The Clatterbridge Cancer Centre NHS
NHS Foundation Trust

2014 - 2015

Quality and Business Intelligence Annual Reports

Contents:

Section 1

Introduction & Annual Report Executive Summary

NHS England provides a single common definition of quality which encompasses three equally important parts, stipulating that high quality care is only achieved when all three dimensions are present.

- Care that is **clinically effective**– not just in the eyes of clinicians but in the eyes of patients themselves;
- Care that is **safe**; and,
- Care that provides as positive an **experience** for patients as possible

Additionally The Care Quality Commission, as England's health and social care services regulator, sets out 5 key lines of enquiry which are used to assess services and ensure delivery of high quality care:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

This Annual report, compiled on behalf of the Trust by the Quality & Information Department, uses these parameters to identify multiple key examples of ongoing delivery of high quality care at The Clatterbridge Cancer Centre NHS FT during 2014-2015.

With the growth of the Trust's Business Intelligence function, supporting delivery of the organisations business, to include quality and service development, as well as commissioning and performance, this Annual report is sub divided into two distinct sections- the Quality Report and the Business Intelligence Report- for ease of reference.

The Quality & Information Department continues to work to support and engage staff across the Trust in the development and delivery of Trust-wide quality improvement programmes, aligned with regulatory requirements and the Trust's Quality Strategy. The Trust recognises providing high quality, effective and regulatory compliant care, whilst continually striving to improve our services and embrace new initiatives and technology, is vital in meeting the local and national expectations of commissioners and our patients. It is essential to provide safe, harm free, effective and patient centred care to achieve the best outcomes for our patients. It is also crucial to promote safe working practices of all staff, both clinical and non clinical, reducing risk and avoidable harm.

Responding to multiple key documents, to include the pivotal Frances Report (Francis, 2013) and Keogh Review (Keogh, 2013), the Trust has continued to be proactive in successfully embracing and addressing any identified areas of improvement and the implementation of

numerous change initiatives throughout the year to enhance our service and the patient experience.

The Trust is committed to ensuring its services meet the patient's needs through robust Clinical Governance arrangements, keeping the patient experience as central. The publication of the Trust annual Quality Accounts aim to enhance accountability to all stakeholders and ensure that a continuous quality improvement agenda continues to be a Trust priority. Work has continued throughout the year to embed and deliver on all regulatory standards, to include Cancer Peer Review measures, the ISO9001: 2008 Quality Management Standard and the Patient Information Standard. Delivery of the Care Quality Commission Fundamental Standards resulted in a green risk rating for the Trust, as identified in the CQC Intelligent Monitoring return. External auditing by the MIAA has been embraced in areas such as Information Governance, and awarded the Trust a rating of 'Significant Assurance' for the second year running, providing validation for the Trust self-assessment against the Information Governance Toolkit standards of 80%. The Trust's Clinical Coding service received an exemplary report from the Cheshire and Merseyside Data Quality and Clinical Coding Academy's audit of inpatient stays, whilst the Payment and Tariff Assurance Framework audit placed the Trust in the best performing 25% of Trusts.

New Nice guidance has been implemented as appropriate over the year and the Trust continues to participate in multiple national clinical audits. A vibrant programme of local clinical audits is also in place. Outcomes data has continued to expand in detail and complexity, supporting Trust activity, whilst external outcomes reporting has also increased, informing benchmarking of eg Systematic Anti- Cancer Therapy. The Trust's comprehensive mortality review programme continues to provide essential analysis and education opportunities for reviewing and improving practice-and celebrating best practice in patient care. Data accuracy continues to be prioritised to support all Trust business and the increased requirement for detailed business intelligence has resulted in a significant rise in contract monitoring and statutory reporting over the year. Development has commenced on supporting provision of a Trust Data Warehouse and EPR function, whilst also providing expert assistance in the TCC Activity modelling.

The Trust maintains compliance against the Freedom of Information Act 2000 and Environmental Information Regulations 2004. Additionally the Trust has maintained adherence to all Health, Safety and Security legislation, whilst rated green by NHS England for its Emergency Preparedness, Resilience and Response service.

Externally reportable risks and incidents remain low, however the Trust continues to challenge and investigate internally as appropriate, and self- assess against the Quality and Risk Management Standards. Patient experience continues a priority throughout and complaints remain low with positive feedback from the Friends and Family Test. A vital active volunteer service is provided which supports patients, carers and staff alike. A patient stories programme of presentations continues to inform the Board and Council of Governors regarding patient experiences, and the introduction of Safety Huddles to the Trust provide proactive management of safety issues in clinical areas. This is strengthened by the continued programme of Leadership Walkrounds, providing visible engagement by Board and Executive members in addressing patient safety issues at source.

The Trust continues to engage with the NHS Safety Thermometer, Sign Up to Safety and Global Trigger Tool initiatives, reviewing and reducing avoidable harm to our patients and promoting a culture of medicines safety. As members of the 'Open and Honest Care: driving improvement' programme, the Trust is committed to publishing data on outcomes and experience.

The Trust continues to invest in staff development to support timely patient care and since 2010, the numbers of Non -Medical Prescribers have continued to expand, with 27 NMPs registered and actively prescribing. These include registered Nurses, Pharmacists and On Treatment Radiographers. The Trust participated in the North West Clinicians Audit, which collectively established and assessed the value of NMP for our patient population, with positive results in the areas of:

- Patient satisfaction
- Improved outcomes
- Effective use of a highly skilled workforce
- Waste reduction
- Improvement in quality of patient care
- Cost efficiencies

The annual North West Organisational audit recognised the Trust for its robust clinical governance arrangements. The NMPs prescribing portfolios continue to expand, to include complex medications and chemotherapy prescribing.

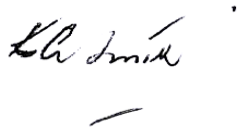
The Trust further continues to focus on improving patient experience, through provision of a Patient Group Directions education and training package for trained clinical staff from many disciplines. As a method of supplying and administering named medications to patients, without the need to see a doctor, this in house training programme continues to enhance our patient experience. There are currently over 200 PGD Practitioners trained and registered with a wide variety of medications now available to be supplied under PGD, to include analgesics, anti-emetics, contrast media and treatment site related creams. Also included are antibiotics for the immediate treatment of febrile neutropenia and sepsis. The PGD Practitioners are also actively engaged in the delivery of the Trust's annual 'flu vaccination programme.

The Trust successfully implemented a new competency, assurance and monitoring framework in January 2014 for all Health Care Support Workers, following the launch of mandatory National Minimum Training Standards by Skills for Care and Skills for Health. These standards set out the requirements for training, conduct and competencies expected of all support workers

Additional education, support and leadership opportunities have been made available to all Trust staff throughout the year. The Practice Development and Research Partnership with Chester University continues to promote learning and skills in evidence based practice, literature searching, audit and practice development initiatives, as well as supporting staff in active research activity. The theoretical framework underpinning the PDRP draws on the combined theories of Maslow (1943), Herzberg *et al* (1959) and Benner (1984). The PDRP

leads have applied for funding opportunities in order to progress three nurse-led research projects this year.

This Quality and Business Intelligence Annual Report aims to outline the key areas of work, aligned to the quality agenda, undertaken by all the Trust staff throughout 14/15, under the guidance and support of the Director of Nursing and Quality.



Kate Smith.
Head of Quality & Information

References:

Benner, P. (1984) *From novice to expert: Excellence and power in clinical nursing practice.* London: Addison-Wesley Publishing Company.

Care Quality Commission (2015). The five key questions we ask. Accessed from: http://www.cqc.org.uk/content/five-key-questions-we-ask

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: The Stationery office.

Herzberg, F., Mausner, B. & Snyderman, B. B. (1959) *The Motivation to Work*. New York: Wiley.

Keogh B (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. Accesses from: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

Maslow, A. (1943) A Theory of Human Motivation. *Psychological Review.* 50, pp. 370-96.

NHS England (2015). What do we mean by high quality care? Accessed from: http://www.england.nhs.uk/about/imp-our-mission/high-quality-care/

Quality Annual Report

Clinical Governance Report: Radiation Services

Executive Summary

Safe and effective

- Maintained registration to the ISO9001: 2008 Quality Management Standard
- Action plan produced to address 5 non-conformities raised at assessments this year
- 91% compliance with Internal Process Audit Plan
- The number of reported radiotherapy errors has increased by 20%
- The number of radiation incidents has reduced by 15%. None with harm associated
- 2 incidents reported to the CQC under IR(ME)R (1 Imaging and 1 Radiotherapy)

Caring and responsive

- Effective initiatives have been implemented to improve the experience of patients attending for single session palliative radiotherapy and of inpatients attending for radiotherapy.

Annual Report

Compliance with the ISO9001: Quality Management Standard

CCC has maintained registration to the ISO9001: 2008 Quality Management Standard across the Trust through 2014-2015. CCC still remains one of the only Trusts in the country to have achieved accreditation across all of its services. The Radiotherapy department has achieved unbroken registration since 1998 and the Trust as a whole since 2007.

Compliance with the IS09001 Quality Management Standard requires twice yearly assessment by an external certification body. Our certification body, the British Standards Institute (BSI) has undertaken two such assessments in October 2014 and March 2015, conducting reviews of the processes and controls across several clinical and non-clinical departments.

<u>October 2014 (2 days)</u>

Areas assessed at the 2 day visit in October 2014 included Physics input into Planning and Treatment, corrective action administration in response to incidents and patient feedback and recruitment within the Human Resources Department. Key elements of the assessment were reported as follows:

Physics: The assessor noted the fully documented comprehensive process and work instructions covering all physics activities.

QA - Comprehensive schedules have been developed to ensure the effective management of the QA and calibration of each piece of equipment. QA files and logbooks were effectively

completed and showed good communication between staff groups when issues were identified or resolved. Records were well maintained, in line with the plans and where delays/anomalies occur notes and concessions were raised.

The assessor observed one QA document that contained hand written amendments and therefore required formal updating along with an associated work instruction.

Planning - Patient records were used to demonstrate the planning aspects of the physicist role. Where queries were raised decisions and subsequent actions were comprehensively recorded.

Commissioning - Commissioning processes were reviewed in relation to the most recently introduced machine. Comprehensive records of commissioning measurements were viewed, including acceptance tests, commissioning tests and reports to support the findings.

Training - The assessor noted the robust training system with levels of competence defined. Training records were seen to be up to date and clearly determine the competencies required and skill levels of each member of staff completing the planning stages of the patient records viewed.

Corrective action administration: The assessor viewed evidence that demonstrated thorough investigation of complaints and incidents and also noted the positive feedback from patient surveys and the extremely encouraging results from the Friends and Family Tests.

Human Resources: The assessor commented on the significant work that has been undertaken to improve the recruitment processes. Discussions with staff showed a clear understanding of business objectives and demonstrated how the team had devised and implemented policies to select, develop and retain the right staff needed to meet these objectives. Processes and guidance documents have been designed and standardised and ensure conformity to all legislative requirements and provide support to all aspects of recruitment activity.

Non-conformities: No non-conformities were raised but a non-conformity related to document control remains open. The assessor noted that a significant amount of time and effort has been implemented to address document control issues and evidence of the identification and significance of the issue is presented at each review undertaken by each directorate. Therefore this issue has not been escalated but will remain open until confidence has been provided of effective control.

March 2015 (4 days)

The visit was undertaken by 2 assessors over 2 days, making it equivalent to a 4 day visit. Areas assessed included outpatient chemotherapy delivery, design and control of software within Physics, project management within Radiotherapy and Physics, Trust wide Service Improvement function and purchasing and control of suppliers within Finance. The

assessors also looked at internal audit, management review and leadership and communication.

In addition to this, a Strategic Review was carried out to ascertain the integrity of the Quality Management System during the current 3 year cycle. This included an interview with the Chief Executive to determine Management's understanding of and continued commitment to the Quality System.

Outpatient chemotherapy delivery – The assessor's report notes that Delamere was clean tidy and well organised and that staff were knowledgeable, enthusiastic and passionate about delivering a good service. Records were easily retrievable and well maintained and there was evidence of clear and concise verbal and written communication of instructions to patients.

The assessor commented on the significant improvement in recording of competency with the introduction of a comprehensive training matrix detailing training undertaken by all staff. Personal training files correlated with information held in the matrix, supporting the effectiveness of the system.

Specific elements of good practice were noted in several processes including the ordering of drugs, checking and cleaning of trolleys and the management of staffing at network clinics. Changes made to the latter have helped achieve continuity of care for patients at the clinics and stability for staff.

Software design and control – The assessor noted that the department have identified this as an area under review. A recent audit has shown that improvements are required in this area and a draft action plan has already been drawn up to this effect. The findings of the assessor supported those identified at internal audit.

Records for several software developments were reviewed and assessed for compliance with the local procedure with inconsistent results, e.g. for a change to the EYEPLAN proton beam planning software a clear summary detailing changes required and actions completed was evident. The report referenced files which provided a clear summary of testing. The files had been created using the defined templates and followed a logical sequence as defined in the procedure. Clear outcomes and exceptions were recorded along with unique references to the test back to a defined change. However the initial development of a BIOPROP script for the planning of prostate patients contained minimal documentation with little information with regards to request or approval details.

2 non-conformities were raised for the following reasons:

- The organisation are not consistently following their own defined procedure for software development and testing.
- The organisation has not accurately identified the key records requirements from the design and development process

Project Management – Again, the assessor noted that the department have already identified this as an area for review. Records for the management of several projects were reviewed and whilst some complied in full with the departmental change management procedure others lacked the necessary supporting documentation.

A non-conformity was raised for the following reason:

- The organisation are not consistently following their own defined procedure for development of new projects.

Service Improvement Function – Improvement projects undertaken on Delamere and in Radiotherapy demonstrated a highly effective approach to project management. Documentation shows thorough consideration of the initial issues. Solutions were devised, trialled and reviewed and stakeholders involved at all stages. The aim of the Radiotherapy project was to increase the number of inpatients treated within core hours and subsequent data analysis shows genuine gains in performance levels.

Purchasing and control of suppliers – After reviewing the current processes for initial assessment and continued evaluation of suppliers 2 non-conformities were raised for the following reasons:

- The organisation are not consistently following their own defined procedure for development of new projects.
- The organisation is not currently monitoring the performance of a key supplier for purchasing and materials management services.

Other comments: The assessors commented positively on improvements made in management review - mostly outside of radiotherapy as the process within radiotherapy has always been assessed as effective.

Significant improvements in compliance with the Trust wide audit schedule were also noted. Again, compliance within Radiotherapy and Imaging has always been good but has now improved across the Trust. The assessor also commented on the work ongoing within radiotherapy to maximize the benefits from audit and improve the efficiency of the audit process.

Non-conformities: Minor nonconformities usually have to be addressed before the next visit in 6 months but as this assessment came at the end of a 3 year certification cycle an action plan has to be submitted to BSI before a new certificate can be reissued. The action plan detailing the nonconformity, the cause and proposed corrective action, with responsibilities and timescales allocated, is provided below.

The completeness and effectiveness of the actions will be assessed at the next visit on 21st and 22nd October 2015. The main part of the next audit will be conducted by following a breast patient from referral to follow-up. The assessor will look at each service that contributes in any way to that patient pathway, including radiotherapy planning and delivery, chemotherapy and any diagnostic interventions.

Action plan to address non-conformities March 2015

NCR Ref	**1162879N1 Software Control and Design**		
Details	The organisation are not consistently following their own defined procedure for software development and testing. The procedure for software development (DPPS.ftwr.d13) requires use of a Software Development Form which was not being used consistently in the areas sampled. The procedure for software testing (DWPP.Test:d10) requires a formal testing programme to be created which was not being consistently created.		
Cause	Processes for recording development, testing and approval of software require review – processes currently inefficient, unclear and in some aspects provide inadequate assurance of control. Lack of training and guidance in processes for developing and testing software Lack of clarity re who is responsible for some steps in the process		
Proposed corrective action		**Responsibility**	**Timescale**
• Appoint a principal programmer, with a remit to ensure the quality of the entire software development lifecycle. • Define responsibility for producing test protocols • Add requirement to record the validation that the software has been correctly deployed. • Produce template agendas for the required standard meetings in the process in order to verify that the necessary documentation is being produced. • Consider risk based approach to software control and design and provide requirements for the authorization of software project to be appropriate for the associated risks. • Ensure all process documentation is updated to reflect amendments to process • Provide training to the project managers, programmers and testers in the newly defined systems. Training record to be developed to allow record of training to be kept. • Perform internal audit every 3 months for the first year following implementation of amendments to process, and annual audits thereafter.		Head of Physics Principal Programmer Principal Programmer Principal Programmer	30.4.15 31.5.15 30.6.15 31.7.16
NCR Ref	**1162879N2 Software Control and Design**		
Details	The organisation has not accurately identified the key records requirements from the design and		

	development process. The retention of records from the design process has not been accurately defined to enable controlled storage and retrievability. Completed forms were not available in several areas of the process and records for key activities such as installation of software and testing in the live environment had been identified.		
Cause	Lack of specification of where records should be kept Mix of paper and electronic records introduces inconsistencies and potential confusion to storage requirements Control currently compromised by retrospective authorization via signing of the software record by senior members of staff		
Proposed corrective action		**Responsibility**	**Timescale**
• Identify and utilize a single version controlled location for developing the code and project management documentation. • Utilise Q-Pulse (electronic Quality Management tool) to manage the storage, authorization and distribution of deployed and obsolete versions of the code and to allow raising and recording of known problems and change requests. • Remove retrospective approval of software projects and provide guidance to ensure that developments are approved at an appropriate level. • Move all current software code and development records into newly identified electronic systems.		Principal Programmer Principal Programmer	31.5.15 31.7.15
NCR Ref	**1162879N3 Process Change Management**		
Details	The organisation is not consistently following their own defined procedure for development of new projects. The procedure for development of new projects requires the creation of approved paperwork (Proposal, Meeting minutes) and submission of updates (3 monthly, post project) by the Project Owners. These were not being consistently completed based on the sample reviewed.		
Cause	Project documentation and reporting structure is no longer appropriate due to significant increase in proposed projects.		
Proposed corrective action		**Responsibility**	**Timescale**
• Location of project documentation to be reviewed to ensure it is accessible to all staff. • Templates to be trialled for all required project documentation – Project Brief, Project Initiation Document, Project Update Report, End of Project Report and Risks and Issue Logs. • Naming convention and system of		Clinical Governance Manager for Radiation Services	31.3.15 8.4.15 30.4.15 30.5.15

version control to be introduced
• Reporting structure to be improved –
  • Template for progress report to be developed.
  • Project Steering Board to be set up for in depth discussion and prioritization of projects.
  • Format of project spreadsheet to be reviewed to ensure it is easy to populate yet still fit for purpose.
• All changes to process to be incorporated into main project management procedure (APJDEVEL).
• Internal audit to be carried out against project management procedure to confirm actions have been implemented and are effective
		30.5.15
		
		30.8.15

NCR Ref	**1162879N4 Purchasing and Control of Suppliers**
Details	The organisation is not currently monitoring the performance of a key supplier for purchasing and materials management services. The SLAs and KPI's stated within the contract with the Wirral trust and not currently being monitored and the meetings held to review performance are not recorded.
Cause	Procedure (SLA) requires review. No formal process for monitoring KPIs or for recording performance discussed at meetings

Proposed corrective action	**Responsibility**	**Timescale**
• A revised set of KPIs to be developed in conjunction with Wirral University Teaching Hospital (key supplier). • KPIs to be formally monitored on a quarterly basis. • Evidence of monitoring to be recorded. • Performance Review Meetings to be minuted with clear actions. • Action plan to be formally agreed at Procurement Board 17.3.15. • Internal audit of process to be carried out to confirm actions have been implemented and are effective.	Finance Manager Finance Manager Clinical Governance Manager for Radiation Services	30.7.15 17.3.15 30.9.15

NCR Ref	**1162879N5 Purchasing and Control of Suppliers**
Details	The organisation is not currently approving, reviewing and evaluating all suppliers performance via a consistent process. The criteria for selecting suppliers, the methods of reviewing and monitoring their performance and records kept are inconsistent dependant on the nature of the suppliers with some records missing during the review.

Cause	Process for selection and evaluation of suppliers is unclear.

Proposed corrective action	**Responsibility**	**Timescale**
• Criteria for selection, evaluation and re-evaluation of suppliers to be developed in conjunction with Wirral University Teaching Hospital. • Process for selection, evaluation and re-evaluation to be documented in controlled procedure. • Internal audit of process to be carried out against selection and evaluation procedure to confirm actions have been implemented and are effective.	Finance Manager Clinical Governance Manager for Radiation Services	30.7.15 30.9.15

Compliance with Internal Process Audit Plan for 14-15

Department	Planned Audits	Completed Audits
Clinical Effectiveness Team	**11**	9
Medical Records	**20**	20
Diagnostic Imaging	**15**	14
CReST	**13**	12
Pharmacy	**4**	3
Radiotherapy/Physics	**15**	14
Medical devices	**2**	0
Clinical Governance	**19**	18
In-patients	**22**	22
Out-patients	**5**	5
Delamere & satellite clinics	**10**	8
Theatre	**6**	3
Human Resources	**11**	11
Total	**153**	**139 (91%)**

We have continued to see a year on year improvement in compliance with the pre-planned audit programme. Compliance has risen from 82% last year to 91% this year. The establishment of the monthly Process Audit Sub-committee has been particularly successful in its objectives of improving and monitoring compliance with the audit plan and ensuring identified actions are carried through to completion. Radiotherapy and Imaging already have local meetings at which audits are reviewed. Plans are in place for the Integrated Care and Chemotherapy directorates to introduce local audit review meetings by the end of quarter 1 2015/16.

Internal Auditor training

There have been 9 internal auditors trained this year. All attended a 2 day internal auditor course in January 15 delivered by BSI.

It is intended that an in-house internal auditor training programme will be developed and rolled out during 15/16.

Audit management using Q-Pulse

Although compliance with the audit schedule is much improved across the Trust, the process for managing the schedule and tracking actions to completion is labour-intensive and inefficient. The data-base used for managing incidents, Q-Pulse, also has a function for managing audits and work has been undertaken this year to develop the use of this function at CCC. The processes for scheduling the audits, adding appropriate details such as scope and audit leads, attaching of reports and raising of non-conformities has been determined, set up and tested in Q-Pulse. All audits on the 15/16 schedule have been added to Q-Pulse in preparation for management of audits and actions to be carried out electronically this year.

Quarter 2 15/16 will see training of auditors to access and record information for audits that they are responsible for and training of heads of section to locate audit reports and access and respond to non-conformities.

Incident Reporting

CCC uses the nationally recommended system for grading and classification of errors as described in 'Towards Safer Radiotherapy (TSRT)' Royal College of Radiology Ref No BFCO (08).

In the terminology employed by TSRT a radiotherapy error is any non-conformance occurring within a radiotherapy process where there is an unintended divergence between a radiotherapy treatment delivered or a radiotherapy process followed and that defined as correct by local protocol. Most such deviations from protocol do not result in radiotherapy incidents. A radiotherapy incident is a radiotherapy error where the delivery of radiation during a course of radiotherapy is other than which was intended by the prescribing practitioner.

Radiotherapy errors are graded in accordance with severity from level 1 to level 5 (high to low)

Level 1: A radiation incident that is reportable under IR(ME)R

Level 2: A radiation incident that is not reportable under IR(ME)R but may have some actual or potential significance for patient

Level 3: A radiation incident of no actual or potential clinical significance for the patient

Level 4: Near miss: This is a potential radiation incident that is picked up and corrected before treatment delivery but after the script/plan has been authorised for clinical use

Level 5: A non-compliance with some aspect of a documented procedure which does not directly affect radiotherapy delivery

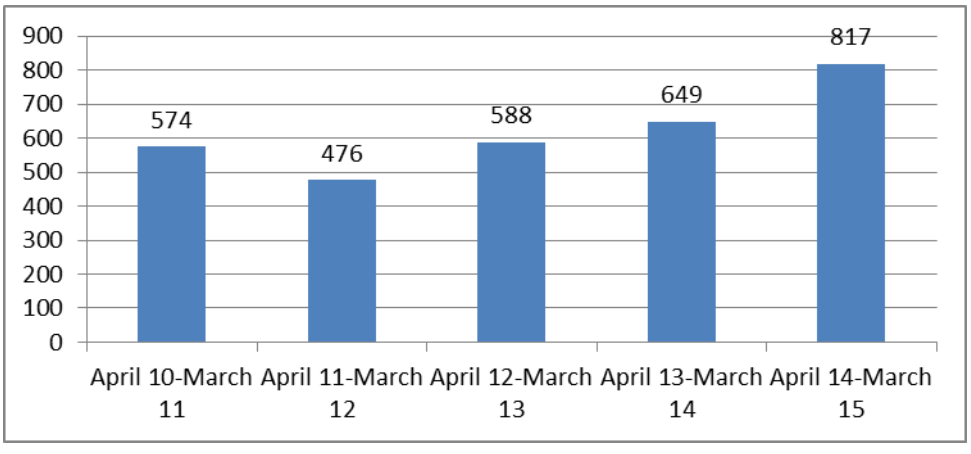
In order to enable classification of the points where radiotherapy errors occur, TSRT breaks down the radiotherapy pathway into constituent elements and assigns each

one a code. This enables the department to produce a clear picture of where problems originate and to direct improvement actions accordingly.

