reason for Non-Compliance	Action Taken to Improve Compliance
One HOHA Pseudomonas aeruginosa infection was identified in March 2023. This is likely to be of an intra-abdominal source. No lapses in care identified.	N/A

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

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU66	Safer Staffing: Overall Fill-Rate	Green ≥90% Red <90%	Statutory		89.3%	94.3%	91.9%	89.9%	91.6%	92.0%	95.4%	94.3%	91.7%	92.3%	94.8%	89.8%		
			Narrative	Performance is marginally below the internal target this month. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. This data is closely monitored at ward level and exceptions reviewed at Divisional meetings.														



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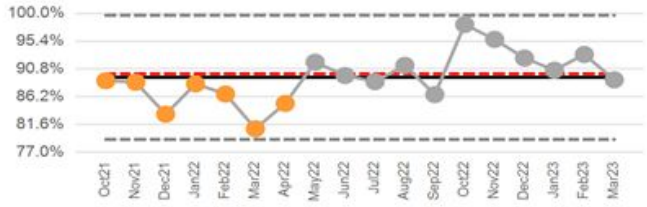
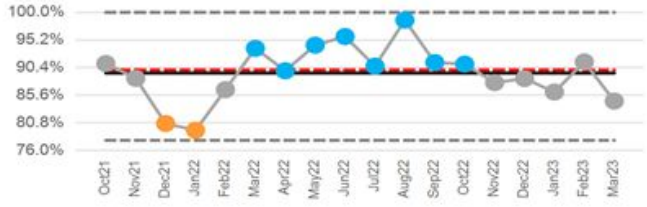
Responsible Forum: Quality Committee

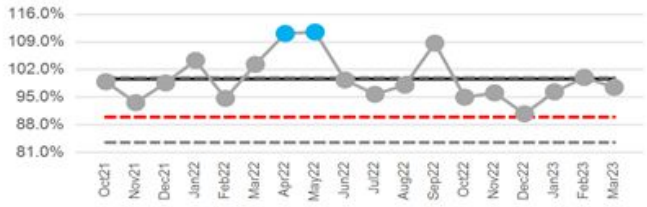
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU61	Average Number of Registered Nurses Filled Shifts - Days	Green ≥90% Red <90%	Statutory		85.1%	91.9%	89.7%	88.7%	91.4%	86.6%	98.2%	95.7%	92.6%	90.6%	93.2%	89.0%		
			Narrative	Performance is marginally below the internal target this month. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. This data is closely monitored at ward level and exceptions reviewed at Divisional meetings.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU63	Average Number of Care Staff Filled Shifts - Days	Green ≥90% Red <90%	Statutory		89.9%	94.3%	95.8%	90.7%	98.7%	91.3%	91.0%	87.8%	88.5%	86.2%	91.4%	84.6%		
			Narrative	Performance is marginally below the internal target this month. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. This data is closely monitored at ward level and exceptions reviewed at Divisional meetings.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU64	Average Number of Care Staff Filled Shifts - Nights	Green ≥90% Red <90%	Statutory		111.1%	111.5%	99.4%	95.8%	98.1%	108.7%	95.0%	96.1%	90.8%	96.4%	100.0%	97.5%		
			Narrative	The target continues to be achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU65	Average Number of Registered Nurses Filled Shifts - Nights	Green ≥90% Red <90%	Statutory		82.5%	87.9%	87.4%	87.1%	91.7%	89.8%	95.7%	96.9%	93.7%	96.5%	95.4%	89.5%		
			Narrative	Whilst performance is marginally below the internal target this month, it is higher than expected. The nature of variation indicates that achievement of the target is likely to be inconsistent.														

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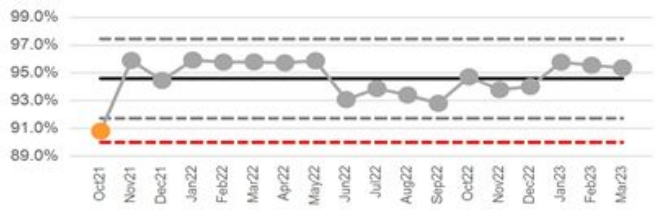
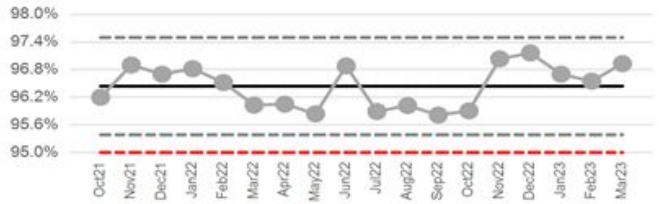
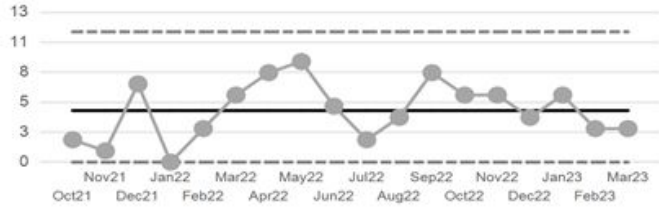
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU60	NICE Guidance Compliance	Green ≥90% Amber 85 - 89.9% Red <85%	Contractual		95.7%	95.9%	93.1%	93.9%	93.4%	92.8%	94.7%	93.8%	94.0%	95.8%	95.6%	95.4%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU75	Patient FFT: % of Respondents Who Had a Positive Experience	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		96.1%	95.8%	96.9%	95.9%	96.0%	95.8%	95.9%	97.0%	97.2%	96.7%	96.6%	96.9%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU11	Number of Complaints	No Target	Contractual		8	9	5	2	4	8	6	6	4	6	3	3		
			Narrative	There were 3 complaints this month, with no significant change noted. Complaints are reviewed at Divisional Quality and Safety meetings, Divisional Performance Review meetings and RQGC. This promotes effective analysis of themes and trends to drive improvement.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU18	Number of Complaints / Count of WTE Staff (Ratio)	No Target	Contractual		0.005	0.005	0.003	0.001	0.002	0.005	0.003	0.003	0.002	0.003	0.002	0.002		
			Narrative	There were 0.002 complaints per staff WTE this month. Complaints are reviewed at Divisional Quality and Safety meetings, Divisional Performance Review meetings and RQGC. This promotes effective analysis of themes and trends to drive improvement.														

Data Not Applicable for SPC

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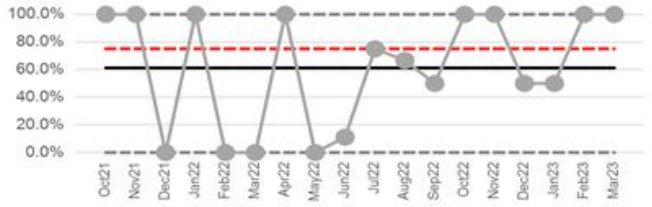
Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU19	% of Formal Complaints Acknowledged Within 3 Working Days	Green 100% Red <100%	Contractual		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
			Narrative	The target continues to be achieved. Performance is as expected and the nature of variation indicates that the target is likely to be consistently achieved.														

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU20	% of Routine Complaints Resolved Within 25 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local		100.0%	0.0%	11.1%	75.0%	66.7%	50.0%	100.0%	100.0%	50.0%	50.0%	100.0%	100.0%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU71	% of Complex Complaints Resolved Within 60 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local		66.7%	-	100.0%	100.0%	100.0%	50.0%	-	-	-	66.7%	100.0%	50.0%		
			Narrative	1 out of 2 complex complaints resolved this month, were resolved within 60 working days. An exception report is provided.														

Data Not Applicable for SPC

Reason for Non-Compliance	Action Taken to Improve Compliance
One of the two complex complaints resolved in March 2023 were resolved within the 60 day target. One was not resolved within the 60 day timescale because the family wished to come in for a resolution meeting and one member of the family was located outside of the UK and the meeting could only be arranged for when they returned. The complaint investigation team met and agreed the issues in December 2022 (within KPI timescales) and met with the family in March 2023.	Not applicable, the family were not able to meet within the 60 day timescale. The complaint investigation team met and agreed issues within KPI timescales in preparation for when the family were ready to meet.

Escalation Route & Expected Date of Compliance
Information Governance Board, Risk and Quality Governance Committee, Quality Committee, Trust Board N/A

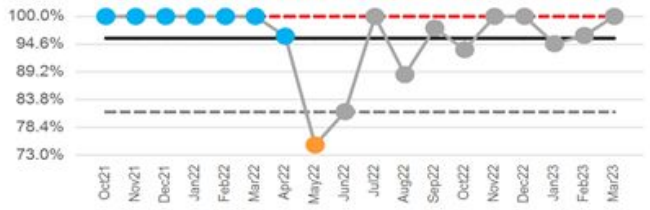
Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

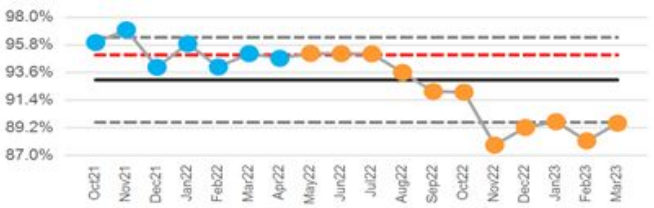
Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU21	% of FOIs Responded to Within 20 Days	Green 100% Red <100%	Contractual / Statutory		96.2%	75.0%	81.5%	100.0%	88.7%	97.7%	93.5%	100.0%	100.0%	94.7%	96.3%	100.0%		
				Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU22	Number of IG Incidents Escalated to ICO	Green 0 Red >0	Contractual / Statutory		0	0	0	0	0	0	1	0	0	0	1	0		
				Narrative	No IG incidents were escalated to the ICO this month.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU23	% of Policies in Date	Green ≥95% Amber 93.1 - 94.9% Red <93%	Contractual		94.7%	95.1%	95.1%	95.1%	93.6%	92.1%	92.0%	87.8%	89.2%	89.7%	88.2%	89.6%		
				Narrative	The target has not been achieved and an exception report is provided. Performance is lower than expected (triggering an exception report) and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
27 of the 259 policies in the Trust have not been reviewed within the review period. • 7 Documents are waiting for approval via meetings/committees which will take place over the next month. • 16 Documents are currently in the process of being updated by their authors. • 3 Documents have been approved in March 2023. Document Control is waiting for the approval evidence and final word version to be submitted. • 1 Document is being changed from a policy to an SOP. Once the new SOP has been completed this will replace the currently policy which will be archived.	The Document Control Officer will continue to send regular reminders for overdue items. Any policies that still continue to sit out of date for long periods without communication to Doc Control are escalated to the Information Governance Manager.

Escalation Route & Expected Date of Compliance
Information Governance Board, Risk and Quality Governance Committee, Quality Committee, Trust Board May 2023

Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month													
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU24	NHS E/I Patient Safety Alerts: Number Not Implemented Within Set Timescale.	Green 0 Red >0	Contractual	0	0	0	0	0	1	0	0	0	0	0	0		
			Narrative	The target has been achieved.													

Data Not Applicable for SPC

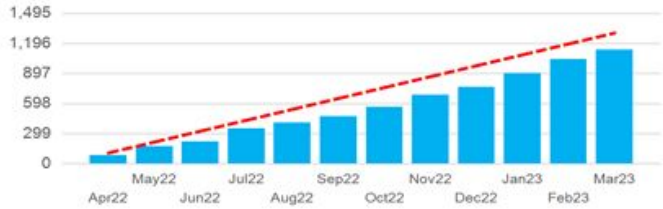
Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

Responsible Forum: Performance Committee

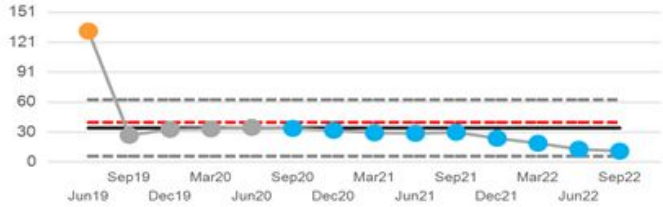
Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month												
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
RI20	Study Recruitment	Green ≥1300 per year Amber 1100-1299 per year Red <1100 per	CCC Strategy	84	89	50	126	57	66	94	118	77	139	137	95		
			Narrative	The monthly performance is below the target and annual target not achieved, therefore an exception report is provided.													



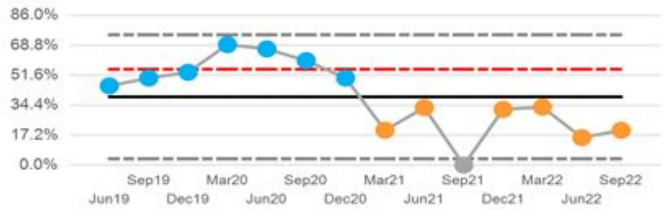
Reason for Non-Compliance	Action Taken to Improve Compliance
1132 patients have been recruited against an internal target of 1300 (87% of target) at the end of Month 12. The main reasons at Month 12 for not achieving the overall target are: • A strategic, clinically-led decision was made in December 2021 to prioritise the set-up and opening of ECMC studies to recruitment. ECMC studies are scientifically relevant but by nature recruit lower patient numbers. This decision was taken to support the renewal of the ECMC bid which was successful. As a specialist Cancer Centre our portfolio does focus more on early phase trials. • Due to limited drug studies opening during 21/22 the pipeline of studies opening has affected recruitment numbers through 22/23. • Still awaiting recruitment data for the Brightlights study from Sponsor. Study closed 31st March 2023 and data should be attributed to the 22/23 final figure. Final recruitment data will be included in the 22/23 R&I Annual Report.	• Continuing to work collaboratively with service departments and research-active staff to open all studies types in a timely way. • Research Priorities meeting taken place to determine where resource will be focused. Follow-up meeting required to progress. • Two Early Phase Clinical Research Fellows appointed and due to start in August 2023 to support Early Phase recruitment. • To note: o CCC is currently top recruiting site for the Paradigm study. Paradigm is a study investigating if a new blood test can provide information about which current treatments for prostate cancer will work best for future patients with this disease. (PI Prof. Isabel Syndikus, Urology). o First patient treated on the TebeMRD trial which is an early phase Melanoma ECMC study (PI Dr Joe Sacco, Melanoma).

Escalation Route & Expected Date of Compliance
R&I Directorate Board, Committee for Research Strategy, Performance Committee, Trust Board Target not met in-year

Metric ID	Metric Name	Target	Metric Type	Year & Month												
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
RI03	Study Set-Up Times in Days	Green ≤40 days Red >40	National Reporting	-	-	13	-	-	11	-	-	-	-	-	-		
			Narrative	Due to 'current pressures on workforce and capacity' The National Institute for Health and Care Research have paused publication of this data until further notice.													



Metric ID	Metric Name	Target	Metric Type	Year & Month												
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
RI21	Recruitment to Time and Target	Green ≥55% Amber 45 - 54.9% Red <45%	National Reporting	-	-	15.8%	-	-	20.0%	-	-	-	-	-	-		
			Narrative	Due to 'current pressures on workforce and capacity' The National Institute for Health and Care Research have paused publication of this data until further notice.													



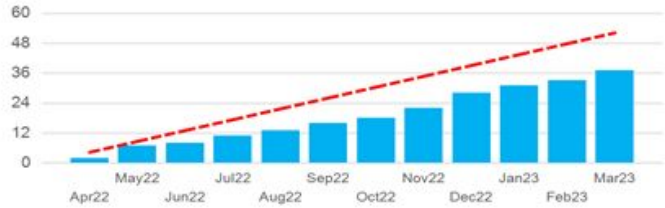
Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

Responsible Forum: Performance Committee

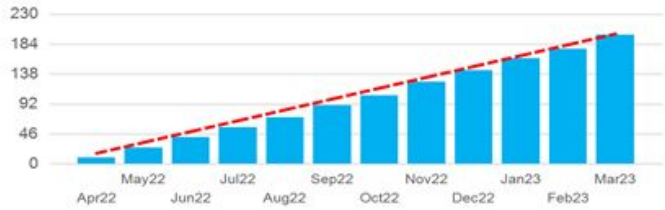
Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month													
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
RI05	Number of New Studies Open to Recruitment	Green ≥52 per year Amber 45 - 51 Red <45	CCC Strategy	2	5	1	3	2	3	2	4	6	3	2	4		
			Narrative	The monthly performance is below the target and annual target not achieved, therefore an exception report is provided.													



