QUALITY ACCOUNT
2022/23

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Contents

Introduction: What is a Quality Account?

Introduction

What is a Quality Account?

Since 2009, as part of the drive across the NHS to be open and honest about the quality of services provided to the public, all NHS trusts have had to publish a Quality Account.

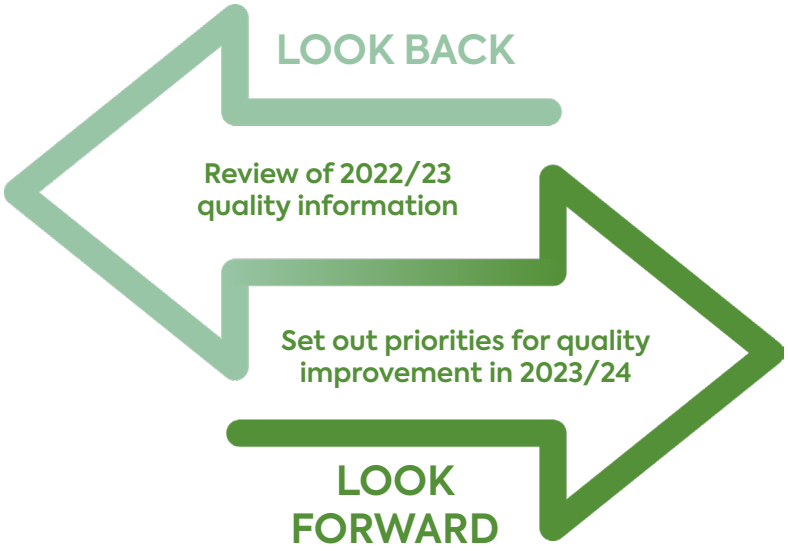
Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

The purpose of this Quality Account is to:

1. Summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2022/23

2. Set out our quality priorities and objectives for 2023/24



Quality Accounts are useful for our Board, who are responsible for the quality of our services, as they can use them in their role of assessing and leading the Trust. We encourage frontline staff to use the Quality Accounts, both to compare their performance with other trusts, and to help improve their own service.

For patients, carers and the public, this Quality Account should be easy to read and understand. It should highlight important areas of safe and effective care being provided in a caring and compassionate way, and also show how we are concentrating on improvements we can make to patient care and experience.

It is important to note that some aspects of this Quality Account are a compulsory legal requirement and are about significant areas and are usually presented as numbers in a table or graphical representation.

This document is divided into three sections:

Part 1	Part 2	Part 3
Introduction to The Clatterbridge Cancer Centre NHS Foundation Trust and a statement on quality from the Chief Executive	Performance against 2022/23 quality priorities and setting our quality priorities for 2023/24	Other information

Part 1: Introduction to The Clatterbridge Cancer Centre NHS Foundation Trust and a statement on quality from the Chief Executive

Introduction to The Clatterbridge Cancer Centre NHS Foundation Trust and a statement on quality from the Chief Executive

Our organisation is committed to improving quality and delivering safe, effective and personal care, within a culture of learning and continuous service improvement.
We strive to strengthen professional leadership, empower doctors, nurses, allied health professionals and all our other clinical and non-clinical staff to lead and deliver quality care and world-leading treatment. This builds on the positive and proactive work that has already been undertaken to maintain patient safety, deliver effective treatments and enhance the patient experience. We will continue in our drive to improve the quality of care for our patients whilst ensuring cost effectiveness and efficiency through the creative use of finite resources.

The Clatterbridge Cancer Centre (CCC) is one of three specialist cancer centres in the UK. We have a unique multi-site care model – we provide radiotherapy at our three main hub sites, systemic anti-cancer therapy (i.e. medical treatments such as chemotherapy and immunotherapy) at six sites and outpatient care at 13 centres. We serve a population of 2.4 million across Cheshire and Merseyside. With almost 1,800 specialist staff we are one of the largest NHS providers of non-surgical cancer treatment and we are consistently rated as one of the best performing hospitals in the Care Quality Commission's national inpatient survey.

Never an organisation to stand still, our mission is to 'Drive improved outcomes and experience through our unique network of specialist cancer care across Cheshire and Merseyside' by working with our academic and healthcare partners across the region to ensure that the care, treatment and outcomes of our patients continuously improve in the future.

This Quality Account contains many examples of our pursuit of innovation and progression towards being a world-class cancer centre.

I would like to take this opportunity to say thank you to everyone in The Clatterbridge Cancer Centre NHS Foundation Trust for their continued commitment to providing the very best innovative treatment and for their compassion and dedication in our shared goal of providing the very best care for our patients.

The Clatterbridge Cancer Centre and its Board has taken all reasonable steps to ensure the information in this Quality Report is accurate. On behalf of the Board I can confirm that, to the best of my knowledge and understanding, the information in this Quality Account is accurate.

Liz Bishop
Chief Executive Officer (CEO)

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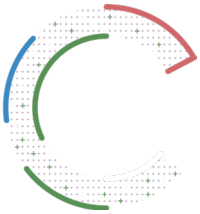
Five Year Strategic Plan 2021 – 2025

Launched in 2021, our Five Year Strategic Plan outlines six priorities:



BE **OUTSTANDING**

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

BE **COLLABORATIVE**

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

BE **A GREAT PLACE TO WORK**

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

BE **RESEARCH LEADERS**

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

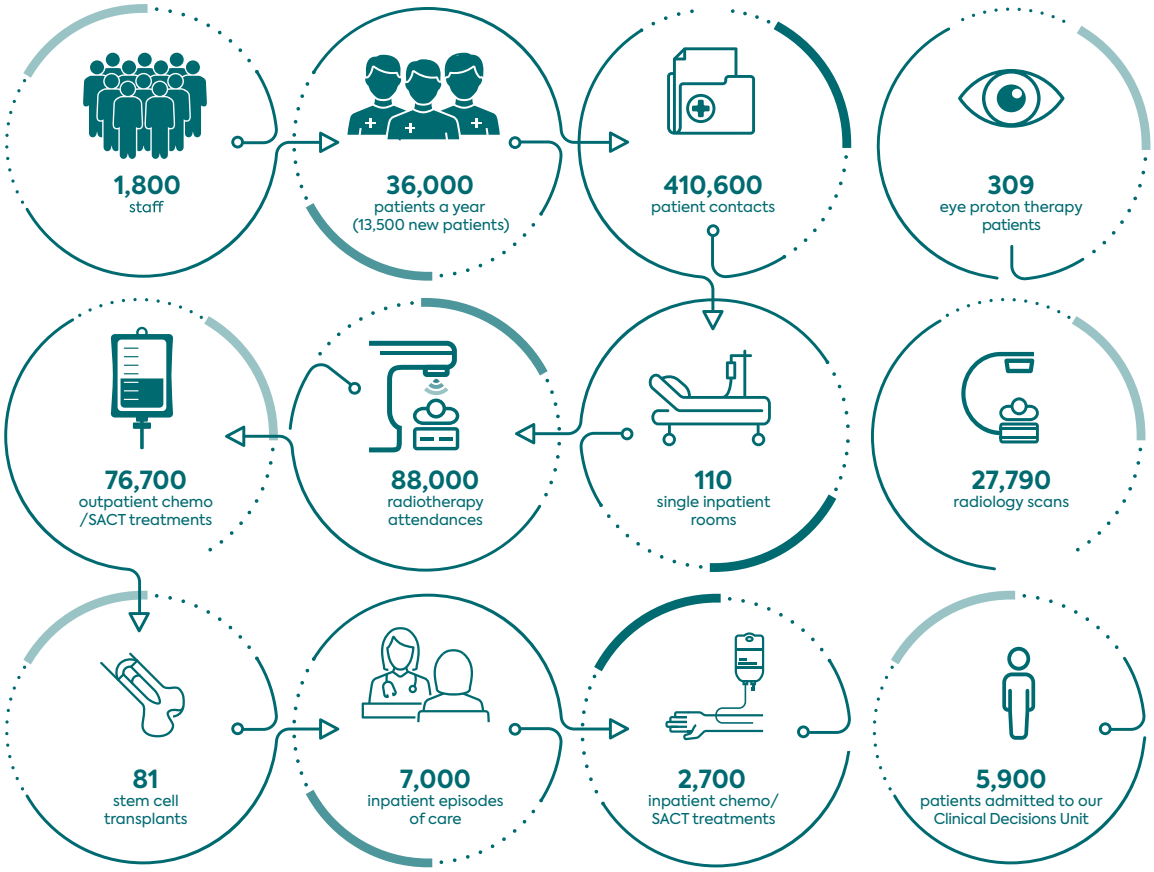
BE **DIGITAL**

Deliver digitally-transformed services, empowering patients and staff

BE **INNOVATIVE**

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

The year in numbers 2022/23



Part 2:
Performance against 2022/23 quality priorities and setting our quality priorities for 2023/24

Performance against 2022/23 quality priorities and setting our quality priorities for 2023/24

Introduction

Our goals will always be to reduce avoidable harm, achieve the best clinical outcomes and provide the best patient experience. That's why we have continued to move forward and improve on our previous objectives and this report will detail our achievements throughout the year.

Our performance against the targets is summarised in the table below. More detailed information is available from page 15.

Category 1: Safe		Performance for the year 2022/23	Action for 2023/24
S1	Develop and implement Infection Prevention and Control E.coli bundle to reduce the number of CCC-associated infections	Partially achieved	Priority 1
S2	Deliver sustained and effective training in escalation and management of incidents and risk	Achieved	Business as usual process
S3	Support a culture of safeguarding awareness, reporting and practice measured against internal and multi-agency action plans	Achieved	Business as usual process
S4	Reduce avoidable harm so 95% of all inpatients receive VTE risk assessment and 100% receive prescribed prophylaxis	Achieved	Business as usual process
S5	Ensure timely and efficient Sepsis/ News2 patient management	Achieved	Business as usual process
S6	Strengthen safer staffing through digital monitoring systems	Achieved	Business as usual process
S7	Strengthen safety culture through standardisation of safety huddle agenda	Achieved	Business as usual process
S8	Invest in research and innovation to deliver excellent patient care in the future	Achieved	Business as usual process

Category 2: Responsive		Performance for the year 2022/23	Action for 2023/24
R1	Deliver patient care closer to home through new clinical model so that 90% of patients travel less than 45 minutes to access treatment	Achieved	Business as usual process
R2	Implement new divisional complaints handling model	Achieved	Business as usual process
R3	Triangulate incidents, complaints and Patient Advice and Liaison Service (PALS) contacts to promote learning and improvements, working closely with the Patient Experience and Inclusion Committee (PEIC)	Achieved	Business as usual process
R4	Strengthen care and experience of patients with additional needs	Partially achieved	Ongoing work-stream
R5	Deliver national learning disability standards	Partially achieved	Ongoing work-stream
R6	Share learning from PALS, complaints, deaths and serious incidents across the patient pathway, working in partnership with the Cancer Alliance	Partially achieved	Ongoing work-stream
R7	Expand the volunteer service to support the opening of the new hospital in Liverpool	Achieved	Business as usual process
R8	Safe return of CCC-Wirral volunteers post-COVID	Achieved	Business as usual process

Category 3: Caring		Performance for the year 2022/23	Action for 2023/24
C1	Continue to achieve top quartile results for patient experience	Achieved	Business as usual process
C2	Deliver outcomes identified in dementia strategy to improve dementia care and patient experience	Partially achieved	Ongoing work-stream
C3	Deliver Patient and Public Involvement Strategy 2019-21 to improve our methods of engagement	Achieved	Business as usual process
C4	Establish a patient experience and involvement group ensuring we listen and respond to what our service users are telling us that matters to them	Partially achieved	Ongoing work-stream
C5	Implement the End of Life Strategy to deliver greater choice and support for individuals nearing the end of life	Achieved	Business as usual process
C6	Implement GDE* quality digital workstreams to include electronic patient information	Achieved	Ongoing work-stream
C7	Implement person-centred care audits and 'always events' in 2022/23	Achieved	Business as usual process

**Global Digital Exemplar, a NHS initiative*

Category 4: Clinical Effectiveness		Performance for the year 2022/23	Action for 2023/24
CE1	Consistently meet national cancer waiting times standards	Partially achieved	Business as usual process
CE2	Reduce unplanned admissions and readmissions	Partially achieved	Business as usual process
CE3	Maintain regulatory compliance	Achieved	Business as usual process
CE4	Improve clinical outcomes through the establishment of SRG* KPIs, monitored via new digitised SRG dashboards	Achieved	Business as usual process
CE5	Achieve 90% compliance with NICE guidelines	Achieved	Business as usual process
CE6	Aim to reduce avoidable deaths to zero by disseminating lessons learnt through quarterly newsletter	Achieved	Business as usual process
CE7	Improve clinical audit monitoring via clinical audit subcommittee	Partially achieved	Ongoing work-stream
CE8	Achieve 90% or better statutory and role-essential training and role based competency compliance across the Trust	Achieved	Business as usual process
CE9	Strengthen management of Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)	Ongoing work-stream	Business as usual process
CE10	Implement stratified follow-up of patients to optimise clinical input and appropriate follow up to meet CQUIN** requirements	Partially achieved	Ongoing work-stream

**SRGs are our 'site reference groups' which oversee care guidelines for each tumour site*
***Commissioning for Quality and Innovation, a NHS initiative*

Category 5: Well-led		Performance for the year 2022/23	Action for 2023/24
WL1	Deliver on Trust's quality-focused strategic priorities	Ongoing work-stream	Business as usual process
WL2	Embed new corporate governance and risk committee structure	Achieved	Business as usual process
WL3	Increase national profile and collaborative working as a system leader against regional & national quality priorities/indicators	Achieved	Business as usual process
WL4	Carry out monthly 'human factors' focused quality and safety leadership walk rounds 2022/23	Not achieved	Business as usual process
WL5	Strengthen nurse and AHP leadership	Achieved	Business as usual process
WL6	Patient and staff experience narrative delivered at Trust Board	Achieved	Business as usual process

The next section provides more detail on our 2022/23 quality priorities and the progress we made in each area. It will also describe where we will direct our quality improvement focus in 2023/24 and how our performance will be monitored and measured.