All radiotherapy errors are reported to the NRLS where they are picked up by the Radiotherapy arm of Public Health England who carry out trend analysis on a national basis and feedback data to the radiotherapy community.

Incidents reported 1-4-14 to 31-3-15
During this period there were 2358 incidents reported across the Trust.
1064 of these were reported by the staff within the radiotherapy department, including Physics, with 817 of these designated radiotherapy errors, i.e. describing a problem that originated on the radiotherapy pathway.

The graph below shows the number of radiotherapy errors reported over the last 5 years



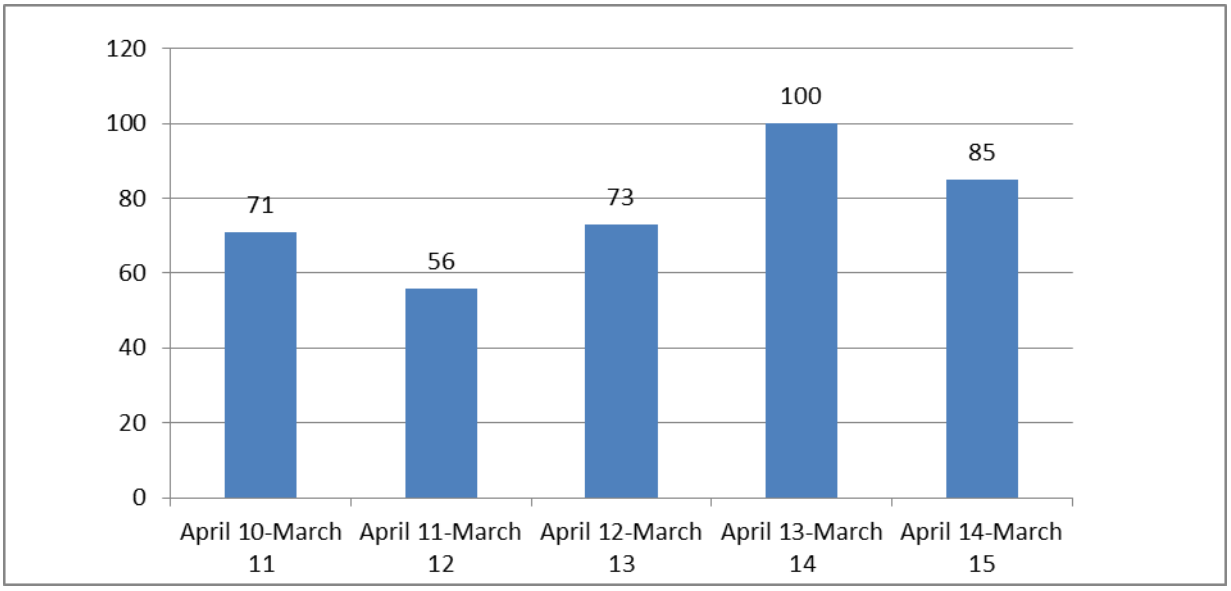
During this year, 85 of the 817 radiotherapy errors were classed as radiation incidents. None of these incidents were considered to have caused actual or potential harm to a patient.

83 were classed as level 3 and 1 as level 2.

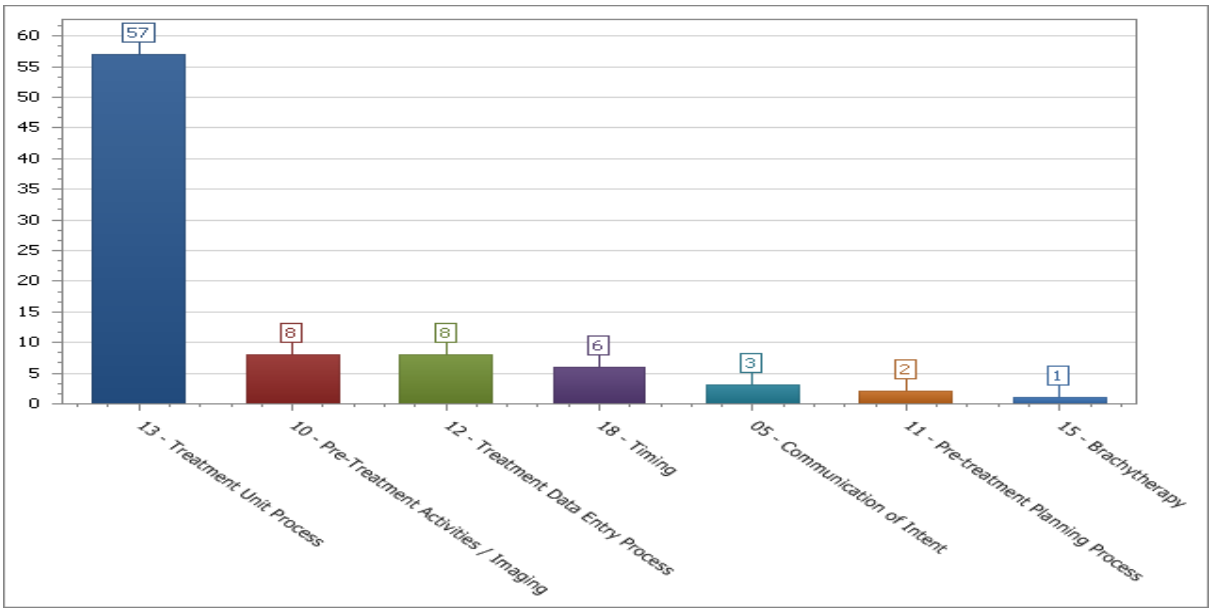
2 level 1 incidents have occurred during this time period (December 2014 and March 2015). Both have been reported to the IR(ME)R Inspectorate at CQC.

Incident reviews are held for all level 1 and 2 incidents in adherence with the Trust's Incident Reporting Policy. All actions attached to the March incident have been completed to the satisfaction of the IR(ME)R inspectorate who have now closed their file on this incident. The December incident remains open.

The graph below shows the number of radiation incidents reported over the last 5 years.



The graph below shows the primary process points on the radiotherapy pathway where the initial failures resulting in radiation incidents have occurred. It can be seen that the majority of initial failures (57) occur in processes concerned with actual delivery of treatment



Comparison with national data

The most recent data analysis report published by Public Health England contains data from December 2014 to March 2015. 56 of the 60 UK centre submitted incident data during the 4 month period in question. There were 1851 radiotherapy errors reported nationally during this period. CCC reported 314 which is 17% of the national total.

There were 615 radiation incidents reported during the same period. CCC reported 40 which is 6.5% of the national total.

Severity grading

The table below shows the percentage of incidents reported at each level (1-5) nationally and locally.

Levels	*% of nationally reported incidents*	*% of locally reported incidents*
1	*2.5%*	*0.6%*
2	*1.8%*	*0%*
3	*29%*	*12%*
4	*30%*	*36%*
5	*36%*	*51%*

Although CCC contributes significantly to the number of radiotherapy errors reported nationally it can be seen from the table that CCC reported errors are far more heavily weighted to levels 4 and 5 (near miss or general non-conformance) in comparison to the national data. This is indicative of an effective incident reporting culture, suggesting that issues are reported early and addressed before they develop into incidents with the potential to cause patient harm.

Further analysis with the national data continues to show a reassuring correlation between the types of incidents occurring at a local and national level, e.g. the most commonly occurring process sub codes (pathway points) are those related to the production, approval or recording of on-set images.

All incidents at CCC continue to be reported on paper and input manually into the local incident database (Q-Pulse). It is hoped that a local electronic incident form will be available by the end of quarter 2 2015/16. Its introduction will enable staff to complete incident forms on line which will then be directly submitted to the database. Automatic notifications from the database will ensure that relevant

managers are made aware of all incidents, can acknowledge their receipt and electronically update actions.

Governance supported developments in Radiation Services

Novalis certification
In April 2014 CCC became one of the first three hospitals in the UK to be granted Novalis certification after successfully undergoing an independent audit of their stereotactic service through the Novalis Certification Programme developed by BrainLab. This is a peer review evaluation that focusses on procedures and protocols that emphasises continual self-assessment and quality improvement.

Breath hold technique for all left sided breasts
A local project to assess the effectiveness of breath holding in breast patients during radiotherapy treatment led to the recommendation that breath holding be used for all left sided breast patients. Investment in equipment and training during this year means that we are now ready to implement this service fully in quarter 1 of 15/16.

Equipment
Our first Varian Edge linear accelerator was accepted and commissioned during this year. It is expected to be brought into clinical use in April 2015. We will be able to benefit from some of its more advanced features once back up is provided by the second Edge which is due to be commissioned during 2015.

A PET/CT is currently being commissioned within the imaging department and it is expected that this will be brought into clinical use by the end of quarter 2 15/16

Paperless working
Preparations have been made for the introduction of electronic approval of plans and electronic checklists. The focus during this year has been on ensuring that these changes can be made safely. Risk assessments have been completed, process documents written and staff training carried out. Both initiatives are expected to be introduced in quarter 1 15/16.

Palliative Radiotherapy Clinic
The poor experience of some patients attending for palliative treatment from other hospital has prompted the introduction of a weekly palliative radiotherapy clinic. Patients can be referred directly to the clinic's lead clinician from April 2015. They will be assessed, planned and treated on the same day and, between interventions, will wait in a dedicated room manned by trained staff. Communication pathways with host hospitals have been improved to ensure that patients arrive with the necessary documentation, medication and with a trained escort. CCC staff have taken responsibility for booking transport for these patients so that the most appropriate mode of transport is booked. This has already greatly reduced the number of patients experiencing an unacceptable wait for return transport.

On the day waits
Work has continued to be carried out within Radiotherapy this year to address the ongoing problem of long on-the-day waits for patients. The percentage of patients

waiting 30 minutes or less for treatment has increased from 42.8% in June 2013 to 76.9% in February 2015.

In patient appointments

The Service Redesign team has led a project this year to improve the experience of patients attending for radiotherapy who are inpatients at CCC. The main focus of the project was to ensure that inpatients, who are often the most poorly patients that we treat, are given appropriate and consistent appointment times. The pilot introduced a redesigned pathway for inpatient radiotherapy treatments for three months and demonstrated excellent results with an improvement of 24% in patients being treated within core hours. Phase 2 of the project to roll out the redesigned pathway across the whole of the radiotherapy department for the benefit of all patients on all wards is currently underway.

Imaging safety initiatives

The Imaging department within the Radiation Services Directorate have introduced 2 major quality and safety initiatives during this year.

A quarterly Quality and Safety Meeting has been introduced which encompasses a wide range of governance issues including incidents, audits, risk assessments, radiation protection, staffing, training, document control, health and safety and infection control issues.

A daily “safety huddle” has also been introduced for each modality which enables staff to review the worklist for that day and encourages staff to be proactive in identifying and addressing any potential difficulties with individual patients, imaging techniques, staffing levels and skill mix. This reduces the risk of having to react to unanticipated problems that may be detrimental to machine efficiency or patient safety.

Clinical Governance Report: Regulation

Executive Summary

Safe, Effective, Caring, Responsive, Well-led:

- **CQC compliance with regulation and inspections** – No formal inspection by CQC in 2014 we anticipate an inspection in the near future. Mock inspection process underway.
- **National Peer Review** – A number of teams underwent self-assessment. Brain CNS, Chemotherapy/pharmacy/intrathecal services were compliant with measures.
- Action plans in place for CUP, Sarcoma, and TYA teams.

Safe, Effective, Well-led:

- **QINC** – Highlighted areas for development around poor documentation. Documentation workshops set up to address this.

Safe

- **Consent**- improvements noted in the annual audit of consent to treat processes.

Annual Report

Registration against Care Quality Commission Fundamental Standards
This replaces the previous CQC Essential standards of Quality & Safety from April 2015 and incorporates the following:

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Care Quality Commission (Registration) Regulations 2009 (Part 4)

The CQC have changed the way that they perform inspections. The new Fundamental standards are based around 5 key questions, are we:

- Safe?
- Effective?
- Caring?
- Responsive to people's needs?
- Well-led?

The Trust was not inspected in 2014 and we expect this to take place after the introduction of the new standards.
In response to this a series of mock inspections were undertaken in all areas of the Trust to establish levels of compliance with the new standards. These inspections proved very beneficial and enabled areas of non- compliance to be addressed.
The inspection teams used a standard set of KLOE's (key lines of enquiry) that enabled them to make judgments about the quality of services provided and

determine ratings for the service based on the 5 key questions. Areas were rated as outstanding, good, requires improvement and inadequate.
Inspection teams comprised of an “expert by experience” who interviewed patients and relatives, inspectors(with clinical and governance backgrounds) who interviewed staff and a “lead” inspector who interviewed managers and observed practice.
There were a number of areas that were rated as requires improvement in one element. In imaging and CCCL there were issues around staffing. In Delamere, satellite clinics, outpatients and radiotherapy there were concerns regarding the safe storage of medicines. Action plans are in place to address medicines security.
There were however a number of areas that were rated as outstanding overall; these were End of life care, Wards, TYA and children. These departments had achieved outstanding and often elements of care demonstrated were “above and beyond”.
The Fundamental standards are as follows:

Regulation	Title and summary of regulation
5	**Fit and proper person: directors** People who have director level responsibility for the quality and safety of care and for meeting the fundamental standards are fit and proper to carry out this important role.
6	**Requirement where the service provider is a body other than a partnership** Nominated individual responsible for supervising the management of regulated activity.
7	**Requirements relating to registered managers** Good character, necessary skills, competence and experience to manage regulated activity.
8	**General** Every regulation must be met for each regulated activity
9	**Person-centred care** People experience effective, safe and appropriate care, treatment and support that meet their needs and reflect their preferences.
10	**Dignity and respect** People are treated with dignity and respect at all times while they are receiving care and treatment. This includes providing privacy, treating them as equals and providing support.
11	**Need for Consent** People give consent to their care and treatment, before it is provided. Providers must obtain consent lawfully and have the knowledge and understanding of the care they are seeking consent for.
12	**Safe Care and treatment** To prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.

13	**Safeguarding service users from abuse and improper treatment** To safeguard people who use the services from suffering from abuse or improper treatment.
14	**Meeting nutritional and hydration needs** People are encouraged and supported to have sufficient food and drink that is nutritional and balanced, people must have a nutritional assessment and a choice of food and drink to meet their different needs.
15	**Premises and equipment** People receive care and treatment in areas that are clean, suitable for the intended purpose, equipment must be maintained used properly and stored securely.
16	**Receiving and acting on complaints** Providers must have an effective, accessible system for identifying, receiving, handling and responding to complaints. All complaints must be investigated thoroughly and action taken where failures identified.
17	**Good Governance** Providers must have effective governance, including assurance and auditing systems or process that assess monitor and drive improvement in the quality and safety of the services provided.
18	**Staffing** To provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people who use the service.
19	**Fit and proper persons employed** Providers must operate robust recruitment procedures and ongoing monitoring of staff to ensure staff remain able to meet requirements.
20	**Duty of Candour** Providers are open and transparent with people who use the service. Providing information, support, and an apology if things go wrong.
20A	**Requirement as to display of performance assessments** Providers must ensure their ratings once they have been inspected are displayed conspicuously and legibly at each location and on the website.
12	**Statement of purpose** Providers must send to CQC statement of information and notify any changes.
13	**Financial position** Providers must have the financial resources needed to provide the services described in the statement of purpose.
14	**Notification of absence** Assurance that the service will continue to be properly managed if the person in charge is absent

15	**Notice of changes** CQC must be notified of specific changes in the running of the service to provide assurance that appropriate action taken.
16	**Notification of death of a service user** CQC must be notified of deaths that occur whilst services being provided in the carrying on of a regulated activity or as a result of such.
17	**Notification of death or unauthorised absence of a service user who is detained or liable to be detained under mental Health Act 1983** CQC must be notified of death/unauthorised absence of a person who is liable to be detained under Mental Health Act 1983
18	**Notification of other incidents** CQC must be notified of incidents that affect the health, safety and welfare of those who use the service.
19	**Fees** Providers give people who use services timely and accurate information about the cost of their care and treatment where they are paying for their own treatment.
22A	**Form of notification to the Commission** Notifications must be made using the forms provided by the Commission.

Robust systems are in place across the trust to ensure the trust maintains it registration with the CQC. Each of the CQC fundamental standards has an assigned lead/s who has supplied evidence to describe how the Trust is compliant with each standard. A database of the compliance and any associated action is maintained by the Clinical Governance Manager (Regulation). A central evidence repository allows the evidence cited to be made available quickly in the event of an inspection.

The Trust also receives an Intelligent Monitoring return from the CQC which details areas of risk based upon data collated about The Clatterbridge Cancer Centre from external sources. A summary of this report is sent to the integrated governance bi-month detailing any identified risks and actions taken to mitigate them. The risk estimate across all outcomes was green in 2014/15.

Development of Robust System for managing consent to treatment processes

Consent training is now a component of mandatory training for all clinical staff.

The annual audit of compliance with the consent to treat process was undertaken. This audit highlighted that there had been significant improvements in the giving of written information but that there needed to be some development regarding the confirmation of consent.

The policy and standard operating procedure relating to consent to treat processes have been updated and reissued.

Quality in Nursing at Clatterbridge

Following on from work started in 2010/11 around the QINC (Quality in Nursing at Clatterbridge) Audit Tool, QINC has now been running for 4 years at CCC.

In 2014/15 7 key areas were identified for improvement or development and data has been collected for these key areas from a number of sources. Working groups and ward managers developed action plans for each area and there has been improvement across the trust in a number of areas.

Audit results highlighted some areas of poor documentation. Documentation workshops have been set up to address this issue and a number of staff have received training.

The key areas identified are detailed below:

Definition of risk area
Incidence of in-patient falls
Quality of Documentation
Pressure Area care
Person centred care
Discharge / Transfer planning
Medicines Management
Understanding of processes for: Dementia assessment /friends and family survey /incident reporting and correct documentation of patients property

Manual for Cancer Services (Peer Review)

The Cancer Peer Review process is designed to assess the quality of cancer services. The Manual for Cancer Services produced by the National Cancer Action Team contains a number of measures against which teams are reviewed for compliance.
In the 2014 Peer Review cycle the service attained the following levels of compliance:

Team undergoing Peer review	2014 Performance
TYA PTC Core	67 % at self-assessment

TYA PTC MDT	64% at self-assessment
CUP MDT	73 % at self-assessment
Brain CNS locality group	100 % at self-assessment
Chemotherapy services MDT	97 % at self-assessment
Oncology pharmacy services MDT	100% at self-assessment
Intrathecal chemotherapy services	100% at self-assessment
Sarcoma locality group	75% at self-assessment

Actions taken by teams scoring less than 90% at peer review

TYA – Teenage and Young Adult
TYA performed poorly for both their MDT and Core services due to a lack of germ cell representation on the TYA MDT and a lack of dedicated dietetic, physiotherapy or occupational therapy support. In response to this, a germ cell consultant has now been employed, it is anticipated that this consultant will sit on the TYA MDT. In regard to the levels of support provided by allied health professionals the numbers of TYA patients in the centre do not require a dedicated service; however the quality of the service provided will be audited. There was also a concern that patient feedback was not collected. This has now been addressed and a new patient feedback system has been launched.

Sarcoma
The Sarcoma team were non- compliant in relation to the lack of evidence that a bone pathway was in place.
This has now been addressed and a new pathway is in development.

CUP – Cancer of Unknown Primary
CUP had a number of non-compliances relating to core membership and MDT core member attendance; this is due to a lack of radiology and pathology cover. Currently there is only one of each speciality in post and therefore cover for leave poses a difficulty. This still remains an issue. There was also a concern regarding a lack of evidence of treatment planning. This has been addressed and there are new forms in place to correct this. Work is ongoing to improve attendance at MDT's and to ensure appropriate cover is in place.

Clinical Governance support and advice was provided to the Integrated Care directorate in the following key areas:

- Monthly governance report provided to the Integrated Care directorate.
- Attendance at monthly Integrated Care directorate meetings.
- Weekly meeting with general manager of Integrated Care.
- Provision of a quarterly clinical governance report for directorate performance review.
- Clinical Governance support with audit processes.

- Establishment of a bi-monthly audit group to manage and monitor audit in the directorate.
- Managing and investigating incidents within the Integrated Care Directorate.

Clinical Governance Report: Medicines Safety

Executive Summary

Safe and effective

- Improved yellow card reporting
- Reduced number of omitted does in the in-patient setting
- Increased medicines related incident reporting
- Establishment of a bi-monthly audit group to manage and monitor audit in the directorate.

Well Lead

- Establishment of a bi-monthly audit group to manage and monitor audit in the directorate.

Annual Report

Background

In recent years a key focus for The Clatterbridge Cancer Centre (CCC) is the development and implementation of a strategic medication safety plan. A medicines safety Team was appointed in September 2013 and it was agreed they would focus its activity based on following 7 point strategic medication safety plan:

- Create, communicate, and demonstrate a leadership-driven culture of safety.
- Improve error detection, reporting, and use of the information to improve learning from medication incidents in order to improve medication safety and establish a fair blame culture
- Evaluate where technology can help reduce the risk of medication errors.
- Reduce the risk of errors with high-alert medications prescribed and administered to high-risk patient populations or at vulnerable periods of transfer through the health care system.
- Involve the patient in medication safety initiatives and medication self management programs.
- Establish a controlled formulary in which the selected medications are based on safety
- Move towards Harm Free Care within the Trust.
- Create, communicate, and demonstrate a leadership-driven culture of safety

Medicines Safety Group (MSG)

The MSG (whose membership includes the MST with the addition of representatives from multi-disciplinary teams whom have a designated interest in medicines safety) has met bimonthly to discuss incidents identified through incidence triaging and other medicines safety issues. The outcomes and actions from these discussions is reported to the Drugs and Therapeutics Committee.

Attendance of the medication safety group meeting earlier in 2014 was acknowledged to be poor, particularly the attendance of nursing representatives.

However attendance in the last quarter of this year has improved significantly as a result of the promotion of medication safety as a key priority for the trust by the MST. The MSG is now acknowledged as an important forum for discussion of medication safety related topics for multiple staff groups.

Medicines Safety Teaching

With the cooperation of the Learning and Development Medicines Safety teaching has been extended to all staff groups who are regularly involved with medication, including updated medicines security information and incidence and yellow card reporting promotion. Feedback from staff on the updated Medicines Safety teaching has been very positive and both areas on reposting discussed have improved across the trust.

- **Improve error detection, reporting, and use of the information to improve medication safety**

Implementation of NPSA Alert NHS/PSA/D/2014/005 " Improving medication error incident reporting and learning"

Following the 2014 Patients Safety Alert the MST has built upon a year's experience of implementing the Improving medication error incident reporting and learning plan. Improved incident reporting was successfully realised, however a gap was identified between an incidence being reported and actions undertaken to reduce likelihood of repeat incidences. A follow up report template for all medicnes incidents is now in use to bridge his gap and is being used with much success.

Incident Triaging

Ongoing bi- monthly triage all medicines related incidents is in place in order to ensure incidents are categorised and managed appropriately, to assist with trend identification and highlight incidents for further action.

A list of medicine incidents is also provided to members of the MST before each meeting to enable any incidents which may be of concern to be raised.

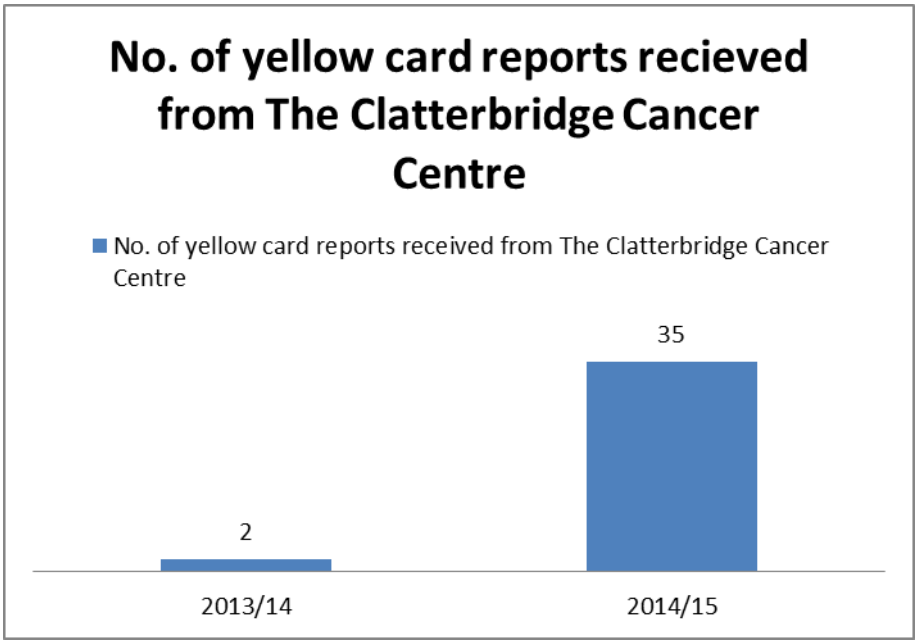
Incident reporting related to medicines

An objective of the MST in 2014/15 was to increase incident reporting and this has been achieved.