Reason for Non-Compliance	Action Taken to Improve Compliance
• 37 studies have opened to recruitment against an internal target of 52 (71% of target) at the end of Month 12. o Of the four studies opened, one is a strategically important Haemato-oncology trial and another is notable as it is a prehabilitiation study supporting head and neck patients having difficulty swallowing and is led by our Speech and Language Therapist and ANPs/ Specialist Team. The other interventional study is in sarcoma with a complex patient population. We have also opened an observational study in mesothelioma. • The majority of studies currently in set-up are complex, supporting the BRC and ECMC strands of the research portfolio. There are currently 30 CTIMP (drug) studies in set-up. • CCC has issued local approval for capacity and capability (C&C) for eight studies. Currently one study is awaiting second stage approval from Pharmacy, seven studies are awaiting Sponsor activation to open. If sponsor had agreed to open these seven studies to recruitment we would have opened 44 studies (85% of target).	• Regular operational meetings with the Clinical Trial Pharmacy and R&I teams to progress/open new drug studies. Recovery plan in place with Pharmacy monitored through R&I Directorate Board. • Work with the Director of Clinical Research and research active representatives to prioritise and open appropriate studies. Review external factors identified via end-to-end review of set-up process and action plan. • Work with the SRG Leads and the Network to optimise opportunities with observational studies. • Work with Sponsors and service departments to open studies to recruitment where all local approvals have been given. • Target not met in year. Strategic decision taken this year to prioritise opening ECMC trials which are complex and can take longer to set-up. This was in support of the ECMC renewal application which was announced as successful in January 2023.

Escalation Route & Expected Date of Compliance
R&I Directorate Board, Committee for Research Strategy, Performance Committee, Trust Board Target not met in-year

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month													
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
RI22	Publications	Green >200 per year Amber 170-200 Red <170	CCC Strategy	10	15	16	15	16	18	15	21	18	18	15	21		
			Narrative	The monthly performance is above target and the annual target has been achieved.													



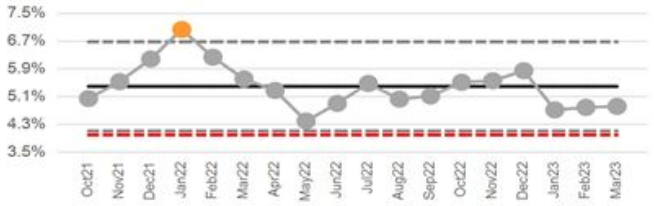
Integrated Performance Report (April 22 - Mar 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Responsible Forum: People Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month													
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
WO01	Sickness Absence	Green ≤4% Amber 4.1 - 4.9% Red ≥5%	Contractual / Statutory	5.3%	4.4%	4.9%	5.5%	5.0%	5.1%	5.5%	5.6%	5.9%	4.7%	4.8%	4.8%		
			Narrative	The target has not been achieved. Although there is no significant change, the target is unlikely to be achieved without significant change and an exception report is therefore provided.													

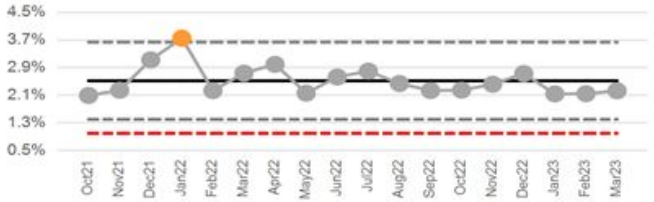


Reason for Non-Compliance	Action Taken to Improve Compliance
Sickness absence has increased from 4.79% to 4.82% for March. This remains above the Trust target of 4%. There were a total of 285 absences within the Trust in March, compared with 265 in February. This is the first increase in two months. There have been 226 short term absences (an increase of 16 from previous month) and 60 long term sicknesses (increased by 4 from the previous month). The top three reasons for sickness remain consistent with February's data, with cold, cough and flu with 57 occasions (an increase of 10 episodes from previous month). The second top reason is gastrointestinal problems, with 49 episodes (an increase of 7 episodes) and the third highest reason was anxiety/stress/depression with 42 episodes (an increase of 6 episodes). With anxiety/stress/depression still appearing within the top 3 reasons for sickness, it is important to highlight that out of the 42, 26 of these are long term sicknesses and 6 occasions ended in March. The other 22 episodes were short term absences and 7 ended in March whilst the other 13 will continue into April.	The HRBP team have recently developed manager 'crib sheets' to support line managers with the management of gastrointestinal problems and anxiety/stress/depression work related and non work related absences. The purpose is to try and have early intervention to reduce sustained sickness absence and/ or future sickness episodes. These are planned to be rolled out within April. The HRBP Team are reviewing short term sicknesses absences relating to anxiety/stress/depression to see if we can support return to work before they enter long term sickness. The HRBP team to continue to have a targeted approach with line managers in recorded level 2 reason in ESR for anxiety/stress/depression as this remains missing for majority of the absences.

Escalation Route & Expected Date of Compliance

Divisional Meetings, Divisional Performance Reviews, Workforce Advisory Committee, People Committee, Trust Board
October 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month													
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
WO20	Sickness Absence (Short Term)	Green ≤1% Amber 1.1 - 1.2% Red ≥1.3%	Contractual / Statutory	3.0%	2.2%	2.6%	2.8%	2.4%	2.2%	2.2%	2.4%	2.7%	2.1%	2.1%	2.2%		
			Narrative	The target has not been achieved. Although there is no significant change, the target is unlikely to be achieved without a significant change and an exception report is therefore provided.													



Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Responsible Forum: People Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
The top reason for short term sickness in March remains consistent with the previous month as cold, cough and flu had a total of 57 absences. This is the first increase in this absence reason since December. The second reason for short term sickness is gastrointestinal problems which has remained second with 46 episodes in March. This has also seen an increase since February where it was at 37 episodes. The third top reason for short term absence is anxiety/stress/depression with 21 episodes. 12 of these episodes were in Acute and Networked services.	The HRBP Team are finalising an action plan to be rolled out from April onwards to focus on reducing short term sickness. This will include a review of our policies and procedures and continuing to provide a targeted approach to improve the health, wellbeing and engagement of our staff, by ensuring access to appropriate services and support. On the back of the quarterly deep dives, the HRBP team to continue to review short term sickness absences paying particular attention to areas with increasing absences due to anxiety/stress/depression. As gastrointestinal problems appears to be on the rise again, the HRBP Team to continue to review any trends in relation to gastrointestinal problems with a targeted approach with line managers if themes continue to develop. Due to short term sickness overall still being high, the HRBP team to ask managers during monthly surgeries to evidence that absences are being managed in line with policy, e.g. what support has been offered, RTW documentation and management of policy stages.

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

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
WO21	Sickness Absence (Long Term)	Green ≤3% Amber 3.1 - 3.5% Red ≥3.5%	Contractual / Statutory		2.3%	2.2%	2.3%	2.7%	2.6%	2.8%	2.7%	3.0%	3.1%	2.6%	2.6%	2.6%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
WO02	% Turnover (Rolling 12 Months)	Green ≤15% Amber 14.1%-14.9% Red ≥14%			17.0%	17.0%	17.2%	16.9%	16.7%	16.3%	15.9%	16.1%	16.2%	15.9%	15.8%	16.0%		
			Narrative	The target has not been achieved. Whilst performance is lower than expected, the target is unlikely to be achieved without significant change and an exception report is therefore provided.														

Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

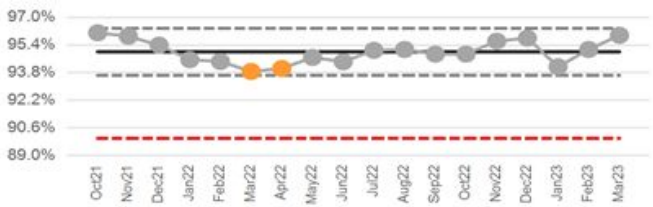
Workforce

Responsible Forum: People Committee

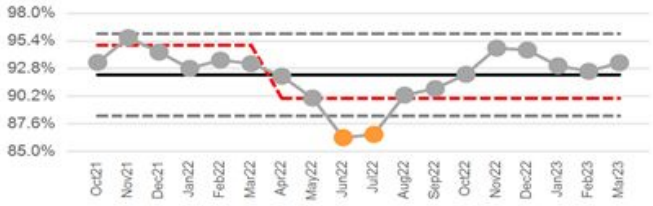
Reason for Non-Compliance	Action Taken to Improve Compliance
The Trust turnover has slightly increased in March following a decrease in the previous two months. It has increased from 15.78% in February to 16.00% in March. This remains above the Trust target and includes all leavers from the Trust, regardless of reason for leaving. Leavers due to retirement and end of fixed term contracts (FTC) were removed from the list of leavers up until the end of February 2023 in order to try and understand whether the Trust would still be above target. With these removed, the Trust would be at 13.77%, which takes us below target. This amounts to 10 leavers due to end of FTC (0 in March) and 38 due to retirement (4 within March) in the last 12 months. There were 24 leavers in March compared with 18 in February. Work life balance was the highest reason for leaving with 13 in total, followed by retirement age with 4 and joint third was Promotion and Relocation with 2 each. Acute care had the highest percentage of leavers in proportion to staff numbers at 2.4% (10 leavers) followed by Networked Services at 1.7% (10 leavers). 8 exit interviews were completed for staff leaving in March which is an increase by 3 since February.	The HRBP Team to continue to push for exit interviews to be completed to ensure that we are receiving useful information which can drive improvements and reduce turnover. The HR Team will link in with managers to understand reasons for non-completion of exit interviews/ questionnaires. The HRBP team to work with managers to try to understand further the reasons that staff are leaving due to 'work life balance' and to ensure that it is being used for the appropriate reason due to the increase of this reason. The HRBPs are currently developing the programme of work around Stay and Grow conversations across the divisions. This will focus on areas with the highest turnover initially with a view to support those who are leaving due to career progression or development opportunities.

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

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
WO07	Statutory Mandatory Training Compliance	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory		94.0%	94.7%	94.4%	95.1%	95.1%	94.9%	94.9%	95.6%	95.8%	94.1%	95.1%	96.0%		
			Narrative	The target has been achieved. Performance is as expected and the target is likely to be achieved consistently. NB: There are specific courses for which we are not compliant. This is closely monitored at People Committee and in Divisional PRGs, with actions identified to improve compliance.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
WO22	Performance Development Reviews (PADR) Snapshot Month End	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual		92.1%	90.0%	86.3%	86.6%	90.3%	90.9%	92.3%	94.7%	94.6%	93.1%	92.5%	93.4%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



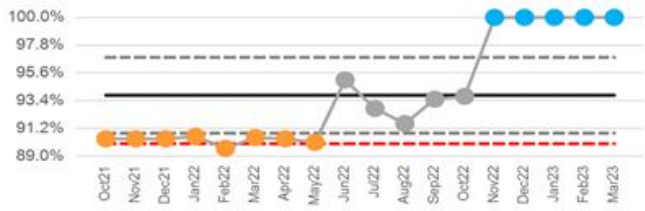
Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Responsible Forum: People Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
WO23	Medical Appraisal	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory		90.4%	90.1%	95.0%	92.8%	91.6%	93.5%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%		
			Narrative	The target has been achieved, at 100%. Performance is better than expected and the nature of variation indicates that achievement of the target is likely to be consistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
WO24	Pulse Staff Survey: Employee Engagement Score	To Be Confirmed	Contractual		-	-	6.90	-	-	7.20	-	-	-	-	-	7.10		
			Narrative	CCC are performing better than the national average (6.4) in this category.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
WO25	Pulse Staff Survey: Advocacy Score	To Be Confirmed	Contractual		-	-	7.10	-	-	7.60	-	-	-	-	-	7.40		
			Narrative	CCC are performing better than the national average (6.3) in this category.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
WO26	Pulse Staff Survey: Involvement Score	To Be Confirmed	Contractual		-	-	6.80	-	-	6.90	-	-	-	-	-	7.00		
			Narrative	CCC are performing better than the national average (6.4) in this category.														

Data Not Applicable for SPC

Integrated Performance Report (April 22 - Mar 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

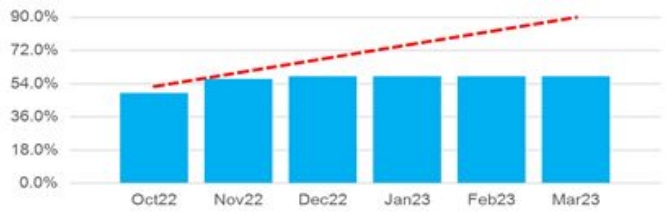
Workforce

Responsible Forum: People Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month												V	A
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23		
WO27	Pulse Staff Survey: Motivation Score	To Be Confirmed	Contractual	-	-	6.90	-	-	6.90	-	-	-	-	-	6.80		
			Narrative	CCC are performing better than the national average (6.6) in this category.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month												V	A
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23		
WO33	Staff Flu Vaccination: % of Frontline Staff Who Have Been Vaccinated	Green ≥90% Red <90% Ending Feb 2023	CQUIN	-	-	-	-	-	-	48.9%	56.5%	58.0%	58.0%	58.0%	58.0%		
			Narrative	The vaccination campaign has now ended, with uptake lower than in previous years, mirroring the regional and national picture. An end of campaign review will be undertaken to identify any lessons for improvement.													



Integrated Performance Report (April 22 - Mar 23)

Finance | Responsible Forum: People Committee

Metric (£000)	In Mth 12 Actual	In Mth 12 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	503	133	370		2,735	1,621	1,114	
CPL/Propcare Surplus/ (Deficit)	(451)	0	(451)		757	0	757	
Control Total Surplus/ (Deficit)	52	133	(81)		3,492	1,621	1,871	
Trust Cash holding	61,246	50,708	10,538		61,246	50,708	10,538	
Capital Expenditure	19,768	21,059	1,291		23,941	23,947	6	
Agency Cap	146	95	(51)		1,761	1,140	(621)	

For 2022/23 NHS Cheshire & Merseyside ICB are managing the required financial position of each Trust through a whole system approach. The Trust submitted a plan to NHSE/I showing a £1.621m surplus for 2022/23. In January the C&M ICB approached the Trust and asked if an improved year-end financial position above the £1.6m plan could be achieved to support the overall system position. The Trust reviewed its group forecast outturn position and has agreed a revised position of £3.5m surplus, including the profit from subsidiary company profits.

The Trust financial position to the end of March is a £2,735k surplus, which is £1,114k above plan. The group position to the end of March is a £3,492k surplus. This is in line with the forecast outturn position agreed.

The Trust cash position is a closing balance of £61.2m, which is £10.5m above plan. Capital Spend is £19.76m in the month and £23.9m for the year, with £15.6m relating to the purchase of Liverpool Paddington CDC.

The Trust is over the agency cap in March by £51k and £621k year to date. Further controls have been put in place by NHSE/I to monitor agency spend and the Divisions have provided exit strategies for all agency spend, these are being monitored regularly throughout the year.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1
26th April 2023

Report lead	James Thomson – Director of Finance					
Paper prepared by	Jo Bowden – Deputy Director of Finance					
Report subject/title	Finance Report – Month 12 2022/23					
Purpose of paper	To present the Trust's financial position at the end of March 2023.					
Background papers	N/A					
Action required	To note the contents of the report					
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work			
	Be Collaborative		Be Digital			
	Be Research Leaders		Be Innovative			

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

The Clatterbridge Cancer Centre NHS Foundation Trust

1. Introduction

1.1 This paper provides a summary of the Trust's financial performance for March 2023, the twelfth month of the 2022/23 financial year.