SAFE

S1. IPC: **Develop and implement Infection Prevention & Control E.coli bundle to reduce the number of Trust-associated infections**

What we did during 2022/23

- We continued, as a multidisciplinary team, to review all the COVID-19 pandemic related guidance ensuring appropriate and proportional implementation
- We continued to maintain higher levels of biosecurity, reducing where possible unnecessary footfall in the clinical sites and maintaining use of personal protective equipment
- We developed a three-year strategy to include a sustained reduction in gram negative bloodstream infections
- We continued to collaborate with other cancer centres with a focus on shared learning and developing a greater understanding of all infections in cancer patients, identification of risk and a standardised approach to addressing the issues raised with this work

There were 14 Clostridioides difficile (C. diff) cases attributable attributable to the Trust against an improvement trajectory of fewer than 17. Therefore this target was achieved.

There were 24 E.coli cases against an improvement trajectory of fewer than 11. Therefore this target was not achieved.

S2. Training: **Deliver sustained & effective training in escalation and management of incidents and risk**

What we did during 2022/23

- We continued to embed the underpinning work undertaken in 2021/22 in relation to the effective management of risk, use of the risk register and strengthened reporting
- We provided senior oversight and scrutiny of the quality and management of significant risks through the monthly Risk and Quality Governance Committee
- We continued to be a high reporting, low harm organisation

S3. Safeguarding: **Support a culture of safeguarding awareness, reporting and practice measured against internal and multi-agency action plans**

What we did during 2022/23

- We continued to implement the Learning Disability Improvement Standards
- We continued to educate staff on the 'Do not attempt cardiopulmonary resuscitation (DNACPR) policy' in relation to people with a learning disability and/or autism
- We continue to encourage a reporting culture with regards to safeguarding issues. The number of concerns raised has increased from 74 in 2021/22 to 147 at the end of Quarter 3 of 2022/23

S4. VTE: **Reduce avoidable harm so 95% of all inpatients receive VTE risk assessment and 100% receive prescribed prophylaxis**

What we did during 2022/23

- We achieved overall compliance of 96% against the target of 95%. This target was achieved
- VTE prophylaxis: We achieved overall compliance of 97% against the target of 95%. This target was achieved

S5. Sepsis: **Ensure timely and efficient Sepsis/News2 patient management**

What we did during 2022/23

- We achieve 95% compliance in patients with suspected sepsis receiving antibiotics within one hour against a target of 90%. This target was achieved.

S6. Safer staffing: **Strengthen safer staffing through digital monitoring systems**

What we did during 2022/23

- We reviewed and refreshed our utilisation of the safer nursing care tool
- We worked collaboratively with the Business Intelligence team to streamline our data collection process to ensure one version of the truth
- We introduced a more robust data validation process
- We achieved an average registered nurse fill rate of 91%, against our target of 90%

S7. Safety culture: **Strengthen safety culture through standardisation of safety huddle agenda**

What we did during 2022/23

- We reviewed and standardised the nursing handover process
- We continue to prioritise the staffing huddle process to ensure patient care and safety messages are effectively shared

S8. Investing in Research and Innovation: **Invest in research and innovation to deliver excellent patient care in the future**

What we did during 2022/23

- We continue to strengthen our research and innovation portfolio
- We opened 37 new clinical trials
- We recruited 1,132 new patients onto clinical trials and studies

RESPONSIVE

R1. Care closer to home: **Deliver patient care closer to home through new clinical model so that 90% of patients travel less than 45 minutes to access care**

What we did during 2022/23

- In 2022/23 we delivered 5,560 chemotherapy (sub-cutaneous and intravenous) treatments in a home setting
- In 2022/23 98% of appointments were within 45 minutes travel time from patients' homes

R2. **Improving complaint management**

What we did during 2022/23

- We merged the Complaints, PALS and Claims functions and moved them under the leadership of the newly developed post of Complaints and Claims Manager
- We received 53 formal complaints which is 0.000125% of our total activity
- We were unable to undertake an audit of the complainant's experience of the Trust complaints process. This will be taken forward in 2023/24

R3. Learning from complaints: **Triangulate incidents, complaints and PALS to promote learning and improvements**

What we did during 2022/23

- We introduced a quarterly aggregated patient safety and experience report which triangulates data and provides trend analysis in order to identify areas for targeted improvement
- We developed in draft format a strategy for learning and improvement. This will be formalised in 2023/24

R4. Improving patient experience: **Strengthen care and experience of patients with additional needs**

What we did during 2022/23

- We maintained 89% compliance for learning disability awareness training for all patient-facing staff
- We continue to provide the Oliver McGowan Foundation training for all Trust dementia/ learning disability and autism champions

R5. Supporting the delivery of national standards: **Deliver national learning disability standards**

What we did during 2022/23

- We continue to work with patients and carers / families with learning disability and/or autism to develop a mechanism for them to feed back on their experience
- We have a special indicator within the electronic patient record (Meditech) to identify patients with a learning disability and/or autism to enable us to cross-reference any patient involved in an incident or complaint
- We participated for the fourth year in the submission for the National Learning Disability Improvement Standards and received our Outcome of Performance Report which is utilised to inform our workplan
- We continue to work in partnership with patients, families and self-advocates via the Confirm and Challenge Group and to progress the workplan and evaluation process for delivery of National Learning Disability Standards
- We reviewed and revised the Trust Learning Disability / Autism Strategy to reflect current guidance

R6. Shared learning: **Share learning from PALS, complaints, deaths and serious incidents across the patient pathway, working in partnership with the Cancer Alliance**

What we did during 2022/23

- We continued where possible and appropriate to share learning from events that span the patient pathway
- We continued to scope the most effective process for sharing learning across the integrated care system

R7. Developing our volunteer programme: **Expanding the volunteer service to support the opening of CCC-Liverpool and the introduction of the family volunteering service at CCC-Liverpool**

What we did during 2022/23

- We continued to develop our volunteer workforce
- We have 66 registered volunteers
- We developed the new role of volunteer dining companions

R8. Developing our volunteer programme: **Safe return of CCC-Wirral volunteers post-COVID**

What we did during 2022/23

- We continued to provide a volunteer service at CCC-Wirral

CARING ENVIRONMENT

C1. **Continue to achieve top quartile results for patient experience**

What we did during 2022/23

- We achieved the best scores in the country in 10 questions of the Adult Inpatient Survey:

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

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

C2. **Deliver outcomes identified in Dementia Strategy to improve dementia care and patient experience**

What we did during 2022/23

- We have reviewed the Dementia Strategy building on the work achieved in the previous three years

- We have re-commenced the Helping Hands inpatient process on the TV that allows patients access to snacks, newspapers by the volunteer workforce. However software difficulties were encountered which resulted in the initiative being paused whilst awaiting solution from the provider

C3. **Deliver Patient and Public Involvement Strategy 2019-21 to improve our methods of engagement**

What we did during 2022/23

- We completed 12 non-executive director (NED) and Governor-led patient experience visits

- We published the 2022-2025 Patient Experience, Engagement, Inclusion and Involvement (PEEII) 'commitment'

C4. **Establish a patient experience and involvement group ensuring we listen and respond to what our service users are telling us that matters to them**

What we did during 2022/23

- The Patient Experience and Inclusion Committee terms of reference were reviewed with meetings occurring quarterly. We also created an operational sub-group, the Patient Experience and Inclusion Operational Group (PEIOG), which meets bi-monthly
- We have reviewed the process for patient, carer and family member involvement and participation in service development throughout the organisation and continued strengthening of the patient and carer voice and experience with the support of key operational staff and medical colleagues

C5. **Implement the End of Life Strategy to deliver greater choice and support for individuals nearing the end of life**

What we did during 2022/23

- We published the 2023-2026 End of Life Strategy

C6. **Implement Global Digital Exemplar (GDE) quality digital workstreams to include electronic patient information**

What we did during 2022/23

- We successfully fulfilled our commitments as part of the Global Digital Exemplar programme and have been accredited as a digital leader

C7. **Implement person-centred care audits and 'always events' in 2022/23**

What we did during 2022/23

- We completed 28 person-centred audits across all areas
- The second Always Event was completed in July 2022 focusing on improved experience within the Outpatient department. Improvements include 'drinks rounds' provided by the volunteers to ensure refreshments are offered when the department is busy and information screens have been installed in the waiting area to provide additional information

CLINICAL EFFECTIVENESS

CE1. **Consistently meet national cancer waiting times standards**

What we did during 2022/23

- Whilst we did not consistently achieve these standards, performance improved during the year:

  - Increased and sustained high numbers of late referrals from other trusts, reducing our ability to start treatment before the 62-day period (starting with GP referral) ends
  - Molecular testing delays at laboratories
  - Administrative errors, exacerbated by the staff shortages, which required staff to work in unfamiliar roles

CE2. **Reduce unplanned admissions and readmissions**

What we did during 2022/23

- We have developed Clinical Decisions Unit (CDU) ambulatory and virtual clinics with bookable slots. This allows additional optimisation of Same Day Emergency Care (SDEC) within CCC
- We have developed our Hotline pathways in collaboration with the Urgent Community Response and SDEC services throughout the region
- We have developed a patient information leaflet to be given at pre-assessment to optimise use of the service
- We have developed call direction technology implementation to ensure only appropriate calls are managed by the Hotline
- We have implemented the 'Relay' app to allow patients with sensory impairments to access the Hotline
- We have embedded a same day arm's length review clinic for complex cases
- We have fully integrated Haemato-oncology into the Hotline process
- The ambulatory pathway and clinic are now embedded within CDU
- We have established an Oncology alert pathway in order to identify patients presenting acutely to Liverpool University Hospitals NHS Foundation Trust (LUHFT) with production of a real-time dashboards
- We have developed a mutual aid policy for LUHFT integrating acute oncology and Emergency Department and Acute Medical Unit to facilitate timely identification and transfer of patients to CCC-Liverpool
- We have introduced a low-risk neutropenic sepsis pathway to promote same-day treatment and reduce the need for admission

CE3. **Maintain regulatory compliance**

What we did during 2022/23

- We participated in seven inspections – five were passed with no improvement actions, two were passed with (2 and 3 respectively) minor actions which have all been addressed

CE4. **Improve clinical outcomes through the establishment of site reference group (SRG) KPIs, monitored via new digitised SRG dashboards**

What we did during 2022/23

- We have developed several topic-specific online dashboards which allow staff to view performance by SRG. These dashboards are continually improved, to suit the needs of staff. A divisional performance dashboard is also being finalised, which will provide an overview of performance by SRG where appropriate to do so

CE5. **Achieve 90% compliance with NICE guidelines**

What we did during 2022/23

- We achieved ongoing compliance of 96%

CE6. **Aim to reduce avoidable deaths to zero**

What we did during 2022/23

- We achieved 100%

CE7. **Improve clinical audit monitoring via Clinical Audit Sub-Committee**

What we did during 2022/23

- We increased the ratio of quality improvement projects against assurance projects by 9%

CE8. **Achieve 90% or better statutory and role-essential training and role-based competency compliance across the Trust**

What we did during 2022/23

- We achieved 95% compliance with statutory and mandatory training
- We achieved 94% compliance with role-based / role-essential training

CE9. **Management of the transition from Deprivation of Liberty Safeguards (DoLS) to Liberty Protection Safeguards (LPS)**

What we did during 2022/23

- We contributed to the new legislation and guidance i.e. Liberty Protection Safeguards (LPS) national consultation on the new LPS process in 2022
- We attended the Cheshire and Merseyside LPS Forum on a quarterly basis to share learning, business cases and provides a great networking opportunity
- We implemented an accredited Mental Capacity Act / LPS training package which was developed by Health Education England and Skills for Health
- We noted the Government announcement on 5th April 2023 on the delay of the implementation of the Liberty Protection Safeguards beyond the life of the current Parliament. LPS is not likely to be implemented (either in its current form or at all) until 2026 at the earliest. We have therefore reviewed our current workstreams to accommodate the changes

CE10. **Implement stratified follow-up of patients to optimise clinical input and appropriate follow-up to meet CQUIN requirements – Patient Initiated Follow Up (PIFU)**

What we did during 2022/23

- We identified the need for a major outpatient transformation project (to include PIFU) and have been progressing this during the year, holding focus groups to identify key areas for improvement which will directly and indirectly benefit patients. We have progressed work on the digital solutions required to support these patient empowerment initiatives