In 2013-14 315 medicine related incident were report and this increased to 446 medicines related incident in 2015/16.

Yellow Card Reporting

Increased yellow card reporting is a major component of the medicines safety plan. In the past year the MST has rolled out yellow card training to targeted staff groups including medical, acute oncology and allied health professionals. The MST has also ensured that yellow card reporting has named leads in medical pharmacy and nursing staffing. As well as working trust wide the MST has also worked with Liverpool Health Partnership. As a result of these measures yellow card reporting has dramatically improved as illustrated in the graph below:



- **Evaluate where technology can help reduce the risk of medication errors**

Electronic Pharmacy Intervention System
A new electronic database to capture pharmacist interventions has been introduced within the pharmacy department, including the launch of a risk rating for each intervention. The database is being used to feed back to prescribers interventions made to improve medication safety for patients.

Escribe (Ascribe Electronic Prescribing)
98% of all chemotherapy prescriptions at CCC are now in an electronic format (with the exemption of trial prescriptions). This has improved medication safety in relation to evidence based regimen prescribing and better nursing documentation of administration. However, no prescribing system is completely error free electronic prescribing is no exception. Different errors to the previous ones identified with paper prescriptions have been identified and risk reduction mechanisms have been needed.

Measuring Height and Weight
There have been a number of incidents related to the incorrect recording of patient heights and weights leading to patient doses of chemotherapy being calculated incorrectly. Following a detailed investigation a number of action were agreed including the purchase of electronic scales and stadiometers with the capacity to autofill metrics in electronic prescribing system (Meditech).

EPR Project
The MST are actively engaging fully with the team responsible for the new EPR system to ensure medicines safety is fully integrated. The clinical governance manager medicines safety is a member of the EPR clinical reference group and regularly attends meetings.

- Reduce the risk of errors with high-alert medications prescribed and administered to high-risk patient populations or at vulnerable periods of transfer through the health care system

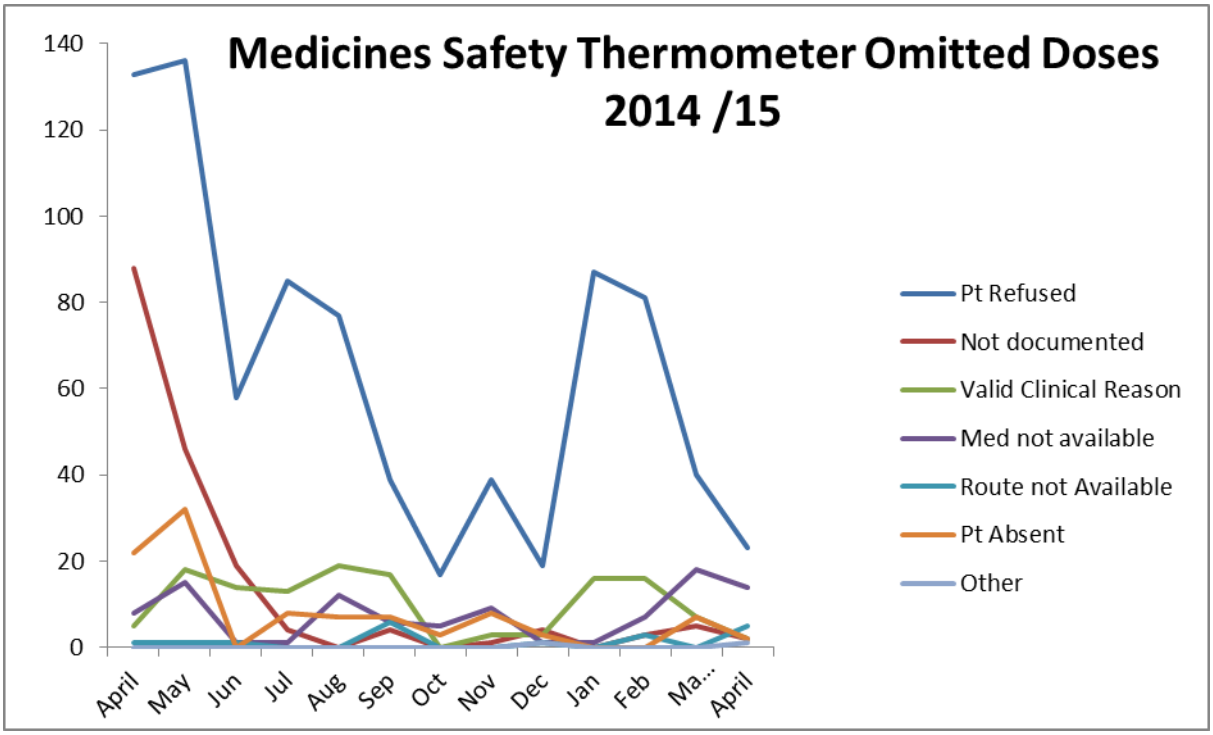
NHS England Safety Alerts related to medicines

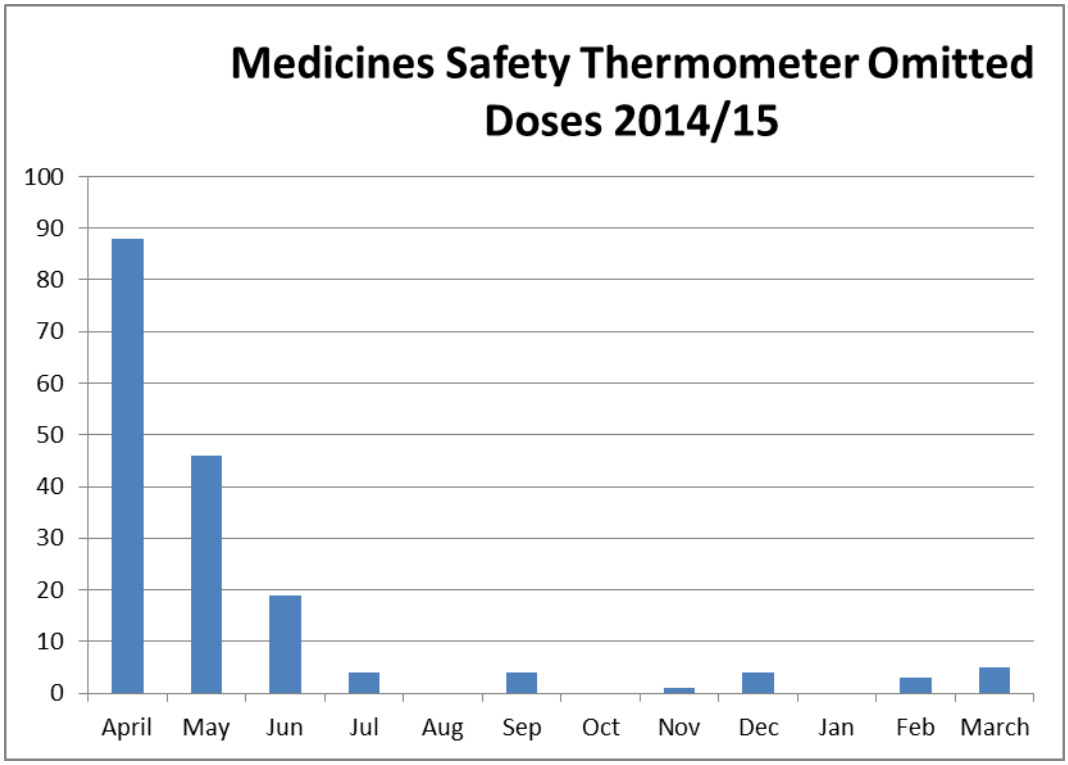
The MST in crucial in ensuring NPSA alerts for high risk medications are implemented in an appropriate and timely manner. NPSA alerts actioned this year include

- Risk of death from asphyxiation be accidental ingestion of fluid/food thickening powder
- Harm from using Low Molecular Weight Heparins when contraindicated
- Risk of death and serious harm from delays in recognizing and treating ingestion of button batteries
- Risk of death or serious harm from accidental ingestion of potassium permanganate preparations
- Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid or opiate treatment
- Risk of death or severe harm due to inadvertent injection of skin preparation solution.
- Managing risks during the transition period to new ISO connectors for medical devices

Medicines Safety Thermometer

The Medication Safety Thermometer is a national tool that is currently being piloted and is designed to focus on the issues of medication error and harm caused from medication error in line with Domain 5 of the NHS Outcomes framework. CCC has been collecting Medicines Safety Thermometer data for a year and form the data collected the MST has been able to put in place a number of improvement procedures. One area for improvement was the reduction in omitted doses for inpatients. Through the introduction of the critical medicines policy and amendment of the drug rounds on the ward the has led to the reduction in omitted medicines as illustrated in the charts below.





- Involve the patient in medication safety initiatives and medication self-management programs

Patient Self Reporting
Patients are encouraged to self-report adverse events using yellow cards. A yellow card reporting event was held in the foyer and information about self reporting is displayed on screens around the trust.

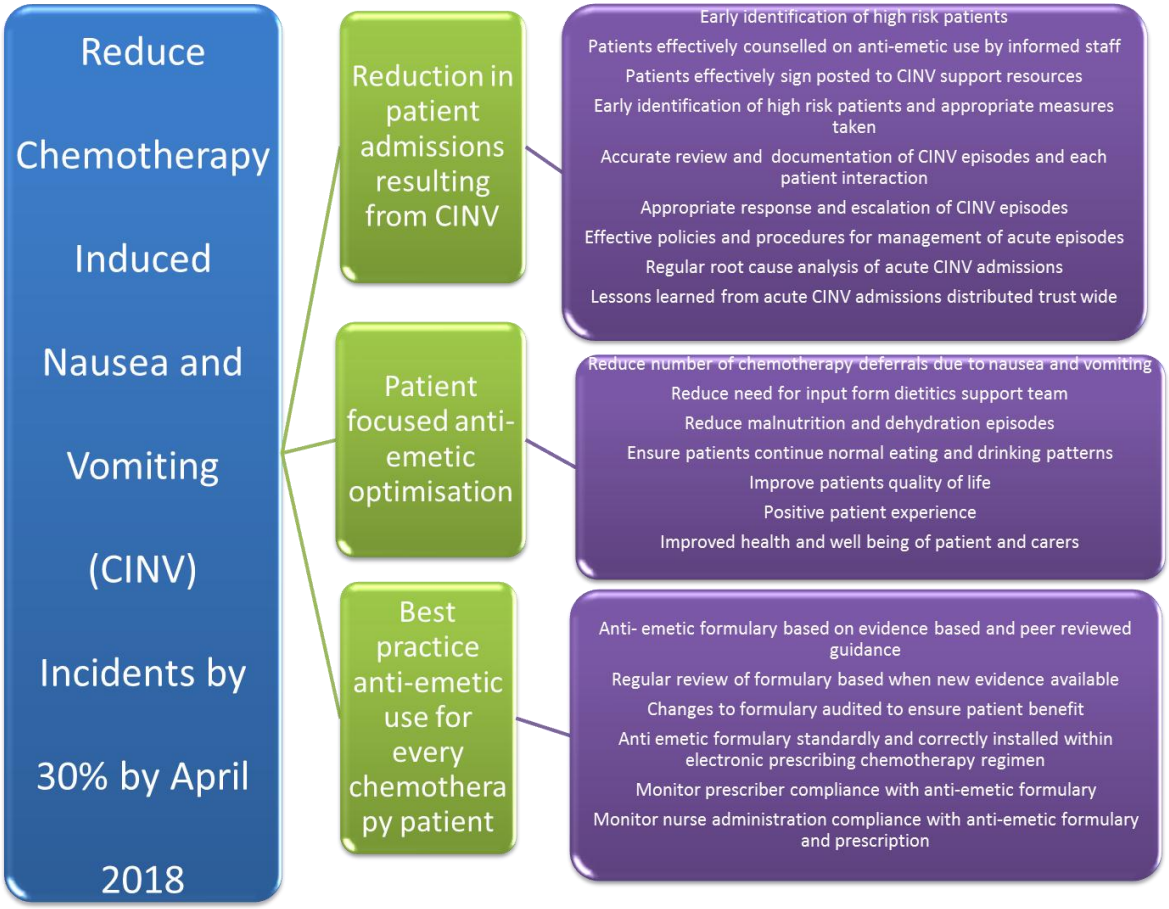
Patient Involvement in Medication Safety
A lay member of the MSG has now been recruited into post who plays in active role in medication safety from a patient's point of view

- Establish a controlled formulary in which the selected medications are based on safety

Non- formulary Approval
A non-formulary approval procedure for requesting non formulary drugs/regimen is now enforced throughout CCC. Site Reference Group (SRG) approval must first be sought, followed by a rigorous approval criteria, ensuring resources, IT and staff training has been undertaken prior to approval by D& T.

- Move towards Harm Free Care within the Trust

Reduction in Chemotherapy induced nausea and vomiting (CINV)
Chemotherapy induced nausea and vomiting (CINV) has been identified as the first area for harm free care initiative and is part pf CCC "Sign up to Safety Programme." Details of the CINV harm reduction plan are detailed in the driver diagram below.



CINV protocol suitability; the effect of domperidone dose reduction, prescribing adherence to protocol and patient experience have been audited; nursing toxicity assessment, patient concordance, emergency admissions for nausea and vomiting and are all currently being audited.

Allergies

Allergies have become a key focus for medicines safety nationally. NICE Guidance on drug allergies (Drug allergy: diagnosis and management of drug allergy in adults, children and young people CG183 September 2014) identified issues including poor clinical documentation of drug allergy and a lack of patient information. A July audit at CCC highlighted the disparity in allergy recording within the trust between inpatient and outpatients. Inpatients drug charts have nearly 100% allergy documentation completed compared to around 20% of systemic anti-cancer therapy (SACT). The MST has trained both medical staff and nursing staff (particularly those involved in pre –assessment) on the importance of correct allergy documentation. A re-audit of allergy status completion is soon to take place.

Drug Driving

As of March 2nd 2015 the Department of Transport has introduced a new offence of driving with certain controlled drugs above specified limits in the blood. The MST has given written advice to all staff detailing the advice they should give to patients and sign posted both clinicians and patients to further information.

Support and advice was provided to the Chemotherapy directorate regarding clinical Governance. Key areas of involvement include:

- Bi-monthly governance report provided to the Chemotherapy operational group
- Attendance at monthly Chemotherapy operational group
- Weekly meeting with chemotherapy mangers
- Provision of a quarterly clinical governance report for directorate performance review.
- Clinical Governance support to the pre-assessment project.
- Establishment of a bi-monthly audit group to manage and monitor audit in the directorate.
- Establishment of robust process around extravasation.
- Clinical Governance support to the Systemic Anti-Cancer Treatment at Home project.
- Development of a SACT nursing competency framework.

Clinical Governance Report: Patient Safety

Executive Summary

Safe

- **NHS Safety Thermometer** – monthly snap shot survey of our inpatient wards identifying the incidence of four specified harms: VTE, Pressure Ulcers, Falls and CAUTI
- **Days Between** – we record and investigate all incidences of the four harms specified by the NHS Safety Thermometer, identifying days between the last identified harm. This information gives a more accurate assessment of harms, as it details days between incidents rather than relying on a one day snapshot of events.
- **Open & Honest Care** – we publish a set of patient outcomes, patient experience and staff experience measures so that patients and the public can see how we are performing in these areas.

Effective

- **Sign Up to Safety** – the Trust is supporting the NHS England's national Sign Up to Safety Campaign and the goal to reduce avoidable Harm by 50% and saving 6000 lives.
- **Global Trigger Tool** monthly case note reviews for measuring adverse events.

Responsive

- Piloting the draft Accessible Information Standard (SCCI 1605) – the Trust must be compliant with the approved standard by the end July 2016.

Well Led

- 15 **Patient Safety Leadership Walkrounds** completed across almost all areas and staff groups. Of the 47 Issues taken forward by the Executives 20 remain outstanding.
- Maintained accreditation with the **Information Standard** for our for our internally produced patient information leaflets.

Annual Report

Patient Information

Throughout 2014/15 we have continued to improve the quality of the information provided to our patients and carers. We have maintained our accreditation with The Information Standard for our internally produced information leaflets. The Information Standard is an independent certification scheme that helps the public to identify reliable and trustworthy sources of health and social care information using a quality mark to signpost, so the public can find it quickly and easily. Accreditation enables the Trust to show a commitment to providing trustworthy information for our

patients. The process of accreditation has resulted in improved governance processes around information production and document control allowing us to demonstrate to the public that our information is both credible and reliable.

There is a rolling programme of review to ensure that all relevant leaflets continue to meet the criteria of The Information Standard.

Patient Safety First Campaign (http://www.patientsafetyfirst.nhs.uk)

Patient Safety First was officially launched at the NHS Confederation Annual Conference (18-19 June 2008) as part of an international move to make hospitals safer. Patient Safety First seeks to reduce harm to patients by changing practice in specific areas, based on existing evidence. The purpose of each of the Patient Safety First interventions is to provide a focus on which to begin or progress improvements in patient safety in our organisation. We have continued to participate in the Leadership intervention during 2014/15.

Leadership Intervention

The Patient Safety First campaign aims to facilitate a fundamental shift in the culture of the NHS by engaging, informing and motivating NHS teams to ensure patient safety is the highest priority. A key intervention for the campaign targets Board and Executive leadership. Leadership Walkrounds are pre-planned visits to a specified department or staff group by members of the Trusts' executive and non-executive directors. The main purpose is for staff to have an opportunity to speak openly to the Trust directors about safety concerns in their area with the premise that when leaders commit genuine attention to improving quality and safety, so will the rest of the staff.

A Walkround within the Trust happens weekly (*except during board week*) on a rolling programme with each individual department being visited approximately every six months. During 2014/15 there were **15** Patient Safety Leadership Walkrounds successfully completed across almost all areas and staff groups.

So far, within the first eight rounds of Walkrounds, **575** issues have been raised by staff and **320** have been taken forward by the Executives. **20** issues remain outstanding from the 2014/15 Walkrounds. Each issue is assigned to an Executive and/or staff member to take forward and is tracked until completion by the Clinical Governance Managers for Patient Safety. All Issues raised are documented in the Issues Log available on the Trust intranet under 'News' so that staff can check for progress on the issues identified for investigation and for action. The Issues log is updated monthly by the Clinical Governance Managers for Patient Safety.

Accessible Information Standard

The Accessible Information Standard (SCCI1605) requires health and social care organisations to identify and record the information and communication support needs of patients and service users (and where appropriate their carers or parents) where these needs relate to or are caused by a disability, impairment or sensory loss.

The standard also requires organisations to take action to ensure that those needs are met.

We were selected as a pilot site for the draft standard, January – March 2015 and our finding informed the final standard which was approved in July 2015.

Global Trigger Tool

The Trust has continued monthly case note review sessions using a CCC adapted version of the IHI Global Trigger Tool (GTT) for Measuring Adverse Events.

The Trigger Tool methodology is a retrospective review of a random sample of inpatient hospital records using "triggers" (or clues) to identify possible adverse events. It is important to note that the IHI Global Trigger Tool is not meant to identify every single adverse event in an inpatient record. The methodology recommended time limit for review, and random selection of records are designed to produce a sampling approach that is sufficient to determine harm rates and observe improvement over time. Due to the subjective nature of the GTT and adaptations made for local use benchmarking is not considered appropriate.

During 2014/15 there was one harm event classified above an F (Temporary harm to the patient and required initial or prolonged hospitalisation).

The following report was submitted to the August 2014 Risk Management Committee:

The Global Trigger Tool case note review for July 2014 (carried out 30/07/2014) review period April 2014, identified one permanent patient Harm (Category of Harm – G).

This is the first time since starting the GTT reviews that a harm above an F (Temporary harm, initial or prolonged hospitalisation) has been identified.

The patient was readmitted within 30 days of the review period admission with Acute Kidney Injury (AKI). The review period admission was a planned admission for Cisplatin chemotherapy. The notes detail permanent harm to the kidneys and referral to a renal specialist; the second line medical reviewer therefore classified the harm as Category G (Permanent patient harm).

The overall percentage of admissions with an Adverse Event for 2014/15 averages at **50%;** therefore half of all patients (*reviewed as part of the GTT process*) are harmed at some point during their stay at CCC. However, the GTT does not take into account preventability. Substantial portions of the Harm Events identified were due to side effects of treatment, some of which are not preventable due to the toxic effects of the chemotherapy and radiotherapy treatments that we use.

Because of the complexity of separating out preventable treatment related harms from avoidable incidents and accidents, combined with a small patient population at CCC, the tool is not expected to give a completely true account until more data has been collected. It remains possible for a patient who has an adverse reaction to

treatment and a complicated mix of side effects to skew the data. Presently, the rate of adverse events varies widely depending on the patients who are selected for review.

NHS Safety Thermometer

The NHS Safety Thermometer provides a 'temperature check' on harm that can be used alongside other measures of harm to measure progress in providing a care environment free of harm for our patients.

The NHS Safety Thermometer measures harm and the proportion of patients that are **'harm free'** from **pressure ulcers, falls, urine infections** (in patients with a catheter) and **venous thromboembolism** during a specific working day.

A Safety Thermometer Survey is a snapshot survey of the four harms {Pressure Ulcers, Falls, Catheters with UTIs and VTE} for all the patients in a ward on a particular day. In order to adhere to the CQUIN requirements, data will be collected on a single day per month on each of the three inpatient wards. This data is uploaded to the NHS Information Centre monthly.

As well as this 'temperature check' we also record all incidences of the Four harms specified by the NHS Safety Thermometer which are attributable to The Clatterbridge Cancer Centre (CCC) across our three inpatient wards.
We use the following criteria for identifying the CCC attributable harms:

- VTE (Venous Thromboembolism) – patient has been an inpatient at CCC within the past 90 days.
- Pressure Ulcers – developed 72 or more hours after the patient was admitted.
- Falls – all patient falls are recorded.
- CAUTI – all urinary tract infections associated with a catheter, according to our Infection Control surveillance definitions rather than simply reporting all patients who have a catheter and a UTI as these may not be directly related.

Pressure Ulcer incident review meetings are held monthly to discuss any CCC Attributable Pressure Ulcers identified during the previous month. Each case is discussed and any actions identified form part of the on-going action plan. The action plan has addressed issues regarding training and changing practice so that all identified pressure sores are reviewed by a Senior Nurse. This has resulted in a more consistent approach to reporting. The Pressure Ulcer policy and Root Cause Analysis forms have been updated to reflect current practice and to capture information e.g. staffing levels, tumour group, whether patient was or had recently received Radiotherapy or Chemotherapy, which may have compromised tissue viability, putting the patient at greater risk. A great deal of work has been carried out investigating dressings and incontinence products in use and looking to standardise practice. Initiatives such as audible alerts for carrying out regular comfort checks, the use of mirrors for visualising hard to see areas are also being investigated. We continue to collaborate with the Royal Liverpool Hospital Tissue Viability Nurses to further improve our knowledge, skills and practice.

Open & Honest Care

We are one of a number of NHS organisations who want to be open and honest with our patients. As a member of the 'Open and honest care: driving improvement' programme, we continue to work with patients and staff to provide open and honest care, and through implementing quality improvements, further reduce the harm that patients sometimes experience when they are in our care. We have made a commitment to publish a set of patient outcomes; patient experience and staff experience measures so that patients and the public can see how we are performing in these areas. The reports are available on our public website and are sent to NHS England monthly.

http://www.clatterbridgecc.nhs.uk/aboutcentre/qualityofcare/transparency_of_care.html

Sign Up to Safety

The Trust is supporting NHS England's national Sign Up To Safety campaign and the goal to reduce avoidable harm by 50% and saving 6,000 lives. Through participating in Sign Up To Safety, CCC commits it's Trust Board and staff to:

1. Put safety first

Patient Safety is at the heart of the Trust Quality Strategy. We are committed to reducing avoidable harm and have decided to focus our plan on the following four Improvement Domains:

- NHS Safety Thermometer denoted avoidable harms
- Medicines Safety
- Improve prevention, recognition and management of the adult deteriorating patient
- Development and implementation of a Radiotherapy Safety Thermometer

2. Continually learn

We aim to continuously learn from our staff and our patients to improve care and safety. We will build on our current systems to further embed a culture of learning.