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

2. Summary Financial Performance

2.1 For March the key financial headlines are:

Metric (£000)	In Mth 12 Actual	In Mth 12 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	503	133	370		2,735	1,621	1,114	
CPL/Propcare Surplus/ (Deficit)	(451)	0	(451)		757	0	757	
Control Total Surplus/ (Deficit)	52	133	(81)		3,492	1,621	1,871	
Trust Cash holding	61,246	50,708	10,538		61,246	50,708	10,538	
Capital Expenditure	19,768	21,059	1,291		23,941	23,947	6	
Agency Cap	146	95	(51)		1,761	1,140	(621)	

2.2 For 2022/23 NHS Cheshire & Merseyside ICB are managing the required financial position of each Trust through a whole system approach. The Trust submitted a plan to NHSE/I showing a £1.6m surplus for 2022/23.

2.3 In January the C&M ICB approached the Trust and asked if an improved year-end financial position above the £1.6m plan could be achieved to support the overall system position. The Trust reviewed its group forecast outturn position and has agreed a revised position of £3.5m surplus.

3. Operational Financial Profile – Income and Expenditure

Overall Income and Expenditure Position

3.1 The Trust financial position to the end of March is a £2.7m surplus, which is £1.1m above plan. The group position to the end of March is a £3.492m surplus, which is in line with the agreed forecast outturn position. These values are subject to external audit.

3.2 The Trust cash position is a closing balance of £61.2m, which is £10.5m above plan. Capital spend is £19.7m in month and £23.9m year to date, with £15.6m relating to the purchase of Liverpool Paddington CDC.

3.3 The Trust is over the agency cap in March by £51k and £621k year to date. Further controls have been put in place by NHSE/I to monitor agency spend and the Divisions have provided exit strategies for all agency spend, these are being monitored regularly throughout the year. Further detail has been provided below.

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Metric (£000)	Actual M12	Trust Plan M12	Variance	Actual YTD	Trust Plan YTD	YTD Variance	Trust Annual Plan
Clinical Income	27,226	20,654	6,571	243,534	229,680	13,854	229,680
Other Income	2,849	2,296	552	21,720	26,161	(4,441)	26,161
Total Operating Income	**30,074**	**22,951**	**7,124**	**265,254**	**255,841**	**9,413**	**255,841**
Total Operating Expenditure	(29,473)	(22,471)	(7,003)	(260,037)	(250,060)	(9,977)	(250,060)
Operating Surplus	**601**	**480**	**121**	**5,217**	**5,781**	**(564)**	**5,781**
PPJV	56	67	(11)	1,076	804	272	804
Finance Costs	(154)	(414)	260	(3,558)	(4,964)	1,406	(4,964)
Trust Surplus/Deficit	**503**	**133**	**370**	**2,735**	**1,621**	**1,114**	**1,621**
Subsiduaries	(451)	0	(451)	757	0	757	**0**
Consolidated Surplus/Deficit	**52**	**133**	**(81)**	**3,492**	**1,621**	**1,871**	**1,621**

The table below summaries the consolidated financial position:

March 2023 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	5,772	7,105
Donated Depreciation	81	981
Fixed Asset Impairment	(5,351)	(5,351)
Trust Retained Surplus / (Deficit)	**502**	**2,735**
Subsiduary Companies	(451)	757
Consolidated Financial Position	**51**	**3,492**

This table shows a fixed asset impairment associated with site redevelopment, the NHS accounting convention is that this charge is excluded from the reported operating financial position.

3.5 The bridge below shows the key drivers between the £503k in month surplus and £133k surplus plan, which is a variance of £370k:

- The Trust is no longer assuming any income for Elective Recovery Fund (ERF) for activity over 104% of 2019/20 and so is showing a £751k under recovery against the ERF income plan in month. The Trust has, however, agreed a fixed amount of £3.5m systems funding from the ICB and is showing £292k in month. The net impact is a £459k under recovery of clinical income.

- Cost and Volume drugs are overspent by £1.4m and are offset by an over recovery of income. As part of the 2022/23 funding agreement with commissioners high cost drugs remain on a pass-through basis.

- The Trust has received guidance to include both costs and income for the 2022.23 non-consolidated payaward that is under review. National central estimates have been provided for inclusion, this amounts to £3.4m for both income and expenditure. After further internal assessmenet a further £180k has been included in pay due to increases in staffing levels and mat leave staff not being included in the calculation.

- Trust Pay costs are overspent by £35k, staff numbers have increased by 13.03 wte.

- Bank spend has increased in month to £227k, a £39k increase. This is mainly due to 1:1 care required on the wards for 7 patients, escalation beds remaining open and CNS payments to cover the junior doctor strike.

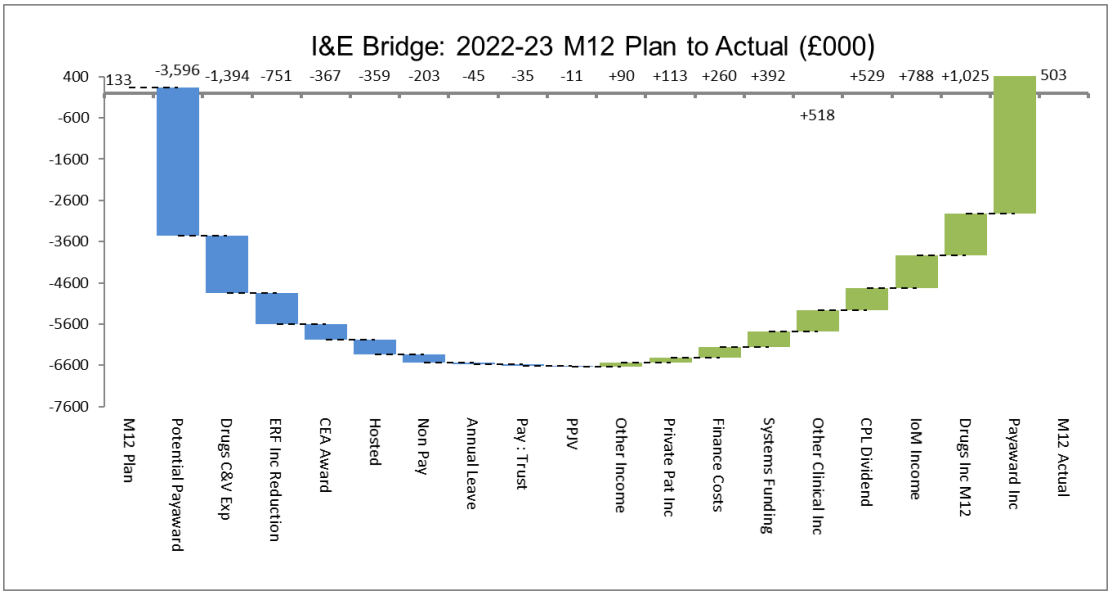
- Agency spend is £146k in month, this is consistent with previous months.

- In terms of Clinical Income the Trust is showing a £788k over recovery for IoM. The Trust has been prudent in previous months regarding the level of income included while contracting discussions were taking place.

- In March the Trust accrued a Dividend payment from CPL of £575k, which is £529k above Trust plan due to this being profiled in twelfths.

- PPJV is below plan by £11k in month, however, there is a £272k profit for the full year.

- Interest receivable is over plan by £451k, this relates to increasing interest rates.



3.6 Bank and Agency Reporting

Bank spend has increased in month to £227k, a £39k increase. This is mainly due to 1:1 care required on the wards for 7 patients, escalation beds remaining open and CNS payments to cover the junior doctor strike.

Agency spend is £146k in month, this is consistent with previous months.

There is a focus on the reduction of agency usage across the Trust and this is reported and monitored through the Trust's Establishment Control Panel and Finance Committee.

See Appendix F for further detail.

The Clatterbridge Cancer Centre NHS Foundation Trust

3.7 Cost Improvement Programme (CIP)

The Trust CIP requirement for 2022/23 is £6.8m, representing 4.5% of turnover. This is broken down into £4.4m recurrent and £2.3m non-recurrent.

The £2.3m non-recurrent element will be met centrally by the Trust. Of the remaining £4.4m recurrent element, £1m will be met by reserves and the remaining £3.4m allocated to the Divisions.

Target		**6,765,000**
NR Contingency		2,300,000
Balance		**4,465,000**
Reserves		1,000,000
Divisional Allocation		3,465,000

Against the full year CIP target of £6.7m, £6.8m of schemes have been identified (101%). Only £2.7m has been identified recurrently against the £4.4m recurrent target. The focus is now on next financial year and the Divisions continue to work on developing a number of recurrent opportunities that are currently being worked through.

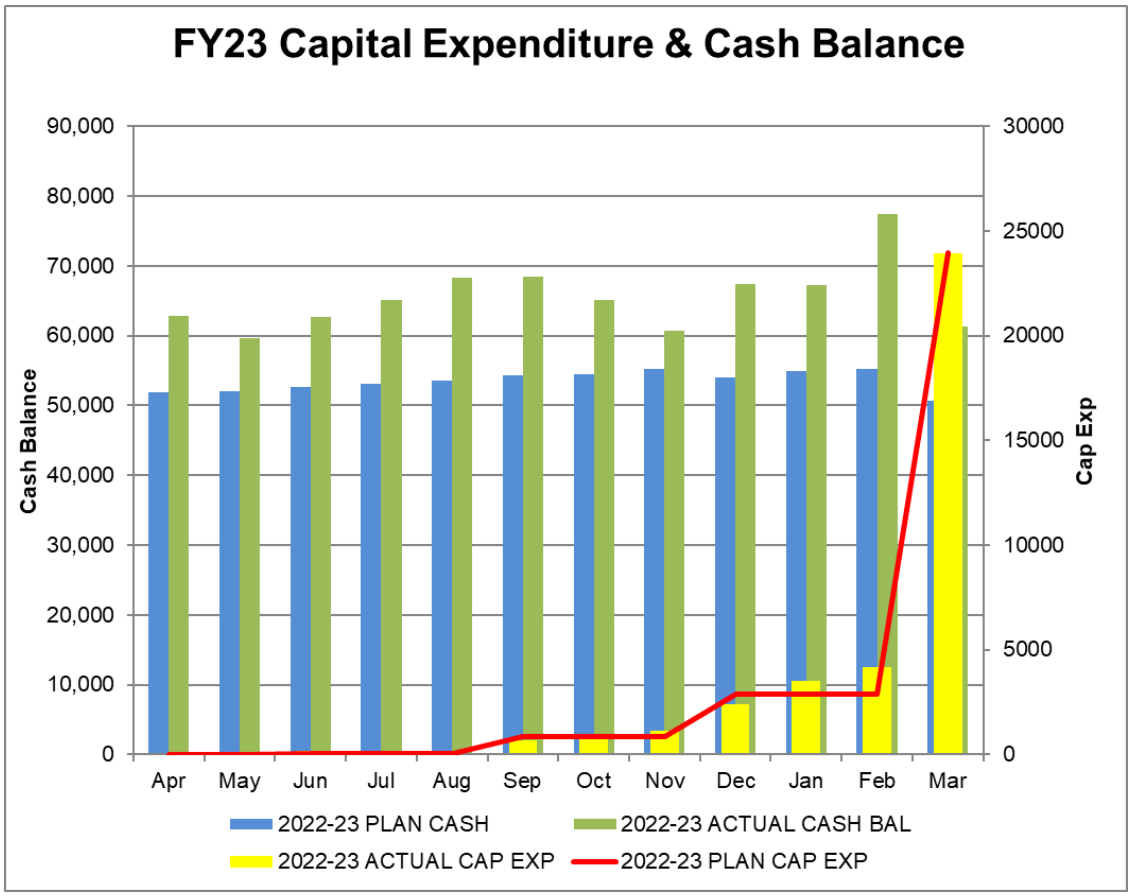
4. Cash and Capital

4.1 The 2022/23 capital plan approved by the Board in March was £7.1m. A further £5.5m national PDC funding was approved to support the Wirral CDC facility, we have subsequently agreed with Wirral University Teaching Hospital NHS FT that they will lead the CDC capital programme and this PDC has now been transferred to them. Additional PDC of £15m has been secured to support the purchase of the former Rutherford site and £747k to support digital developments.

4.2 Capital expenditure of £23.9m has been incurred to the end of March.

4.3 The capital programme is supported by the organisation's cash position. The Trust has a current cash position of £61.2m, which is a positive variance of £10.6m to the cash-flow plan.

The Balance Sheet (Statement of Financial Position) is included in Appendix B and Cash flow in Appendix C.



This chart shows monthly planned and actual Cash Balances and Planned Capital Expenditure for 2022/23.

5. Balance Sheet Commentary

5.1 Current Assets

The Trust's cash balance at the end of March is £61.2m, this is £10.6m above plan figure of £50.7m. The Trust has £9.1m of deferred income above plan and additional cash of £1.4m for interest receivable not planned.

Receivables are in line with plan, demonstrating that debt continues to be collected promptly.

5.2 Current Liabilities

Payables (non-capital creditors) are in line with plan.

Deferred Income is £9.1m above plan. This relates in the main to R&I income and Cancer Alliance both of which have a number of multi-year schemes which are ongoing.

6. Recommendations

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

- The delivery of planned financial targets
- The final 2022/23 surplus position
- The continuing strong liquidity position of the Trust

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix A – Statement of Comprehensive Income (SOCI)

(£000)	Month 12			Cumulative YTD			2022-2023	
	Plan	Actual	Variance	Plan	Actual	Variance	%	Annual Plan
Clinical Income	18,706	24,207	5,501	223,267	231,582	8,315		223,267
Other Income	988	2,041	1,053	9,533	12,343	2,810		9,533
Hosted Services	3,256	3,826	570	23,041	21,330	(1,711)		23,041
Total Operating Income	**22,951**	**30,074**	**7,124**	**255,841**	**265,254**	**9,413**	**0%**	**255,841**
Pay: Trust (excluding Hosted)	(6,681)	(11,041)	(4,360)	(78,733)	(82,324)	(3,591)		(78,733)
Pay: Hosted	(879)	(1,127)	(248)	(10,122)	(8,833)	1,289		(10,122)
Drugs expenditure	(7,679)	(9,073)	(1,394)	(92,148)	(95,886)	(3,738)		(92,148)
Other non-pay: Trust (excluding Hosted)	(4,307)	(4,626)	(319)	(54,964)	(59,407)	(4,443)		(54,964)
Non-pay: Hosted	(2,925)	(3,607)	(682)	(14,093)	(13,587)	506		(14,093)
Total Operating Expenditure	**(22,471)**	**(29,473)**	**(7,003)**	**(250,060)**	**(260,037)**	**(9,977)**	**-1%**	**(250,060)**
Operating Surplus	**480**	**601**	**121**	**5,781**	**5,217**	**(564)**	**15%**	**5,781**
Profit /(Loss) from Joint Venture	67	56	(11)	804	1,076	272		804
Interest receivable (+)	386	837	451	4,626	6,095	1,469		4,626
Interest payable (-)	(434)	(423)	11	(5,213)	(5,113)	100		(5,213)
Interest right of use (-)	0	(23)	(23)	0	(102)	(102)		0
PDC Dividends payable (-)	(365)	(544)	(179)	(4,377)	(4,438)	(61)		(4,377)
Trust Retained surplus/(deficit)	**133**	**503**	**370**	**1,621**	**2,735**	**1,114**	**8%**	**1,621**
CPL/Propcare	0	(451)	(451)	0	757	757		0
Consolidated Surplus/(deficit)	**133**	**52**	**(81)**	**1,621**	**3,492**	**1,871**	**8%**	**1,621**