WELL LED

WL1. **Deliver on Trust's quality-focused strategic priorities**

What we did during 2022/23

- We were rated one of best hospitals in England for inpatient care in CCQ's National Inpatient Survey 2021, published in October 2022
- We delivered a successful programme to support the opening of Liverpool University Hospitals NHS Foundation Trust's new Royal Liverpool University Hospital, adjacent to and connected by link corridors with our CCC-Liverpool hospital, ensuring the readiness of our services and maintaining high-quality, safe and effective patient care
- We developed a programme to make the necessary preparations for introducing a Chimeric Antigen Receptor T-cell (CAR-T) therapy service
- Invested to improve the quality of our CCC-Wirral site and began a programme to coordinate further improvement, investment and redevelopment of the site

WL2. **Embed new corporate governance and risk committee structure**

What we did during 2022/23

- We embedded the new committee structure, ensured terms of reference and membership reflected the purpose of the committee, and continue to make small tests of change as required

WL3. **Increase national profile and collaborative working as a system leader against regional and national quality priorities/ indicators**

What we did during 2022/23

- We continued to host and lead the Cheshire and Merseyside Cancer Alliance transformation programme
- We continued to lead the Cheshire and Merseyside Urgent Cancer Care Programme, working with system partners to deliver improvements and gaining national recognition for this work
- We continued to lead the Cheshire and Merseyside Community Diagnostic Centre programme, and the region's wider diagnostic programme
- We played an active role in the integrated care system and provider collaborative for the region (CMAST)
- We engaged in NHS Cheshire and Merseyside's review of acute hospital services in Liverpool

WL4. **Carry out monthly 'human factors' focused quality and safety leadership walkrounds**

What we did during 2022/23

- We were unable to commence the quality and safety walkrounds in 2022/23. They have commenced in Quarter 1 of 2023/24

WL5. **Strengthen nurse and AHP leadership**

What we did during 2022/23

- We continued to develop our nursing and AHP leadership capacity
- We provided bespoke 'Leadership for All' clinical leadership training for 16 Band 7 AHPs from all professions
- We provided bespoke leadership training for Band 6 ward-based nurses
- We supported 10 nurses to attend a professional development day delivered by Steve Head

WL6. **Patient and staff experience narrative delivered at Trust Board**

What we did during 2022/23

- The Board received five video patient stories and four staff stories – one staff story was deferred due to industrial action

27th April 2022	Staff story	Apprenticeship schemes within digital workforce
25th May 2022	Patient story	Blood Cancers patient story
29th June 2022	Staff story	International nurse recruit
27th July 2022	Patient story	Acute Care Teenage and Young Adult (TYA) patient story
28th September 2022	Staff story	Bright Ideas scheme and innovation
26th October 2022	Patient story	Research & Innovation patient story
30th November 2022	Staff story	My leadership journey at CCC – Macmillan Physiotherapy Team Lead and Temporary AHP Workforce Project Lead
25th January 2023	Patient story	Welfare Benefits patient story
29th March 2023	Patient story	Sarcoma patient story

Our quality priorities for 2023/24

Our quality priorities for 2023/24 have been developed based on the data and themes identified through our patient feedback, complaints, concerns, incident and harms reviews and professional judgement. They are described in below, using clear, jargon free language, specific measurement criteria and monitoring process.

Priority 1 – To ensure patient safety by reducing the number of cases of healthcare-associated infection: Clostridioides difficile (C. diff) and Escherichia coli (E.coli)

Aim:

To demonstrate a sustained reduction in the number of healthcare-associated infections per 1,000 bed days (inpatient wards)

This will be evidenced by:

- Fewer than 13 attributable cases of C. diff infection per annum
- Fewer than 10 attributable cases of E.coli bloodstream infection (BSI) per annum
- We will continue to implement our gram-negative organism reduction strategy
- We will continue to provide education and training across all staff groups
- We will continue to work with colleagues in ensuring the environment is safe from an infection prevention and control perspective
- We will continue to deliver our collaborative programme with The Christie NHS Foundation Trust and The Royal Marsden NHS Foundation Trust, focusing on all elements of infection prevention and control, as well as looking to standardise approaches across the cancer specialty

How improvements will be measured and monitored

- We will continue to monitor and present our figures monthly to the Trust Board via the Director of Infection Prevention and Control
- We will present data and action plans via divisional meetings to learn from infection control incidents and reviews

Priority 2 – To ensure patient safety by reducing the incidence of pressure-related skin damage developing in patients while they are receiving inpatient care

Aim:

To demonstrate a sustained reduction in the number of category 2 & 3 pressure sores per 1,000 bed days (inpatient wards)

This will be evidenced by:

- No category 4 pressure sores per annum
- Reduction of 10% in category 3 pressure sores per annum based on 2022/23 data
- Reduction of 10% in category 2 pressure sores per annum based on 2022/23 data
- There will be evidence-based assessments and processes in place which are utilised and monitored
- There will be a presentation on the work of the improvement collaborative
- There will be a refocus and rebrand of the existing harm-free care process to ensure it meets the needs of the organisation in driving improvements and reducing avoidable harm

How improvements will be measured and monitored

- We will continue to monitor and present our figures monthly to the revised harm-free care meeting
- We will present data and action plans via divisional meetings to learn from incidents and reviews
- Aggregated data will be published in the quarterly patient safety and experience report

Priority 3 – To ensure patient safety by reducing the incidence of falls resulting in low harm or above in patients while they are receiving inpatient care

Aim:

To demonstrate a sustained reduction in the number of falls resulting in harm per 1,000 bed days (inpatient wards)

This will be evidenced by:

- No avoidable falls resulting in moderate harm or above per annum
- 10% reduction in low and no harm falls per annum based on 2022/23 data
- We will develop a falls reduction improvement collaborative

- There will be a refocus and rebrand of the existing harm-free care process to ensure it meets the needs of the organisation in driving improvements and reducing avoidable harm
- We will participate in the regional falls prevention meetings to both learn and share learning across the integrated care system

How improvements will be measured and monitored

- We will continue to monitor and present our figures monthly to the revised harm-free care meeting
- We will present data and action plans via divisional meetings to learn from incidents and reviews
- Aggregated data will be published in the quarterly patient safety and experience report

Priority 4 – To develop a bespoke quality accreditation programme to provide robust evidence of the quality of care provided to patients during an inpatient stay

Aim:

To produce a meaningful accreditation framework to enable the ward teams to evidence the quality of care they are providing, with a clear structure to celebrate success and recognition (inpatient wards)

This will be evidenced by:

- There to be a clear set of measurable quality standards
- There to be a clear framework to gather and measure evidence of care
- There will be co-production of the framework with a cross-section of ward staff and multi-professional colleagues

How improvements will be measured and monitored

- We will monitor and present our progress quarterly at a steering group meeting
- We will have an accreditation product to implement by 2024/25

Priority 5 – To reduce avoidable patient harm and improve the experience of care by ensuring lessons are shared when care and treatment goes as planned, as well as when it doesn't go as planned

Aim:

To develop a Trustwide strategy which embeds a culture of learning from success based on a model of continuous improvement

This will be evidenced by:

- We will collaborate and engage with colleagues to understand how best to identify and share learning
- We will produce a clear and easy to follow strategy taking into account different learning styles

How improvements will be measured and monitored

- We will monitor ongoing progress via a quarterly update to the Risk and Quality Governance Committee
- We will have a finished strategy launched by Quarter 4 of 2023/24

Part 3:
Other Information

Statements of assurance from the Board

Review of services

- Acute oncology
- Clinical oncology
- Medical oncology
- Chemotherapy
- Radiotherapy
- Haematology and transplantation
- Brachytherapy and molecular imaging
- Teenage and young oncology
- Radiology
- Proton Beam Eye Therapy

We have reviewed all the information we have on the quality of care provided by all our relevant health services. This takes place through the monthly performance review process, Risk and Quality Governance Committee and the Trust Executive Group meeting.

The information provided in Part 3 of this quality report covers the three aspects of quality: patient safety, clinical effectiveness and patient experience.

Seven-day hospital services

During 2022/23 we have continued our improvement work to ensure patients receive timely access to clinical expertise, building on the work undertaken in previous years to support the seven-day clinical standards.

Time to first consultant review:

The Consultant of the Week model is well established and has enabled us to once again meet the 14-hour time to first review target in 95% of cases against an internal target of 90%.

Access to diagnostic tests:

We continue to provide access to CT and MRI services 24 hours a day, seven days a week.
We continue to have access to a diagnostic service 24 hours a day, seven days a week.
We have maintained our agreement with our local colleagues at Liverpool University Hospitals NHS Foundation Trust for specialty diagnostic services.

Access to consultant-directed interventions:

We have maintained our agreement with our local colleagues at Liverpool University Hospitals NHS Foundation Trust for access to specialist care and interventions 24 hours a day, seven days a week via consultant and emergency referrals.

Ongoing review by consultant twice-daily for high-dependency patients, daily for others:

We provide a daily consultant ward round (seven days weekly) supported by senior specialty doctors, including resident on call to provide 24-hour cover.

We ensure consultant-led review of unwell patients. The critical care team attend medical team handover to identify any deteriorating patients to provide early intervention as high dependency / critical care services, beds and consultant provision are provided by colleagues at Liverpool University Hospitals NHS Foundation Trust.

In addition, in 2022/23 we introduced the following initiatives:

- We introduced a new consultant model of care for inpatient care. This model ensures a dedicated daily inpatient consultant allocated to all wards. This supports timely continuity of care and senior reviews
- We introduced additional specialist cardiology support from Liverpool Heart and Chest Hospital and the formalisation of a cardio-oncology MDT
- General medical support for inpatients has commenced and will be expanded over the next 6-12 months
- Diabetic inpatient review and support from Diabetic Specialist Nurses and Diabetic Medical Consultant

Learning from deaths

As a tertiary specialist trust, managing only patients with a cancer diagnosis, The Clatterbridge Cancer Centre does not participate in HSMR and SHMI reports.

Our own 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 one year post-bone marrow transplant mortality

A comprehensive case note review is undertaken on all deaths that are found to have one or more trigger. This uses an evidence-based structured judgement case note review tool developed by the Royal College of Physicians (RCP).

Case review and selection process

Outcomes from these reviews are discussed by the Trust Mortality Surveillance Group (MSG), who in turn will escalate any problems in care, if identified, to the Executive Review Group (ERG). Ratings for care are made on a scale of 1 to 5, where 5 represents excellent care and 1 means a serious problem in care has been identified.

Phase I – Responsible consultants independently review the care patients received to highlight areas of concern

Phase II – An in-depth structured judgement review (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

There is also an assessment of whether any issues in care had an impact on outcome and, in particular, assessment of avoidability of that death. Overall care or avoidability ratings of 1 and 2 are immediately escalated to Executive Review Group for further scrutiny.

Structured judgement review (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

The process aims to highlight examples of excellent care, as well as identifying where improvements and learning is needed. Feedback is provided to responsible clinicians and also to families if they have raised a concern, or should a review identify a serious lapse in care.

The data in this report represents the findings validated up to the most recent Mortality Surveillance Group. Quarter 4 mortality figures will be validated at the MSG meeting on the 26th May 2023.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Continue to achieve top quartile results for patient experience	39	47	50	53	189
Number of deaths that have undergone structured judgment review (SJR)	39	47	50	53	189
Number of completed SJRs	36	31	36	22	132
Number discussed at Mortality Review Meeting (MRM)	0	2	6	5	8
Number of deaths that have triggered COVID-19 review	0	1	50	0	3
Number of completed COVID-19 reviews	0	1	2	0	3
Number discussed at MRM	0	0	0	0	0

On-site deaths annually	2022-2023	2021-2022	2020-2021	2019-2020	2018-2019
Total deaths in year	136 (ex Q4)	132	102	85	65
Deaths following emergency admission	100	56	65	72	59
Emergency admissions in year	970	993	1,081	1,280	1,529
% deaths / total emergency admissions	10.3%	5.6%	6.0%	5.6%	3.8%
Total admissions (excluding day cases)	1,829	2,373	1,838	1,932	2,267
% deaths / total admissions	7.4%	5.6%	5.5%	113/1,932 5.8%	88/2,267 3.8%

Trust-level mortality data summary	2022-2023	2021-2022	2020-2021	2019-2020	2018-2019	2017-2018
30 day mortality rate (solid tumour radical chemotherapy)	0.7%	0.5%	0.8%	0.8%	0.7%	0.67%
30 day mortality rate (solid tumour palliative chemotherapy)	6.0%	5.4%	6.0%	5.6%	7.4%	6.1%
30 day mortality rate (haemato-oncology)	2.9%	3.7%	2.3%	3.2%	5.2%	4.1% (July 17-March 18)
30 day mortality rate (radiotherapy)	2.9%	2.7%	3.1%	3.7%	3.9%	3.5%

Learning from deaths

Aspects of good practice and areas for improvement are fed back to the appropriate clinician. Any concerns identified are also shared within directorates or more widely, especially if associated with an incident or complaint.

An example of learning from mortality reviews during this reporting period includes:

A patient was noted to be unwell when attending for a blood transfusion. The patient was subsequently admitted to an acute trust that night with a deterioration in condition and died some time later following fast-track discharge home to die.