We conducted our first Safety Culture Survey in August 2014. We will ensure we act on the feedback from all staff and will continue to conduct these surveys every two years across the Trust and more frequently in departments where we need to focus on improvement.

As a result of our first Safety Culture Survey we will introduce new systems to improve feedback on incident reports and investigations. We will also focus more on investigating near misses.

3. Honesty

We are committed to being transparent about the quality and safety of our services. We believe that the public have a right to know about how their specialist cancer centre is performing in the areas that are important to them. We have developed a 'High Quality & Safe Care' section on our public website which includes information on key areas of quality and safety such as harm free care, waiting times, complaints, cleanliness, and patients and staff opinion of our hospitals. This information can be found under the following headers:

- **Safe** - Open and honest care, safety thermometer, medicines thermometer, healthcare associated infections, patient led assessment of the care environment, incident reports, Sign Up to Safety
- **Effective** - Compliance with patient risk assessments, 30 day mortality post treatment
- **Caring** - Ward nursing staff levels, patient feedback
- **Responsive** - Compliance with cancer waiting times
- **Well led** - Integrated performance report, staff feedback, nursing care indicators, quality accounts

We will build on the amount of information that we provide including feedback from patients and the public via a web questionnaire to ensure that the information is what patients want to see and that it is easy to understand.

We plan to further develop this website to include benchmarks of how we perform against other Trusts.

Transparency of Care

We are committed to ensure that patients who use our services can easily see information about how we are performing and developing. Our Wards currently display a large amount of information. We are committed to reviewing and further developing this information to ensure it is comprehensive, is easily understandable and meets patients' needs. We will work with our clinical experts, ward leaders and our Patient Council to achieve this. We will then look to roll this out to other clinical areas.

Patient Stories

We have a programme of videoing patient stories and presenting these at each Public Board Meeting and our Council of Governors meeting. We will further develop this programme in conjunction with our public Governors and will roll out the use of patient story videos to all clinical departments.

1. Collaborate

Patient Pathways

We have appointed a Cancer Pathways Project Manager for Network Cancer pathways, who will lead a project to review and improve cancer pathways across the Cheshire & Merseyside network of cancer services. The project will involve complex analysis of cancer pathways, comparison with national best practice, development of recommendations to improve the cancer patient's journey through the health and social care system, reporting the recommendations to participating hospitals and working with managers in acute hospitals to ensure that recommendations are implemented.

Patients at the Heart of Safety

Patients are at the heart of the care and treatment that we provide and will experience and see things in a different way to staff. We will work with patients to improve safety including implementing a system where we encourage patients, carers and visitors to be able to easily report any safety concerns that they have.

1. Support

Training and Development

As a result of our first Safety Culture Survey we will introduce Health and Safety briefings for staff in all departments focusing on key health and safety themes throughout the year.

We will support staff to improve safety, including medicines safety, by implementing a new Patient Safety Training Program
This will include:

- Root Cause Analysis Master Class for staff who investigate safety issues
- Develop a program of training in Human Factors for Healthcare

We will also review our processes and systems for providing support for staff who raise concerns or are involved in an incident, complaint or claim.

Clinical Governance Report: Risk Management

Executive Summary

Safe and Responsive

- Risks on the register have increased but there is a lower number of high risks compared to the previous year
- Increase in incidents reported but the harm levels continue to remain very low, with only 3 incidents resulting in moderate harm
- A comparison to other Trusts in our NRLS cluster, confirms a good reporting culture with high levels of patient incidents reported but low levels of harm
- Externally reportable incidents remain low
- No serious incidents reported but 13 incident reviews held in 2014/15
- 4 Letters of Claim received in 2014/15, with an additional 9 potential claims
- 5 deaths investigated by the Coroner in 2014/15, with staff being required to attend two of the Inquests
- All safety alerts received via CAS were acknowledged and actioned in 2014/15
- The first internal assessment of the Quality and Risk Management Standards was completed in January 2015

Annual Report

Risk Assessments and Risk Register

Departments reviewed their risks as part of their risk registers and this was monitored via the Risk Management Committee. High level risks (12 and over) reviewed quarterly by the Integrated Governance Committee and high risks (15 and over) are monitored at each monthly Board meeting.

At the end of 2014/15 there were 612 open risks on the register. The table below shows the grading of the open risks on the register and compares them across the last 4 years. The number of risks has increased but the number of risks 9 and over has decreased.

Risk Grade	**Number on Register end of 2011/12**	**%**	**Number on Register end of 2012/13**	**%**	**Number on Register end of 2013/14**	**%**	**Number on Register end of 2014/15**	**%**
1-3 (Very Low)	68	12%	63	12%	70	12%	64	10%
4-8 (Low)	286	51%	277	51%	297	49%	403	66%
9-12 (Moderate)	203	36%	203	37%	221	37%	137	22%
15 (High)	5	0.9%	4	0.7%	12	2%	8	1.3%
Total	**562**		**547**		**600**		**612**	

Source of Risks on the Register

A review of the Register showed that the risks were identified from a number of sources as detailed in the table below:

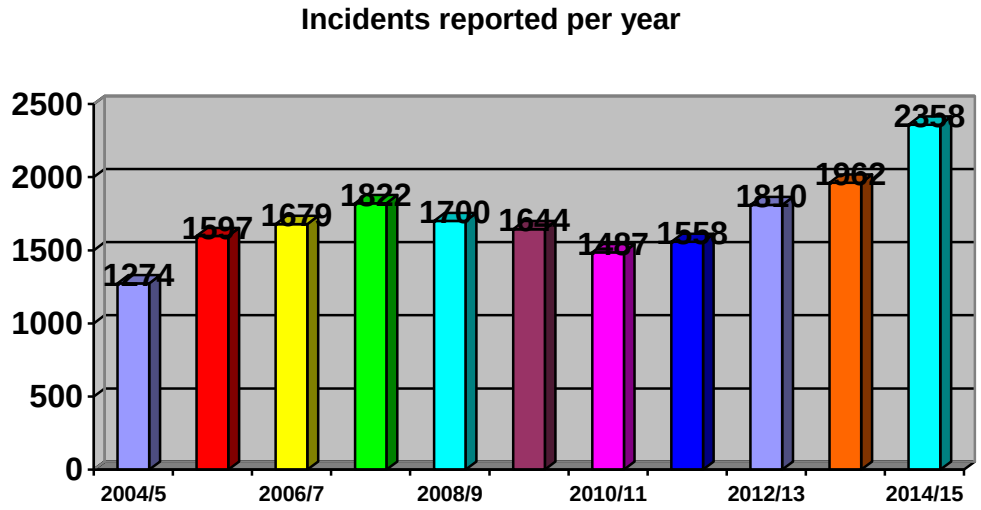
Source of risk	Total 12/13	%	Total 13/14	%	Total 14/15	%
Risk Assessment	378	69%	428	71%	463	76%
Board Assurance Framework	34	6%	42	7%	48	8%
Incidents	26	5%	27	4.5%	25	4%
Guidance/alerts	7	1%	5	0.8%	7	1%
Audit	3	0.5%	2	0.3%	3	0.5%
Board identified risks/Annual Plan	11	2%	17	3%	9	1.5%
Complaints	0		0		0	
Claims	0		0		0	
Departmental assurance framework	88	16%	79	13%	57	9%

The table above shows that the majority of risks are identified from risk assessments and the assurance frameworks.

Incident Reporting

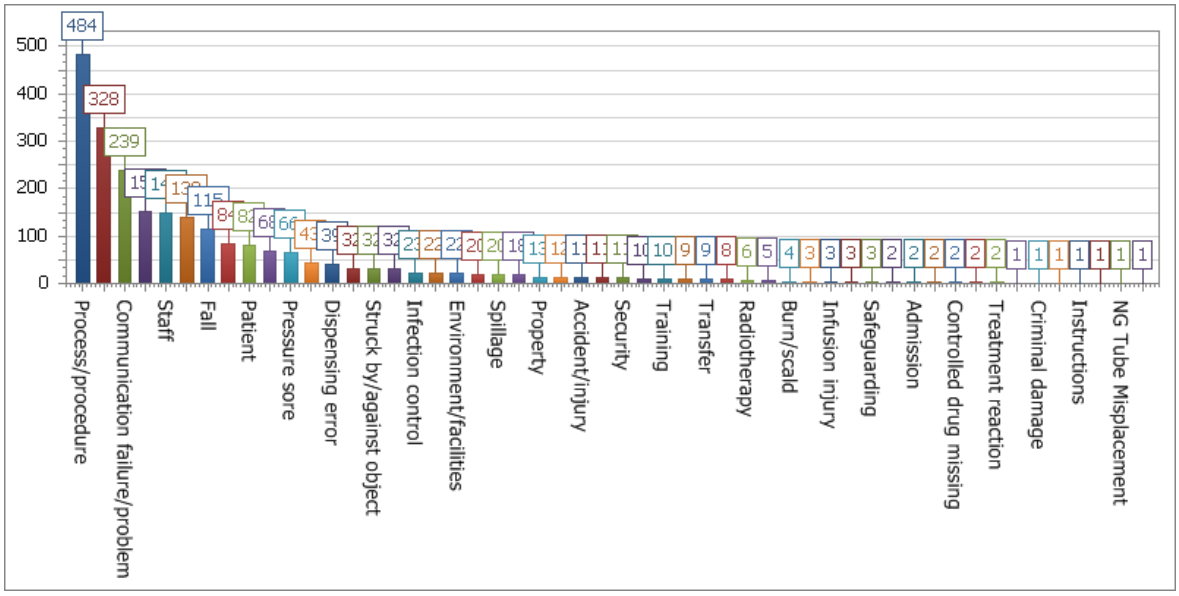
The reporting of incidents by staff is one of the most efficient and effective systems of identifying risk. It enables action to be taken and lessons to be learnt with the aim of preventing recurrence. The Incident Reporting Policy sets out details of the system in place, including the investigation, analysis and learning from incidents. Incidents and actions taken were fed back to staff via the monthly Team Brief.

2358 incidents were reported from 1/4/14-31/3/15 and this was an increase compared to 1962 in the previous year. The chart below shows the total number of incidents reported in previous years.



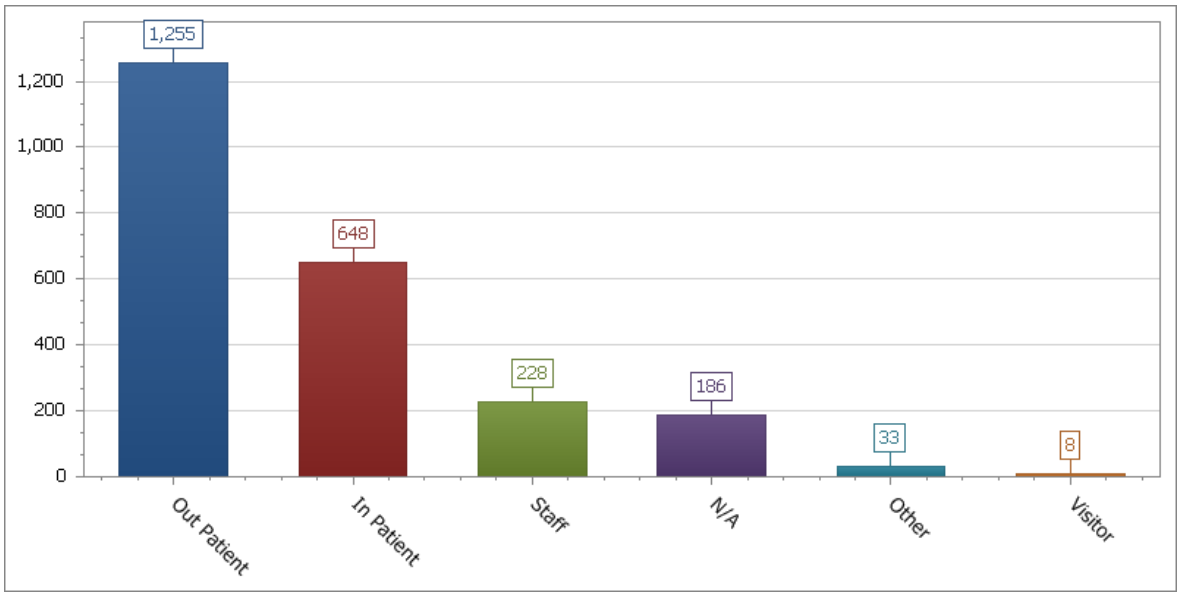
The type of incidents reported can be seen in the table below, with procedure, documentation, communication, workload/staffing and falls incidents being the highest incident types reported.

Incident Type



Person concerned

The majority of incidents were patient incidents, followed by staff incidents, with the remaining involving visitors, volunteers, agency staff or not involving a specific person as shown in the table below.



Reported by staff group

The chart below shows that incidents have been reported by most staff groups in 2014/15, but mainly by Radiation Services and Integrated Care Directorates.

Chart to show reported by staff group

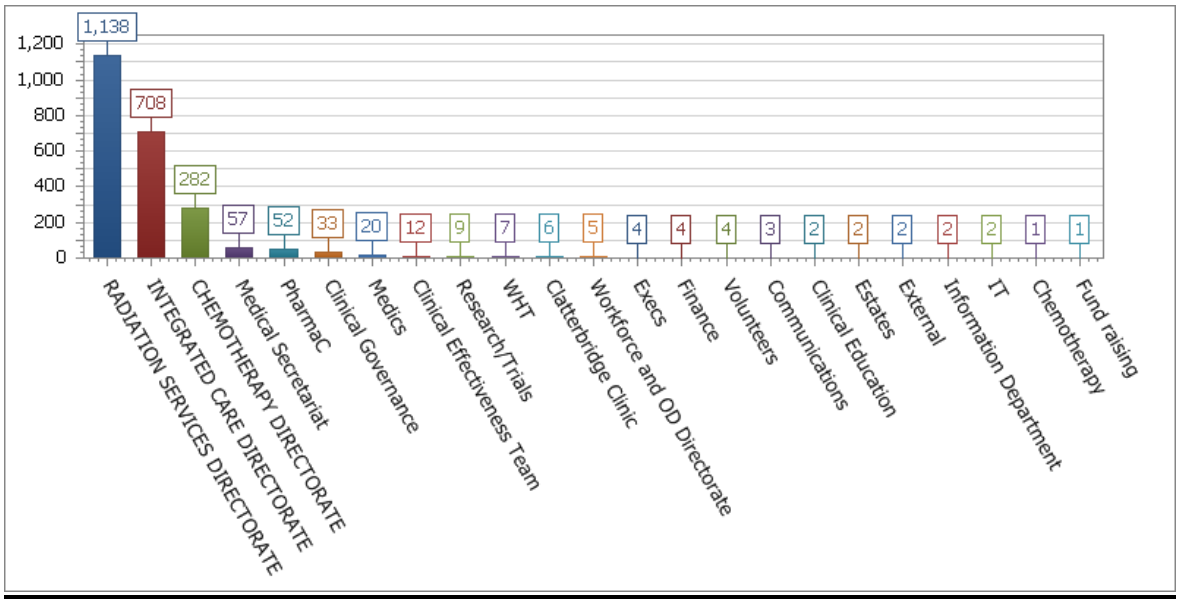
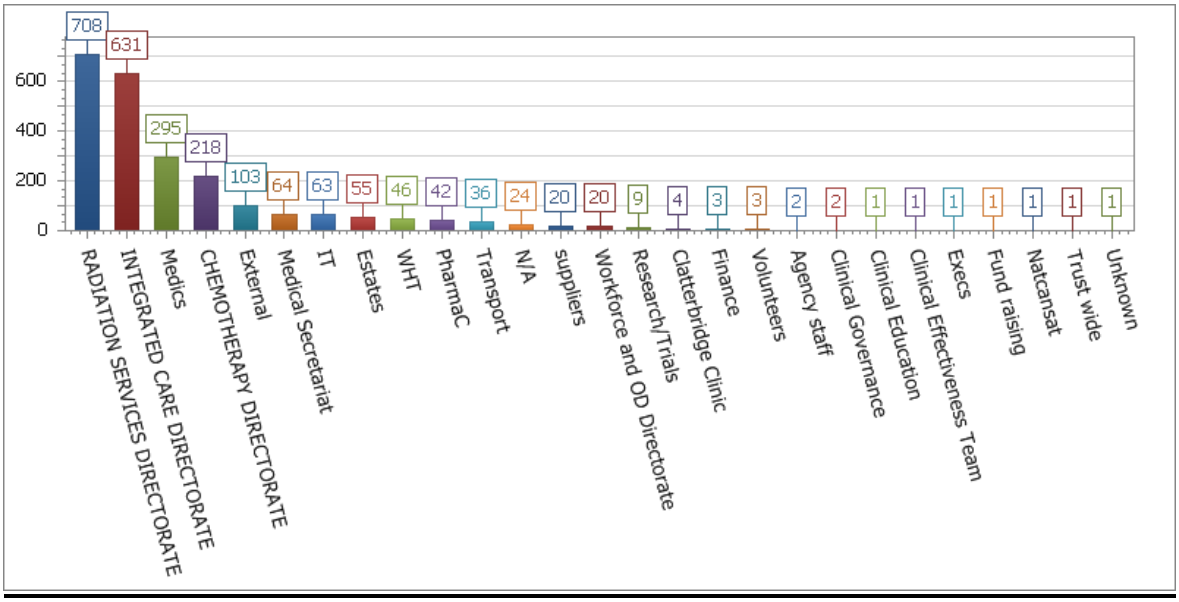


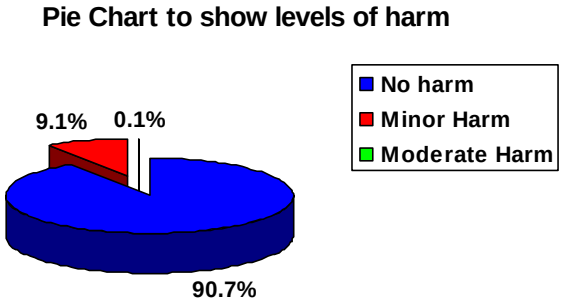
Chart to show which department the incident was raised against



The chart above shows that the majority of incidents were raised against Radiation Services and Integrated Care Directorates.

Levels of Harm

Of the 2358 incidents reported 9.3% resulted in harm. Of the 220 incidents that resulted in harm, 215 (9.1%) resulted in low harm and 3 (0.13%) resulted in moderate harm.



The 3 moderate harm incidents involved two inpatients and one outpatient. The harm was a result of a fall (hip fracture), a pressure ulcer (grade 3) and an extravasation. An incident review was held following each incident and action plans were developed and monitored by the Risk Management Committee.

Externally Reported Incidents

All externally reported incidents are monitored at each Risk Management Committee meeting via the externally reported table. A summary of the last 5 years can be seen below:

External body	2010/11	2011/12	2012/13	2013/14	2014/15
HSE (RIDDOR) **Note: from April 2012, over 3 day injuries changed to 7 days**	2	2	2	3	2***
HSE - other				2	
MHRA	1				
SHOT	0	2			
CQC (IRMER)	0	2	2	1	2*
STEIS	0	1	2	3	2****
NRLS	1283	1237	1623	1392	1668
SIRS	18	20	17	19	14
Information Commissioner			1	1	1**
DOLS (applications)					13

* Diagnostic CT Imaging error (7356), Treatment to incorrect tattoos (8815)
** Confidentiality Breach (7619)
*** Struck by/against (8240) and Manual Handling (8086)
**** Pressure Sore Grade 3 (7008) and Fall (7807)

1668 patient incidents were reported to the National Reporting and Learning System in 2014/15. Six monthly Organisation Patient Safety Incident Reports are published each year. The reports highlighted that CCC are the highest reporter of incidents in the cluster (acute specialist organisations), showing a good reporting culture. The report also highlighted that the levels of harm are very low compared to others Trusts in the cluster.

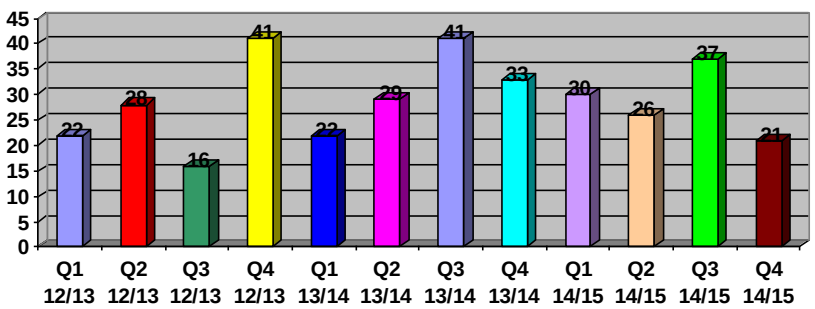
Trust performance against selected quality metrics 2014/15:

	April 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
MRSA bacteraemia cases / 10,000 bed days	0	0	0	0	0	0	0	0	0	0	0	0
C Diff cases / 1,000 bed days	1	0	0	0	0	0	0	0	0	0	0	0
'Never Events' that occur within the Trust	0	0	0	0	0	0	0	0	0	0	0	0
Chemotherapy errors (number of errors per 1,000 doses)	2 in 5812= 0.34	2 in 5674= 0.35	4 in 5365 =0.75	6 in 6004 =0.99	0	2 in 5776 = 0.35	2 in 6107= 0.33	1 in 5267 =0.19	1 in 5227= 0.19	1 in 5591 =0.18	0	1 in 5705= 0.17
Radiotherapy treatment errors (number of errors per 1,000 fractions)	3 in 7241 fractions = 0.41	7 in 7556 fractions = 0.93	3 in 7754 fractions = 0.39	4 in 8201 fractions = 0.49	2 in 6692 fractions = 0.3	4 in 6887 fractions = 0.6	13 in 6959 fractions = 1.9	6 in 6428 fractions = 0.9	9 in 7131 fractions = 1.26	7 in 7246 fractions = 0.96	10 in 6478 fractions = 1.5	12 in 7388 fractions = 1.6
Falls / 1,000 inpatient admissions	2 in 309 =6.5 (2 low harm)	10 in 306 =32.7 (2 low harm)	10 in 294 =34.01 (2 low harm)	5 in 295 =17 (1 low harm)	6 in 263 =22.8 (no harms)	7 in 317 =22.1 (3 low harms)	17 in 292= 58.2 (1 mod harm, 4 low)	4 in 271 = 14.8 (4 low harms)	4 in 282 =14.2 (1 low harm)	7 in 307 =22.8 (3 low harm)	1 in 269= 3.7 (no harms)	4 in 298= 13.4 (2 low harm)

The above data is collected on a monthly basis and is monitored by the Board via the Performance Dashboard.

Falls

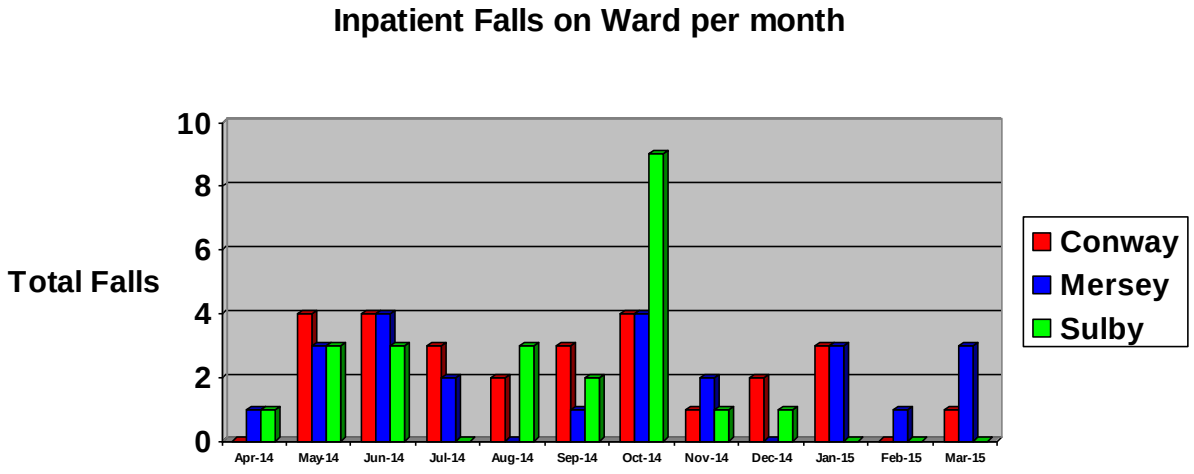
Chart to show ALL falls per quarter over the last three years



Falls reported by person concerned in 2014/15

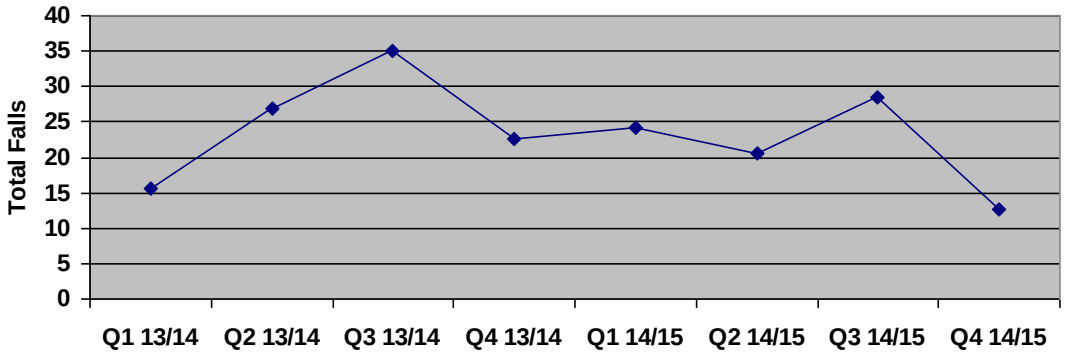
Person concerned	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15
Inpatient	22	18	25	13
Staff	3	4	7	4
Outpatient	5	4	3	4
Visitor				
Volunteer			2	
Student				

The tables above show that the majority of falls are due to inpatient falls. Falls reports are monitored at the Manual Handing/Falls Prevention Group which meets quarterly. All inpatients receive a falls risk assessment on admission and if assessed as 'at-risk of falls', a falls care plan is implemented on the wards. Monitoring of the completion of falls assessment and fall care plans takes place at every Manual Handing/Falls meeting and this information is cascaded to the wards. Each ward reviews their falls to identify any ward level trends.