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix B – Balance Sheet

£'000	Audited 2022 (Group Ex Charity)	Plan 2023 (Trust only)	Year to date Month 12		
			YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	3,211	3,162	2,693	6,738	4,045
Property, plant & equipment	184,599	173,627	174,356	202,149	27,793
Right of use assets	0	0		10,633	10,633
Investments in associates	977	800	800	1,304	504
Other financial assets	0	115,276	0	0	0
Trade & other receivables	449	434	433	869	436
Other assets	0	0	0	0	0
Total non-current assets	**189,236**	**293,298**	**296,990**	**221,692**	**(75,298)**
Current assets					
Inventories	5,640	3,000	2,459	4,176	1,717
Trade & other receivables					
NHS receivables	7,749	7,084	6,882	8,566	1,683
Non-NHS receivables	6,278	10,915	10,603	10,651	48
Cash and cash equivalents	80,726	50,708	53,041	70,033	16,992
Total current assets	**100,393**	**71,707**	**72,985**	**93,425**	**20,440**
Current liabilities					
Trade & other payables					
Non-capital creditors	6,918	32,207	32,697	32,828	132
Capital creditors	36,547	1,958	1,987	2,915	927
Borrowings					
Loans	1,908	1,730	1,730	1,899	169
Lease liabilities		0	0	334	334
Provisions	4,214	94	99	1,533	1,434
Other liabilities:-					
Deferred income	15,669	5,577	5,504	14,641	9,136
Other	0	0	0	0	0
Total current liabilities	**65,255**	**41,565**	**42,017**	**54,150**	**12,133**
Total assets less current liabilities	**224,374**	**323,440**	**327,958**	**260,967**	**(66,991)**
Non-current liabilities					
Trade & other payables					
Capital creditors	120	0	0	0	0
Borrowings					
Loans	32,090	30,360	31,350	30,360	(990)
Lease liabilities	0	0	0	10,354	10,354
Other liabilities:-					
Deferred income	0	1,018	(0)		0
Provisions	197	115	527	1,274	747
PropCare liability	(1)	113,436	(776)		776
Total non current liabilities	**32,406**	**144,929**	**149,810**	**41,988**	**10,887**
Total net assets employed	**191,968**	**178,511**	**178,148**	**218,979**	**40,831**
Financed by (taxpayers' equity)					
Public Dividend Capital	72,219	72,219	72,219	88,793	16,574
Revaluation reserve	4,558	2,699	2,699	6,879	4,180
Income and expenditure reserve	115,191	103,593	103,230	123,307	20,078
Total taxpayers equity	**191,968**	**178,511**	**178,148**	**218,979**	**40,831**

The Clatterbridge Cancer Centre
NHS Foundation Trust

Appendix C – Cash Flow

March 2023 (M2) £000s	FT	Group	Group (exc Charity)
Cash flows from operating activities:			
Operating surplus	9,518	12,039	10,565
Depreciation	10,119	10,128	10,119
Amortisation	804	804	804
Impairments	- 5,214	- 5,214	- 5,214
Movement in Trade Receivables	- 6,310	- 6,820	- 6,783
Movement in Other Assets	3,433	- 0	- 0
Movement in Inventories	1,791	1,465	1,465
Movement in Trade Payables	- 11,855	- 5,120	- 5,120
Movement in Other Liabilities	- 4,411	- 1,028	- 1,028
Movement in Provisions	- 944	- 2,693	- 2,693
CT paid	-	- 290	- 290
Impairements /revaluations Annual	2,498	2,498	2,498
Balance figure	137	137	137
Charity funds			
Net cash used in operating activities	**(436)**	**5,904**	**4,458**
Cash flows from investing activities			
Purchase of PPE	- 22,244	- 22,373	- 22,364
Purchase of Intangibles	- 4,331	- 4,327	- 4,327
ROU Assets	- 11,150	- 11,177	- 11,177
Proceeds from sale of PPE	9	9	9
Interest received	6,095	1,556	1,524
Investment in associates	750	750	750
Net cash used in investing activities	**(30,871)**	**(35,562)**	**(35,585)**
Cash flows from financing activities			
Public dividend capital received	16,574	16,574	16,574
Public dividend capital repaid			
Loans received			
Movement in loans	- 1,730	- 1,730	- 1,730
Capital element of finance lease	10,670	10,688	10,688
Interest paid	- 5,122	- 542	- 542
Interest element of finance lease- rou	- 102	- 118	- 118
PDC dividend paid	- 4,438	- 4,438	- 4,438
Finance lease - capital element repaid	-	-	-
Net cash used in financing activities	**15,853**	**20,434**	**20,434**
Net change in cash	**(15,455)**	**(9,224)**	**(10,693)**
Cash b/f	**76,701**	**82,815**	**80,726**
Cash c/f	**61,246**	**73,591**	**70,033**

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix D – Capital

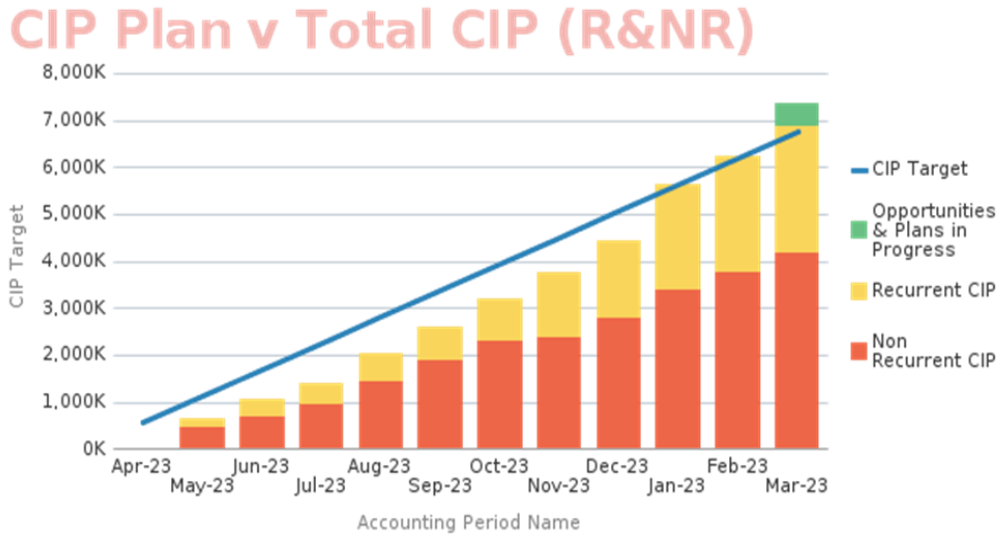
Capital Programme 2022-23
Month 12

The Clatterbridge Cancer Centre NHS Foundation Trust

Code	Scheme	Lead	BUDGET (£'000) NHSI plan 22-23	Approved Adjustments	Budget 22-23	ACTUALS (£'000) Actuals @ Month 12	Variance to Budget	FORECAST (£'000) Forecast 22-23	Variance to Budget	Ordered?	Complete?	Comments
4142	***(21/22)*** TCC - Liverpool	Peter Crangle	0	0	0	0	(0)	0	(0)			
4142	***(21/22)*** TCC - Liverpool - Artwork	Sam Wade	0	0	0	(12)	12	(12)	12			
4142	***(21/22)*** TCC - Link Bridge installation	Peter Crangle	0	0	0	1,099	(1,099)	1,099	(1,099)			
4300	***(21/22)*** CCCW CT Simulator (Brilliance 2)	Louise Bunby	0	0	0	1	(1)	1	(1)			
4306	***(21/22)*** CCCL Ward 2 Sluice	Jeanette Russell	0	0	0	0	(0)	0	(0)			
4307	***(21/22)*** CCCL Ward 4/5 bathroom conv	Pris Hetherington	0	60	60	69	(9)	69	(9)	✓	✓	£59,804 approved charity funding
4313	***(21/22)*** CCCL Terraces		0	10	10	10	0	10	0	✓	✓	Additional cost on prior year scheme
4323	***(21/22)*** CCCL Ward 2 blood room conv		0	0	0	3	(3)	3	(3)	✓	✓	Additional cost on prior year scheme
4401	CCC-L Ward 3 bathroom conversion	Kathryn Williams	0	32	32	0	32	0	32	-	-	Delayed to 2023/24
4407	CCC-A Cherry linac replacement		160	(120)	40	47	(7)	47	(7)	✓	✗	work done - waiting for costs
	Major roofing works	Peter Crangle	500	(500)	0	0	0	0	0	-	-	Replaced with below Propcare plan
	6 Facet lifecycle	Peter Crangle	533	(533)	0	0	0	0	0	-	-	Replaced with below Propcare plan
4420	Propcare 22-23 Capital Plan	Peter Crangle	0	817	817	218	599	218	599	✗	✗	Forecast spend reduced
4414	CCC-L Fridge electrical works	Peter Crangle	0	9	9	9	0	9	0	✓	✓	
4419	CCC-W PPU Refurb	Peter Crangle	0	0	0	15	(15)	15	(15)	✓	✓	
4428	CCC-L M1 Service Counter Chilled Beam Installation		0	0	0	34	(34)	34	(34)	✓	✓	
4433	CCC-A Estates Work and Rebranding	Emer Scott	0	25	25	0	25	0	25	✗	✗	Approved at CIG 31st Jan
	Contingency	*n/a*	200	270	470	0	470	125	345	-	-	
	Estates		**1,393**	**70**	**1,463**	**1,494**	**(31)**	**1,619**	**(156)**			
4180	***(19/20)*** CCCL HDR & Papillon tfr costs		0	0	0	0	0	0	0	✓	✓	Moved to revenue 19-01-23
4189	***(19/20)*** Draeger IACS Monitoring C700		0	0	0	(2)	2	(2)	2	✓	✓	Refund received due to overcharge
4192	***(19/20)*** Cyclotron	Carl Rowbottom	450	0	450	331	119	331	119	✓	✗	Ongoing scheme
4303	***(20/21)*** CCCA Linear Accelerator - Maple		0	0	0	0	(0)	0	(0)	✓	✓	
4331	***(21/22)*** Donated Scalp Cooler - Wirral		0	(2)	(2)	(2)	0	(2)	0	✓	✓	VAT recovery on charitably funded asset
4332	***(21/22)*** Donated Scalp Cooler - Halton		0	(2)	(2)	(2)	0	(2)	0	✓	✓	VAT recovery on charitably funded asset
4309	Voltage Stabilisers	Martyn Gilmore	0	60	60	71	(11)	71	(11)	✓	✗	Installation delayed
	CCC-A Cherry linac replacement		2,460	(2,460)	0	0	0	0	0	-	-	Delayed to 2023/24
4404	HDR Brachytherapy equip (Applicators)	Chris Lee	110	24	134	140	(6)	140	(6)	✓	✓	
4429	Varian - Aria Software	Carl Rowbottom	500	0	500	1,185	(685)	1,185	(685)	✓	✗	not receipted yet 28/3
4430	Varian - Eclipse Software	Carl Rowbottom	0	0	0	1,010	(1,010)	1,010	(1,010)	✓	✗	not receipted yet 28/3
4400	Hand Hygiene Scanner		0	0	0	12	(12)	12	(12)	✓	✓	Transferred from revenue
4402	Moving and Handling Training Equipment	Kate Greaves	0	29	29	29	0	29	0	✓	✓	
4406	Ultrasound CCC-L	Julie Massey	0	80	80	85	(5)	85	(5)	✓	✗	Showing as receipted and invoiced 24/3
4415	RFID Asset Tracking System	Julie Massey	0	200	200	186	14	186	14	✓	✗	Showing as receipted and invoiced 24/3
4416	Donated Scalp Cooler - Liverpool	Fiona Courtnell	0	10	10	10	0	10	0	✓	✓	Transferred from revenue
4417	Additional Pilot Systems for CIT	Julie Massey	0	12	12	12	0	12	0	✓	✓	
4418	CCC-L MRI Acceleration Software	Marc Rea	0	40	40	40	0	40	0	✓	✗	Marc Rea email 24/03 confirms fully installed, showing as receipted and invoiced 28/3
4426	Suncheck server hardware	Simon Temple	0	16	16	16	0	16	0	✓	✓	
4436	Aseptics Q-Pulse		0	0	0	50	(50)	50	(50)	✗	✗	Email to Rachel Newsham 20/03 - Jo B verbal confirmation from Tori that its been received
4431	QA3 Device	Martyn Gilmore	0	11	11	11	0	11	0	✓	✓	
4432	Prostate Brachytherapy Template Kit	Chris Lee	0	11	11	11	0	11	0	✓	✗	Receipted 2nd March
4434	Linac VT8 Gating Camera System	Martyn Gilmore	0	76	76	76	0	76	0	✓	✗	Martyn Gilmore email 20/3/23 confirms receipt. Receipted as at 28/3, not invoiced
4437	2x Resusci Anne		0	0	0	17	(17)	17	(17)			Identified in over £5k review
4438	Philips Defibrillator		0	0	0	7	(7)	7	(7)			Identified in over £5k review
4439	X-Ray Tube Linac H191396		0	0	0	0	0	0	0			Identified in over £5k review
4444	X-Ray Stretcher		0	0	0	6	(6)	6	(6)			Identified in over £5k review
4445	Shielded Cupboard		0	0	0	10	(10)	10	(10)			Identified in over £5k review
4447	Visual Coaching Device		0	0	0	19	(19)	19	(19)			Identified in over £5k review
	Contingency	*n/a*	400	1,570	1,970	0	1,970	(47)	2,017	-	-	
	Medical Equipment		**3,920**	**(325)**	**3,595**	**3,325**	**270**	**3,277**	**317**			
4138	***(21/22)*** Infrastructure	James Crowther	0	0	0	66	(66)	66	(66)	✓	✓	
4139			0	0	0	(2)	2	(2)	2			
4190	***(20/21)*** Digital Aspirant Programme	James Crowther	0	0	0	16	(16)	16	(16)	✓	✓	
4316	***(21/22)*** Digital Diagnostics Capability Prg	James Crowther	0	0	0	(35)	35	(35)	35	✓	✓	VAT review on prior year invoices
4317	***(21/22)*** Intelligent Automation (RPA)	James Crowther	0	0	0	(0)	0	(0)	0	✓	✓	
4320	***(21/22)*** Digital Infrastructure	James Crowther	0	0	0	(129)	129	(129)	129	✓	✓	VAT review on prior year invoices
4403	Server/Citrix/Cyber upgrade	James Crowther	360	0	360	344	16	344	16	✓	✗	Revised IT plan approved Sept CIG
4408	Sharepoint	James Crowther	0	360	360	297	63	297	63	✓	✗	Revised IT plan approved Sept CIG
4409	VDI expansion	James Crowther	455	422	877	1,000	(124)	1,000	(124)	✓	✗	Revised IT plan approved Sept CIG
4410	Digital Transformation & Optimisation	James Crowther	0	175	175	25	150	25	150	✓	✗	Revised IT plan approved Sept CIG
4411	Windows Upgrade	James Crowther	0	49	49	58	(9)	58	(9)	✓	✗	Revised IT plan approved Sept CIG
4412	Security Hardening	James Crowther	0	170	170	87	83	87	83	✓	✗	Revised IT plan approved Sept CIG
4413	Structured Cabling	James Crowther	0	10	10	5	5	5	5	✓	✗	Revised IT plan approved Sept CIG
4423	Rapid7 Vulnerability Manager	James Crowther	0	186	186	293	(107)	293	(107)	✓	✗	Additional scheme approved Oct CIG
4424	Mobile Computer Devices (Carts)	James Crowther	0	50	50	60	(10)	60	(10)	✓	✗	Additional scheme approved Oct CIG
4425	MS Teams meeting rooms	James Crowther	0	49	49	90	(42)	90	(42)	✓	✗	Additional scheme approved Oct CIG
	Core IT programme	James Crowther	785	(785)	0	0	0	0	0	-	-	Revised IT plan approved Sept CIG
4422	DDCP 22-23	James Crowther	0	747	747	786	(39)	786	(39)	✓	✗	New PDC funded scheme
4427	Cyber Capital Access Management	James Crowther	0	37	37	44	(7)	44	(7)	✓	✗	New PDC funded scheme
4405	Website	Emer Scott	100	0	100	10	90	10	90	✗	✗	Expected to slip into 2022/23
4440	DSS Desktop hardware		0	0	0	8	(8)	8	(8)			Identified in over £5k review
4441	Cisco Catalyst		0	0	0	7	(7)	7	(7)			Identified in over £5k review
4442	Cisco Nexus x2		0	0	0	16	(16)	16	(16)			Identified in over £5k review
4443	Installation of Fibre Link		0	0	0	12	(12)	12	(12)			Identified in over £5k review
4446	Dell Storage MD1400		0	0	0	14	(14)	14	(14)			Identified in over £5k review
	Contingency	*n/a*	0	(114)	(114)	0	(114)	(71)	(43)	-	-	
	IM&T		**1,700**	**1,355**	**3,055**	**3,073**	**(18)**	**3,003**	**52**			
	CDC National PDC		5,500	(5,500)	0	0	0	0	0			
	IFRS 16 - Chemo Cars		0	49	49	49	0	49	0			
	IFRS 16 - CCC-L Fridge Freezer		0	36	36	36	0	36	0			
	IFRS 16 - CCC-L SE Corner Portakabins		0	0	0	0	0	0	0			Jo B verbal 13/3 - now likely mid April
4421	Liverpool Paddington CDC - purchase	James Thomson	0	15,000	15,000	15,000	0	15,000	0			
4421	Liverpool Paddington CDC - costs		0	0	0	214	(214)	214	(214)			
4421	Liverpool Paddington CDC - IFRS 16		0	0	0	0	0	0	0			
4435	Liverpool Paddington CDC - CT Scanner		0	750	750	750	0	750	0			need serial number and invoice
	Other		**5,500**	**10,335**	**15,835**	**16,049**	**(214)**	**16,049**	**(214)**			
	TOTAL		**12,513**	**11,434**	**23,947**	**23,941**	**7**	**23,947**	**(0)**			