The review group noted record-keeping on the day of treatment was inadequate. The lead 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 as expected. The audit lead was assured that this was a one-off incident of missed documentation but arranged further training on essential documentation.

Essential documentation training has been delivered to all chemotherapy administration staff by an external solicitor in collaboration with the Trust Legal and Governance Manager. The individual involved also received appropriate support following this error.

Participation in clinical audits and national confidential enquiries

During 2022/23, we participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in and participated in during 2022/23 are as follows:

Audits: cases submitted

National Clinical Audit and NCEPOD eligible studies	Cases submitted
National Lung Cancer Audit (LUCADA)	12/12 (100%) files uploaded successfully via COSD
National Bowel Cancer Audit	474/648 (73%) oncology treatment records uploaded. The remaining 27% were not uploaded due to not being registered by the acute trust or the acute trust having not uploaded the tumour record for treatment to be appended
National Oesophago-Gastric Cancer Audit	176/235 (75%) oncology treatment records treatment uploaded. The remaining 24% not being uploaded were due to not being registered by the acute trust
National Prostate Cancer Audit (NPCA)	12/12 (100%) files uploaded successfully via COSD
National Audit of Breast Cancer in Older Patients	12/12 (100%) files uploaded successfully via COSD
Quality of Life Questionnaire for Stereotactic Radiosurgery (SRS)	226 patient questionnaires collected
Cardiovascular screening prior to stem cell transplantation in the United Kingdom	Data was collected between March 2022 and June 2022 utilising a 26-item questionnaire. All data submitted within required timescales
PRIMROSE CSF – Cerebrospinal Fluid Collection in Breast Cancer	11 samples collected across the country, of which 9 are from us. National goal is to collect 75

National Clinical Audit and NCEPOD eligible studies	Cases submitted
National Audit of Care at the End of Life (NACEL) – Round 4	All aspects of the audit were completed within the agreed timeframe. A bespoke infographic and dashboard was received from NACEL and one of our Consultants in Palliative Medicine devised a local action plan which was agreed at the Trust Mortality Surveillance Group

The reports of eight national clinical audits were reviewed by the provider in 2022/23 and we intend to take the following actions to improve the quality of healthcare provided.

National Clinical Audit and NCEPOD eligible studies	Actions to improve quality of care
NBOCAP (Bowel Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2022/23 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance
NOGCA (Oesophago-Gastric Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2022/23 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance
NCLA (Lung Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2022/23 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance

NPCA (Prostate Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2022/23 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance
The National Audit of Breast Cancer in Older Patients	The annual report and recommendations were reviewed by the SRG. Data submissions continue to be extracted from COSD dataset SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance
National Audit of Care at the End of Life (NACEL) – Round 4	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2022/23 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance
British Society of Blood and Marrow Transplantation and Cellular Therapy (BSBMTCT)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance
Cardiovascular screening prior to stem cell transplantation in the United Kingdom	The recently released recommendations will help unify pre-transplant cardiovascular screening practice in the UK and we will ensure our compliance

*SRG – Site Reference Group

Commissioning for Quality and Innovation (CQUINs)

CQUIN is a mechanism for commissioners to reward quality by linking a proportion of our income (1.25 per cent in 2022/23) to our success in meeting quality improvement goals. We achieved all our CQUIN goals in 2022/23 except for the staff influenza vaccination target. Whilst this was disappointing, the lower uptake than in previous years was mirrored across the whole NHS and not just local to us.

Registration with the Care Quality Commission

The Clatterbridge Cancer Centre NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered to provide diagnostic and screening procedures, treatment of disease and disorder.

The Clatterbridge Cancer Centre NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against The Clatterbridge Cancer Centre NHS Foundation Trust during 2022/23.

CQC responsive inspection

The Clatterbridge Cancer Centre NHS Foundation Trust has not been part of any responsive inspections during 2022/23. We have however continued regular engagement with the CQC.

CQC inspection programme

The Clatterbridge Cancer Centre NHS Foundation has not been part of any CQC Inspection Programme during 2022/23.

Quality of information

The Clatterbridge Cancer Centre NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS Number was: 99.9% for admitted patient care and 99.9% for outpatient care. The Trust does not provide accident and emergency care
- Which included the patient's valid General Practitioner Registration Code was: 99.65% for admitted patient care and 99.1% for outpatient care. The Trust does not provide accident and emergency care

The above figures are in line with the SUS data quality dashboard methodology. We were subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission and gained high assurance for the second consecutive year.

Data quality improvement plans 2022/23

Actions to improve data quality have been implemented as part of our Data Management Group cycle of business. This included:

- A Data Quality Audit carried out by Mersey Internal Audit Agency around the Commissioning Data Set process, which received substantial assurance
- A full refresh of the Cancer Waiting Times Dashboard to support accurate tracking of cancer access targets
- Improvements in the data quality metrics relating to contract monitoring, clinical and administrative data sets

Information governance

The Clatterbridge Cancer Centre NHS Foundation Trust's Data Security and Protection Toolkit compliance overall score for 2021/22 resulted in standards met. Mersey Internal Audit Agency, our internal auditors, provided assurance to the evidence submitted in the Toolkit. The 2022/23 Data Security and Protection Toolkit assessment is covering July 2022 to July 2023. We are working towards continued compliance, with internal auditor verification in place.

Freedom to Speak Up

The Trust Board is committed to supporting a culture where staff feel comfortable and safe to speak up. By actively listening to our staff, we are able to reflect, learn and improve the working environment for staff and ultimately provide safe and effective patient care.

There are a number of ways in which staff can raise any concerns they have around how the organisation functions.

We encourage staff to have open conversations with their line manager and we encourage line managers to actively listen when concerns are raised. We recognise that this may not always be the easiest or most appropriate route, so we also have local Freedom to Speak Up Champions across our sites.

They are supported by a Freedom to Speak Up Guardian, an Executive Lead and a Non-Executive Director. Contact details of all the staff involved in the Freedom to Speak Up process are published around the Trust, shared as a standard item at Trust induction and are on a permanent screensaver on all computers. The process is also underpinned by a Raising Concerns in the Workplace Policy which advises staff who wish to raise a concern on the various routes available and expectations of the organisation to respond.

Activity is reported on an anonymous basis to the Quality Committee and Trust Board.
In addition we have a number of qualified Mental Health First Aiders situated across the Trust whose contact details are available on our intranet.

Research and Innovation

The Research and Innovation Directorate reached a higher level of achievement this year. We are delighted to report that not only are we an associate partner with The Royal Marsden in gaining Biomedical Research Centre (BRC) status, we also retained CRUK Experimental Cancer Medicine Centre (ECMC) status for the next five years.

These two national funding awards – in combination with our collaboration with the Liverpool Clinical Research Facility – are remarkable as this is the first time that we have held such prestigious awards, especially in such a competitive national setting. This means that we can now expand our early phase trial portfolio bringing novel therapies to our patients and establishing us on a national platform as leaders in the key themes within the BRC and ECMC, notably in the cancer vaccine field.

Highlights of the year:

- We opened 37 research trials and studies to recruitment (45 given permission to open in the Trust)
- 1,132 participants were recruited into research studies
- We are on target to exceed 500 participants into non-commercial NIHR portfolio studies gaining an extra £25k of funding for research at CCC
- We appointed a new Research Quality Manager
- Successful outcomes following sponsor audits of high-recruiting complex early phase trials
- The Innovation team has received over 150 Bright Ideas to date, with 98 submissions received in the last year
- The Big Ideas Scheme was launched, encouraging requests for funding to pump-prime larger scale projects. Two awards have been made from the inaugural funding round:

    Digital Home-Based Physical Activity – providing funding for an eight-month prehabilitation pilot of 40 immunotherapy patients to demonstrate the impact of exercise on efficacy of immunotherapy treatments

    Unplanned Care and Cancer – providing funding to analyse data from across Cheshire and Merseyside for unplanned Emergency Department attendances and admissions from cancer patients to develop a risk stratification tool to enhance patient care

- We raised the profile of our research through regional and national television, articles in the national and regional press and social media

Clinical trials / Research portfolio

The focus this year was on the early phase trials portfolio as part of the strategy to successfully retain ECMC status and to continue to build our reputation and skill set in such complex drug trials. The early phase trials unit at CCC-Liverpool and use of our Clinical Research Facility have facilitated this step-change in capacity. We have opened the third Replimune trial using an oncolytic virus to infect and kill cancer cells, and become a pipeline site for the series of trials using novel vaccines to combat cancers.

- MOAT and NEBULA: we recruited the first national participants to these trials
- TebeMRD: we recruited our first patient on the study, a key trial in the melanoma portfolio

There is strength in depth in the support given by Radiotherapy as the regional centre supporting the ATNEC trial and continuing as national lead recruiter to the PivotalBoostand Brioche trials. The portfolio continues to diversify with the welcome opening of the prehabilitation study SIPS MART. We hosted the first face-to-face cognitive behavioural therapy (CBT) workshop nationally for the MANCAN2 prostate cancer study.

We also supported the RAPID PROTECTION trial for immunosuppressed patients highly vulnerable to infection with SARS-CoV-2 virus. This extended our research reach nationally and we could also support non-cancer patients as part of this trial.

CCC-led trials and studies

The portfolio of studies where we act as sponsor to support novel research led by our staff is important to encourage and assure our leadership in areas of research strength. We opened the MPN (myeloproliferative neoplasms) Registry. This is the first national registry of its kind in this disease area and expanding in the number of participating sites across the UK.

The TACE-3 trial led by Professor Dan Palmer opened to recruitment of patients in France. This is the first time we have led and recruited participants into an international trial. The national COMICE trial, led by Dr Rosie Lord, for patients with advanced recurrent cervical cancer closed to recruitment and is entering the analysis phase. The translational element of the trial is now underway to deliver further insight into this disease.

The UNCOVER study led by Professor Andy Pettitt has expanded to the UNCOVER Plus Platform study, with the award of £278,968.87 from Blood Cancer UK following a highly competitive national call which will fund research for the next 3 years. The new funding from Blood Cancer UK will allow the UNCOVER study to be extended by finding out how the treatment of blood cancer has changed during the pandemic. It will also look at the pros and cons of different blood cancer treatments to see which of them work best in different situations. The research will involve a network of collaborators from across the UK including not only senior blood cancer doctors but also patients and early career researchers.

The Clatterbridge Cancer Centre Biobank

195 participants donated samples to our biobank this year, with huge support from our staff following a recruitment drive to collect age-matched samples from healthy volunteers. We developed a collaboration to support the national Teenage and Young Adult (TYA) cancer biobank and also a key collaboration to support novel research in drug-induced cardiotoxicity, thus extending the nature and number of samples biobanked for novel research.

Innovation

The innovation arm of Research and Innovation (R&I) was successfully established with some key submissions supported for patient benefit:

- Metastatic Spinal Cord Compression patient experience – enhanced through collaboration with Serious Brands and University of Liverpool to provide a customised stand offering access to entertainment and self-completion of patient assessments

- Adapted clothing – our first patient-initiated idea to allow for the addition/removal of outer layer of clothing without risk of dislodging lines

The R&I Communications Manager has been integral to the successful dissemination of the active research and innovation portfolio with regional and national television reports raising our profile. There has been a lot of activity both in print and online which is business critical in ensuring greater visibility of our research and increased recruitment to our clinical trials.

Other information

Review of Quality performance in 2022/23

The Board of Directors believes that quality of care should where possible be reported and scrutinised frequently so that adverse trends can be identified early.

The monthly quality performance for the Trust as a whole are reviewed at the Trust Executive Group meeting with key senior clinical leaders, as well as the Director of Research.

Quality metrics for individual divisions are reviewed as part of the regular performance review meetings with the executive team. Any matters of concern are followed up either through the divisional meetings or through the Risk and Quality Governance Committee.

The Board's Quality Committee is responsible for providing board assurance on quality issues, and the Board of Directors hear directly from patients at alternate board meetings via video patient stories with supporting improvement plans as required. Reports on quality of care are also made to the Council of Governors. The executive team regularly review the quality of care within the hospital through visits to clinical areas. Non-executives and governors also undertake monthly visits to clinical areas to hear directly from patients and staff about their experience of the hospital.

This section of our Quality Account draws on monthly performance reports and includes additional annual indicators for which annual reporting is appropriate. The data is drawn from regular surveys, audits or routine data systems that have been established to provide a focus on and assurance about quality of care.

Patient experience stories to the Board

Board meetings are held monthly (with the exception of August and December) and patient and staff stories are shared on alternate months.

Date	Subject
30/03/2022	Psychological Medicine Service Experiences
25/05/2022	Ward 1 (Day Ward), Wards 4 and 5 (Haematology-Oncology) Experiences
23/07/2022	Teenage and Young Adult Service Experiences
26/10/2022	Research and innovation Service Experiences
25/01/2023	Welfare Benefit Service Experiences
29/03/2023	Clinical Nurse Specialist, Site Specific Disease Group – patient experiences

Friends and Family Test

The NHS Friends and Family Test (FFT) is an important tool whereby the organisation receives direct, regular and real time feedback from our patients. This feedback is used to help shape and further improve our services for our patients.