Ongoing work at ward level is taking place to improve the monitoring of falls and falls prevention. RCAs are completed for all inpatient falls, safety huddles have been introduced across all wards and the use of falling leaves to display patients at risk of falls.

Chart to show total inpatient falls per 1000 inpatient admissions per quarter for for 2013/14 and 2014/15



Serious Incident Panels

No serious incidents were reported in 2014/15.

Internal Incident Reviews

13 internal incident reviews took place during the year. The reviews were undertaken for those incidents not graded as serious but either because they have the potential to be serious, or if there has been a trend/multiple incidents and so they require a more in depth investigation. A root cause analysis was undertaken for all the incidents below and an incident review meeting held with key staff in attendance to review the incident. Action plans were produced for all of the incidents, which have been monitored at each Risk Management Committee meeting until completion. They have also all been reported via Team Brief as a feedback mechanism to all staff.

Table to show Incident Reviews held in 2014-15

Incident Number	Date of incident	Date of review	Incident	RCA report – action plan
6877	July 14	15/8/14	Cetuximab - Patient was prescribed 3 weekly Cisplatin and 5FU with weekly Cetuximab however the patient did not receive day 8 and day 15 Cetuximab for the first 3 cycles.	Completed
7008	16/6/14	25/7/14	Pressure ulcer grade 3 elbow. All pressure sores attributable to CCC following this incident, all had an incident review.	Completed
N/A	N/A	23/5/14	Missed Doses A trend of in-patients not receiving medicines they have been prescribed has been identified. This was identified as a result of the VTE phrophylaxis audit and has been supported by data from ward spot checks and medicines safety thermometer.	Completed
7726	8/9/14	No formal IR held	Wrong scan	Completed
7356	23/7/14	21/9/14	Patient attended for CT scan. The examination was modified as suitable venous access couldn't be obtained. Unfortunately the patient's hands remained on her chest instead of above it during the scan and the resultant images were non diagnostic. Scan needed to be repeated. (Repeat exposure due to operator error = IR(ME)R reportable)	Completed
7620	8/7/14	21/10/14	Patient referred for MUGA scan as part of screening for ST03 clinical trial. However the study did not have research ARSAC approval as it was approved here prior to the trials MUGA service being available. This resulted in a procedure being performed which was not appropriately justified or authorised under protocol. Radiation exposure of 12msv received by patient.	Ongoing
7807	15/10/14	23/11/14	Fall – hip fracture	Completed
N/A	N/A	7/8/14	Height/Weight discrepancies	Completed
7246	18/6/14	18/7/14	Cisplatin chemotherapy was administered by more than 12 hours and a chemotherapy trained nurse was not present during the infusion.	Completed
8292	4/12/14	Dec 14	Patient received 25 doses of Fluorouracil instead of the intended 24. This happened because the 2 administering nurses failed to record the administration electronically and subsequently the prescribing doctor re-prescribed later cycles.	Completed
7904	3/11/14	5/3/15	Ascribe Database	Completed
8815	10/3/15	22/4/15	Radiotherapy Reportable incident - Radiotherapy given to incorrect area. Patient was prescribed palliative radiotherapy to 2 areas of the spine for impending cord compression. The patient had received previous radiotherapy to bladder. On the 3rd and 4th fraction, the tattoos from the previous bladder radiotherapy were used to set up and deliver treatment. Therefore an 8 x 8cm area of the pelvis received an unintended dose of 8Gy.	Completed
9038	4/2/15	22/6/15	Patient given half dose of Capecitabine	Ongoing

In addition to the incident reviews held above, the incident below occurred in December 2014 but was not formally reported until July 2015 and an incident review was held on 23/9/15.

Incident Number	Date of incident	Date of review	Incident	RCA report – action plan
9802	9/12/15	23/9/15	Delivery of whole brain radiotherapy after incorrect diagnosis of brain metastases	Ongoing

Claims

All claims, both clinical and non clinical, were reported and monitored at each Risk Management Committee and to the Board via the Integrated Governance Committee.

New Claims/Potential Claims

2 new claims (one clinical and one non clinical) have been received and 9 new potential clinical claims were received in 2014/15, as detailed in the table below

New claims/potential claims 2014/15

Claim Number	Claim Date	Incident date	Nature of Claim	Status of Claim
2015/01	LBA 30/3/15	August 2014	Extravasation	Letter Before Action
2014/10	LBA 26/3/15	2012	Delay in informing the community regarding discharge	Letter Before Action
2014/09	LOC 27/2/15	2011	Failure to refer for follow up, to carry out 3 monthly CT scans and to refer to lung MDT	Letter of Claim
2014/08	LBA 20/2/15	Nov 2014	Treatment – PICC line	Letter Before Action
2014/07	LOC 29/10/14	3/10/14	Needlestick injury to domestic – from needle disposed of in bin bag	Letter of Claim – Portal Claim
2014/06	LBA 8/10/14	2013	Delayed diagnosis	Letter Before Action
2014/05	LBA 28/7/14	2012	Radiotherapy reaction	Letter Before Action
2014/03	LBA 21/7/14	Aug 13	Failure to act on a lump	Letter Before Action
2014/02	LBA 23/6/14	Not given	No details given	Letter Before Action
2014/01	LBA 4/4/14	Jan 2013	Radiotherapy - paralysis	Letter Before Action

Ongoing claims from previous years

A number of files for potential claims have been closed in 2014/15 due to no progress and will not be opened again unless a Letter of Claim is received; however the following claims have progressed or were settled in 2014/15:

Claim Number	Claim Date	Incident date	Nature of Claim	Progress/Action
2008/02	Letter of Claim 23/1/14	2004	Previous complaint 07 and claim 09. Failure to report on CT examination. CT reported as normal in 2004 following GP referral. In 2006 an MRI elsewhere revealed an acoustic neuroma.	Claim settled - £20k damages, costs £120k
2013/06	LBA 1/7/13	2011	Failed to take into account that pt was already taking methotrexate which continued during chemo resulting in breakdown of immune system	Letter of Claim received.
2013/04	LBA 24/4/13	1/2/13	Incorrect documentation of HER2 status resulting in unnecessary Herceptin x11	Letter of Claim received.

One claim from a previous year was settled in 2014/15 as detailed in the table above. Two cases progressed in 2014/15 as Letters of Claim were received.

Inquests

The Coroners requested reports following the deaths of 5 patients in 2014/15, as detailed in the table below.

Inquest Number	Date of Request	Coroner	Reports sent	Date of Inquest	Staff requested to attend	Conclusion
1/14	23/4/14	Liverpool	12/5/14	-	None	Natural Causes PM report sent to consultant.
2/14	19/5/14	Cheshire	9/6/14	13/10/14	None	Industrial disease
3/14	27/6/14	Liverpool	10/7/14	-	None	Natural causes
4/14	2/9/14	Liverpool	1/10/14	15/10/14	2 Consultants	Narrative
5/14	24/11/14	Liverpool	14/11/14	15/10/14	None	Natural causes

A further inquest was held in 2014/15, following the death of a patient in the previous year:

Inquest Number	Date of Request	Coroner	Reports sent	Date of Inquest	Staff requested to attend	Conclusion
09/13	3/12/13	North Wales	27/1/14	28/8/14	Consultant	Natural Causes

Safety Alerts

There were 129 alerts issued by the Central Alerting System over the period 1st April 14 - 31st March 2015.

Originator	Total	%
DH Estates and Facilities	59	46%
MHRA Medical Devices Alerts	53	41%
NHS England (Patient Safety Alerts)	17	13%

All alerts were acknowledged and assessed to determine whether action was required. Action was not required for 105 (81%) of the alerts.

For the 24 (19%) alerts that action was required, action was completed for all of them.
All alerts are monitored at the Risk Management Committee and reported to Integrated Governance Committee and Health and Safety Committee.

NHSLA Risk Management Standards/Risk Management Audit Sub Committee

The Quality and Risk Management Standards were developed for 2014/15 based on the NHSLA Risk Management Standards, which included additional risk areas for CCC, e.g. checking pregnancy status, sepsis, intentional rounding and additional needs.

The Quality and Risk Management Standards audit plan was monitored by the Risk Management Audit Sub Committee which met monthly to review audits and monitor the audit plan.

On 19th and 20th January, the first internal assessment was completed by the Director of Nursing and Quality and the Risk Management Facilitator, with assistance of the Clinical Governance Managers. Non compliances were followed up and an audit plan has been developed for 2015/2016, which continues to be monitored at the Risk Audit Sub-Committee.

For further details please see Risk Management Annual Report 14/15

Clinical Governance Report: Health and Safety

Executive Summary

This section details the areas covered for Health, Safety & Security and covers :

- Updated Health & Safety Policies, Security Policies and Terms of Reference for the H&S Committee.
- Four areas formally audited.
- Comprehensive Health, Safety, Fire, Conflict Resolution and Security Training for all staff.
- Health & Safety Environment Assessment for all departments.
- Upgraded CCTV Coverage, particularly in public and high risk areas.
- NHS Organisational Crime Profile & Action Plan with High Risk Areas identified.
- Analysis of Health and Safety Incidents for trend analysis, RIDDOR Reports static for the 5th consecutive year.

Annual Report

The Clatterbridge Cancer Centre NHS Trust is a Specialist Hospital with over 960 employees. The safety of patients, staff and visitors is paramount and therefore the Trust continues to encourage a pro-active approach to health and safety to ensure we comply with existing and new health and safety legislation.

All staff groups have access to our specialist team with expertise in health and safety, moving and handling, fire, security and Emergency Preparedness, Resilience & Response. In addition, advice is available from radiation protection, infection control and occupational health via other specialist teams.

As part of our pro-active approach, risk assessments are reviewed by all departments to identify any potential risks and to put controls in place to prevent, where possible, any injuries, ill health or damage to patients, staff, visitors and property.

Regular reports on all accidents, dangerous occurrences and ill health are presented at our bi-monthly health and safety committee and any action plans agreed are implemented. The purpose of this committee is to assist the Trust Board in the effective discharge of its responsibilities for health, safety and environmental governance management and internal control.

The Health & Safety at Work Act sets out employer's duties, Section 2(1) states:

"It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees".

Within the Trust, health and safety responsibilities lie with the Executive Team, via the Director of Nursing & Quality. The Health and Safety agenda is ultimately overseen by the Health & Safety Advisers and the Health & Safety Committee.

Health & Safety Policy & Auditing

During the course of the year, a number of Policies were updated and submitted to the Health & Safety Committee for approval prior to going to Integrated Governance Committee. These Policies were:

- Display Screen Equipment Multiple Monitors
- General Health & Safety Policy

In addition, the Committee also submitted for discussion its own Terms of Reference to enable a discussion about the work of the committee and its membership.

A number of areas were formally audited, these were:

- Security
- Inoculation
- Violence & Aggression
- Falls

The latter two were audited as part of the Environmental Risk Assessment, which is discussed elsewhere in this report.

Fire

A comprehensive program of fire drills has been developed to ensure that the Trust is compliant with Fire legislation and is run on a rolling basis by Technical Services. All fire drills and unwanted fire alarms are recorded and any actions raised are addressed at departmental level and through the Health and Safety Committee as a standing item on the agenda.

Further Fire Marshal training sessions have been arranged during the report period, these have been delivered by an external training provider. Further training is planned throughout 2015/2016 and all fire marshals complete a monthly checklist within their area. Marshal sessions can include Evac+ Chair training and the Trust also has a trained Trainer for the Evac+ Chairs who arranges half day sessions for staff training.

Fire Safety training is provided to all staff as part of new starter Induction and face to face training is repeated bi-annually, with workbook sessions required during the interim years as part of Core Skills Training. Along with other subjects, sessions have been aligned to North West and national Core Skills Standards to ensure training delivered is consistent with other Trusts.

Fire evacuation equipment training has continued to take place over the last year. Following an Emergency Planning Exercise in hospital evacuation, wards in particular identified a further training need with Albac Mats and Bed Straps for vertical evacuation of patients. Further training has been made available for 2015/2016, with the intention to timetable sessions and to also make trainers available to do sessions using the wards own staff and equipment. Wards are able to book trainers into their areas to suit their own staffing levels.

Environmental Risk Assessment Tool

This documentation is completed on an annual basis by all departments. The purpose of this documentation is to act as a guide for all areas to help identify any shortfalls in compliance with relevant Health and Safety Legislation.

The document is divided into different sections and if hazards are identified, a full Risk Assessment must be completed under the Trust Risk Management Policy. Following completion, compliance is audited by the Health & Safety Advisers with the department head and an action plan is developed to ensure that any risks are controlled. A follow up visit is agreed to check on Action Plan progress.

The findings of these are reported to the Health & Safety Committee on annual basis. The 2015 process is scheduled to take place earlier than in previous years and will be going out to departments in June. After a disappointing return from some areas in 2014 additional training for managers will be provided and an allocated date for the audit will be given with 6 weeks notice.

Areas covered by the Environmental Risk Assessment are:

- Environment (working)
- Work Equipment
- Waste Arrangements
- Substances hazardous to health
- Fire Precautions
- Manual handling
- First Aid
- Infection Control
- Display Screen Equipment
- Latex
- Security
- Radiation
- Chemotherapy
- Legionella (Water System Management)
- Slips, Trips & Falls

Health and Safety Training

Health and Safety Training continues to be provided in structured format to enable compliance with H&S legislation. Previously an emphasis has been placed on Management training to establish a baseline for ensuring Health & Safety responsibilities are understood and what departmental commitment is required. Following on from this, a wide range of sessions are now available aimed at all levels of staff.

Health & Safety, Risk Management, Fire Safety and Inanimate Load Training is provided to all new staff on Induction with Health & Safety, Fire Safety and Inanimate Load training provided within Core Skills Training on an ongoing basis. Animate Load training is provided to clinical staff at Induction and Core Skills.

The comprehensive package of training for staff at all levels includes:

- On Call training for Senior Managers
- Display Screen Equipment Assessor Training
- Fit Testing (correct fitting of masks)
- Health & Safety for Managers
- Fire Marshall
- First Aid training (provided by an external company and all non-clinical areas have first aiders and equipment to ensure compliance).
- Evac+ Chair Training
- Vertical & horizontal evacuation of patients
- Conflict resolution
- Security
- Hazardous Substances
- Emergency Planning

These training courses are provided on an ongoing basis with repeat dates throughout the calendar year.

Health and Safety Incidents

Chart 1: Health & Safety Incidents

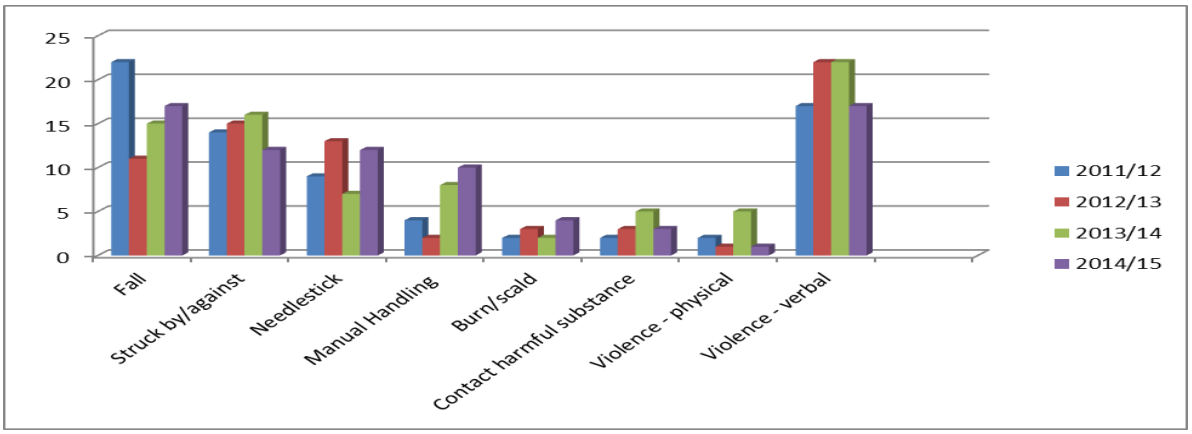


Chart 1 shows a mixture of plus and minus performances over 2013/2014, with various root causes and background.

The number of needlestick injuries sustained have increased despite the transfer to Safety Needles, in line with the 'Health and Safety (Sharps Instruments in Healthcare) Regulations 2013', however, most of the injuries can be seen as avoidable which provides an opportunity for further reduction.

Burns have increased slightly but both physical and verbal violence have reduced, and are commented on in the Security section of this report.

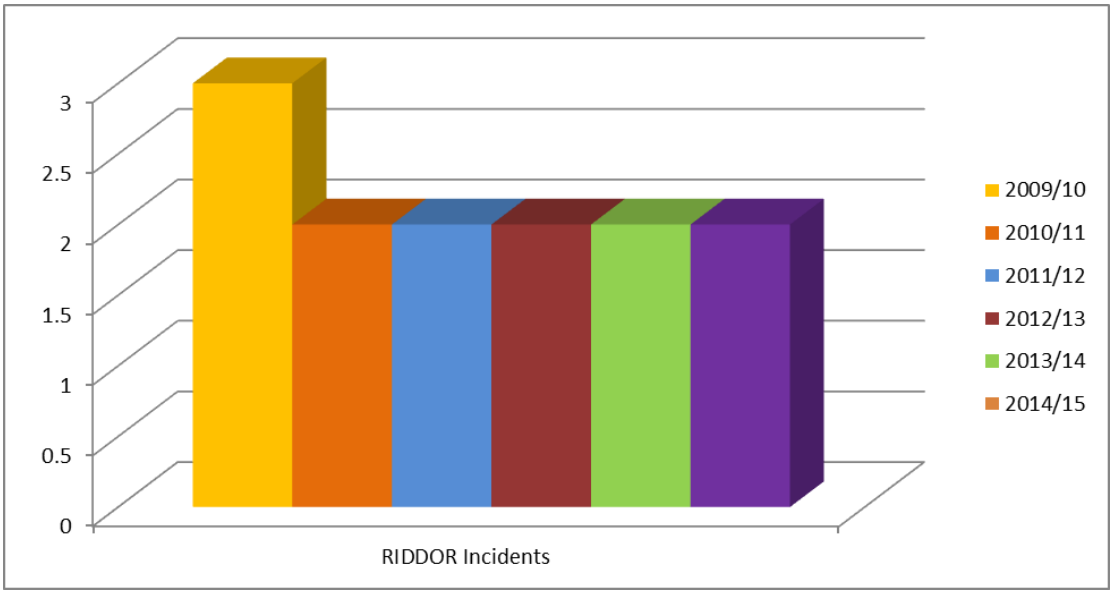
Whilst Falls and Manual Handling have increased, struck by/against and contact with harmful substances have reduced.

RIDDOR Incidents

Under the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations there is a requirement to report accidents which result in staff being absent from work for more than seven days.

The chart below shows the number of reported incidents over the last six years and shows an initial reduction down to consistency, with two incidents again being reported in the year 2014/15, the fifth year running that this number has occurred.

Chart 2: RIDDOR Incidents



Flu

The 2014/15 Flu Vaccination Campaign resulted in vaccination uptake of 57.8% off frontline staff which is a lower uptake than previous years. The start of the campaign was blighted by an issue with the PGD for the vaccines which resulted in a delay to the start of the campaign by one month. The end of the campaign was then hampered by exaggerated media reports over the effectiveness of the vaccine.
The Trust will continue to encourage flu vaccination uptake amongst staff and will launch the next campaign in September 2015, with campaign planning commencing in July.

Security

The following policies are reviewed and updated in a recurring cycle and were completed within the report period in line with the new 'Standards for Providers'.

- Lone workers
- The prevention and management of Violence and Aggression
- Lockdown Policy
- Security Policy
- Security Strategy

All departments have completed risk assessments in the above areas which were checked as part of the Environmental Risk Assessment by the Health & Safety Adviser & Local Security Management Specialist (LSMS) with the audit report presented with appropriate action plan to the health and safety committee. Any shortfalls were then followed up by further checks.

The Trust has upgraded the CCTV system and reviewed coverage throughout the site and is now in the process of reviewing security guard cover under the service level

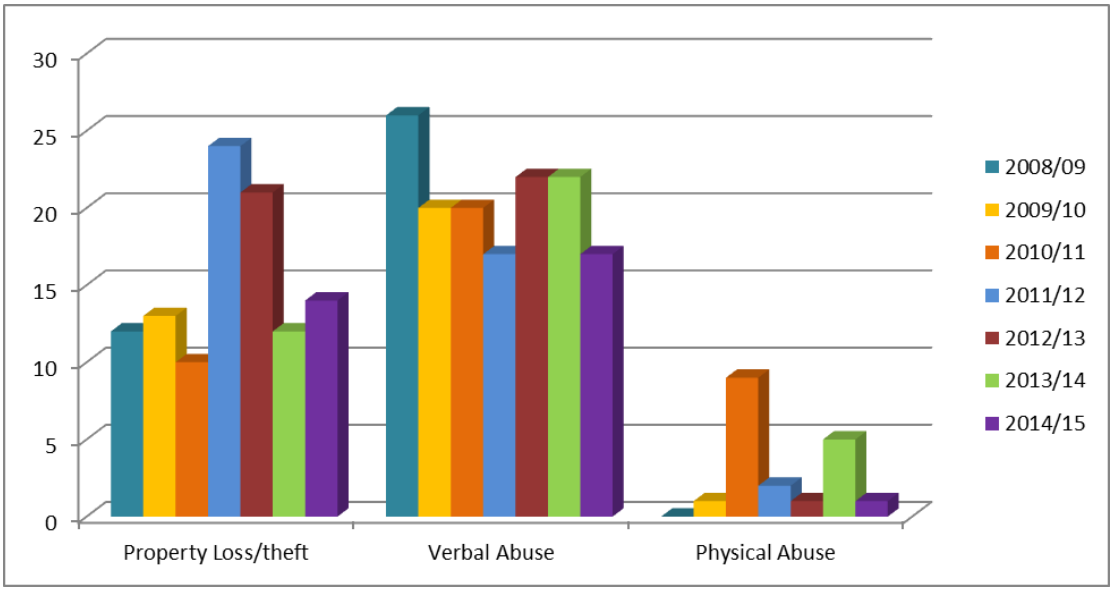
agreement with Wirral University Teaching Hospitals. The Trust has continued to develop a positive relationship with Merseyside Police to ensure access for advice and information.

The Trust completed the annual Organisation Crime Profile and adheres to standards set by NHS Protect. This is completed within one month of signing the contract with Commissioners.

The Trust completed, in line with the nationally agreed security management principles, a site security risk assessment and an action plan which is continuously reviewed and monitored through the Health and Safety committee. Revised SRT Security Standards will be submitted by November 2015.

As part of Security awareness for staff, a training presentation is delivered to all new and existing staff as part of Induction and Core Skills. This covers physical and non-physical assaults including verbal, the importance of incident reporting to help identify trends and the potential risk of unauthorised people 'tailgating' staff into access controlled areas. The training advocates a Pro-security culture for all staff.

Chart 3: Security Incidents



The comparison does show an increase in security incidents last year compared to previous years. There is an increase in Property Loss & Thefts, while the number of Verbal Abuse has decreased. With regard to Physical Abuse, there was 1 incident and it was due to a clinical condition.

Based on the loss/theft statistics the LSMS and Head of Technical services have identified areas deemed high risk throughout the Trust, to place additional security measures to prevent further incidents. The areas include:

- Cash handling departments

- Server rooms
- Switch gear rooms
- Areas that store drugs.