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix E – CIP



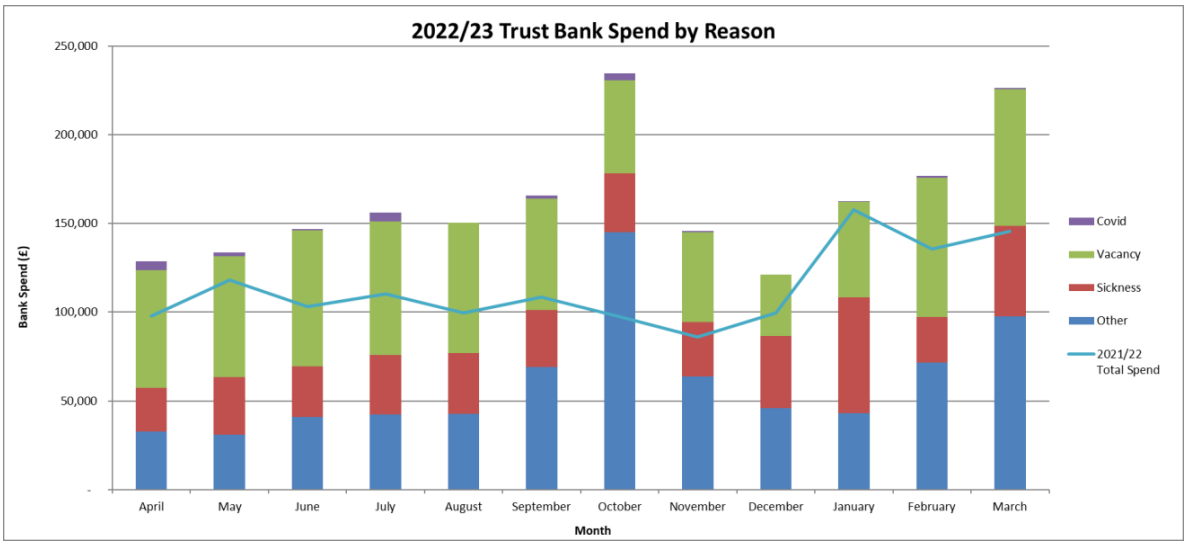
Division	Target	Total CIP	Recurrent CIP	Variance	Delivery % to date
CENTRAL CIP	3,300,000	4,084,656	1,789,932	784,656	124%
NETWORKED SERVICES	1,096,368	849,863	115,136	(246,505)	78%
ACUTE CARE	877,743	982,376	391,376	104,633	112%
RADIATION SERVICES	880,168	664,886	204,982	(215,282)	76%
CORPORATE	610,721	261,845	195,686	(348,876)	43%
Total	**6,765,000**	**6,843,626**	**2,697,112**	**78,626**	

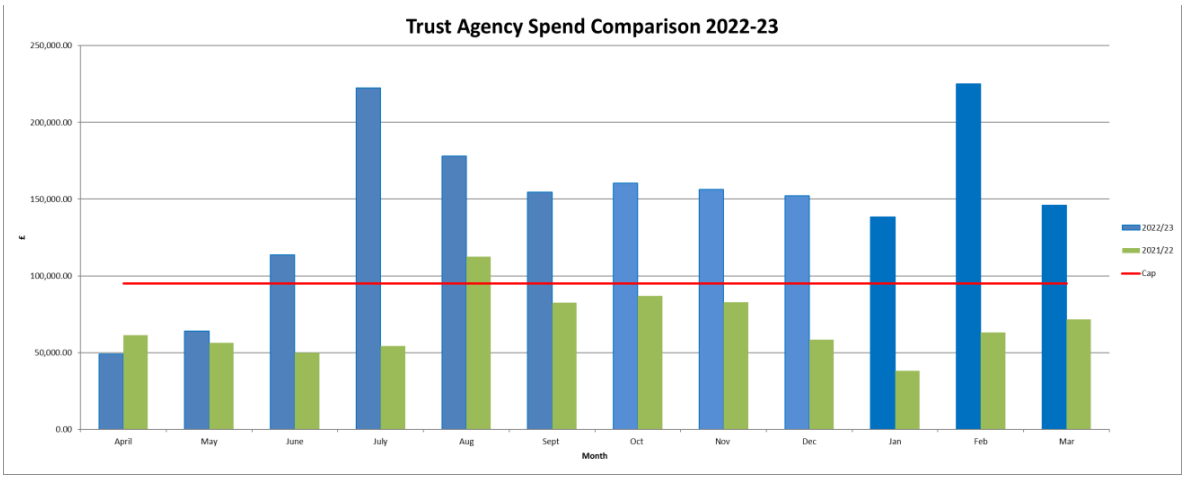
Full Year Plan (Recurrent & Non-Recurrent Split)

Recurrent	4,465,000	2,697,112	2,697,112	(1,767,888)	60%
Non-Recurrent	2,300,000	4,146,514	0	1,846,514	180%
Total	**6,765,000**	**6,843,626**	**2,697,112**	**78,626**	

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix F – Bank and Agency





The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 26th April 2023

Report lead	Julie Gray, Chief Nurse				
Paper prepared by: In attendance at the visit:	Quality Improvement Manager - Claire Smith Non-Executive Director – Unable to attend due to server weather Governor – Glen Crisp				
Report subject/title	NED and Governor Walk-round – 9th March 2023				
Purpose of paper	The purpose of this report is to provide Trust Board with a summary of the NED & Governor Patient Experience visit to the CANtreat Chemotherapy Unit, Halton.				
Background papers	n/a				
Action required	To approve content/preferred option/recommendations				
	To discuss and note content				X
	To be assured of content and actions				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work		X
	Be Collaborative		Be Digital		
	Be Research Leaders		Be Innovative		

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

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The Clatterbridge Cancer Centre NHS Foundation Trust

Division	Networked Services	Location	CANtreat Chemotherapy unit Halton	Date	9th March 2023
In attendance – Panel			In attendance – Patient & Staff		
Governor	Glen Crisp		Senior Manager facilitating the walk round		Claire Bennett Laura Selby
Non-Executive	Unable to attend		Number of Patients		4
Patient Experience Team	Claire Smith		Number of Staff		3

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

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

Positive Patient Comments:

- Love coming to the clinic apart from having the treatment, staff and toast are brilliant.
- New chairs very comfortable
- This place picks me up.
- Thankful for the invaluable clinic and staff
- No improvements necessary as staff are brilliant
- Phenomenal staff and fantastic care
- Ward manager is amazing, she remembers us all.
- Following a rare reaction I was able to be referred to dermatology straight away. The departments worked together to allow me to continue with treatment.
- Volunteers are fabulous, just the best.

Areas where immediate action was taken on the day:

- One patient noted having to travel from Warrington to Halton to have bloods taken. The unit manager arranged a solution during the visit so he could access phlebotomy closer to home, much to the delight of the patient who has a terminal diagnosis.

Areas for improvement:

- Some occasional appointment changes but it's rare.

Service response: *Highlight in **Bold** actions to be added to PEIC action plan*

- If appointments need to be changed the patient will be contacted with the new appointment times.

The Clatterbridge Cancer Centre NHS Foundation Trust

Staff Feedback: Staff were asked to describe their experience of providing patient care at CCC NB: *This is not a verbatim record but an overview of the key themes raised during the conversation.*
Positive Comments: • Senior staff discussed a planned refurbishment for the clinic, updating the current space and providing some private areas for both patients and staff. However, the team are keen not to lose the open and airy feel of the clinic, which fosters support and friendships between patients. • Staff also discussed the Milestone bell on the wall, they are very proud that the poem which accompanies the bell was written by one of their long term patients. • The clinic now has an increased number of cooling caps which staff felt had made a difference. • All staff gave extremely positive feedback of working at the unit. Although sometimes feeling isolated from main site CCCL, they feel part of a strong, close and supportive team. Lots of improvements with regard to recruitment and retention have been key to this. • Staff reported feeling supported and grateful for educational opportunities. • One staff member hopes to train as a nurse and is working at the unit to gain clinical experience. As a HCA she reported being trained in much more than other trusts, i.e. cannulation and PICC line/port care, allowing her to expand her knowledge. • One member of staff who had recently joined from another trust felt that CCC are better at team building and providing a sense belonging, she feels able to bring her past experience to the team with new ideas being welcomed. • Staff felt privileged to be able to make good relationships with patients, seeing them at regular intervals and sharing their journey.
Areas where immediate action was taken on the day: None

Areas for improvement:	Service response:
• Pharmacy deliveries - the clinic is closed on Wednesday so chemotherapy deliveries occur on a Thursday morning. Unfortunately this requires appointments to start half an hour later which can have a knock on affect for patients having treatment especially those who have a long regime.	In the process of recruiting a part time and full time HCSW. They will be responsible for managing the delivery, which will free up the nurses to start treating from 08:30

• More oncology education sessions to further develop staff knowledge of treatment regimens and likely disease progression.	Update staff in safety huddles to make them aware of clinical educational centre at CCC and various courses available for CCC staff. Regular communication on available courses for staff.
Observations on the day • Very calm and relaxed atmosphere.	

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1
26th April 2023

Report lead	Julie Gray, Chief Nurse				
Paper prepared by	Nikki Heazell – Head of Patient Experience				
Report subject/title	Non-Executive Director and Governor Engagement Annual Review				
Purpose of paper	To review the effectiveness of Non-Executive Director and Governor engagement with staff and patients.				
Background papers					
Action required	To approve content/preferred option/recommendations				
	To discuss and note content				√
	To be assured of content and actions				√
Link to: Strategic Direction Corporate Objectives	Be Outstanding	√	Be a great place to work		√
	Be Collaborative	√	Be Digital		√
	Be Research Leaders	√	Be Innovative		√

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

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

Equality & Diversity Impact Assessment

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Paper
April 2023

1. Summary

The purpose of this paper is to provide the Board of Directors with a review effectiveness of the 2022/23 the monthly Governor and Non-Executive Director (NED) lead patient and staff engagement sessions. It will provide assurance of the output and improvement actions taken to demonstrate the value of the process and to ensure it remains meaningful and adds value to our quality ambitions.

2. Background

For the last 10 to 15 years, walk-rounds have been widely used in healthcare organisations to improve both safety and experience for patients and staff. They gained traction following the public inquiry into poor care at the Mid Staffordshire NHS Foundation Trust and the subsequent publication of the Francis Report which questioned why the warning signs of serious failings were not recognised. Walk-rounds can identify early concerns when they are undertaken authentically and with the full commitment of the organisation. To be most meaningful walk-rounds are approached with enquiry and support and are not a form of surveillance or control. Conversations with patients and staff are not restricted or orchestrated to avoid challenging topics, they are organic and open. The role of the walk-round is to provide an opportunity and a safe environment for patients and staff to raise concerns, provide a process to ensure action is taken on issues raised and to provide feedback to services and the Board of Directors on how patients experience care.

3. Introduction

Governor and Non-executive lead walk-rounds have been in place at Clatterbridge Cancer Centre for many years and have proven to be a valuable method of hearing directly from patients and staff. Governor and Non-Executive Directors have a unique role in providing the eyes and ears of the outsider but with privileged access to the inside of the hospital. The walk rounds are arranged and supported by the Corporate Governance and Patient Experience teams. A brief report is produced for discussion at Board of Directors, which includes all positive feedback plus, any improvement actions identified, together with feedback from the service including timescales for completion.

The process was reviewed in quarter 1 2022/23 and the revised reports commenced in June 2022, therefore this paper relate to 10 months rather than 12 months.

During the engagement sessions both patients and staff have the opportunity to speak with the visiting team. Concerns which require immediate action are addressed on the day. Other improvement actions are monitored at the Quarterly Patient Experience and Inclusion Committee.

4. Areas of The Clatterbridge Cancer Centre visited during Non-Executive Director and Governor engagement sessions

Site	Division	Service	Date
CCC-W	Networked Services	Delamere Ward	June
CCC-L	Acute	Ward 2 (Level 2) Ward 3 (Level 3)	July
CCC-W	Networked Services	Out-Patient Department Cyclotron Private Patient Unit	August
CCC-A	Radiation Services	Radiotherapy	September
CCC-L	Networked Services/Corporate	Out-Patients Department (M1), Cancer Information Centre (M2)	October
CCC-L	Radiation Services	Radiotherapy (M3) Imaging (Floor 0) Pre-treatment (Floor 0)	November
Aintree MD	Networked Services	Marina Dalglish Chemotherapy Unit	December
CCC-L	Acute/Radiation Services	Ward 1 –Day ward Clinical Intervention Service	**2023** January
CCC-L	Networked Services/Research/Acute	Chemotherapy Unit (Floor 6), Clinical Trials Unit (Floor 6)	February
Halton Hospital	Networked Services	CANTreat Chemotherapy Unit	March

5. Feedback from patients and staff

The feedback received from both patients and staff during the walk rounds was consistently positive. Patients and staff were keen and willing to share their experiences of the organisation. General themes from patients focussed on the friendliness of the staff, their expertise and willingness to provide patient focused care. Staff commented on the environment, the opportunities for professional development and the sense of being part of a team.

There were, as expected, some areas where improvement could further enhance the experience for patients and staff.

5.1. Patient Experiences

The top 3 areas identified for improving our patients experiences are:

- Communication
- Facilities
- Waiting Times

5.1.1. Communication:

Examples of issues highlighted around Communication include:

- Being offered the choice for face to face appointments.
- Text messaging reminder service not stating the site of appointment.
- Appointment letters arriving late and are unclear.
- Signposting and wayfinding at CCC Liverpool is very unclear and difficult to navigate.

5.1.2. Communication Actions Undertaken:

✓ Remote clinics continue to be provided with patients welcoming this option, however more face to face appointments are being offered as appropriate.

✓ Text messaging reminder service has been updated to inform patients of the site location of their appointment, for example CCC Wirral, CCC Liverpool, CCC Aintree.

✓ There is a work stream addressing the digitalisation of patient appointment letters. All letters have been reviewed and updated with patient input. The letters are with HCC (Health Care Communications), with testing underway and the aim of 'Going Live' in quarter 1 with phase 1 for e-Referrals for OPD / Specialist services.

✓ A work stream has been established to address signage throughout CCC Liverpool.

5.1.3. Facilities:

- Quiet Room facility in CCC Wirral with comfortable seating for when patients have received bad news within the Out-Patient Department.
- Increase in seating capacity, post covid restrictions ending, to ensure adequate seating for patients and relatives/carers/friends at CCC Aintree.
- Improve refreshment facilities at CCC Aintree, due to CCC Liverpool and CCC Wirral having beverage bays, patients at CCC Aintree are dependent upon WRVS Service provision which is very limited in operation.

5.1.4. Facilities Actions Undertaken:

- ✓ A flexible approach to this has been agreed and a space is identified daily depending on room capacity for a Quiet Room area in OPD at CCC Wirral. The team have improved communication of this facility by adding daily location to patient information board. A Quiet Room is available in the Cancer Information Centre if patients require a quiet space as an alternative measure.
- ✓ Seating capacity was increased within the patient waiting areas to enable visitors to accompany patient's appointments comfortably in CCC Aintree.
- ✓ A beverage bay has been installed by PropCare within the CCC Aintree site to ensure equity of service provision across the main Clatterbridge Sites.