The response rate for FFT and individual ward/department results is collated monthly and high-level results published in the performance report, as well as all the results from FFT being available to all staff to see on our intranet.

The FFT monthly scores, measured as a percentage of positive scores, ranged from 89% to 100% for the inpatient ward areas and from 96% to 98% for the outpatient/day case areas.

National Adult Inpatient Survey 2022/23

The Clatterbridge Cancer Centre has again received excellent results in the annual adult inpatient survey commissioned by the Care Quality Commission (CQC).

Patients were eligible to participate in the survey if they were aged 16 years or over and had spent at least one night in hospital. The survey was significantly different to previous years' surveys with regards to methodology, sampling month and questionnaire content. This survey was conducted using a push-to-web methodology (offering both online and paper completion).

684 patients were invited to complete the survey. Of these 196 patients completed the survey. This gave us a 33% response rate which is slightly lower than the average response rates for similar trusts and in comparison to our response rate for last year.

The results from our patients' feedback was again excellent, with an overall rating of experience as 9.1 out of 10. The Clatterbridge Cancer Centre has been identified as one of the nine top-performing trusts, being categorised as 'Much better than expected'. This is because the proportion of respondents who answered positively to questions about their care, across the entire survey, was significantly above the trust average.

The Clatterbridge Cancer Centre was:

- Much better than most trusts for 21 questions
- Better than most trusts for 15 questions
- Somewhat better than most trusts for 2 questions
- Same as most other trusts for 8 questions

An action plan was developed to improve on key areas of patient experience and is monitored through the Patient Experience and Inclusion Committee.

Patient led Assessments of the Care Environment (PLACE)

On 28th October 2022 Clatterbridge Cancer Centre – Liverpool (CCC-Liverpool) participated in the annual Patient-Led Assessment of the Care Environment (PLACE).

PLACE assessments put patient views at the centre of the assessment process, and use information gleaned directly from assessors to report how well a hospital is performing in the areas assessed. Peer-reviewing NHS provider professionals and patient assessors – both through patient associations and patient/carer/governor representation – make up at least half of each assessment team, which offers them the opportunity to drive developments in the health services they receive locally. The assessment focuses entirely on the care environment and does not cover clinical care provision or staff behaviours.

It is a great achievement that CCC-Liverpool scored higher than the national average in five of the six domains, and much higher than average for both 'Dementia' and 'Disability'.

Although we scored lower than the national average for provision of food, this was not unexpected and we were already in the process of changing supplier. That has now taken place so we expect to see this improvement reflected in the next assessment.

	Cleanliness	Food & Hydration	Privacy, Dignity & Wellbeing	Condition, Appearance & Maintenance	Dementia	Disability
National Average	98.00%	90.20%	86.10%	95.80%	80.60%	82.50%
Trust Average	98.12% ↑	84.06% ↑	92.23% ↑	97.54% ↑	91.54% ↑	82.50% ↑

Safer staffing

The Safe Staffing levels indicator is a national quality measure that was introduced in 2014. It looks to measure and ensure that a hospital's nursing staffing requirements are being met. The measure focuses on two distinct groups of staff: registered nurses and non-registered care staff. The data collected each day for both day and night shifts allows a member of the public to see whether the actual number of staff on duty met what was planned on a ward. This data is then submitted at ward and Trust level nationally and is made visible on the NHS.uk website. The data is also made visible to patients and visitors in real-time on each ward.

The monthly data on our safe staffing levels and the six monthly reports can be seen in the public Board papers at: https://www.clatterbridgecc.nhs.uk/about-centre/corporate-matters/meetings

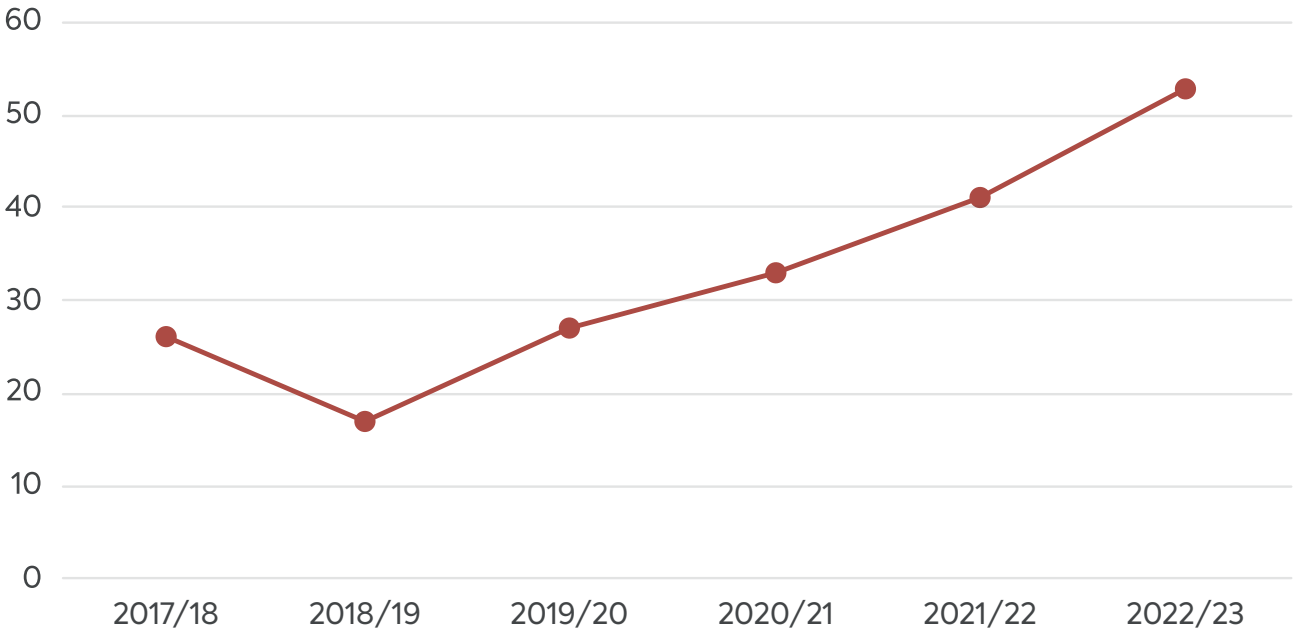
A detailed report is presented to the Board of Directors every six months to ensure there is Board oversite of safe staffing levels and the impact on quality and patient care.

Clinical indicators – Patient Experience

Complaints

In 2022/23 The Clatterbridge Cancer Centre received 53 complaints.

Complaints received per financial year



We continue to promote the resolution of concerns at clinical level with a clinician focus on local resolution to ensure ongoing improvement in care and service delivery. When a formal complaint is received, the complaint contact is always offered a face-to-face meeting with the clinical team in the first instance.

To ensure executive director oversight, all new complaints are reviewed weekly by the Executive Review Group and triangulated with incidents, claims and inquests.

Learning from complaints 2022/23

The following table gives examples of complaints issues that have been raised and associated actions taken as a result:

Issue	Actions taken
Portering staff did not communicate effective handover to ward staff when bring patient to ward	Portering staff have reviewed their processes and ensure that a verbal handover is given to ward staff
Consent form was not available on the electronic system for consultation appointment	Admin Services have implemented a new process for checking that consent forms are available on the system prior to treatment appointment
Concern that patient's CT scan had been reported incorrectly	Scan was peer reviewed and conclusion that report was incorrect. Radiologist reflected on error and reported to Radiology Events and Learning meeting to share learning
Concern raised that patient had been prescribed incorrect medication	Full incident review undertaken and reported. Pharmacy staff retrained on the process for labelling, dispensing and accuracy checking medication
Concern that patient not been provided location of appointment and did not know whether to attend CCC-Wirral or CCC-Liverpool	The leaflet provided to the patient had the wrong address. Admin Services have withdrawn all out-of-date leaflets so that patients not provided with wrong address

Issue	Actions taken
Concern that patient had not been informed of long delay to treatment being dispensed	Delay caused by process issue with treatment spreadsheet used by Pharmacy. Changes made to who in the organisation can access the spreadsheet to prevent further errors
Teenage and Young Adult patient unable to see their youth support worker as they do not attend the hospital on the days they are receiving their treatment	Working practices have been changed so that the treatment days and youth worker working days align
Concern about the way in which a staff member communicated treatment options to the patient	Clinicians reflected on the language used and will adjust how this is communicated in future
Patient's address had not been updated on all Trust systems leading to a letter being sent to previous address	New process implemented to ensure that all Trust systems are updated when patients inform us of a new address
Patient had not been sent a clinic letter following their first Consultant appointment	A new process has been implemented to alert Admin Services when a new patient letter has not been sent out
Concern raised in respect of the length of time the patient waiting for the Hotline telephone service to be answered	An agenda item has been added to the Hotline Working Group meetings to look at the length of time patients are waiting for the phone to be answered
Patient was not provided with the correct medication forms upon discharge	A review of CDU discharge process was untaken. A new process for a 'Day After Discharge' call to be made to patients to ensure they have the correct forms and information

Clinical indicators – Patient safety

Healthcare-associated-infections

We maintained high levels of biosecurity throughout 2022/23 with continued mask wearing to reduce the spread of respiratory viruses such as COVID-19 and influenza and case rates remained low. However we have experienced a higher than expected level of other reportable infections.

MRSA bacteraemia

In 2022/23 we have had no cases of MRSA bacteraemia, against a threshold of 0.

Clostridioides difficile

There were 14 cases of Clostridioides difficile infections (CDI) that were healthcare-associated as against an agreed threshold of no more than 17. Upon full root cause analysis, there were no healthcare-associated cases due to lapses in care.

Each case of CDI is subjected to a rigorous review and multi-disciplinary root cause analysis. This has demonstrated that each attributable case of CDI was induced by the specialist treatment. The treatments we provide make our patients more susceptible to CDI and this is balanced against the importance of delivering effective cancer treatments.

E.coli

There have been 24 cases of E.coli against a threshold of no more than 11.

Pseudomonas

There have been 11 cases of Pseudomonas against a threshold of no more than 1 – however, 50% related to one patient with complex health issues.

Klebsiella

There have been 17 cases of Klebsiella against a threshold of no more than 8.

There has been a full multidisciplinary review of all cases and possible reasons for the increase, with no clear source identified. Therefore a full improvement strategy has been launched to refresh, knowledge and understanding, fundamentals of care, clinical skills and competencies and patient education. A reduction in E.coli and CDI is priority 1 for 2023/24.

Incident management

We have a strong system of incident reporting and review which enables us to identify underlying problems and to learn from events, thereby preventing recurrence. We upload patient safety incidents from our internal Datix system to the National Reporting and Learning System (NRLS).

Comparison of our reporting practices with those of trusts in the same cluster of specialist trusts shows that we have good levels of reporting and low levels of patient harm, indicating an appropriate culture of reporting and learning within the organisation.

All reported incidents are investigated, with the level of investigation commensurate with the incident grade. All incidents with an impact grade of 3 (moderate) and above, out of a maximum of 5, are reported on a weekly basis to the executive team. These incidents are triaged by an executive review team consisting of the Chief Nurse, the Medical Director and the Associate Director of Clinical Governance. The outcome of the investigation is then presented to this review group. The same process is followed for complaints and claims and any concerning trends identified via any route.