The following strategy to prevent further incidents is to install additional:

- CCTV
- Swipe access
- Key security (key presses)

The Trust continues to work hard to reduce the risk of security incidents by a combination of preventative measures, increased training, investigation and raising awareness of the role of the LSMS.

Lone Worker Devices

Staff identified as needing to visit patients/public homes have now been provided with a lone worker device. This system enables staff to discreetly call for assistance in a potentially dangerous situation and has the ability to quickly and accurately locate the whereabouts and movements of lone workers when an alert is activated.

The Trust has invested in a further 5 devices for the chemotherapy at home service and the appropriate training and escalation information provided to Reliance.

The LSMS receives monthly reports from Reliance, the device monitoring company to indicate usage and alerts and this is reported to the health and safety committee.

Conflict Resolution Training

To reduce the incidence of verbal and physical abuse against staff, Conflict Resolution Training (CRT) is mandatory for all frontline staff that come into contact with members of the public

The Trust has 2 in house trainers to deliver CRT and this enables flexibility and more frequent sessions for departments. An additional two staff have been trained from Learning & Development (L&D) to increase the number available.

To ensure compliance with the NHS Protect target of 100%, refresher training has been developed and will result in a shorter session lasting for 2 ½ hours for staff who have received the full training previously. Extra sessions have been timetabled to assist achieving this target. Current status is 81%.

The training will be changed in line with NHS Protect guidance to include staff dealing with “Clinically Challenging Behavior in the NHS”. And will be delivered from June 2015.

The Trust has also agreed to become a third party reporting Centre for Hate Crime and participated in the launch with Merseyside Police in February 2015. This will enable

anybody to report any hate crime they have either experienced or witnessed anonymously within the Trust and providing a private area to do this or the appropriate contact details with leaflets and posters.

An annual security work plan has been developed and included within this report.

Clinical Governance Report: Emergency Preparedness, Resilience & Response

Executive Summary

This section details the areas covered for Emergency Preparedness, Resilience & Response and covers :

- Alignment with Mersey Region EPRR to eliminate dual attendance with Mersey and Cheshire.
- Complete review and re-write of all Plans & policies following national guidance and in the spirit and principles of ISO 22301.
- 'Green' RAG compliance against NHS Core Standards for EPRR and assurance confirmation received from NHS England.
- Representative attendance at Local Health Resilience Partnerships and Practitioners Group Meetings.
- Business Impact Assessment Process completed by all departments.
- On Call arrangements enhanced by use of Resilience Direct secure government webspace, dedicated EPRR Inbox and Met Office Hazard Manager Log in.
- Participation in the National Capabilities Survey.
- Full Exercise Programme internally and attendance at regional exercises.
- Re-design and re-equipping of the Emergency Resources Store.

Annual Report

The Trust is a Category 1 responder under the Civil Contingencies Act 2004 and has a statutory and moral obligation to be prepared to respond to major incidents and have appropriate plans in place.

The Health & Social Care Act places a duty to have in place a Director of EPRR who will be known as the Accountable Emergency Officer (AEO), This role is fulfilled by the Director of Nursing & Quality, Helen Porter. This role will also sit on the Local Health Resilience Partnership (LHRP).

Support to this role will be from an Emergency Planning Officer (EPO) who will operate at practitioner level and attend meetings of the Practitioners Sub Group - PSG (Cheshire) and Health Response Group - HRG (Merseyside). This role is fulfilled by the Health & Safety Adviser/EPO, Steve Povey.

April 2015 has seen the merger of the Mersey and Cheshire, Warrington & Wirral LHRP's. This will result in the longer term in the Trust aligning to Mersey LHRP and HRG only, however, in the short term the EPO will continue to attend the Cheshire PSG during the transition period.

The Trust has an Incident Control Centre (ICC) located in the Executive Offices and a back up ICC location in the HR Conference Rooms. The latter back up location is under consideration for change either to the JKD building or a possible joint initiative with WUTH and CWP who are also on the site.

National & Regional Emergency Planning & Assurance

In November 2014 the Trust were required to provide Assurance to NHS England that EPRR arrangements were in place and to provide an Action Plan for any improvements or shortfalls.

NHS England guidance – 'Core Standards for Emergency Preparedness, Resilience and Response (EPRR) is the document that stipulates individual EPRR requirements.

Further to this, within the NHS England documentation - 'Business Continuity Management Toolkit – EPRR – BCP Checklist, Appendix 3.2' there is a requirement for planning within Business Continuity to follow the principles of ISO 22301. The checklist then details a number of requirements some of which align with the Core Standards. To ensure as full a picture as possible for the Trust compliance, an alignment document detailing both the Core Standards and BCP Checklist was produced with details of the Trust compliance level for all points.

The Trust has systematically re-drafted all documentation into a format in the spirit of the ISO Standard. This has involved the re-write of all Plans and Policies and has resulted in more policies which are streamlined to specific areas. These policies were completed in the Autumn of 2014 and presented to the Emergency Planning Committee and the Trust Board for approval. Following Trust Board, the agenda, minute point discussing the plans and the Assurance documentation were completed and sent to NHS England as part of the assurance process.

The Trust declared Green/Full compliance with the Assurance Core Standards.

Local Inter-agency arrangements

The Emergency Services and other relevant partners join together to form the Local Resilience Forum (LRF) that takes collaborative responsibility for the preparing and testing of local plans. Both Cheshire and Merseyside have LRF groups.

Additionally, with reference to healthcare, there are also Local Health Resilience Partnerships (LHRP), again with groups in both Cheshire and Merseyside. LHRP meetings are attended by the Trust AEO.

Under the LHRP there are further groups which the Trust Emergency Planning Officer (EPO) attends. These groups are known as the Practitioners Sub-Group (PSG) in Cheshire and the Health Response Group (HRG) in Merseyside.

With the Trusts location on the Wirral, the AEO and the EPO attend both Cheshire and Merseyside group meetings. This is due to the fact that the Trust is part of Cheshire, Warrington & Wirral for healthcare emergencies but because of Police Force boundaries, are part of Merseyside for multi-agency emergencies. As mentioned in the introduction, the Merger of the two LHRP's will result in single attendance for the Trust AEO and EPO once the changeover to Mersey only has been completed.

Trust Planning

The NHS England document 'NHS Commissioning Board Command and Control Framework – For the NHS during significant incidents and emergencies' contains the operational guidelines. With regard to the Incident Coordination Centre (ICC), the Trust has two ICC's identified and equipped in the event of one not being available. The equipment list which the ICC should contain which has been updated to reflect technological changes and the requirements of ISO 22301 and is continually monitored.

During the latter part of the year some negotiation began with other Trusts on the Clatterbridge site to discuss how emergency control may be better approached, these talks are ongoing.

As part of an ongoing process the Trust has tasked each department with completing an assessment of their functions and essential equipment required to enable advanced planning in the event of an emergency. As part of this, for more specialised pieces of equipment departments are encouraged to enter into negotiation with suppliers for preferential supply agreements in the event of emergency. Stage 2 of departmental assessments is scheduled to take place in 2015 which will result in forward planning for equipment and space requirements, to make recovery following an incident a more simplified process.

To support On Call Managers, access to the EPRR Email inbox was made available at all times. The Met Office Hazard Manager Service was subscribed to with a generic Trust username and password, to allow access to specialist weather and forecasting information. Alerts from this service are sent to the EPRR email.

To support On Call Managers, the Trust has provided log-ins to 'Resilience Direct (RD)' which is a specialist, secure, government hosted web facility for EPRR resources. All trust documentation has been uploaded to RD which allows access via the web and ensures that all Trust policies and all supporting information is available at all times without relying on the issuing of CD's. Access to partner organisations information is also available either via upload within the Trust RD pages or via linking to the organisation directly.

The Trust submitted data as part of the National Capabilities Survey. Comparison of results shows the Trust in a favorable position in comparison with other trusts, with the majority of responses being consistent or better. A full analysis of results was submitted to the March Emergency Planning Committee.

Following the re-development of the Research & Innovation Centre, the Emergency Planning Resource Store has been re-located to the portacabin adjacent to Imaging and the resources have been renewed and updated to include a wider range of resource.

Incidents & Events

The NHS Standard Contract, Service Conditions, outlines the criteria to be met for Emergencies and Incidents, whilst a number of the Service Conditions link with specific requirements of the Assurance Framework there are a number of additional requirements.

Most significant is the condition that providers MUST develop joint planning and training exercises including;

- a six monthly communications exercise.
- an annual desktop exercise.
- a major live or simulated exercise every 3 years.

Communications drills were traditionally done by the LHRP's to check Trust response every six months, however, this would only exercise a maximum of two people per annum, this has also lapsed following changes and re-structure at regional level. To check all staff response, the Trust EPO has developing an internal communications exercise that will mean on call staff are contacted at least quarterly. This will commence in 2015/16 and the first timed response will be conducted in April.

The respective LHRP's are including training and exercising within their Work Plans to ensure that a significant test of resources is done for all Trusts. The relative groups are tasked with proposing the theme for training and exercises.

Exercises

As part of the EPO role, post holders are expected to be willing to become members of the Emergency Planning Society and the Business Continuity Institute. This is to ensure that the appropriate level of training and expertise is available.

Within the Trust a programme of training and exercising is in place. Following the revised EPRR documentation suite at the end of 2014, all On Call Staff received training in the new policies, Hazard Manager use and Resilience Direct.

The following Exercises also took place within the Trust.

- Exercise Artemis (Hospital Lockdown)
- Exercise Dora (Missing Child)
    - Exercise Dora 2 – (for Radiotherapy Section managers)
- Strike Preparation (Industrial Action)

During the course of the year the Trust has been represented externally not only at LHRP, PSG and HRG meetings but also at Multi Agency Exercises and Event Preparation:

- Exercise Nightingale (Pandemic Flu) at Aintree
- Exercise Wildfire – (Foodborne illness) at Warrington
- Exercise – EPRR Arrangements at Widnes
- Exercise – Ebola Preparedness & Response at Liverpool
- Cunard 175 Celebrations / 3 Queens visit to Liverpool
- Open Golf Health Preparedness

Partner Exercise

Exercises alongside other NHS Trusts are currently being planned via the PSG and HRG as part of the respective LHRP Work Plans. These are in addition to exercises organised by individual organisations e.g. Public Health England.

The EPO also attends the joint Cheshire and Mersey Business Continuity Group.

Risk Management

Risk Management approaches are being developed via the Departmental Business Continuity Assessments. Significant risks within the assessments are being allocated a RAG Status (Red/Amber/Green) as to their effect on Business Continuity. Where risks have ongoing implications, they are then formally Risk Assessed under the Trust Risk Management Policy and placed on the Risk Register if appropriate.

The Trust once again vaccinated staff as part of the Department of Health seasonal influenza campaign, achieving a vaccination rate of 57.8% of frontline staff. This was a reduction on previous years, partially due to issues with the PGD for giving the vaccines and latterly following negative publicity on the effectiveness of the vaccine.

Audit & Self Assessment

The Health & Safety Adviser & EPO collates and audits departmental plans and publishes them within the EPRR Suite of documents.

EPRR Policies are prepared and undertake Self Assessment by the EPO, Policies and Plans are submitted to the Emergency Planning Committee before proceeding to Information Governance Committee for final approval.

Clinical Governance Report: Patient Experience

Executive Summary

Caring and responsive

- Complaints are responded to effectively and in a timely manner
- Learning from PALs and Complaints is accepted within the culture of CCC
- The Board is aware of Complaints and trends from PALs in realtime
- FFT is embedded within the Trust

Annual Report

Formal Complaints

The table below gives an overview of the complaints received, the subject of the complaint and any actions taken as a result of the complaint. It also indicates if the complainant has escalated their concerns to the Parliamentary Health Service Ombudsman (PSHO) and the outcome, if known, of that escalation.

Date Received	Complaint no/	Narrative	Response date	Comments	Grade/ Upheld/PHSO
30/04/2014	01/2014	Patient was unhappy as she had not received an outpatient and felt the attitude of the person she spoke to was inappropriate, explanations and apologies were offered.	08/05/2014	NFA	2 partially upheld No PHSO
29/05/2014	02/2014	Patient unhappy with attitude of consultant and treatment option offered. Meeting with MD and CE explanations and apologies offered	18/08/2014	Further questions responded to	2 Not upheld PHSO yes- not investigated
24/06/2014	03/2014	Patient's wife unhappy with communication between the healthcare providers involved in patient's care and chemotherapy administration. Explanations were offered and a meeting offered which was declined.	02/10/2014	Meeting with doctors declined, NFA	2 No No PHSO

09/07/2014	04/2014	Patient was unhappy with the way she was spoken to and made to wait in Diagnostic Imaging for her scan	24/07/2014	Apologies offered	2 yes No PHSO
10/07/2014	05/2014	Patient was hit by radiotherapy machine. Apologies offered.	30/07/2014	Apologies offered	2 yes No PHSO
11/08/2014	06/2014	Contact from advocate on behalf of bereaved relative. Patient not given bone infusion and delay in referring to palliative care	29/09/2014	Apologies offered	2 yes PHSO ongoing
15/08/2014	07/2014	Contact from MP. Patient unhappy that a possible new treatment was not made available to her..Offered explanations as to why explained further treatment options	28/08/2014	Explanation offered	2 No No PHSO
03/09/2014	08/2014	Relative raised concerns regarding communication and recurrence of disease.	25/10/2014	Explanations offered and apologies, contact from son to thank us for response	2 No No PHSO
1/10/2014	09/2014	Relative has questions relating to treatment and care and communication with other Trusts	29/10/2014	Explanations offered.	2 partial Yes PHSO (ongoing)
13/10/2014	10/2014	Patient has questions relating to treatment and side effects	19/11/2014	Questions answered.	2 No No PHSO
02/01/2015	11/2014	Family unhappy that patient attended for a number of appointments expecting chemo. Then declined chemo due to being too poorly	03/02/2015	Apologies and explanations offered- changes made to LMC clinic proposed	2 yes No PHSO
10/02/2015	13/2014	Bereaved relative has questions relating to care and treatment as felt chemo dose was inappropriate as weight recorded incorrectly	30/03/2015	Reassurance offered and apologies	2 partial No PHSO

25/02/2015	14/2014	Patient unhappy as they had been told disease had become metastatic then told that it was not metastatic	02/04/2015	Explanations and apologies offered	2 Yes No PHSO
18/03/2015	15/2014	Patient and family expressed concern at communication from referring hospital to CCC also internal communication in radiotherapy	05/05/2015	Explanations and apologies offered	2 no No PHSO
25/03/2015	16/2014	Daughter of patient concerned that recurrence had not been diagnosed in timely manner despite GP raising concerns about patient	06/07/2015	Apologies offered	2 Yes N/K PSHO

Summary 2014/15

Total complaints received 16

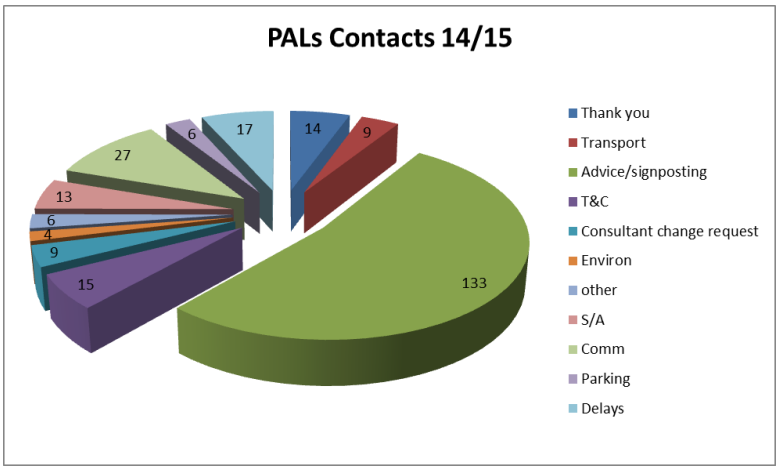
Subject matter of complaint:

Treatment and Care	12
Communication	1
Staff attitude	3

All complaints have been reviewed by The Council of Governors Patient Experience Group

PALS

A total of 263 Pals contact were received this year, Please see graph below for a breakdown of contacts.

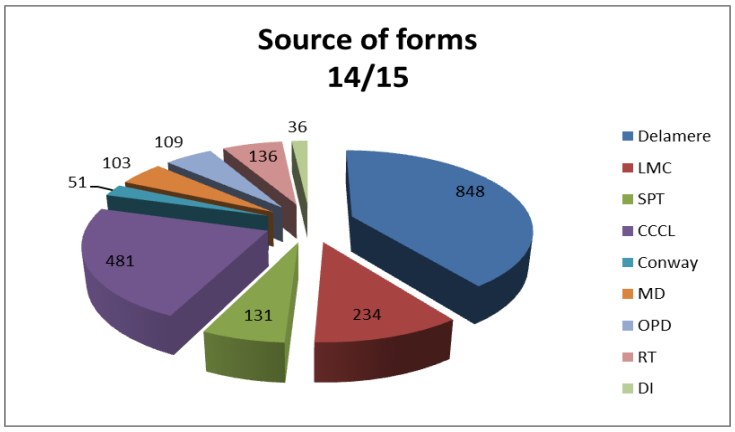


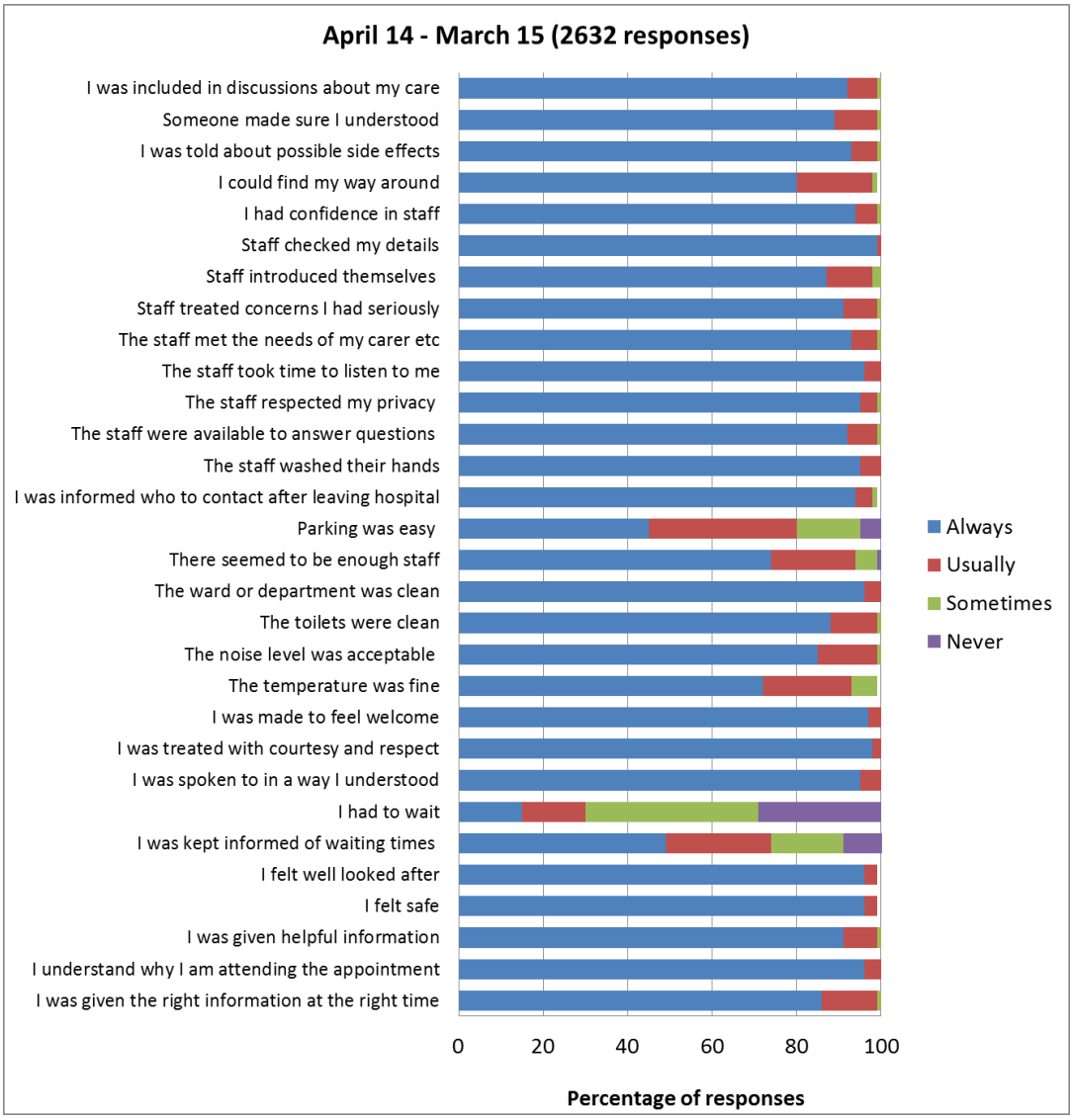
Staff continue to refer patients to PALs along with referrals from PALs volunteers and via patient information. The majority of PALS concerns are dealt with on a face-to-face basis or on the telephone, contact is also made by e-mail and responded to by e-mail.

Patient Feedback Survey

Since June 2007, the Trust has given every patient completing a course of treatment at the centre a patient experience feedback from to ensure that the Trust has 'real time' information about the patient's experience, which it can act upon. This has proved an effective method of monitoring our services and consolidating good work that goes on all around the Centre. Results are available on the Trust website. We have received over 20,000 feedback forms during this time.

During the time period April 2014 to March 2015 we have received 2632 forms compared to 2063 from the previous year. The following chart identifies the source of the forms during this year:





The Friends and Family Test (TFF)

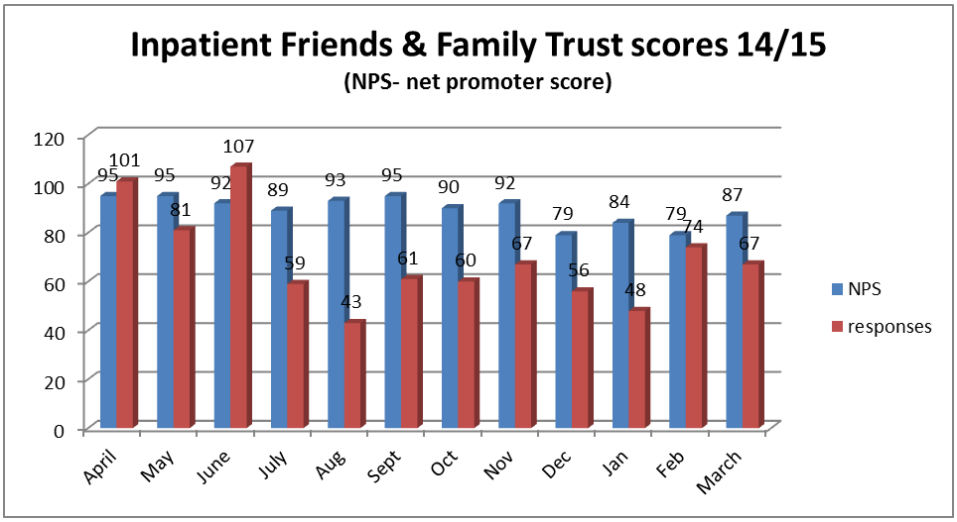
In December 2012 CCC began the implementation of The Friends and Family Test in preparation for it's national launch in April 2013. The goal of the The Friends and Family Test is to improve the experience of patients. It will provide timely feedback from patients about their experience. All NHS Trusts have a requirement to ask every inpatient the following question:

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

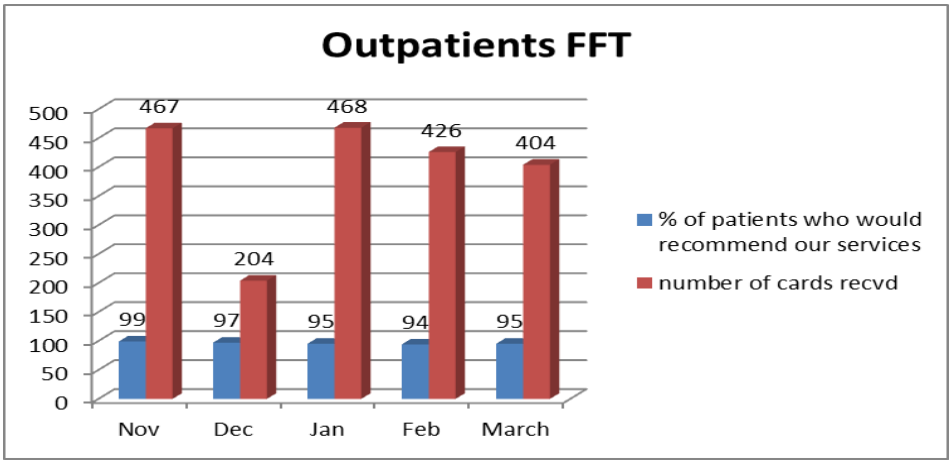
[] Extremely likely
[] Likely
[] Neither likely or unlikely
[] Unlikely
[] Extremely unlikely
[] Don't know

From April 1st 2013 it became mandatory across the NHS, however here at CCC we decided to start from December 1st 2012 to ensure a robust system was in place by April.