5.1.5. Waiting Times:

- Hospital taxi transport difficult – living in a block of flats means waiting outside in the car park to ensure the taxi is not missed (sometimes between 20 – 60 mins).
- Waiting times for ambulance services and taxi transfers for patients, waiting can be very lengthy.

5.1.6. Waiting Times Actions Undertaken:

- ✓ Booking desk advised that when they are made aware that patients live in flats/ gated premises, a comment is required on the online booking system. Transport drivers are asked to call the patient directly when they are at their residence. Radiographers to reiterate this when requesting hospital transport for patients living in flats/gated premises.
- ✓ Services are provided by an external provider. Telephone numbers of external providers are provided to patients to raise concerns re lengthy transport waits. Admin teams contact transport providers after a defined time period to be able to provide updates on waiting times to patients. Beverages are available to patients in the transport lounge whilst waiting. Future plans in place to trial a bleep system, to enable the patients to be able to leave the transport lounge if they wish. Taxi audit recently undertaken and draft taxi policy being written.

5.2. Staff Experiences

The top 3 areas identified for improving staff experiences are:

- Staffing
- Facilities
- Service Improvement

5.2.1. Staffing

- Staff reported that there had been some issues with staffing levels, however, mostly they felt that this was improving and they were aware of future plans for recruitment. Although staff appreciated that they were not alone, they sometimes felt so busy that they struggled to give patients the extra time they may need.
- Capacity vs demand for Welfare Benefit Service provision with only having 2 Benefits advisors and increased demand for the service by service users due to financial pressures of the cost of cancer and the cost of living crisis. Restricted service offer currently due to capacity versus demand.
- Most staff also cover the Ormskirk clinic too, however, this is not as well staffed and sometimes it can be really difficult to escalate issues there and have someone make a decision quickly.

5.2.2. Staffing Actions Undertaken:

- ✓ There were 6 vacancies due to staff promotions within in CCC, with 1 post left to recruit to. Safe staffing levels maintained with support from the hubs.
- ✓ Additional Welfare Benefits Advisor recruited on a 6 month fixed term contract. Macmillan to fund 2 Welfare Benefits positions until December 2024.
- ✓ We now send 3 trained staff rather than two on the busier of the two Ormskirk days. One of which is usually a Deputy Manager and the team are aware that the ANP on site in Marina Dalglish is available on the phone if they need extra advice. This has helped with team confidence in going out to Ormskirk and they feel much more supported.

5.2.3. Facilities:

- Patients report to staff that chairs are uncomfortable
- The clinic is running out of space due to the demand. Especially now that we can welcome visitors back, the treatment area can become very noisy and cramped.
- Some patients who have also been treated in CCC Liverpool complain that the chairs at Marina Dalglish are not as comfortable, they are also manual recliners.

5.2.4. Facilities Actions Undertaken:

- ✓ More comfortable chairs acquired for the patients with a view to locating further chairs with the support of Vinci.
- ✓ Space is at a premium in the department, the upgrading of the patient waiting area has provided a nice relaxing environment for patients to wait. Clinic chairs are used appropriately to ensure maximum capacity is utilised.
- ✓ There are no current plans future to renew the chairs

5.2.5. Service Improvement

- The Clinical Interventions Team leader is currently developing a business case for the team to introduce a nurse led Hickman line insertion service. The service will prevent patients receiving PICC lines when this may not be the most appropriate line for them. It will also prevent some patients being sent to LUHFT for Hickman lines.

- Taking the Cancer Information and Support Service Centre at CCC Liverpool out to the inpatient wards/OPD services to provide holistic support and make every contact count.

5.2.6. Although not an urgent issue, staff mentioned a potential way chair space could be improved preventing wasted time on the Chemotherapy Treatment Unit.

5.2.7. Service Improvement Actions Undertaken/In Progress

✓ Business case currently being developed as a necessary development to support the CAR-T service.

✓ Following the successful recruitment to staff vacancies, The Cancer Information and Support Centre staff are now providing staff awareness sessions of the services it provides to staff teams/areas across the organisation with further development work ongoing.

✓ The Chemotherapy Treatment Unit (CTU) are currently reviewing the on treatment review (OTR) service. They also have an Advanced Nurse Practitioner so patients can be reviewed and treated even when initially deferred. This reduces the delays with chair times and waiting for doctors to review.

6. Conclusion

Our patients are provided with a range of ways to provide their feedback through inpatient surveys, social media, the Trust website, NHS Choices, national surveys, face to face engagement, PALS/ complaints service provision and The Friends and Family Test. Service user and staff involvement enables individuals lived experiences to help Clatterbridge Cancer Centre to learn and improve services, so that services are shaped to meet the needs of our local community. Involvement and Co-production is achieved through service users, family members and staff working together and is at the heart of everything we do. Non-Executive Director and Governor engagement sessions have enabled significant service improvements for both patients and staff to be undertaken, demonstrating the value this provides to our Quality ambitions.

7. Recommendations

The Board of Directors is requested to note the actions taken as a result of the Non-Executive Director and Governor engagement sessions and support the continuation of the process into 2023/24.

Title of meeting: Trust Board Part 1
Date of meeting: 26th April 2023

Report lead	Julie Gray, Chief Nurse				
Paper prepared by	Julie Gray, Chief Nurse				
Subject/Title	Risk Management Strategy 2023 - 2026				
Purpose of paper	To share the revised strategy with the Board of Directors for approval				
Background papers	The State of Health Care and Adult Social Care in England 2014/15 - Care Quality Commission The National Patient Safety Strategy (NPSS) 2019 -NHS England Patient Safety Incident Response Framework 2022 – NHS England				
Action required	To approve content/preferred option/recommendations				√
	To discuss and note content				
	To be assured of content and actions				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	√	Be a great place to work		√
	Be Collaborative	√	Be Digital		√
	Be Research Leaders	√	Be Innovative		√

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

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

Equality & Diversity Impact Assessment

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

Meeting of the Board of Directors
26th April 2023
Risk Management Strategy 2023 – 2026

1. Background

The Clatterbridge Cancer Centre NHS Foundation Trust is committed to implementing the principles of good governance, defined as the system by which the organisation is directed and controlled, at all levels, to achieve its objectives and meet the necessary standards of accountability, probity and openness.
The Trust recognises that the principles of governance must be supported by an effective risk management system that is designed to deliver improvements in patient safety and care as well as the safety of its staff, volunteers and visitors.
The Trust is required to have a Board approved document for managing risk that identifies accountability arrangements, resources available and contains guidance on what may be regarded as acceptable risk within the organisation.
This Risk Management Strategy and Policy provides a structured approach to the management of financial, reputational, clinical, non-clinical and project risks. It is a requirement for regulators such as Care Quality Commission and NHS Improvement and for external accreditations e.g. JACIE standards in Haematology and Transplantation.

The purpose of this document is to define the Trust's Strategy for Risk Management for the period 2023-2026.

This 2023-2026 strategy builds on the successful implementation of the 2019-2023 strategy by strengthening some existing elements and identifying new key objectives.

2. Introduction

The focus of this strategy is to build on the previous three year strategy which set out the fundamentals of risk management and the operational processes in place at that time. This 2023 – 2026 strategy has at its heart the promotion of a risk conscious environment where safety is paramount to its central remit. The content has been completely refreshed and written in an easy to follow format, in plain language and free from jargon, with the intension that staff at all areas of the organisation can access it and understand how the organisation plans to keep people who use our services safe and free from harm. The key themes throughout the strategy were developed in collaboration with a cross section of staff from different divisions and grades from across the organisation via facilitated workshop.

3. Key Principles

A number of key principles set the expectations for staff and managers in relation to risk management:

- The approach will be reflected consistently in divisional risk management arrangements;
- Risks will be actively managed and assurance sought about the effectiveness of actions taken;
- The risk register will be a live set of records, providing up to date and accurate information about risks identified and how they are managed;
- Responsibility for the management of identified risks is clearly allocated to the person best placed to do so;
- High-risk areas and activities will attract greatest focus and attention;

- There will be learning from analysis of incidents, complaints and claims, and explicit roll-out of identified improvements.

4. Risk management objectives 2023 to 2026

New to this strategy is the inclusion of a set of 5 clearly articulated objectives which set out the actions to be undertaken over the coming three years. This sits under an overarching aim: *to increase the Trust's risk maturity and promote a positive risk management culture so that consideration of risk is integrated in all decision-making and we can evidence that risks are actively managed.*

The benefits of this approach are:

- Increase patient safety
- Enhance quality of care and patient experience
- Improved staff morale and productivity
- Cost efficient risk management/reduction
- Financial savings from reduced risk (e.g. claims and insurance premiums)
- Protection from prosecution
- Enhanced corporate reputation

Achievement of these objectives will be monitored by an annual review paper presented to the Board of Directors.

5. Conclusion

The 2023 – 2026 Risk Management Strategy clearly defines the strategic direction of risk management within the organisation, taking a proactive approach to robust developing systems and process that both maintain safety and promote creativity and adoption of a safety II culture.

TRUST WIDE STRATEGY

Risk Management Strategy

DOCUMENT REF: STWMRISK

(Version No: 6.0)

Strategy Owner	Chief Nurse
Name and designation of author(s)	Chief Nurse
Approved by	Board of Directors
Date approved	16th April 2023
Review date	April 2024
Review type	Yearly
Target audience	All staff
Links to other strategies, policies, procedures	Risk Management Operational Policy
This document replaces…	Risk Management Strategy 2023 - 2026 V6.0

Circulation/Dissemination:

Date added into Q-Pulse	
Date notice posted in the Team Brief	
Date document posted on the intranet	

Version History:

Date	Version	Author name and designation	Summary of main changes
January 2010	2.0	Vicky Davies – Risk Management Facilitator	Updated with new systems in place. Included detailed monitoring section.
June 2012	3.0	Vicky Davies – Risk Management Facilitator	Minor changes
August 2012	4.0	Vicky Davies – Risk Management Facilitator	Minor changes
October 2013	4.1	Vicky Davies – Risk Management Facilitator	Added new Quality and Risk Management Standards
October 2014	4.2	Vicky Davies – Risk Management Facilitator	Updated changes to Patient Safety First Campaign and added Sign up to Safety Campaign
October 15	4.3	Vicky Davies – Risk Management Facilitator	Minor updates – updated TOR for Integrated Governance Committee
November 17	5.0	Vicky Davies – Risk Management Facilitator	Minor updates – change in committees, removal of out of date campaigns. Updated risk escalation process.
January 2020	5.1	Matt Downey – Risk Management Facilitator	Minor Updates – change of author, change of review date, change in committee name, change in responsibilities, addition of updated TOR for RMC
March 2022	5.2	Christopher Lube – Associate Director of Clinical Governance and Patient Safety	Update of roles and responsibilities, committees and risk register population process and escalation in line with introduction of DCIQ and revised committee structure.
March 2023	6.0	Julie Gray - Chief Nurse	Full review of the existing strategy.

Section 1: Risk Management Strategy

1. Introduction

The goal of risk management is to identify potential problems before they occur, understand how likely they are to happen and the consequences should they do so, and implementing the most effective way of controlling them. Risk management looks at both internal and external risks that could affect the delivery of services and achievement of an organisation's objectives.

An overriding consideration in everything we do is the safety of the care we deliver. According to the CQC report, *The State of Health Care and Adult Social Care in England 2014/15*, factors affecting the safety of services include failure to investigate incidents properly and learn from them so they do not happen again, and ineffective safety and risk management systems. The National Patient Safety Strategy (NPSS) published by NHS England in 2019 provides important central direction and coordination to implement a consistent approach across the NHS. The NPSS requires a number of changes to be made at Trust level and these are integral to how we will develop our risk management approach across our services.

When the management of risk goes well it often remains unnoticed. However, when it fails, the consequences can be significant and high profile. Effective risk management is fundamental to prevent such failures.

The current context for healthcare services is complex and changing rapidly due to a wide variety of external factors. This presents threats but also opportunities to do things differently to improve health outcomes for the populations we serve. It is important that everyone who works for us and with us understands what needs to be protected and controlled carefully, and what types of risk might be taken in order to innovate and improve our services. This is done through defining the Trust's risk appetite for different types of risks and decisions.

2. Purpose and scope

The Trust is required to have a Board approved document that sets out its approach to risk management. It is a requirement of regulators such as Care Quality Commission and NHSE and for external accreditations e.g. JACIE standards in Haematology and Transplantation.

This Risk Management Strategy and supporting risk management policy provides a structured approach to the management of all types of risk across all areas of the Trust, and sets out key areas of development to increase risk maturity over the next three years, 2023 to 2026. The overarching aim will be to ensure that the Trust has an effective risk management system where consideration of risk is embedded as a way of working throughout the Trust, including organisational policies, procedures, business planning, business case development, change management, performance management, and clinical and corporate governance.

Risk management is the responsibility of all staff within their sphere of work. The approach set out in this document applies to people working at the Trust but also to those employed by external parties. The Trust has adopted a methodology and a common system that is flexible enough to accommodate differences between the various professional functions involved in the delivery of its services, both clinical and non-clinical. These differences will be reflected in job descriptions, specific policies, standard operating procedures, and defined methods for carrying out detailed risk assessments and learning from clinical and non-clinical incidents. It is important that this strategy and policy is also understood in conjunction with the other key documents listed on the front sheet.

A number of key principles set the expectations for staff and managers in relation to risk management:

- The approach will be reflected consistently in divisional and corporate risk management arrangements;
- Risks will be actively managed and assurance sought about the effectiveness of actions taken;
- The risk register will be a live set of records, providing up to date and accurate information about risks identified and how they are managed;
- Responsibility for the management of identified risks is clearly allocated to the person best placed to do so;
- High-risk areas and activities will attract greatest focus and attention;
- There will be learning from analysis of incidents, complaints and claims, and explicit roll-out of identified improvements.

3. Risk management policy statement and risk appetite

The Clatterbridge Cancer Centre recognises that the management of risk needs to be embedded in how the organisation is directed and controlled to achieve its objectives, keep patients, staff and visitors safe, comply with the legal and regulatory framework, and protect the organisation's assets and reputation.

Risk management is integral to good governance, considered decision-making, and continuous improvement across all areas of the Trust and at all levels. Well designed and consistently applied risk management arrangements will assist the organisation anticipate and adapt to changes in its operating environment, while delivering safe, effective and efficient services.

Definitions for levels of risk appetite levels set out in the table below have been adopted from the 2020 Good Governance Institute's Risk Appetite for NHS Organisations Matrix.

Risk Appetite Level	Definition
NONE	Avoidance of risk and uncertainty is a key organisational objective
MINIMAL	As little as reasonably possible (ALARP). Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
CAUTIOUS	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
OPEN	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward and Value for Money (VfM)
SEEK	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk.
SIGNIFICANT	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

The Trust Board commits to encouraging a positive risk culture, where the successful management of risk is recognised, and where people feel confident to raise concerns and will be appropriately supported when things go wrong.

Risk Appetite Statement

The Clatterbridge Cancer Centre NHS Foundation Trust recognises that its long term sustainability depends upon the delivery of Strategic Priorities and ambitions in addition to its relationships with service users, staff, public, regulators and strategic partners. As such, The Clatterbridge Cancer Centre NHS Foundation Trust will not accept risks that materially provide a negative impact on patient safety.

In contrast, The Clatterbridge Cancer Centre NHS Foundation Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has a greater appetite to pursue partnerships, commercial gain and clinical innovation in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment; this includes the development of our Subsidiary Companies. In addition, in pursuit of its Strategic Priorities, The Clatterbridge Cancer Centre NHS Foundation Trust is willing to accept, in some limited circumstances, risks that may result in some limited financial loss or exposure.

The table below illustrates an example of the Trust Risk Appetite Statement.