National reports

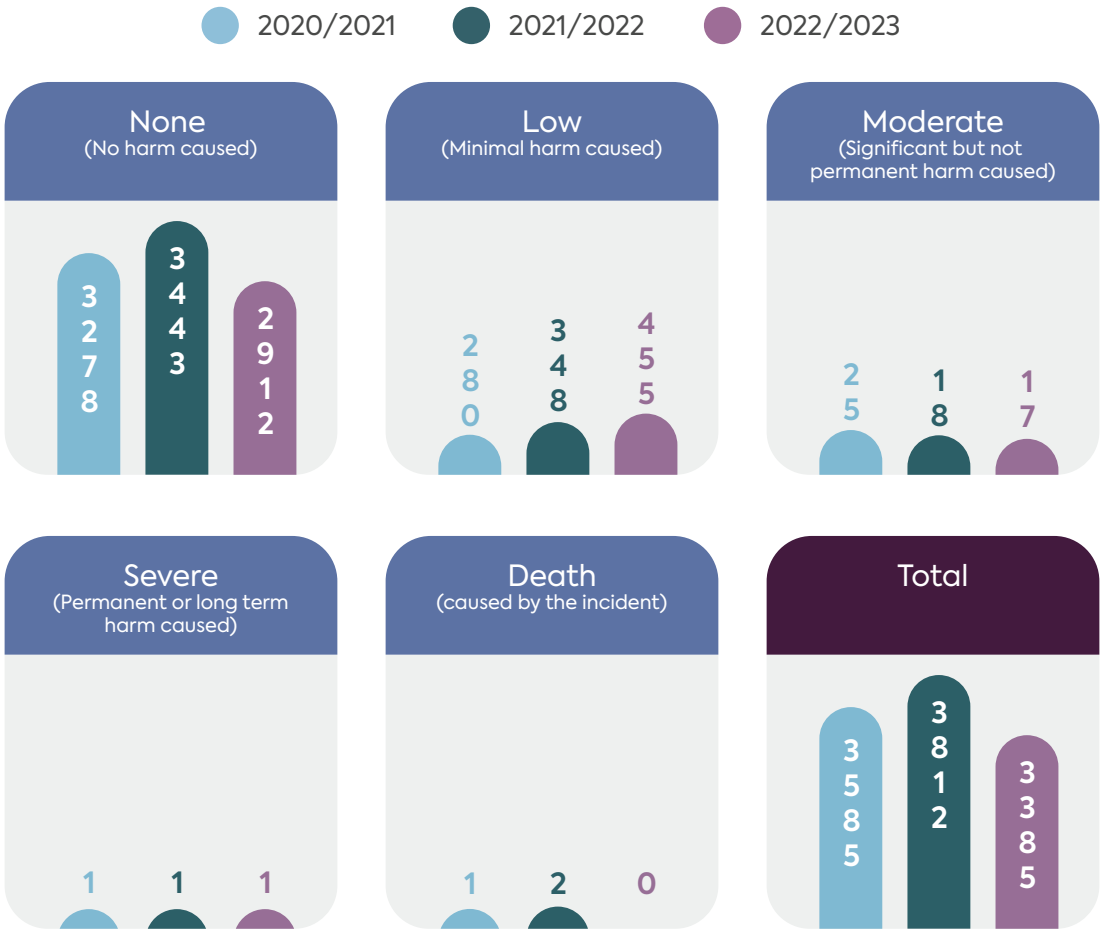
We review and act upon national reports that are directly relevant to the services we provide or where we can transfer equivalent learning. During the year we reviewed and where required developed actions for learning from three national reports:

- Ockenden Review March 2022 – Review of maternity services at Shrewsbury and Telford Hospital NHS Trust. Report reviewed, actions developed
- Kirkup Report October 2022 – Review of maternity and neonatal services at East Kent following concerns of quality and outcomes in care. Initial actions identified regarding communication and training amongst clinical staff and a follow-up work currently in progress
- Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services – December 2022 – BBC panorama programme focusing on the Edenfield Centre, Greater Manchester Mental Health NHS Foundation Trust

Patient safety incidences

The Clatterbridge Cancer Centre has a small number of inpatient beds compared with other hospitals, and over 95% of our activity is ambulatory care (outpatients and day cases).

Patient Safety Incidents by Severity



There has been a slight decrease in reported patient safety incidents in 2022/23. This may be related to variations in activity during and following the pandemic as well as changes to internal reporting, triage processes and national reporting requirements. It is not of statistical relevance but will continue to be monitored.

Never event

There have been 0 never events since 2010.

Serious incidents

There were 5 serious incidents reported this year. These were all subject to a full investigation and scrutiny at a non-executive led panel which provides an additional level of objectivity and assurance that a robust investigation process was followed and the correct conclusion reached. The cases related to:

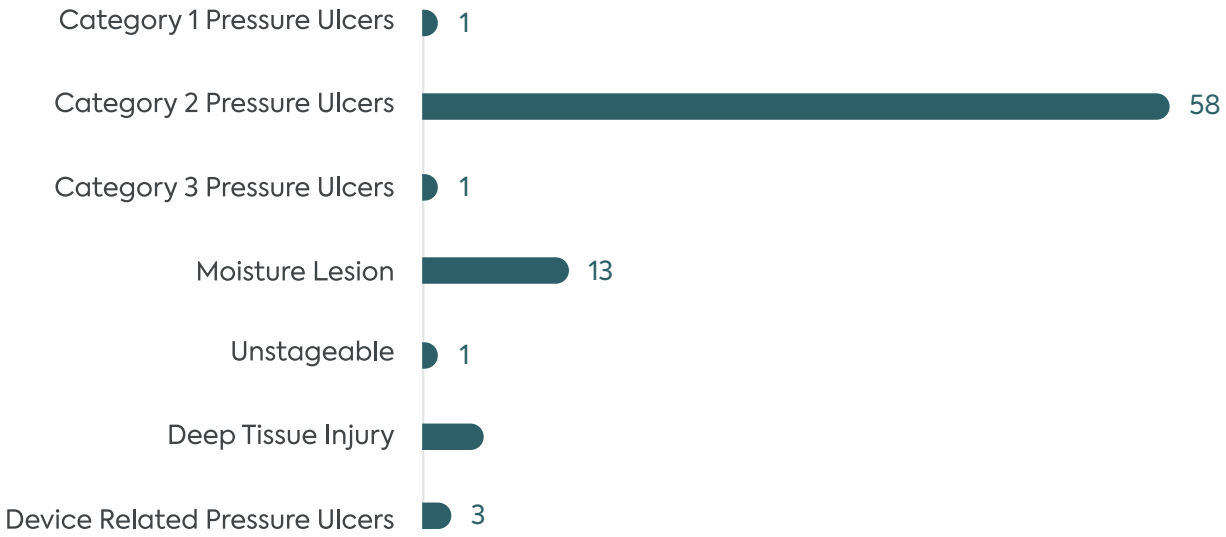
- Discharge documentation not completed at time of discharge – whilst the patient didn't experience harm as a consequence of this issue, the investigation highlighted a systemic process issue. Therefore this was upheld as a serious incident. All improvement actions have been implemented
- Outpatient fall resulting in a fractured femur – this was an unpreventable accident and therefore stood down from a serious incident
- Incorrect dose of capecitabine chemotherapy dispensed – this was reduced to a low-harm incident
- Patient developed paralysis from a Metastatic Spinal Cord Compression – this was as a result of disease progression and sadly could not have been avoided, so was re-categorised as a clinical event
- Patient required surgery following an extravasation injury – investigation in progress

Pressure ulcers

We currently review and discuss pressure ulcers at a dedicated harm-free care meeting led by the Associate Chief Nurse, they are monitored to enable us to identify trends more easily.
We have a dedicated Tissue Viability Nurse who provides education and clinical support and advice. The team have been engaged in an improvement collaborative supported by the Advancing Quality Alliance (AQuA). This work is still in progress.

A reduction in pressure ulcers is quality priority 2 for 2023/24. There was no previous improvement target identified for the percentage reduction in avoidable pressure ulcers, so the 2023/24 data will provide a baseline on which to assign an improvement target.

Hospital Acquired Pressure Ulcers 2022/2023



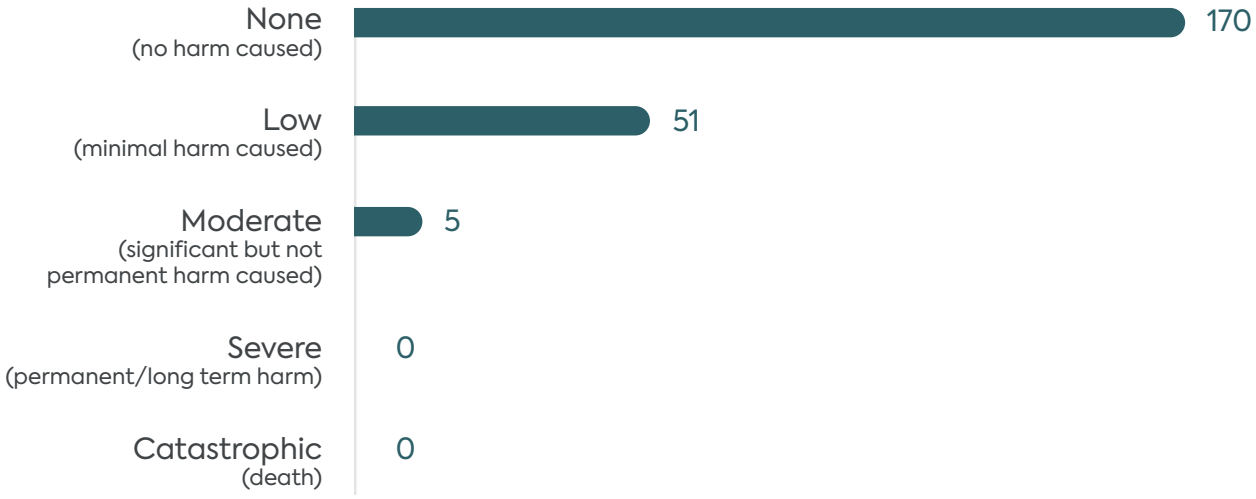
Patient falls

In 2020 the inpatient services moved into our new hospital in Liverpool (CCC-Liverpool) which provides patients with single rooms. This means that visibility of those patients at risk of falling is more challenging and requires different models of care.

We currently review and discuss falls at a dedicated harm-free care meeting led by the Associate Chief Nurse, and falls are monitored to enable us to identify trends more easily. In 2023 we created a new post of manual handling trainer and falls prevention lead. This role has been successfully recruited into and the impact is already evident.

Reduction in falls is quality priority 3 for 2023/24. There was no previous improvement target identified for the percentage reduction in avoidable falls, so the 2023/24 data will provide a baseline on which to assign an improvement target.

Falls by Severity of Harm (2022/2023)



Guardian of Safe Working

The Trust, in partnership with the Guardian of Safe Working, regularly reviews exception reports to ensure safeguards are in place to maintain safe hours of work and service commitments do not comprise the educational experience of medical trainees. A total of 20 exceptions were reported, of which none were highlighted as immediate safety concerns for 2022/23. Of the 20 reports, all were due to hours/rest and none were due to missed educational opportunities. We are working with the doctors and divisional managers to review the work schedules and the medical staffing establishment to see what, if any changes are required.

Clinical indicators – Clinical effectiveness

National and local clinical audits show that the care provided by The Clatterbridge Cancer Centre is effective in prolonging life and reducing the pain and distress associated with cancer and its treatment. Reports are discussed at the quarterly morbidity and mortality meetings with the technical reports available to Board members if required.

Cancer survival is dependent upon the type of disease – some cancers have worse prognosis than others (e.g. lung cancer) and therefore geographical differences in survival are often related to the relative incidence of poor prognosis cancers in that region. In the North West, there is a poorer overall health related to deprivation and a particularly high rate of lifestyle-related cancers: in particular, smoking-related cancers that have poor prognosis.

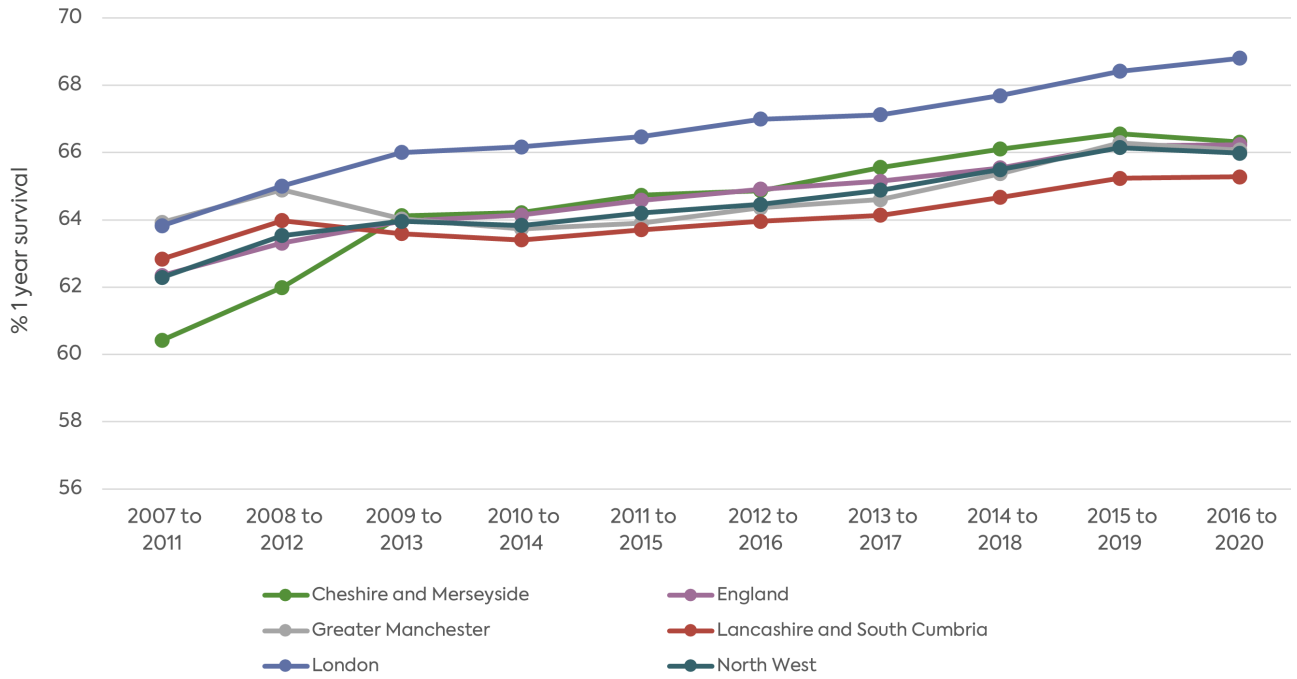
As a specialist cancer centre, we only see patients in specific parts of the patient pathway following diagnosis rather than at the point of diagnosis and may not see some patients at all, depending on their type of cancer and the stage of their cancer at diagnosis. For some cancer types only the most advanced patients are referred to our care.

These differences need to be accounted for when benchmarking survival outcomes for our patients against national figures. Where national survival data are available by stage at diagnosis, we are able to show comparable one-year survival for our patients compared to the national average.