We opted to try a paper based system in the form of postcards. The guidelines state that the patient must be asked the question at discharge or within 48 hours of discharge. The aim is at least a 15% response rate. We have distributed collection boxes on the wards and at the main desk.
The results so far have been very encouraging with regard to patient's recommendations, however work is needed in certain areas to ensure all patients are given the opportunity to complete the questionnaire.



FFT was rolled out to all outpatients in November 2014, in readiness for the mandatory roll out in April 2015. It provided us with a very positive starting point.



Patient and Public Involvement Activity

During 2014/15 the Trust has engaged with patients and stakeholders to further develop its services.

Activities have included:

- The further open day for Healthwatch (formally LINKs), and members and representatives from local OSCs which focused on our Quality Accounts. The feedback continues to be very positive from these sessions.

The Patient's Council has continued to assist us with:

- Local surveys
- Lay reading of all patient information
- Engagement with current patients
- Staff interviews
- Audits
- Staff Awards
- Peer Review
- PEAT/PLACE walkabouts

The views and experiences of people that use our services have influenced our service priorities and plans through a number of mechanisms, these include:

- Our Governors and members as a Foundation Trust
- Patient and Carer involvement in specific projects
- Responding to complaints, concerns and praise.

To maintain our aim of 'Providing excellent care to people with cancer' we must provide care that is excellent in the view of the patients and carers that use our services. We aim to continue to increase patient and public involvement in the planning and delivery of our services. This is being done in the following ways:

- Strong engagement with our Governors in developing our forward plans
- Strengthened links with Healthwatch
- Asking all patients who complete an episode of care to complete a 'Patient feedback form', which gives the Trust real time feedback. This information is also provided on our website
- Engagement with our members directly and through our Governors
- Analysis of Friends and Family results
- Continue to engage with varied groups (Wirral Deaf Society, Clwyd patients council, John Holt Cancer Foundation).

External Surveys

During this year CCC participated in the 2014 national inpatients survey. The Care Quality Commission 2013 inpatient survey involved 156 acute and specialist NHS trusts and received responses from more than 59,000 patients, with a response rate of 45%.
CCC had a response rate of 52%.

Compared to last year we were significantly better on 1 question and the scores showed no difference on 59 questions. Compared to other Trusts we were significantly better on 51 questions, worse on 1 and the same on 10.

The results are available on NHS Choices website
http://www.cqc.org.uk/provider/REN/survey/3

Clinical Governance Report: Volunteers

Executive Summary

- Number of hours of voluntary service given. The total number of recorded hours of voluntary work coordinated by the CCC Volunteer Coordinator was 11305 hours. This figure is for the Volunteer Team only and excludes the independent organisations such as the WRVS and League of Friends and the Patients' Council. The number of active volunteers on the Volunteer Team for April 2014 – March 2015 is 88 volunteers attending at least weekly for at least three hours per week. This is an increase of 18.91% on the number of active volunteers for the previous period.
- Recruitment of new volunteers has been a priority considering that new volunteers had not been recruited for almost two years. 21 new volunteers were successfully recruited and are now in voluntary placements. This figure is set to rise as recruitment continues. 6 volunteers left The Trust during the financial year.
- Recruitment has commenced for a new volunteer position of 'Care Companion', volunteers are being sought to spend time on a one to one basis with patients (under the supervision of staff) who may have additional needs and require more help.
- Training for volunteers has been completed by the majority of volunteers. Core Skills mandatory training sessions are being held for volunteers alongside new staff being brought into The Trust. There are a few volunteers who have been off for a long term due to ill health, these volunteers are yet to complete this training, however, Core Skills sessions have been booked for those that have now returned.
- Training around safeguarding is currently being reviewed to make improvements and will be implemented when finalised.

Dementia Awareness training sessions are available for volunteers to attend alongside staff, there has been considerable interest and uptake from the volunteers.

In addition to the activities and services provided by the Volunteer Team, the Volunteer Coordinator **liaises with other voluntary organisations**:

- In-patients are visited by **Wirral Manx Society** members, **Chaplaincy** volunteers and **Radio Clatterbridge** volunteers.

- The **League of Friends** continues to make funds available.

- The **RVS** Project Leader recruits and manages the volunteers working in the shop, cafeteria and tea bar.

Value Added by Volunteers

Costs of CCC Volunteer Team are mainly met from The Trust's charitable funds.

- Given that volunteers are complementary not supplementary and do not undertake paid staff roles, it can be difficult to evaluate their contribution in financial terms. However the VIVA (Volunteer Investment and Value Audit) provides one tool for attempting this exercise. The model used at CCC involves valuing the volunteers' time at the NHS minimum wage of Band 1 Point 1 of the pay scale. At this rate, the volunteers' contribution to the trust is worth almost £100,000.

- Based on this figure, and setting against it the Volunteer Coordinator's salary, which is the main cost associated with the Volunteer Service, the volunteers' **net** contribution to The Trust is over £87,000 per annum and the VIVA ratio is 1:9.2. i.e. for every £1 that CCC invests in its Volunteer Team, it receives services to the value of £9-20 and The Trust's investment in its volunteers is multiplied more than nine fold. A Europe-wide VIVA study carried out by the Institute of Volunteering Research in large voluntary organisations (e.g. Scouts, National Trust) showed returns of between 1.3 and 13.5, with most between 3 and 8. The return in smaller organisations was usually between 2 and 8. With a return of 9.2, CCC exceeds the usual return for volunteer-involving organisations throughout the UK and Europe.

- This conservative figure significantly undervalues the real contribution, since the services and skills of many of the CCC volunteers should be valued more highly than the NHS minimum wage, particularly in areas such as the Massage Service and the HeadStrong Service, where volunteers have been required to undertake a significant amount of role-specific training in their own time. A more accurate (and significantly higher) figure for the value of CCC's volunteers could be arrived at by valuing the volunteers' roles differentially, according to the skill level required for each specific volunteer role.

Annual Report

Volunteer Roles 2014 - 15

Volunteer roles at CCC are mainly concentrated on enhancing the Patient Experience. They also contribute to Patient Safety, particularly for outpatients, e.g. by facilitating safe access to the relevant department. Health and Safety and Infection control issues are carefully considered in drawing up all Volunteer Task Descriptions. Where volunteers are directly providing services to patients (e.g. Simple Hand and Foot Massage Service) the effectiveness of the service is regularly assessed and monitored with assistance from the Clinical Effectiveness Team.

This year, CCC Volunteers have assisted in the following areas:-

Main Foyer Enquiry Desk Guide and Message Service

- Delamere Day Case Unit
- Diagnostic Imaging Reception
- Radiotherapy Arrivals
- Outpatient Clinic
- Radiotherapy Refreshment Trolley
- PALS service
- Patient Information Service
- Medical Records
- Human Resources
- Executive Office (FT Membership)
- Clinical Education
- Simple Hand and Foot Massage
- HeadStrong
- Patients' Library
- Befriender – Welsh and Isle of Man patients
- Pets as Therapy Visitor

At CCC, the Volunteer Coordinator directly manages most of the volunteer services. This is different from most NHS Volunteer Co-ordinator roles elsewhere. Normally a hospital Volunteer Co-ordinator would be responsible for selection, recruitment and support of volunteers but day to day management would be delegated to the staff in the area where the volunteer is placed. At CCC this only occurs in PALS, MacMillan Cancer Information Centre, Diagnostic Imaging, and Outpatients Clinic. All other volunteers are directly managed by the Volunteer Co-ordinator.

Head Strong Service Development

CCC's HeadStrong service continues to be the busiest HeadStrong Service in the country. Every patient accessing the service is asked to complete an Evaluation Form. Feedback continues to be consistently excellent. The previous recruitment issue has been addressed and more volunteers have started with HeadStrong. The new volunteers have settled in their roles and are working very well as a team. The new accommodation for the HeadStrong service is well under way and is expected to be completely finished by May 2015 which will enable the volunteers to provide this very valuable service in a pleasant non-clinical area.

Hand and Foot Massage Service Development

During the year from 1st April 2014 to 31st March 2015 a total of **935** massages were provided to patients in the Radiotherapy Treatment Area, all inpatient wards and Delamere Day Case Unit. This figure is considerably lower than previous years'; this can be partly attributed to the reduction in the number of volunteers carrying out this service. The last recruitment drive for Massage volunteers was in 2009, there are currently not enough volunteers to run this service every day of the week. Recruitment for this service will take place once the most effective way to recruit volunteers for this service has been established. In previous recruitment drives through the local media large numbers of people have applied to be massage volunteers thinking it would lead them to being able to perform massages on a professional level which is not the case, but resulted in many hours of the Volunteer

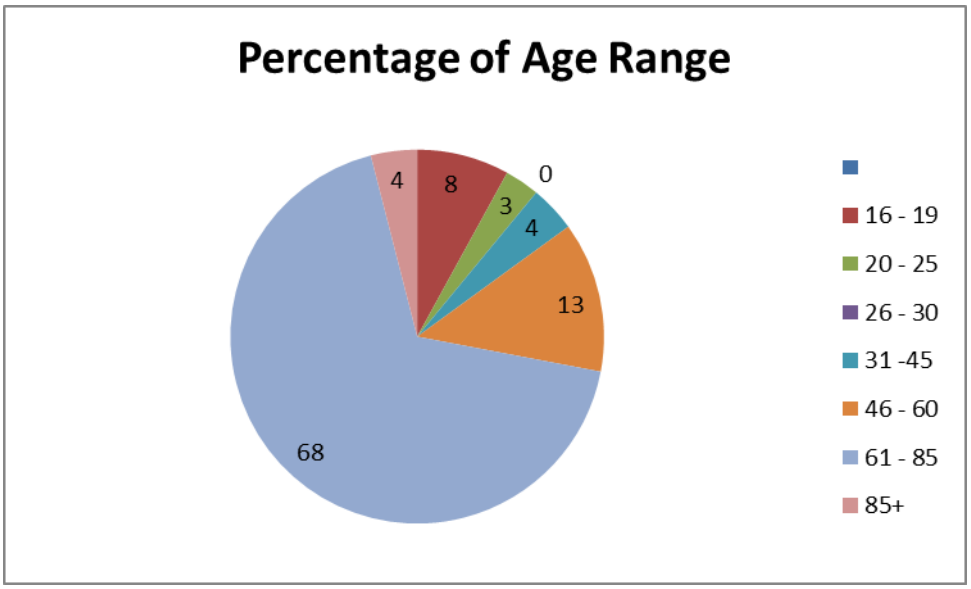
Co-ordinator and the Volunteer Manager's time trying to establish who was genuinely interested in becoming a volunteer for The Trust.

Characteristics of volunteers

Because so much of CCC's activity is outpatient activity, volunteer roles are concentrated within the times of clinics, Monday to Friday from 8am to 4pm. This makes it difficult to place volunteers who are in full time work or education and want to volunteer in their free time. During 2014 – 2015 the effort to provide placements for school sixth formers who are interested in health service careers has continued and students have been recruited and placed when their school or college timetable allows. The volunteer department regularly receives requests from students for short term Work Experience or internships etc, but is not currently able to accommodate these requests, which are passed to Human Resources. There has also been an increase in the number of mature students going into healthcare as a change in profession who wish to volunteer to gain the relevant experience in support of their applications to further education.

Volunteer Policy – was updated in February 2015 and is due for review in 2018.

Volunteer Demographics
The 88 volunteers are broken down as follows:
81% are female
19% are male
4.5% have a disability



Retention rates continue to be very high with only a very small number of volunteers leaving after a short period with The Trust, reasons for withdrawing from volunteering are usually associated with personal circumstances rather than not being able to settle comfortably as part of the volunteer team.

Volunteer Recognition

Volunteers are well established at CCC and are highly regarded by Trust board and staff. As a thank you to volunteers an evening celebration is held annually. Volunteers are often nominated by members of staff for the monthly Staff Achievements award.

Business Intelligence Annual Report

Section 3

Clinical Governance Report: Clinical Effectiveness Team (CET)

Executive Summary:

NICE guidance dissemination and Implementation

- The Trust is continued to assess and implement the NICE guidance that were relevant to the Trust. Yearly audit demonstrated the policy has been adhered to and reports were submitted to the relevant committee.

Clinical Audit

- The Trust took part in all relevant national clinical audits i.**e.** DAHNO, LUCADA, NBOCAP and NOGCA and also took part in 3 additional national audits.
- The clinical audit sub-committee approved 35 new local clinical audit projects and 35 existing clinical audit projects were completed in 14/15.
- During 14/15, four audit presentation events took place – (Lung, Upper GI & HPB, Colorectal and Breast SRGs), these events were proven to be valuable in disseminating audit findings and share good clinical practices.
- A number of posters from clinical audit projects were published at various International/European Conferences. One of posters was awarded highly commended at the Royal College Audit meeting.

Clinical Dataset

- SACT – The Trust continues to supply validated Systemic Anti-Cancer Therapy (SACT) data to the Chemotherapy Intelligence Unit monthly which includes regimen details, cycle details and drug and dosage detials.
- COSD – The Cancer Outcomes and Services Dataset (COSD) is a replacement of the National Cancer Dataset based on the recommendations from the Cancer reform Strategy (2007) and the Strategy for Cancer (January 2011). It includes all cancer types and the complete patient pathway from initial diagnosis to patient deceased. The Trust has been providing all treatment related data and MDTs data monthly to fulfil the COSD data submission.

Annual Report:

CET consists of 3 teams: Clinical Officers, Clinical Coding and Clinical Audit. The service provided includes facilitating NICE guidance implementation and assessment process, inputting and validation of clinical data (inc. primary tumour details, chemotherapy and radiotherapy treatment details etc), facilitating clinical audit (local and national audits), clinical mortality review programme, clinical coding for HRGs and medical statistics support.

Nice Compliance and Audit
There were 131 sets of new NICE guidance published during 14/15, details as follows:

Category	Number published	Number applicable to CCC	Compliance Status
CG	15	2	1 x Partially compliant 1 x Awaiting reply from local lead
DG	5	0	
HST	1	0	
IP	33	0	
MTG	7	0	1 x missed from dissemination
NG	7	2	1 x Partially compliant 1 x Awaiting reply from local lead
PH	5	0	
QS	29	6	1 x Compliant 1 x Partially compliant 4 x Awaiting reply from local lead 5 x missed from dissemination
SG	1	1	1 x Awaiting reply from local lead
TA	28	10	6 x Compliant 4 x Awaiting reply from local lead 1 x missed from dissemination
Total	**131**	**21**	

The following guidance were deemed partially compliant at the time of assessment, an implementation plan has been developed which are in the process of being actioned.
CG179 - Pressure ulcers
NG5 - Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes
QS82 - Smoking: reducing tobacco use

NICE audit carried out during 14/15
Six audit were carried, 4 Technical Appraisals and 2 Clinical Guidance. Results showed the Trust is fully compliant with 5/6 sets of guidance. The partial complaint is CG151 Neutropenic sepsis and action plan has been developed by the Acute Oncology SRG. All NICE audit reports were reported to the Integrated Governance Committee.

Clinical Audit

National Clinical Audit and Study
Over the past year the Trust has continued to support several national audit projects. Patients' treatment details and mortality data were submitted to the following projects:

- DAHNO (Data for Head and Neck Oncology)
- LUCADA (Lung Cancer Data Audit)
- NBOCAP (The National Bowel Cancer Audit Project)

- NOGCA (National Oesophago-Gastric Cancer Audit)

The purpose of the audits is to improve the care and outcomes of patients. They provide valuable comparative information at national and local level through annual reports which contain case mix analysis of anonymised data and recommendations and guidance for future care. Participation is monitored as part of the Care Quality Commission regulatory requirement.

In addition to the above audits, the Trust also participated in the following National audits:

- National Re-audit of Breast Radiotherapy Practice
- National Teenage and Young Adults Service Evaluation
- National Proton Beam Therapy Ocular Melanoma

NCEPOD

CCC participated in the following NCEPOD study during 14/15

- Gastrointestinal Haemorrhage Study

Audit Sub-Committee

Audit Sub-Committee meets monthly to approve proposed clinical audits that were suggested by health professionals. Members of the Sub-committee are made up with representatives from patients, various departments and health professionals. (i.e. Clinician, Radiotherapy, Pharmacy, Diagnostic Imaging and audit team, etc.) During 2014/15, the sub-committee approved 35 clinical audit proposals in total over 6 face to face meeting and further 2 virtual meetings. Four audit presentation events took place in 14/15 – (Lung, Upper GI & HPB, Colorectal and Breast SRGs). An overview of the audit events were also feedback at the audit sub-committee meetings by the Chair of the group.

Completed Local Clinical Audits

There were 35 completed local clinical audits during 2014/15, of which 23 confirmed good practice, 8 made improvements to clinical practice and 4 sustained improvement.

Three Examples of Changing Clinical Practice due to Audit Findings

Audit 1) Audit of Rates of Acute Kidney Injury Following High Dose (≥75mg/m2) Cisplatin Chemotherapy at Clatterbridge Cancer Centre (CCC) – Dr C Brammer

Audit Objective(s):

1) Establish if there is an increase in acute kidney injury where there is a gap between the administration of hydration and commencement of high dose cisplatin

Actions:

1. Outpatient/Daycase delivery of Cisplatin 80mg/m2 or lower should be standard of care for all patients using the rapid hydration regime.
2. A more rapid schedule of pre and post hydration should be considered for patients receiving 100mg/m2 so that Cisplatin and immediate post Cisplatin fluids are not being commenced out of routine working hours
3. All patients at high risk of Cisplatin associated AKI should be monitored after treatment with U+E performed 5-7 days following treatment. AKI becomes apparent 5-7 days following Cisplatin delivery
4. Routine chemotherapy (including post hydration fluids) should not be given outside of the normal working day when staffing levels are lower. This currently constitutes a systems failure which is putting staff and patients at risk.
5. If an AKI develops after cisplatin chemotherapy a dose reduction should be routine for subsequent cycles to prevent further harm.
6. Re audit to be performed after changes have been made
7. Note: When switching from Cisplatin to Carboplatin following to development of Cisplatin induced AKI a measured method (ie EDTA GFR) must be used for obtaining GFR for carboplatin dosing. Pathological losses of creatinine following Cisplatin induced AKI in addition to physiological losses may lower serum creatinine and therefore overestimate GFR if calculated methods to estimate GFR are used in this situation.

Audit 2) Audit of the Amber Care Bundle (ACB) (AMBER – Assessment, Management, Best Practice, Engagement, uncertain Recovery) – S Cubbin, Dr A Coackley, Dr E Ahmed

Audit Objective(s):

1) The aim of the audit was to implement the AMBER care bundle onto the three inpatient wards and audit its effectiveness

Actions:

1. Ward Champions on each ward now
2. Information on the Intranet
3. AMBER care bundle tab on Maxims so that conversations can be captured and recorded by nursing staff
4. Survey to consultants, asking about experiences so far
5. AMBER care bundle leaflet for staff approved
6. To make the ACB a more prominent feature within doctors handovers and part of their handover/discussions
7. Improve usage within step up beds
8. Forge stronger links with Acute Oncology
9. Ongoing teaching/support of staff

Audit 3) Re-audit of nursing care documentation of patient pressure ulcer care – C Smith

Audit Objective(s):

1) To see if an initial assessment of the patients pressure areas was made within the first 6 hours of admission to the ward (as per NICE guidance).
2) To see if the evaluation of care had been made during each shift.
3) To see if a reassessment had been made and recorded at 7 day intervals for those patients a who had been assessed as being at risk (i.e with a waterlow score 10 or above).
4) To see if a relevant care plan had been initiated.

Actions:

Objective number	Ward/ Action required	Responsibility
1	***Conway*** - To continue monitoring patients on admission to maintain 100% compliance.	All staff/Nurse practitioners
	Mersey - 100 % Compliant - continue to promote best practice	Nursing staff
	Sulby **-** Re-iterate at ward meeting ongoing education	Ward Manager, Senior staff nurses, Nurse Practitioners
2	***Conway*** **-** Staff to document on each patient within 12 hours. Ward manager/senior staff nurses to re-inform staff and encourage them to undertake the documentation. Staff are aware of the need to document.	Managers /ward staff
	Mersey **-** Rationale for greater than 12 hourly documentations required to assess change practice	
	Sulby **-** Ongoing education. Book staff onto document work shop	Ward Manager, Senior staff nurses, Nurse Practitioners
3	***Conway*** **-** To ensure that Conway ward continues to check and update Waterlow scores on all patients twice weekly- Sunday and Wednesday unless there is a conditional change	Ward staff
	Mersey **-** Establish a set day for reassessment i.e Sunday	Nursing staff
	Sulby **-** Ward manager and senior nurses to do spot checks	Ward Manager, Senior staff nurses, Nurse Practitioners
4	***Conway*** **-** Staff aware to check pressure areas and document and start care plans if at risk/have pressure sores.	Ward staff/senior staff/manager
	Mersey **-** Staff educated in creating care plan and appropriate action process	Nursing staff
	Sulby **-** Ongoing education	Ward Manager, Senior staff nurses, Nurse Practitioners

Sharing Audit Findings
Trust audit leads are encouraged to share their audit findings at the SRG Audit Presentation events and Regional Meetings. Several abstracts and posters have also been submitted and presented at conferences. The following are some examples of posters/abstracts accepted by conferences are listed below:

European Society for Radiotherapy and Oncology (ESTRO)
An audit of consistency in bladder position with the introduction of micro-enema in planning and treatment preparation – *D Hutton, J Callender*

National Cancer Research Institute (NCRI) Poster Presentations
Uveal Melanoma: A review of patients undergoing surgical resection for hepatic metastasis – *Dr A Olssen Brown, Dr E Marshall, Dr J Sacco, J Upton*

Use of Adjuvant Brachytherapy in Endometrial Carcinoma: An audit of current practice at The Clatterbridge Cancer Centre – *Dr C McCormick, Dr M Chopra, H Wong, Dr K Whitmarsh, Dr K Hayat*

Outcomes in stage IV non-small cell lung cancer treatment: an observational study – *Dr C Escriu, H Wong, M McKay, Dr E Marshall*

European Association of Palliative Care
Evaluating End of Life Care at Clatterbridge Cancer Centre using the VOICES Questionnaire – *E Sugrue, Dr A Coackley*

Health Professionals' views on new local documentation for end of life care to replace the Liverpool Care Pathway (LCP) – *M Dowbekin, Dr A Coackley*

The British Thoracic Oncology Group (BTOG)
Use of Blood Transfusions in patient receiving Vinorelbine Oral and Carboplatin Chemotherapy for Advanced Non-Small Cell Lung Cancer (NSCLC) – *Dr A Tufail, Dr M Latif, Dr M Imran, H Wong, Dr J Littler, Dr J Maguire, Dr A Siva, Dr N Bhalla, Dr A Pope, Dr C Eswar*

European Society for Medical Oncology (ESMO)
Wait & See policy following Complete Clinical Response to Chemo-radiotherapy in Rectal Cancer – Single Centre Experience – *Dr M Latif, N Day, Dr A Montazeri*

Audit Training / Awareness Session
We continue to provide information to SHOs on how we can support them in their audits.

Training and advice for those interested in undertaking an audit is delivered on an individual or group basis by the Clinical Effectiveness Co-ordinators as required.

Clinical Information
There were 197 clinical data ad-hoc requests during the period of 2014/15, some of which provide support to the freedom of information request and to the decision making process for Trust strategies and clinical service developments.

Clinical Effectiveness

Accuracy of Clinical Data
In order to ensure completeness and accuracy of the chemotherapy codes in Maxims, CET have written a number of data quality reports. Two examples of such reports are as follows:
Maxims has a cycle recorded but PAS says chemotherapy deferred
Maxims does not have a cycle recorded but PAS says chemotherapy given

The outcome of CET running the above two reports is that all outpatient chemotherapy attendances had appropriate OPCS codes attached where applicable, therefore 100% completeness.

Systemic Anti-Cancer Therapy Dataset (SACT)
In order to support the SACT dataset, the CET officers continue to input the full prescription into Maxims, data items include drugs, dosage, method of administration, etc. SACT dataset is validated daily against completeness and quality.

Cancer Service Outcomes Database (COSD)
We are responsible for uploading information from the Unknown Primary and Teenage & Young Adults MDTs and also include all chemotherapy and radiotherapy treatment details delivered by the Trust into the COSD.

Supporting SRGs
Site Reference Groups (SRGs) are multi-disciplinary professional groups which include consultants, specialist nurses, radiographers, clinical trial nurses, etc. Research projects, local protocols including chemotherapy & radiotherapy and audit of clinical practice are discussed.