Category	**Risk Appetite Level**
Quality & Safety (Be Outstanding)	CCC has a **NO** appetite for risk that compromises patient safety *or* CCC has a **MINIMAL** appetite for risk that may compromise patient safety
Patient Experience (Be Outstanding)	CCC has a **MINIMAL** appetite for risk that affect the experience of our service users
Compliance and Regulatory (Be Outstanding)	CCC has a **MINIMAL** risk appetite for compliance and regulatory risks that may compromise the Trust's compliance with its statutory duties and regulatory requirements.
Clinical Innovation (Be Research Leaders & Be Innovative & Be Digital)	CCC has an **OPEN** risk appetite to innovation that does not compromise the quality of care.
Financial and Value for Money (Be Outstanding)	CCC has a **MINIMAL** risk appetite to financial risk in relation to statutory compliance. CCC has a **CAUTIOUS** risk appetite for risk that supports investments that help to grow the organisation.
Workforce (Be a Great Place to Work)	CCC has a **MINIMAL** risk appetite to risks that impact on our workforce as there are limited circumstances whereby we would accept risks that would impact on the achievement of being a great place to work. Nor would be accept risks that may compromise the safety of any staff member.
Reputation (Be Outstanding)	CCC has a **MINIMAL** risk appetite for actions and decisions that are taken which may be in the interest of ensuring quality and sustainability of care may also affect the reputation of the Trust
Partnerships (Be Collaborative)	CCC has an **OPEN** risk appetite for partnerships which may support and benefit the communities we serve.

4. Evaluation of existing risk management arrangements

The Trust was last inspected by the CQC in December 2019 and was rated good overall, but requiring improvement for the well-led domain, partly due to findings relating to the oversight and management of risks.

At the start of 2022, Good Governance Institute (GGI) concluded a developmental well-led review that was commissioned by the Trust Board. It is good practice to carry out such developmental reviews periodically outside of the formal inspection regime, and the Board

recognised that the Trust had gone through a significant amount of change since the CQC's assessment. GGI highlighted many areas of good practice but also suggested a few areas where risk management could be improved, including risk register usage, clarity and usage of the Board Assurance Framework, and the user-friendliness of the risk management strategy and policy.

Also early in 2022, the MIAA carried out a review of the Trust's risk management arrangements, providing substantial assurance that systems were well designed and consistently implement.

An important aspect of evaluating the Trust's risk management arrangements has been to gather feedback from practitioners. In February 2023, we invited feedback from members of the Risk and Quality Governance Committee and other key staff who support risk management processes in the Trust. The information and suggestions provided through this exercise have been incorporated into the development of this strategy. They indicated an ambition to increase risk maturity and consistency of approach across operational areas, and to promote risk management as a positive activity that makes a difference. This valuable feedback has helped identify a number of priority objectives that are set out below.

5. Risk management objectives 2023 to 2026

Overarching aim: to increase the Trust's risk maturity and promote a positive risk management culture so that consideration of risk is integrated in all decision-making and we can evidence that risks are actively managed.

Objective 1 - **Process and tools**: We will develop a comprehensive risk management process, ensuring people have appropriate tools and guidance		
Aim	Action	Year
Clearer, more user-friendly guidance	Refreshed policy, procedural guidance and templates	1
Fit for purpose risk information system	Optimise functionality and configuration of Datix	1
Consideration of risk integrated into business planning, decision-making, and forecasting performance	Review of processes (narrow it down to business planning, business case process, and report template for decision papers)	2
Evidence-based risk assessments and risk response planning	Refocus scrutiny on the rationale underpinning risks assessments and action planning	2
Risk register analysis to identify themes and interdependencies	Resource and functionality	3
Objective 2 - **Knowledge and skills**: We will enhance the knowledge and skills of staff to feel competent and confident about risk management		
Consistency of understanding of risk management principles and process	Review and relaunch the risk management training offer, tailored as required for different staff levels	1
Analytical skills for risk identification and risk assessment, e.g. RCA	Dedicated training for key staff	1
Improve confidence using Datix	Continued roll-out and identification of local experts	2
Objective 3 - **Governance**: We will ensure that oversight of risk management focuses on ensuring risks are actively and effectively managed		

Accountability	Clarify responsibilities of risk owners through policy guidance and ensure right people are held accountable for the management of risks	1
Risk reporting	Review the format and content of risk register reports and improve reporting functionality	1
Divisional governance	Develop a consistent approach across divisions based on good practice	2
Compliance	Develop the capacity and capability in the quality governance team to support compliance with risk management processes	2
Objective 4 - **Communication**: We will communicate positively and clearly about risk management focusing on shared learning, common understanding of priorities, and the outcomes of managing risks well		
Lessons learned	Review the mechanisms for dissemination of learning from incidents to ensure the right messages reach the right people	1
Reframe risk management as a positive (Safety II)	Review existing communication channels and content to highlight successes and focus on positive outcomes from risk management	2
Risk appetite	Develop risk appetite cascade to operational levels to ensure common understanding	3
Objective 5 - **Patient Safety**: Continue to implement the National Patient Safety Strategy to embed a risk-based approach to provision of care		
Patient Safety Incident Response Framework (PSIRF)	Develop a Patient Safety Syllabus training needs assessment & roll out training to priority groups	1
Patient Safety Incident Response Framework (PSIRF)	Increase visibility of the weekly Executive Review Group meetings by providing an open seat to all levels of staff	2
Patient Safety Incident Response Framework (PSIRF)	Implement the use of a human factors investigation tool to identify systems based causal factors and risks that arise from all incident investigations	3
Safety culture	Identify if staff feel psychologically safe to raise concerns by undertaking a staff survey	1

6. Strategy Implementation and monitoring

The Risk Management Strategy will be implemented through the Risk Management Policy. Achievement of the objectives described in section 5 will be monitored by an annual review paper presented to the Board of Directors. The Board will review the Risk Management Strategy making any changes required to reflect national and regulatory standards, best practice, together with learning and improvement opportunities identified internal or external via reviews the of risk management systems.

Title of meeting: Trust Board Part 1
Date of meeting: 26th April 2023

Report lead	Sheena Khanduri, Medical Director			
Paper prepared by	Helen Wong, Quality Manager (Audit & Statistics)			
Report subject/title	Mortality Dashboards & Summary Report 2022-2023 Q3			
Purpose of paper	To present Q3 22/23 Mortality summary report			
Background papers				
Action required	For noting			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

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

1.0 Background

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

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

2.0 Mortality Review Inclusion Criteria

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

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

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

3.0 Case Review and Selection Process

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

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

4.0 Dashboard Interpretation

Data coverage: January 2022 – December 2022 for comparison to previous quarters

Year	2021/22	2022/23			Total
	Q4	Q1	Q2	Q3	
Total Patient Deaths	179	166	197	209	751
Number of Inpatient Deaths	32	38	44	46	160
Number of Outpatient Deaths	147	128	153	163	591
Outpatient (Requiring Review)	125	104	126	136	491
No. Cases Requiring Review	157	142	170	182	651
No. Cases Reviewed Phase 1	112	125	118	119	474
% Cases Reviewed Phase 1	71%	88%	69%	65%	73%
No. Cases Reviewed at Phase 2	78	87	69	41	275
% Cases Reviewed Phase 2	70%	70%	58%	34%	58%
No. Cases Selected Phase 3	12	8	5	6	31
No. Cases Discussed Phase 3	10	8	3	3	24
% Cases Discussed Phase 3	83%	100%	60%	50%	77%

**Process takes a minimum of 6 months to complete*

- 58% (275/474) of cases had completed an independent peer review (Phase II) from January 2022 – December 2022 deaths. The process can take a minimum of 6 months to complete.
-
- From this, 31 cases have been selected for discussion out of which, 24 cases have been discussed (x10 inpatients and x14 Community/Other Hospital).
  The scores for these cases are:

  - Inpatient SJR RCP Scores: All x10 cases were scored 6.
  - Community/Other hospital inpatient RCP Scores: All x14 cases were scored 6.

  Of the remaining x7 cases awaiting discussion:

  - x3 are due to be discussed in Q4 2022/23, x1 will be discussed in Q1 2023/24 and the remaining x3 are awaiting a convenient date for discussion from the responsible consultant
  -
- 0 mortality cases this quarter were subject to LeDeR review (Learning Disability)
- 0 mortality cases this quarter were subject to a Child Death Overview Panel review (CDOP

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

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

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

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

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

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

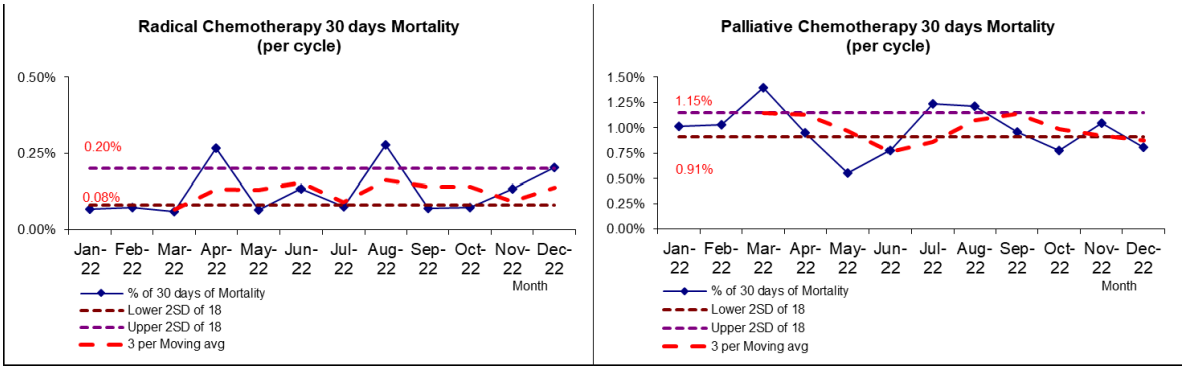
The control limits (lower & upper 2 standard deviation – brown dash line on chart) are reviewed annually and are set by the best performing annual figures from 2009 onward. All data points fallen inside the control limits are deemed to be within tolerance.

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

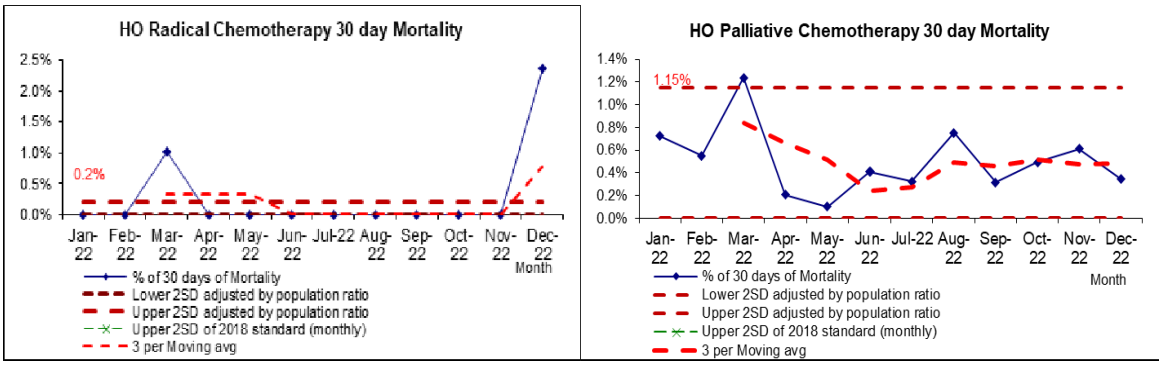
January 2022 – December 2022 treatment activities

- Results showed the 3 monthly moving average mortality for each of the areas were within tolerance.

6.1 Chemotherapy 30 day mortality (Solid Tumour)

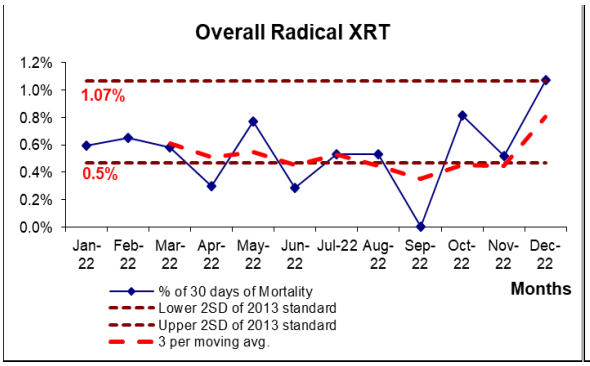


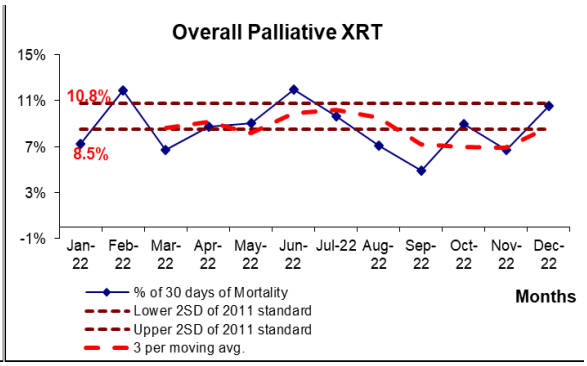
6.2 Chemotherapy 30 day mortality (Haemato-oncology)



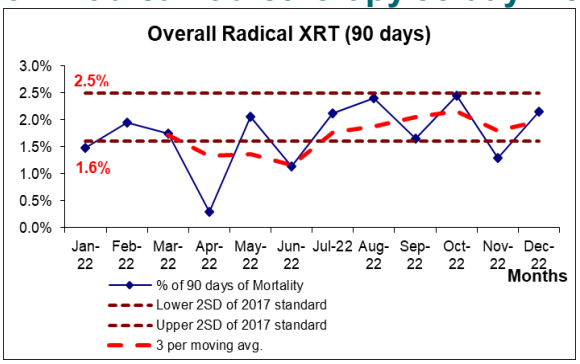
**Due to small number of patients in the radical chemotherapy group, the single peak was related to a single death of that particular month.*

6.3 Radiotherapy 30 day mortality





6.4 Radical radiotherapy 90 day mortality



1.0 Background

The Quality Surveillance Team (QST), formerly National Peer Review Programme, lead an Integrated Quality Assurance Programme for the NHS and is part of the National Specialised Commissioning Directorates, Quality Assurance and Improvement Framework (QAIF).

The role of the QST is to improve the quality and outcomes of clinical services by delivering a sustainable and embedded quality assurance framework for all cancer services and Specialised commissioned services within NHS England.

The dashboards makes use of spine chart and SPC spark lines to be interpreted as follows:

2.0 SSQD Q2 2022-2023 Overall Summary

Summary:

The data shows that the outcome of patients receiving stem cell transplantation in Liverpool remains well above average compared to national outcomes and remain fairly consistent. This data is short-term and submission is not mandatory, this affects national figures and averages and means data becomes unreliable. Short-term data is subject to fluctuation in smaller and medium sized transplant centres.

It should be noted that for Quarter 2 (2022-2023) there are no negative indicators and this has been consistent over previous quarters.

The more robust process of mandatory data collection is the data submitted to BSBMT who in turn release an annual report (Appendix 3). This data indicates profound improvement and outcomes indicate we are well within national average compared with centres across the country (Appendix 1: Figures 3 and 4). This achievement can be assigned to the overall improved survival in recent years Appendix 2: Figures 15 and 16)

3.0 BMT02a-A -Proportion of patients with successful engraftment

*• Numerator Description - Number of patients where engraftment was successful (successful defined as neutrophil count of > 0.5 * 10^9 per litre for three consecutive days by day plus 28)*
• Denominator Description - Total number of patients transplanted in the first 6 months of the previous 7 month reporting period
• Interpretation Guidance - Higher is better

QTR	Period	Num	Denom	Value	National Average	Chart	Trend
QTR 3 21-22	Jul 21 - Dec 21	43	44	97.7	97		
QTR 4 21-22	Oct 21 - Mar 22	45	45	100	94.7		
QTR 1 22-23	Jan 22 - Jun 22	37	37	100	97		
QTR 2 22-23	**Apr 22 - Sep 22**	34	35	97.1	97.1		

3.1 BMT06-A – Percentage of transplant patients registered in research trials

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

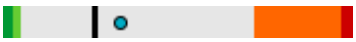
QTR	Period	Num	Denom	Value	National Average	Chart	Trend
QTR 3 21-22	Jan 21 - Dec 21	20	74	27	10.6		
QTR 4 21-22	Apr 21 - Mar 22	12	74	16.2	11.7		
QTR 1 22-23	Jul 21 - Jun 22	14	82	17.1	10.6		
QTR 2 22-23	**Oct 21 - Sep 22**	11	77	14.3	12.8		

3.2 BMT08a-A – Percentage of patients dying within 100 days of transplant

The table below demonstrates the numbers in the numerator and denominator for Quarters 3-4 2021-2022 & QTR 1- 2 2022-2023. We had two deaths in Quarter 4 (21-22), 1 death in Quarter 1 and 1 death in Quarter 2 (22-23).