One and five-year cancer survival

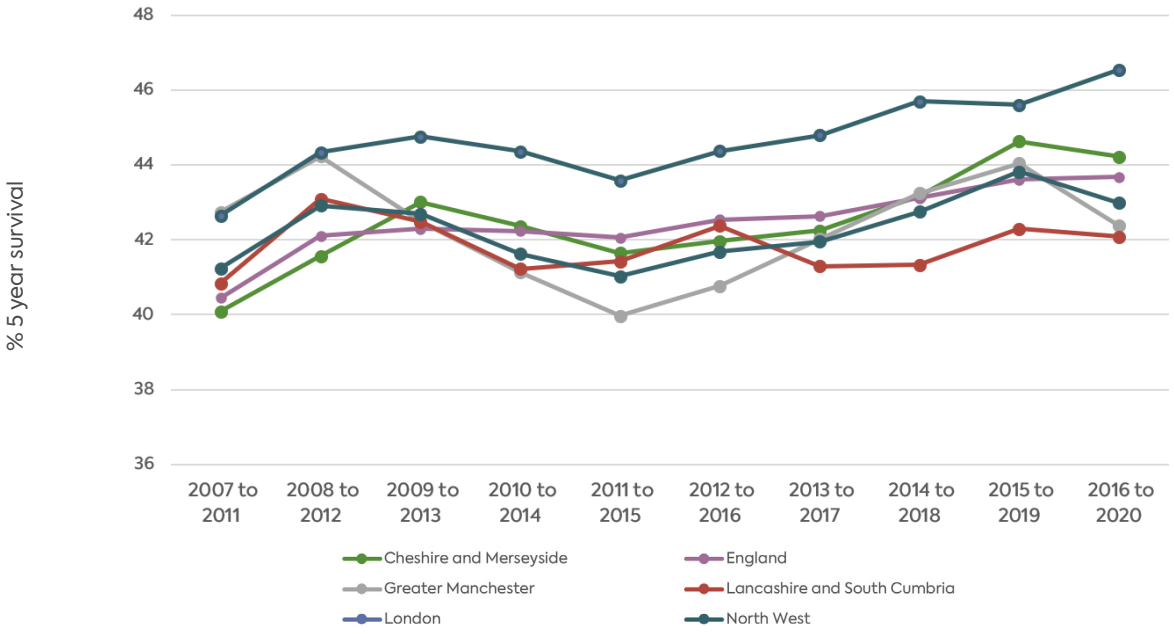
One-year survival

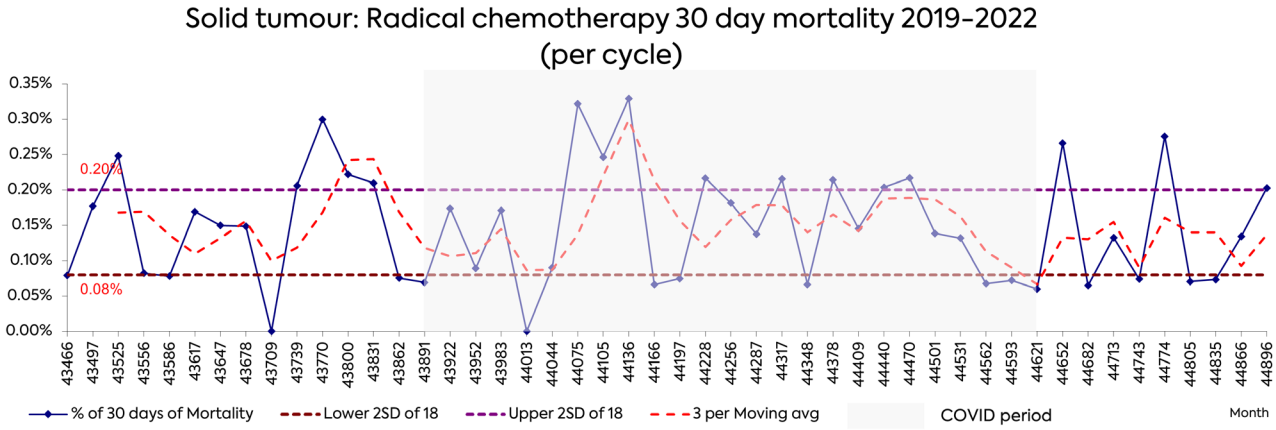
Each point on the graph below represents the percentage (trend estimates) of adult cancer patients (aged 15 to 99) who were alive one year after diagnosis. The data was averaged over 13 selected cancers by region over five years. The latest rolling data point covers patients diagnosed between 2016 and 2020 and followed up to 2021.

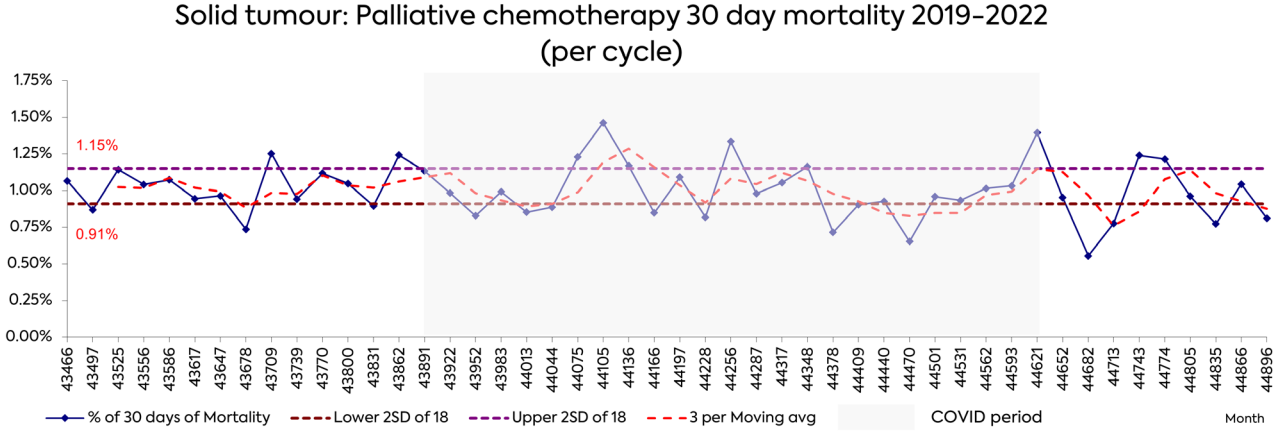


Five-year survival

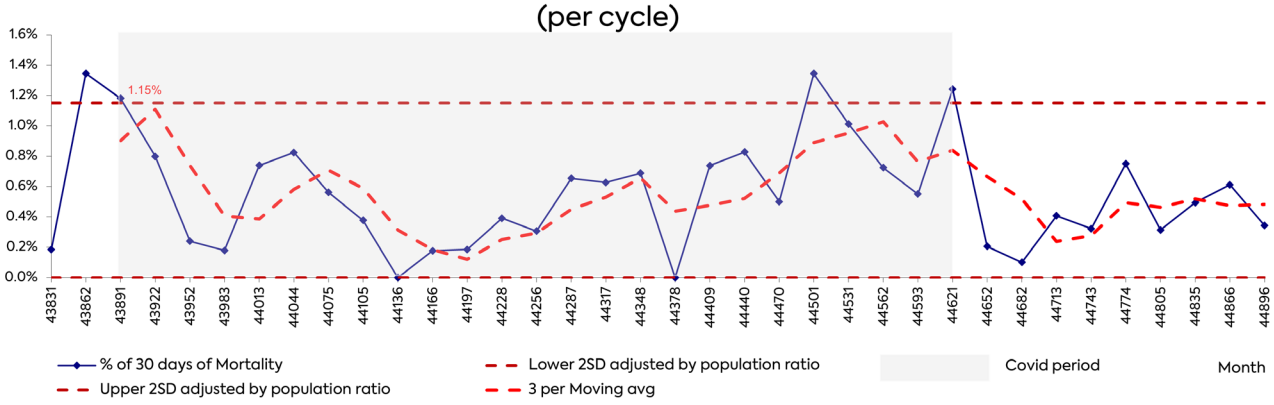
Each point on the graph below represents the percentage (trend estimates) of adult cancer patients (aged 15 to 99) who were alive five years after diagnosis. The data was averaged over 13 selected cancers by region over five years. The latest rolling data point covers patients diagnosed between 2016 and 2020 and followed up to 2021.



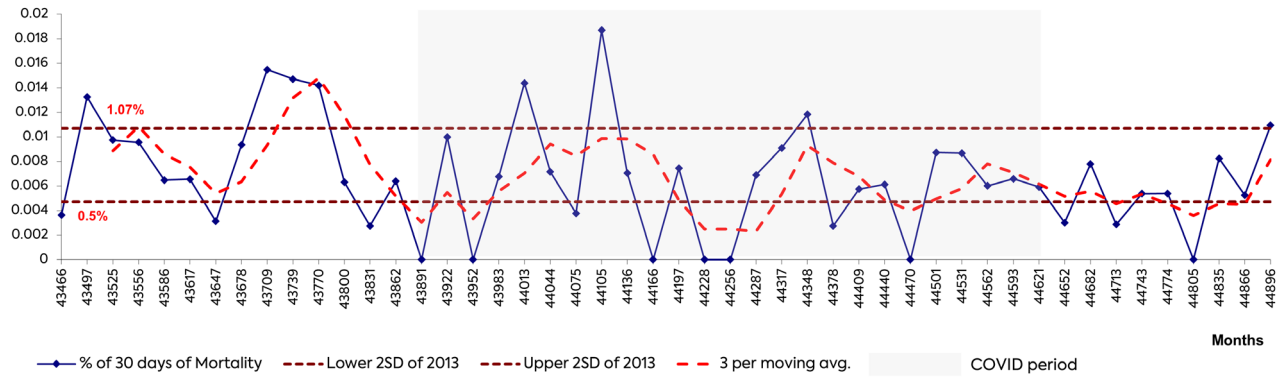




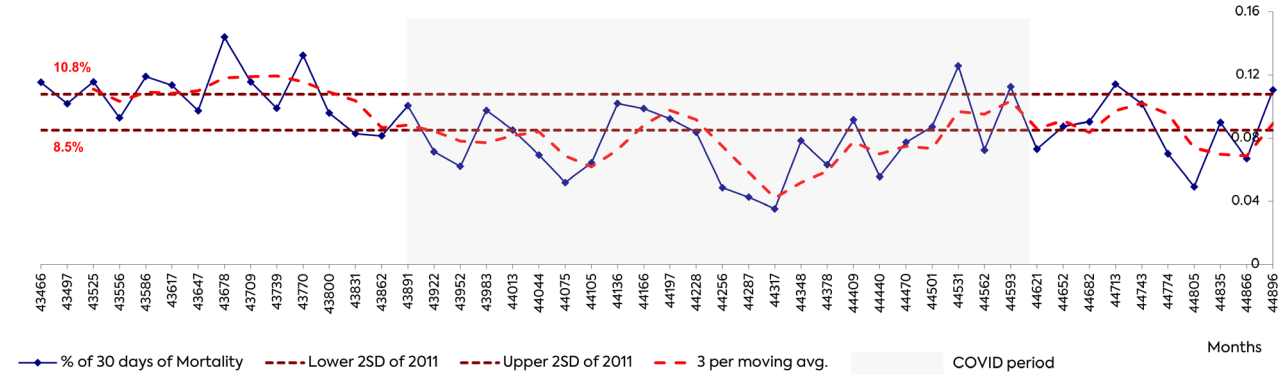
Haemato-oncology: Palliative chemotherapy 30 day mortality 2020-2022 (per cycle)



Overall radical radiotherapy 30 day mortality 2019-2022



Overall palliative radiotherapy 30 day mortality 2019-2022



Quality surveillance

The Quality Surveillance Team (QST) – formerly the 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 data shows that the outcome of patients receiving stem cell transplantation in CCC-Liverpool remains well above average compared to national outcomes and remain fairly consistent. However it must be noted that 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.

Key performance indicators (KPIs)

Quality data and metrics are monitored through the Trust Board Integrated Performance Report (IPR) and through performance and quality review processes. The Board, in consultation with stakeholders, has determined a number of metrics against which it can measure performance in relation to the quality of care it provides as demonstrated within our IPR.

We have chosen metrics which are relevant to our specialty (i.e. non-surgical oncology), driven by directives such as the NHS System Oversight Framework, and which are identified as important to the public.

The following table presents compliance against a number of key quality indicators, which are routinely monitored by the Trust.