Overall, these results remain within average for outcome of Autologous Transplant and Quarter 2 demonstrates improved outcomes from previous Quarters.

• Numerator Description – Number of patients in denominator who dies within 100 days of transplant
• Denominator Description – total number of autologous transplants in the first 365 days of the previous 465 day reporting period
Interpretation Guidance – Lower is better

QTR	Period	Num	Denom	Value	National Average	Chart	Trend
QTR 3 21-22	Jan 21 - Dec 21	*(1)	*(46)	2.2	1.7		
QTR 4 21-22	Apr 21 - Mar 22	*(2)	*(46)	4.4	1.5		
QTR 1 22-23	Jul 21 - Jun 22	*(1)	*(42)	2.4	1.3		
QTR 2 22-23	Oct 21 - Sep 22	*(1)	*(48)	2.1	1.5		

3.3 BMT09a-A – Percentage of patients alive at 1 year post transplant

- *Numerator Description – Number of patients in denominator alive 1 year after transplant*
- *Denominator Description – Total number of autologous transplants in the first 12 months of the previous 24 month reporting period*

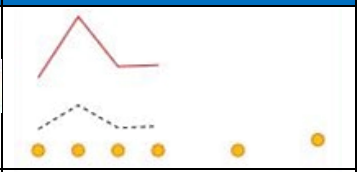
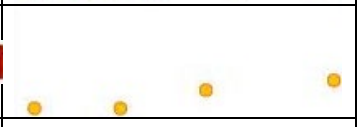
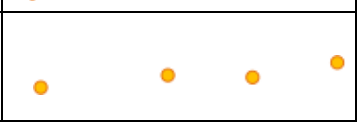
Interpretation Guidance – Higher is better

QTR	Period	Num	Denom	Value	National Average	Chart	Trend
QTR 3 21-22	Jan 21 - Dec 21	41	43	95.3	93.2		
QTR 4 21-22	Apr 21 - Mar 22	48	50	96	92.7		
QTR 1 22-23	Jul 21 – Jun 22	45	47	95.7	93.6		
QTR 2 22-23	**Oct 21 - Sep 22**	44	45	97.8	92.8		

3.4 BMT13-A – Percentage of patients dying within 100 days of transplant

- *Numerator Description – Number of patients in denominator who died within 100 days of allogenic transplant*
- *Denominator Description – Total number of allogenic transplants in the first 365 days of the previous 465 day reporting period*

Interpretation Guidance – Lower is better

QTR	Period	Num	Denom	Value	National Average	Chart	Trend
QTR 3 21-22	Jan 21 - Dec 21	*(1)	*(24)	4.2	8.6		
QTR 4 21-22	Apr 21 - Mar 22	*(2)	*(31)	6.5	8.1		
QTR 1 22-23	Jul 21 - Jun 22	*(2)	*(33)	6.1	7.1		
QTR 2 22-23	**Oct 21 - Sep 22**	*(3)	*(34)	8.8	7.1		

4.0 Haemopoietic Stem Cell Transplant Alerts

QTR	Detail
QTR 3 21-22	• For Quarter 3 2021.22 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 0 Positive alerts, 1 neutral alert Submission Audit Log Negative Alerts 0 Positive Alerts 0 Neutral Alerts 1
QTR 4 21-22	• For Quarter 4 2021.22 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 1 Positive alert, 0 neutral alerts Last AA Outcome (AA 2019/2020): Routine surveillance Last SD Score (SD 2019/2020): 100.0 Latest SSQD Alerts (SSQD Q4 2021/2022): Positive Alerts: 1, Negative Alerts: 0, Neutral Alerts: 0 Submission Audit Log Negative Alerts 0 Positive Alerts 1 Neutral Alerts 0
QTR 1 22-23	• For Quarter 1 2022.23 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 1 Positive alert, 0 neutral alerts SSQD description: SSQD Q1 2022/2023 Last AA Outcome (AA 2019/2020): Routine surveillance Last SD Score (SD 2019/2020): 100.0 Latest SSQD Alerts (SSQD Q1 2022/2023): Positive Alerts: 1, Negative Alerts: 0, Neutral Alerts: 0 Submission Audit Log Negative Alerts 0 Positive Alerts 1 Neutral Alerts 0
QTR 2 22-23	• For Quarter 2 2022.23 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 0 Positive alert, 0 neutral alerts SSQD description: SSQD Q2 2022/2023 Last AA Outcome (AA 2019/2020): Routine surveillance Last SD Score (SD 2019/2020): 100.0 Latest SSQD Alerts (SSQD Q2 2022/2023): Positive Alerts: 0, Negative Alerts: 0, Neutral Alerts: 0 Submission Audit Log Negative Alerts 0 Positive Alerts 0 Neutral Alerts 0

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Number of Deaths in Scope and Phase 1, 2 & 3 Reviews

Year	Number of Deaths in Scope	Total Deaths Requiring Phase 1 Review	Total Deaths Reviewed (Phase 1)	% Deaths Reviewed (Phase 1)	Total Deaths Reviewed (Phase 2)	% Phase 1 Reviews Reviewed (Phase 2)	Total Deaths Selected for Review (Phase 3)	Total Deaths Discussed (Phase 3)	% Discussed (Phase 3)
2022/23	572	494	362	73%	197	54%	19	14	74%
Q3	209	182	119	65%	41	34%	6	3	50%
Q2	197	170	118	69%	69	58%	5	3	60%
Q1	166	142	125	88%	87	70%	8	8	100%
Total	572	494	362	73%	197	54%	19	14	74%

Total Number of Learning Disabilities in Scope

Year	No.	LeDaR Completed	Potentially Avoidable (Score <= 3)
2022/23	1	1	-
Q3	0	0	-
Q2	1	1	-
Q1	0	0	-
Total	1	1	-

Total Number of Children in Scope

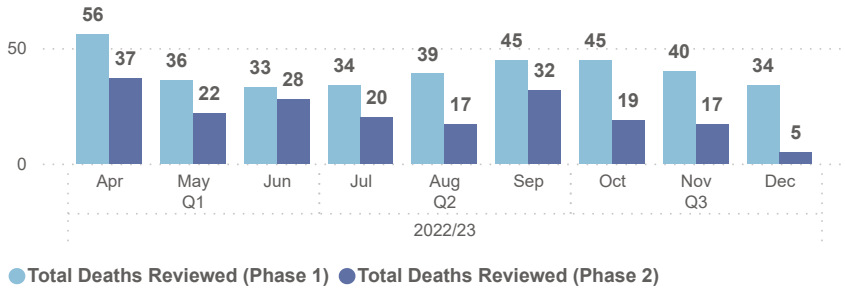
Year	No.	CDOP Completed	Potentially Avoidable (Score <= 3)
2022/23	1	1	0
Q3	0	0	-
Q2	1	1	0
Q1	0	0	-
Total	1	1	0

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

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

Year	Score 1 - Definitely Avoidable	Score 2 - Strong Evidence of Avoidability	Score 3 - Probably Avoidable (more than 50:50)	Score 4 - Probably Avoidable but not very likely	Score 5 - Slight evidence of avoidability	Score 6 - Definitely Not Avoidable
2022/23	0	0	0	0	0	74
Q3	0	0	0	0	0	19
Q2	0	0	0	0	0	23
Q1	0	0	0	0	0	32
Total	0	0	0	0	0	74

Number of cases reviewed at Phase 1 & Phase 2



Inpatient Deaths - Learning from Deaths between Jul 2020 and Dec 2022

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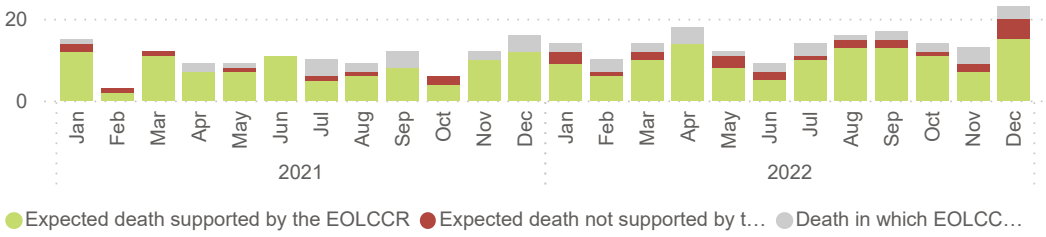
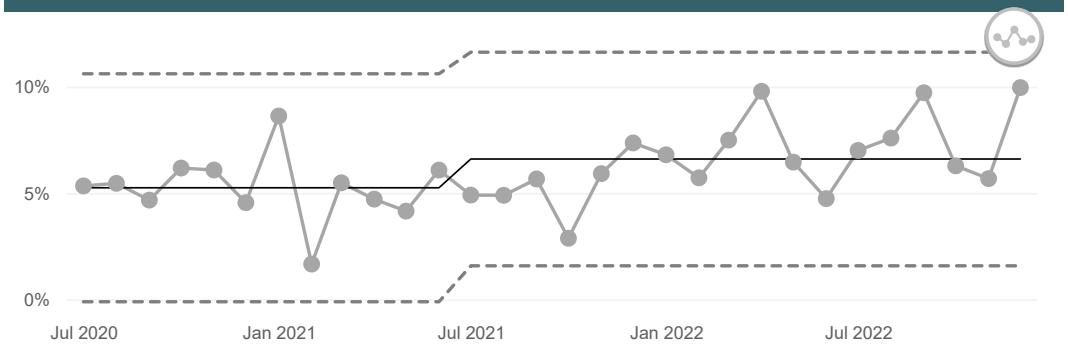
End of Life Care and Communication Record



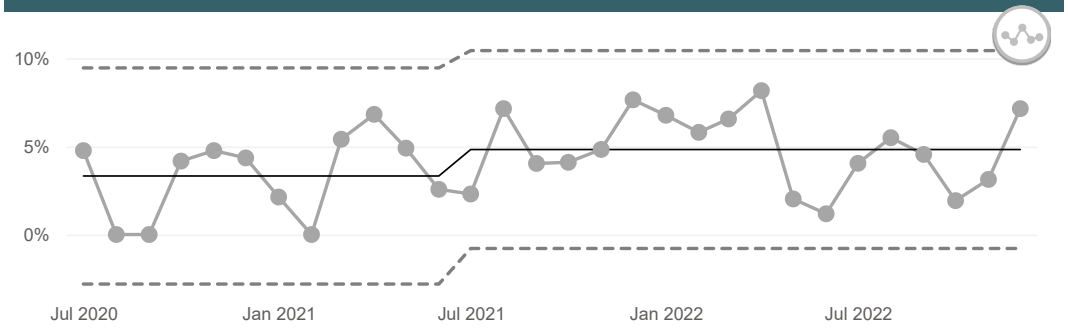
Date of Death	Information	Count
Dec 2022	Declined EoLCCR	1
	SpPCT advised EoL not started	3
	Sudden deterioration	1
Nov 2022	Should have been on EoLCCR ward advised but not started	2

Inpatient Mortality - All Admissions (Solid Tumour & HO) - Excluding Elective Admission LOS = 0



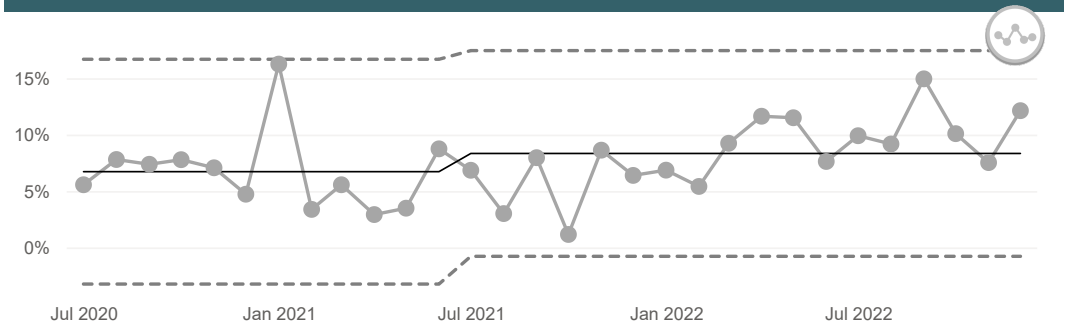
Metric	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21
Number of Deaths	8	6	7	10	9	9	15	3	12	9	9	11
Number of Inpatients	150	110	150	162	148	198	174	181	219	191	217	181

Elective Admission Mortality (Solid Tumour & HO) - Excluding LOS = 0



Metric	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21
Number of Deaths	2	0	0	3	3	4	2	0	6	6	5	2
Number of Inpatients	42	33	55	72	63	92	94	92	111	88	102	78

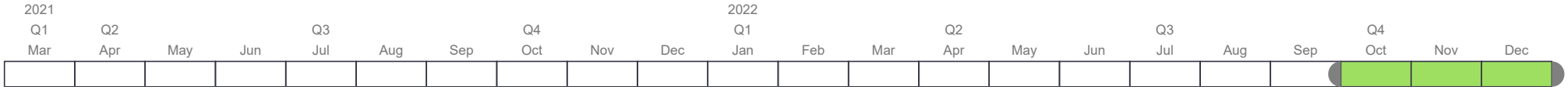
Non-Elective Admissions Mortality (Solid Tumour & HO)



Metric	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21
Number of Deaths	6	6	7	7	6	5	13	3	6	3	4	9
Number of Inpatients	108	77	95	90	85	106	80	89	108	103	115	103

Lessons Learned from Mortality Review

The Clatterbridge Cancer Centre NHS Foundation Trust



ID	Year	QTR	Background	Action	CCC Lessons learned	Closure date
155	2022/23	Q3	A patient was noted to be unwell when attending for a blood transfusion. A review was requested and the symptoms ascribed to anaemia. On the subsequent Monday treatment was delivered and there was no documentation as to the clinical state of the patient. The patient was subsequently admitted to an acute Trust that night with SOB and PE's and died sometime later following fast-track discharge home to die.	The MRM group stated that note keeping on the day of treatment was inadequate and asked the ward manager to investigate. The lead SACT nurse conducted an audit looking at 12 separate patients who this staff member had treated over a one month period and all documentation was present in Meditech. The audit lead was assured that this was a one off incident of missed documentation but arranged further training on essential documentation for the SACT delivery team	Essential documentation training has been delivered to all SACT administration staff by an external solicitor firm and the Trust Legal and Governance Manager. The individual involved also received appropriate support following this error.	01/10/2022

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 26th April 2023

Report Lead	Jane Hindle, Associate Director of Corporate Governance			
Paper prepared by	Paul Buckingham, Interim Associate Director of Corporate Governance			
Report subject/title	Use of the Trust Seal			
Purpose of paper	The purpose of this report is to advise the Board of Directors of the occasions where it was necessary to use the Trust Seal during 2022/23.			
Background papers	Not applicable			
Action required	The Board of Directors is recommended to: • Receive the report and note that the Trust Seal was used on one occasion during 2022/23.			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Use of the Trust Seal

1. Introduction

The purpose of this report is to advise the Board of Directors of the occasions where it was necessary to use the Trust Seal during 2022/23.

2. Background

The Trust Seal tends to be used infrequently and its use is usually in relation to the signing and sealing of documents relating to land and property transactions. The Trust's Scheme of Reservation & Delegation requires that use of the Trust Seal is formally reported to the Board of Directors on an annual basis and on each occasion of use.

3. Current Situation

There was one occasion where it was necessary to use the Trust Seal during 2022/23. Details as follows:

Reference No	Date	Details
01-22/23	16/3/23	Form TR1 – Transfer of Title for The Rutherford Cancer Centre, 2 Mason Street, Liverpool, L7 3EW. Approved By: • Dr L Bishop, Chief Executive • Mr J Thomson, Director of Finance

4. Recommendation

The Board of Directors is recommended to:

- Receive the report and note that the Trust Seal was used on one occasion during 2022/23 as detailed above.