Performance against additional quality indicators relevant to CCC

Indicator	2022/23	2021/22	2020/21	2019/20
18 weeks from point of referral to treatment (patients on an incomplete pathway)	97% (92%)	99% (92%)	98% (92%)	99% (92%)
28 day Faster Diagnosis Standard (formally monitored from Oct 2021)	82% (75%)	75% (75%)	N/A	N/A
62 day wait for first treatment from urgent GP referral for suspected cancer	80% (85%)	85% (95%)	91% (85%)	88% (85%)
62 day wait for first treatment from NHS cancer screening service referral	87% (90%)	86% (90%)	97% (90%)	87% (90%) KPI definition changed in 2019/20
Maximum 6 week wait for diagnostic procedures	100%	100%	100%	100%
'Never events'	0	0	0	0
Clostridiodes difficile (C.diff) – attributable	12 (annual 17)	14 (annual 11)	5 (annual 4)	11 (annual 4)
C diff cases per 1,000 bed days	0.39	0.58	0.24	0.47
MRSA bacteraemia cases per 10,000 days	0	0.42	0	0.43
Attributable category 2 or above pressure ulcers per 1,000 bed days	1.93	2.04	1.99	2.90
Patient Friends and Family Test: recommend the Trust for care and treatment	96%	96%	94%	88%

All indicators: Data source: The Clatterbridge Cancer Centre (CCC). Targets are shown in brackets

Our People Commitment

Our workforce – including staff, volunteers and students – are our greatest asset and are key to ensuring we continue to deliver high-quality care. The Trust is therefore committed to ensuring staff are supported, valued and have opportunities to grow and develop.

Our five-year People Commitment (2021-2025) is made up of five workforce pillars – Looking after our people, Valuing our people, Developing our people, Workforce for the future, and Digital Workforce – and outlines our plans for the next five years to build on our successes so far and to enable us to deliver our strategic priority to 'Be a great place to work'.

Equality, diversity and inclusion is the golden thread that runs through all five pillars. We recognise the importance of ensuring our workforce is representative of our local population and the importance of celebrating diversity and embracing inclusion.

The Trust is committed to creating the best culture for staff and our People Commitment is one of the key enablers for achieving this.

Staff survey 2022

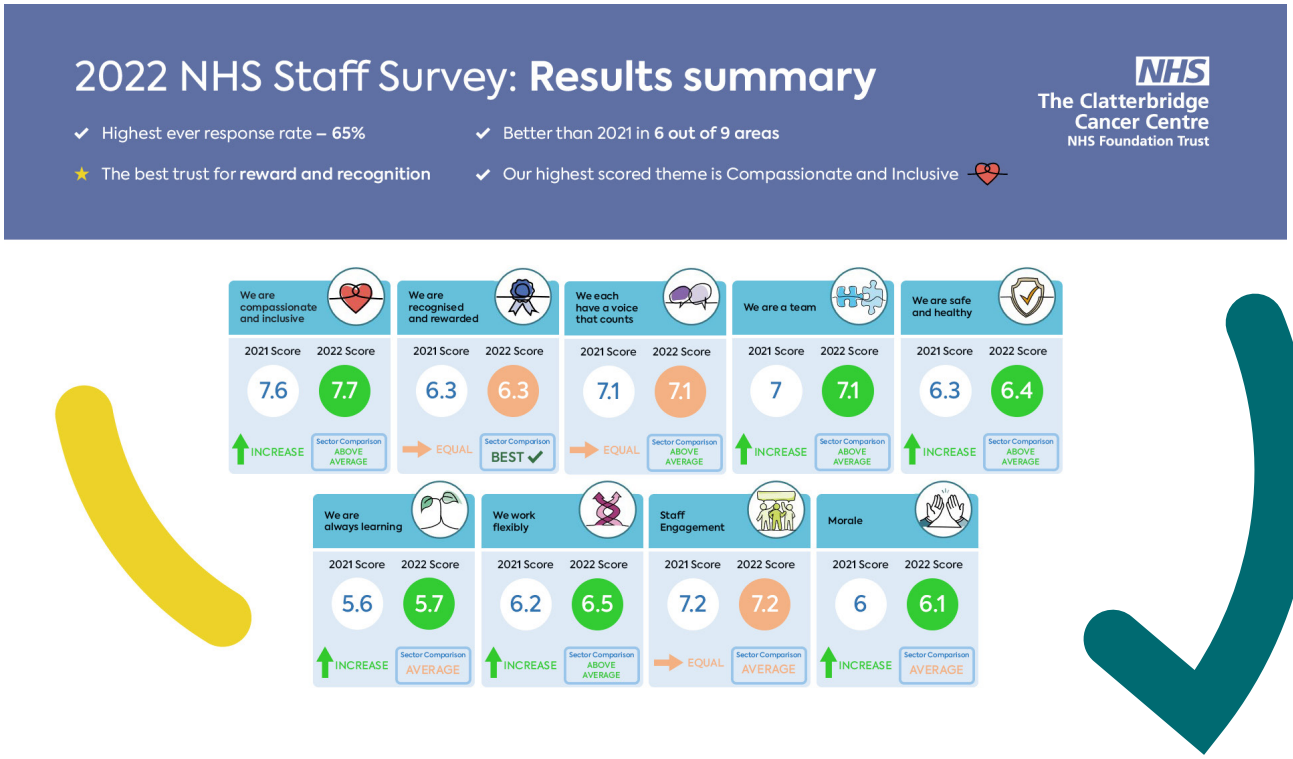
We are committed to listening to the views of staff and recognising their achievements on a regular basis. We believe that motivated and engaged staff deliver better outcomes for our patients and our ongoing aspiration is to improve levels of staff engagement on a year-on-year basis, as measured by the NHS National Staff Survey.

The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS 'People Promise' and retain the two previous themes of engagement and morale. These replaced the 10 indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

Our response rate for the 2022 staff survey was 65% (1,087), which is an increase of three percentage points from the previous year (62%) and significantly above the specialist acute sector median of 52%.

The staff survey results are categorised under seven primary NHS People Promise themes and two additional themes, staff engagement and morale, which are scored on a scale of 0-10 where a higher score indicates a better result.

Results



Headlines from the 2022 survey

We saw improvements in six out of the nine themes in comparison to 2021, with the other areas remaining the same as 2021. 'We work flexibly' saw the greatest in year improvement and 'We are compassionate and inclusive' remained the Trust's highest performing theme.

In comparison to our sector we scored:

- Best for 'We are recognised and rewarded'
- Above average for 'We are compassionate and inclusive', 'We have a voice that counts', 'We work flexibly', and 'We are safe and healthy'
- Average for 'We are always learning', 'Morale' and 'Staff engagement'

Feedback from external parties on The Clatterbridge Cancer Centre 2022/23 Quality Account

Comments from Healthwatch Liverpool

Healthwatch Liverpool thanks The Clatterbridge Cancer Centre for the opportunity to comment on the Trust's Quality Accounts for 2022/23. Despite being another challenging year for the NHS, we wish to commend the Trust on its performance against its quality priorities for the year, and its excellent performance in the latest NHS National Adult Inpatient Survey where it scored highest in the country for 10 questions, including questions covering waiting times for admission, being kept informed, privacy, pain control, staff communication, discharge instructions and ongoing care plans, respect and dignity. We know how important all these issues are to patients and we continue to receive extremely low levels of negative feedback about the Trust.

This is reflected in the low levels of formal complaints dealt with by The Clatterbridge Cancer Centre this year; only 53 (from approximately 35,000 patients), although the trend remains on an upward trajectory. We were interested to read the Learning From Complaints 2021/22 section and we support the introduction of an outreach model to address issues of concern raised by patients/family members as quickly as possible and to reduce formal complaints even further, to the benefit of the patients and the Trust. The merging of the complaints, PALS and claims functions and the introduction of a Complaints and Claims Manager is also welcome.

We understand that the ongoing impact of COVID-19 has continued to cause delays in early referrals to Clatterbridge from other NHS providers, and staff absences across the Trust, and that this is a significant factor in preventing the Trust from consistently meeting national cancer waiting times standards. However, we would like to see strategies for improvements in 2023/24. We would also be interested to know more about the impact/outcomes of the measures taken to reduce readmissions and unplanned admissions.

As we mentioned last year, we're particularly supportive of the work the Trust does around Learning Disability awareness training for staff, as well as on The Clatterbridge Cancer Centre's commitment to support for neurodiverse patients and those with dementia. We hope that the Helping Hands initiative will continue despite software challenges. We'd also still like to see more emphasis on other protected characteristics and inclusion.

Care Closer to Home continues to be a welcome clinical model, reducing the stress on patients and family members/cares.

We would also like to congratulate the Trust on recording zero Never Events this year, and on meeting its target of fewer than 17 cases of C.diff attributable to the Trust (14 cases were recorded). The hope for a reduction in C.diff cases is something we mentioned in our comments last year so we are particularly pleased that this has been achieved. However, the trajectory for E.coli has not been so positive so we are pleased to see that this is highlighted as a Quality Priority for 2023/24, along with reductions in Category 2 and 3 pressure sores and in falls. We also hope to see a decrease in cases of pseudomonas and klebsiella.

The achievement of 95% compliance in patients with suspected sepsis receiving antibiotics within one hour (against a target is 90%) is also worthy of note, as are consistent safe staffing levels.

We note that the number of safeguarding issues raised by staff increased from 74 in 2021/22 to 147 at the end of Quarter 3 of 2022/23, and we support the culture which allows staff to feel safe in raising their concerns.

We understand the reason for a primary focus on inpatient care within this document, but we would also be interested to know more about improvements to the quality of care for outpatients since these make up 95% of the Trust's patients. However, we note the consistently high monthly scores given for outpatient/day case services in the monthly Friends and Family Tests.

We would very much like to increase opportunities for Healthwatch Liverpool's involvement and dialogue around Patient Experience and Inclusion, listening to patient voices, Patient-Led Assessments of the Care Environment and co-production initiatives. We are particularly keen to conduct an on-site Healthwatch Listening Event as early as possible in 2023/24. We also hope to continue to have regular contact with the Cheshire and Merseyside Cancer Alliance team.

We congratulate The Clatterbridge Cancer Centre on its achievements in 2022/23 and we look forward to a continued positive relationship with the Trust over the year ahead.

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Ms J Gray
Director of Nursing
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1st June 2023

Dear Ms Gray

Re: Quality Accounts 2022 - 2023

I am writing on behalf of Cheshire and Merseyside ICB representatives along with NHSE/I Specialist Commissioning who had the opportunity to jointly comment on the Clatterbridge Cancer Centre (CCC) draft Quality Account for 2022-23. Partners express their thanks for the Quality account presentation that was delivered to Cheshire and Merseyside commissioners for 2022 – 2023 on Thursday 18th May 2023.

This letter provides the response from NHS Liverpool place as lead commissioner on behalf of Cheshire and Merseyside ICB colleagues.

Cheshire and Merseyside ICB recognise the pressures and challenges for the organisation and the local health economy in the last year following the move to the new Clatterbridge Cancer Centre unit. The transformation of cross site changing of services is also recognised.

We note the Priorities, key achievements and progress made in 2022 – 2023:

1. The Trust continues to enhance positive patient experience whilst achieving some of the highest patient experiences in the country. The Quality accreditation priority enabled the celebration of success and the recognition of staff within the in-patient wards. The framework has allowed the staff to focus their attention on delivering the evidence in relation to best care.

2. The Liverpool CCC building has provided additional privacy and dignity to patients which has been well received. The new premises have enabled additional clinical trials which will ensure enhanced care to patients in the future.

3. There was clear evidence of collaborative working with system partners – C&M urgent cancer care, community diagnostic centre amongst other initiatives.

4. The panel noted the advantages of having the CCC premises located next to Liverpool University Foundation Trust (LUFT) and Liverpool University allowing for collaboration, increased exposure to clinical trials and wider support to patients as required. This is an example of how co-locating Providers can enhance patient / family care. This proves to be a best practice within Cheshire and Merseyside locality and should be considered when reviewing estates and / or hospital moves.

5. Safer staffing levels have remained compliant throughout 2022 / 2023. Examples within the presentation identified opportunities to move across the organisation to enable safely managed services.

6. Significant development work has continued throughout CCC – virtual wards, outreach model to address issues at the earliest opportunity.

7. The initiation of personal thank you cards for the patients to share their journey and experiences via patient stories is an excellent example of positive practice and should be considered for sharing across Cheshire and Merseyside. Another example of positive practice identified within the presentation highlighted by the panel was Door to needle time for sepsis patients who are undergoing chemotherapy.

On behalf of Cheshire and Merseyside ICB / Liverpool place have noted and accepted the Trust's ambition and intention to continue the work in relation to maintaining CDiff targets below national predicted levels alongside wider infection prevention control priorities. The continued work with AqUA to develop safe care and experience of care including the reduction of falls risk will enhance the patient journey. The continued development of the quality accreditation programme will develop confident and resilient staff. The panel identified they would have benefited from the Trust including a Patient Safety Incident Response Framework (PSIRF) update.

Cheshire and Merseyside ICB / Liverpool Place recognises the challenges for providers in the coming year. We look forward to continuing working with Clatterbridge Cancer Centre during 2023 – 2024 as you continue to deliver improvement in service quality, safety, and patient experience, as well as continuing to strengthen integrated partnership working to deliver the greatest and fastest possible improvement in people's health and wellbeing within a strong, safe and sustainable health and care system.

Cheshire and Merseyside ICB / Liverpool Place would like to take this opportunity to say thank you to Clatterbridge Cancer Centre staff for their care, courage, and commitment to the ensuring the people of Liverpool, Cheshire and Merseyside receive high quality, safe and effective care and for your on-going commitment locally to system partnership working.

Yours sincerely

JL Lunt.

Jane Lunt
Associate Director for Quality and Safety Improvement
Liverpool Place

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