A Clinical Effectiveness Co-ordinator is assigned to **all** SRGs to promote and support clinical audit activity and to input into issues relating to the completeness and accuracy of clinical data in Maxims.

References

Audit Policy (PTWDAUDT)
NICE National Clinical Guidance Policy (Dissemination, Review, Implementation & Monitoring of National Clinical Guidance) (PCGONICE)
CET Operational Policy (CET-03)
Clinical Audit Sub Committee – Terms of Reference

Section 4

Clinical Governance Report: Clinical Outcomes

Executive Summary:

- The 2014 30/90 day treatment mortality analysis showed a better mortality performance than 2013 analysis and no additional regimen was identified to be added to the monitoring list
- There was higher percentage of assessment form completed by consultants compared to previous year and the mortality review programme has well attended
- Fifty-one percent of cases that were discussed at the review meetings had generated actions, of these actions, 68% have been completed and with the rest actions are on-going to be fully implemented

Annual Report

Clinical Outcome Form

The collection of clinical outcome data is continued. This form collects disease relapse/recurrence, treatment response and toxicity. The collected information will contribute to the clinical outcome measures highlighted in the Cancer Reform Strategy 2007.

30/90 Days Treatment Mortality Analysis

The 30 day chemotherapy and radiotherapy mortality (split by intent: Radical and Palliative) performances were reported to the Trust Board as part of the Quality Report. At the year end, an individualised performance report was distributed to all consultants, presented in the format of control charts and analysed by logistic regression statistics which allowed performance comparison between consultants and observed trends over time.

From the 2014 completed analysis, no additional chemotherapy regimen was identified to be added to the monitoring list together with the existing 4 regimens. Results also showed improvement to the overall mortality for chemotherapy and radiotherapy with the previous year data.

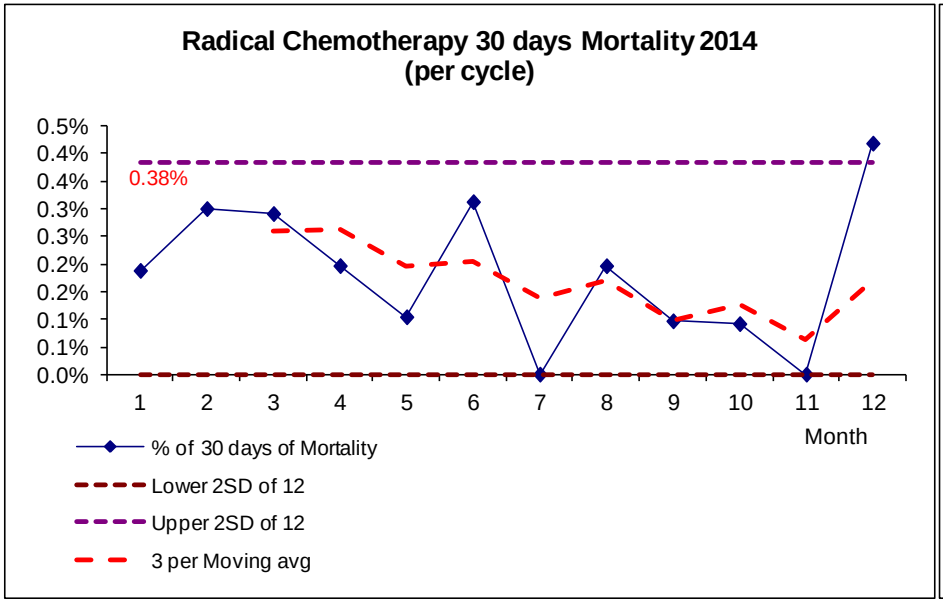
The overall CCC performance for Chemotherapy and Radiotherapy 30 day mortality is as follows:

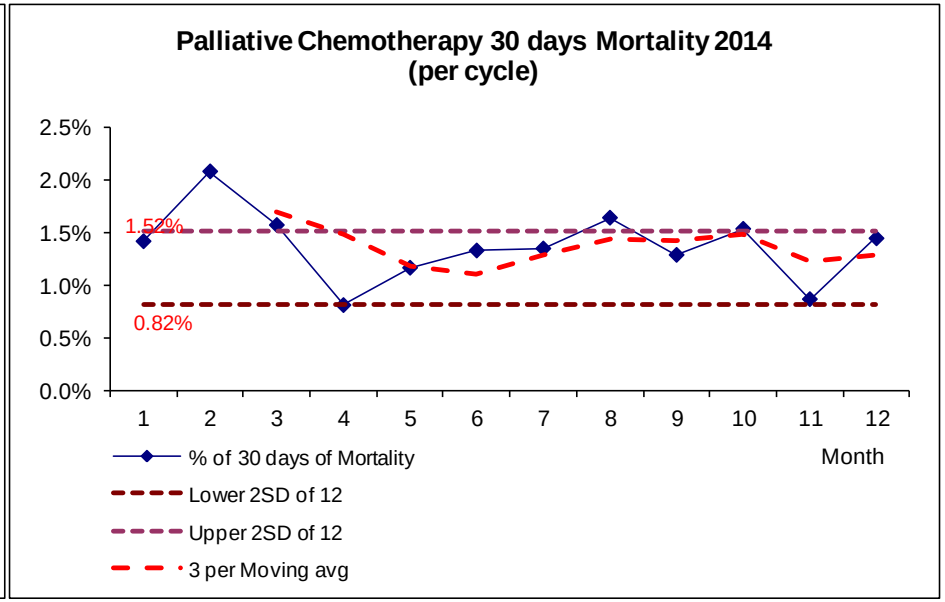
Radical Chemotherapy - overall

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
30 days mortality	2	3	3	2	1	3	0	2	1	1	0	5	23 patients
%	0.2%	0.3%	0.3%	0.2%	0.1%	0.3%	0.0%	0.2%	0.1%	0.1%	0.0%	0.4%	0.2% cycles (0.9% patients)
No. of Cycles	1066	1002	1033	1019	964	962	1070	1020	1037	1095	1006	1197	12471 cycles (2351 patients)

Palliative Chemotherapy - overall

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
30 days mortality	22	27	22	12	17	18	20	22	19	24	12	21	236 patients
%	1.4%	2.1%	1.6%	0.8%	1.2%	1.3%	1.4%	1.6%	1.3%	1.5%	0.9%	1.4%	1.4% cycles (7.9% patients)
No. of Cycles	1549	1295	1397	1476	1455	1351	1480	1338	1472	1560	1380	1450	17203 cycles (3024 patients)



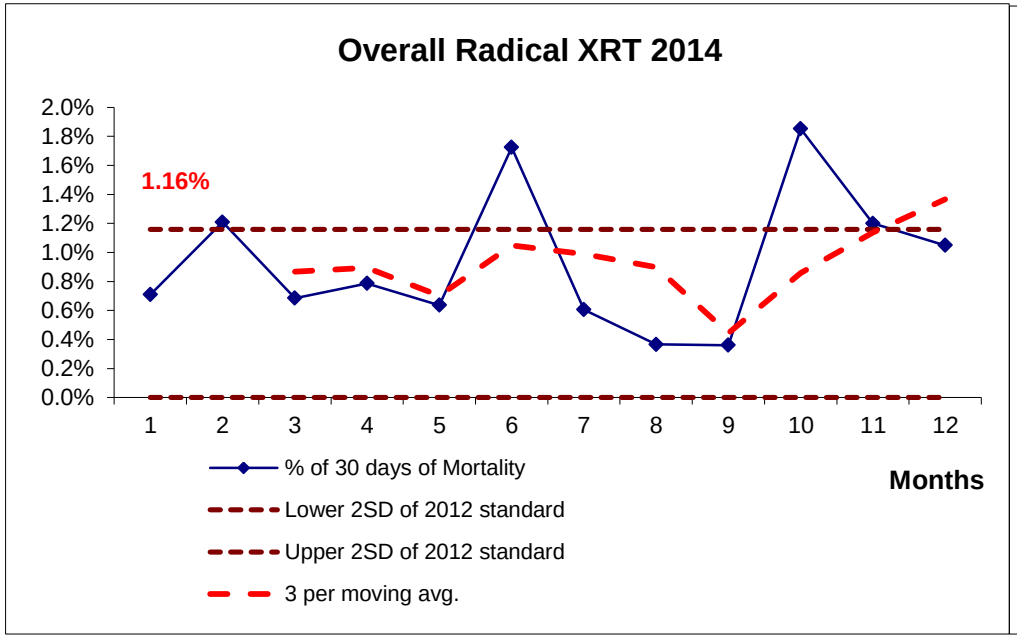


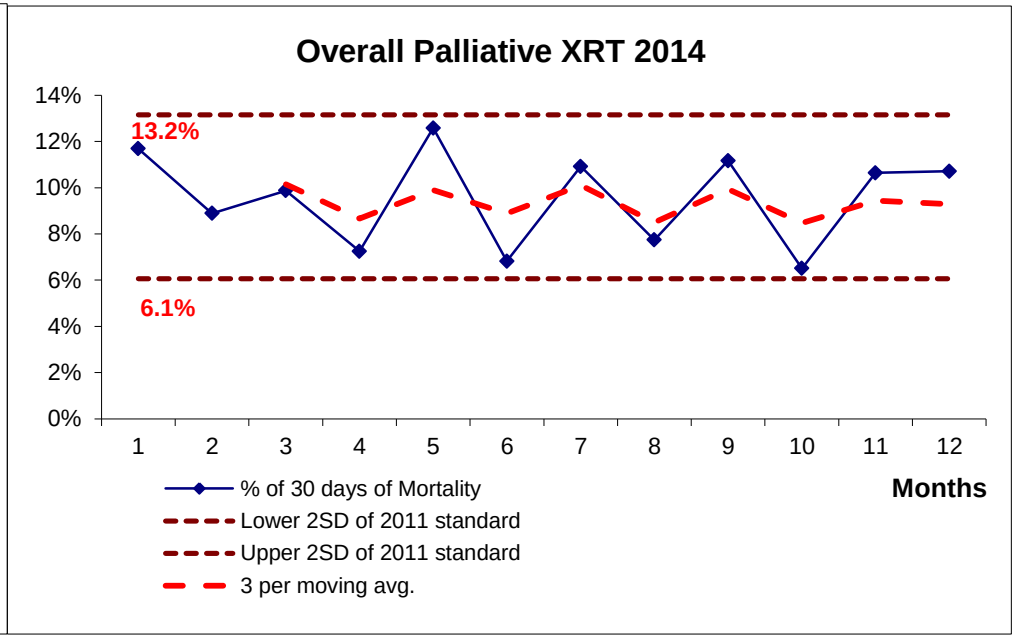
Overall Radical Radiotherapy

Month	1	2	3	4	5	6	7	8	9	10	11	12	Total
30 days mortality	2	3	2	2	2	5	2	1	1	5	3	3	31 patients
%	0.7%	1.2%	0.7%	0.8%	0.6%	1.7%	0.6%	0.4%	0.4%	1.9%	1.2%	1.0%	0.9% cycles (0.9% patients)
No. of XRT courses	282	248	292	254	314	290	330	273	277	270	250	286	3366 cycles (3300 patients)

Overall Palliative External Beam Radiotherapy

Month	1	2	3	4	5	6	7	8	9	10	11	12	Total
30 days mortality	18	12	16	10	19	12	19	12	22	14	15	21	190 patients
%	11.7%	8.9%	9.9%	7.2%	12.6%	6.8%	10.9%	7.7%	11.2%	6.5%	10.6%	10.7%	9.5% cycles (11.2% patients)
No. of XRT courses	154	135	162	138	151	176	174	155	197	215	141	196	1994 cycles (1704 patients)



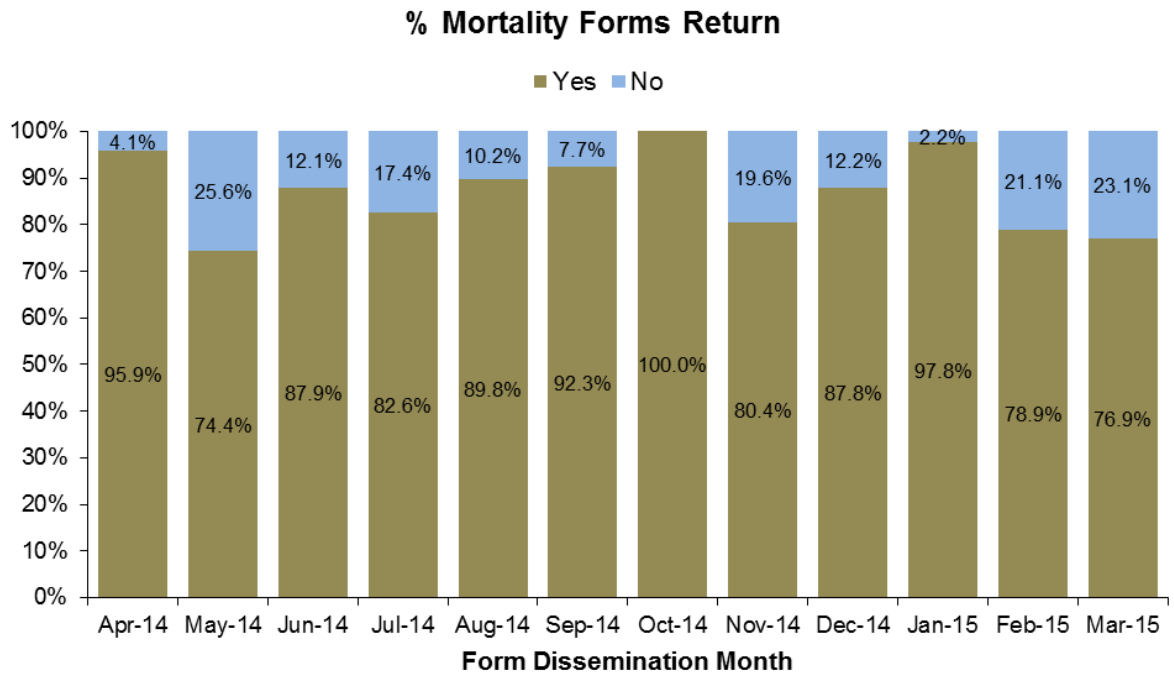


Mortality Review Programme

The Trust started a mortality review programme in June 2012 to review all patients deceased as inpatient, patients deceased within 30 days of their last treatment and patient deceased within 90 days of radical radiotherapy treatment. This is part of the overall Trust mortality review programme and provides a platform for recognition of best practice models as well as a tool for education, critical analysis and active peer support.

No. of mortality forms completed

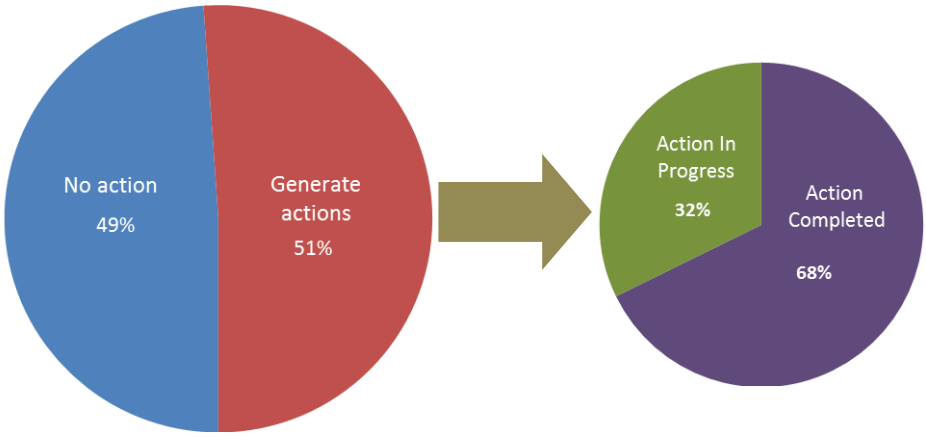
During April 14 – March 15, 594 patients were identified as part of the mortality review programme, 104 forms were exempted from sending to consultant for assessment as they were spinal cord or Bone metastases patients treated with protocol dosage 20Gy/#5 or 8Gy/#1, as agreed with consultants. Hence 506 forms were sent to consultants to complete, 441 (87%) returned, a continuous improvement from 81% of previous year. The following graph showed the percentage of completed form per month.



Action from Mortality Review Meetings

From the 441 completed proformas, 45 cases were selected for discussion at the Trust's monthly Mortality Review meeting.

Out of 45 cases discussed, 23 were concluded as no further action was required, 22 cases generated 31 actions to improve clinical practice, of which 68%(21/31) actions have been completed and 32%(10/31) actions are in progress.



Examples of actions are:

- Update protocol for standardised treatment for cord compression
- Develop new warning label for oral chemotherapy package stating to stop the oral chemotherapy if patient is admitted to hospitals
- Raise individual case concerns to relevant secondary hospitals or MDTs
- Advice all senior responsible clinicians to discuss DNAR/CPR as early as possible
- Standard post discharge medical letter to be sent out within 24 hours of discharge for all emergency admissions
- Provide additional education to Junior doctors on how to manage a major haemorrhage

CCC Cancer patient survival rate by Specific Tumour Group

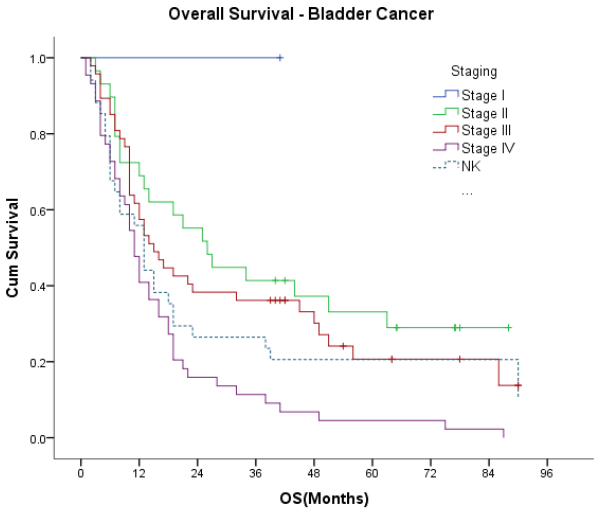
This section presents the overall survival for patients referred to CCC who were diagnosed with one of the following 5 cancers (Bladder, Head and Neck, Kidney, Liver and Pancreas) betweenJan-2007 to Dec 2011 with at least 12 months follow up.

Time Period: Newly diagnosed cancer between 2007- 2011.

Bladder:

Overall Survival:
1 year survival 55%
5 year survival 19%

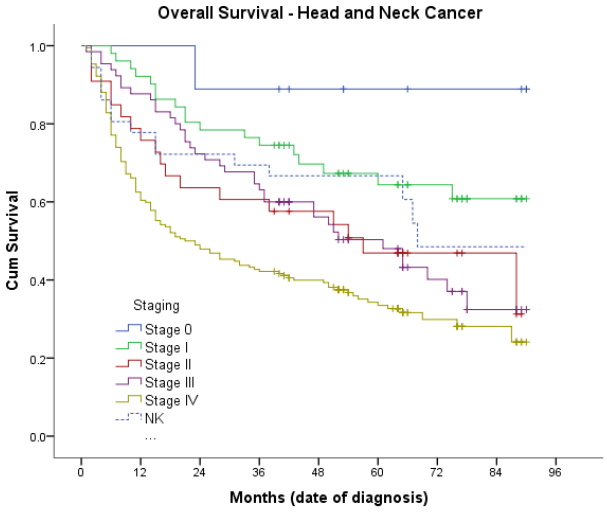
Staging	Total N	Median Survival (Months)
I	1	-
II	29	26
III	47	15
IV	44	11
NK	34	13
Overall	**155**	**13**



Head and Neck:

Overall Survival:
1 year survival 73%
5 year survival 46%

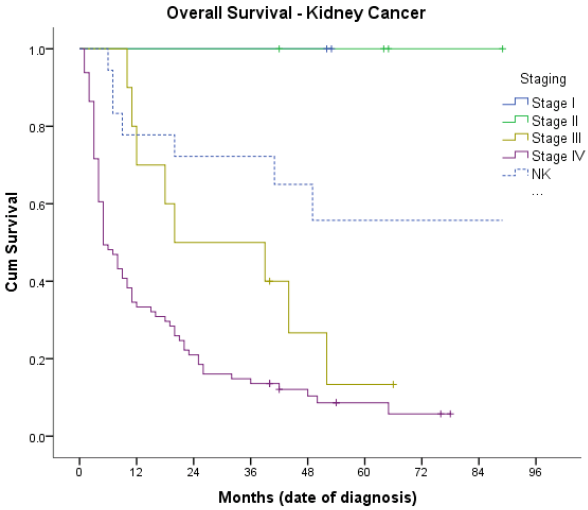
Staging	Total N	Median Survival (Months)
0	9	-
I	51	-
II	33	57
III	65	61
IV	192	21
NK	36	68
Overall	**386**	**51**



Kidney:

Overall Survival:
1 year survival 47%
5 year survival 21%

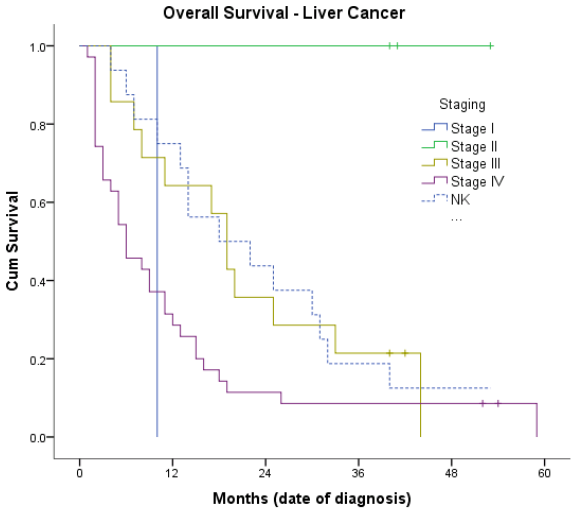
Staging	Total N	Median Survival (Months)
Stage I	2	-
Stage II	4	-
Stage III	10	20
Stage IV	81	5
NK	18	-
Overall	**115**	**10**



Liver:

Overall Survival:
1 year survival 49%

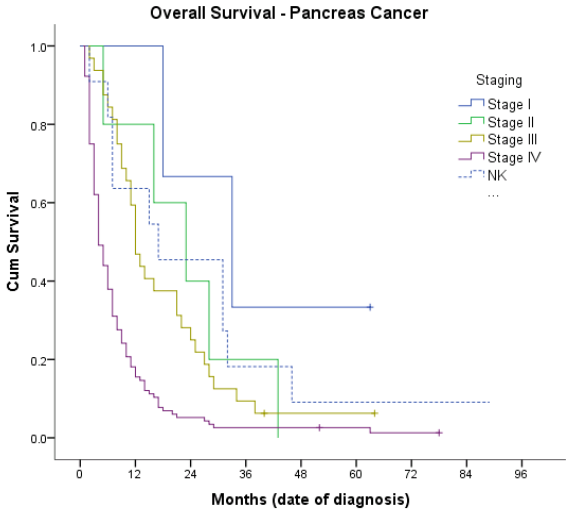
Staging	Total N	Median Survival (Months)
Stage I	1	10
Stage II	3	-
Stage III	14	19
Stage IV	35	6
NK	16	18
Overall	**69**	11



Pancreas:

Overall Survival:
1 year survival 28%
5 year survival 4%

Staging	Total N	Median Survival (Months)
Stage I	3	33
Stage II	5	23
Stage III	32	12
Stage IV	116	4
NK	11	17
Overall	**167**	**7**



Section 5

Clinical Governance Report: Clinical Coding

Executive Summary:

Clinical Coding IG audit 2014/15: Attained a level 3 - Primary diagnosis 95 % Secondary Diagnosis 96.72% Primary procedure 98.91% and Secondary procedure 96.36%

- Action plan: Update Policy and Procedure document, Write a local policy for Soft Tissue Ewings, In-House clinical coding training to continue

Payment and Tariff Assurance Framework audit 2014-15 FZ and CZ HRG chapter audited – results placed Trust in best performing 25 % of Trusts

- Action plan: Review audit and training provided to the team to determine if programmes are sufficient to identify and reduce coder errors.
- Work with clinicians to improve the level of information for coding, especially on recording infusion cycles.
- An audit programme to be implemented to look at outpatient procedures

Annual Report

Clinical Coding

The Trust currently employs two qualified Accredited Clinical Coders and a whole time novice coder who is planning to sit the ACC examination in March 2016. We also have support from two members of the Clinical Effectiveness Team who are qualified as clinical coders and spend 1 day a week in the coding environment.

To ensure the quality of clinically coded data, it is paramount all coding staff keep up to date with programmes of learning and development and attend all predetermined coding courses including refresher courses and neoplasm coding workshops.

The Clinical Coding Department comply with the Information Governance (IG) Toolkit requirement 505 which states there must be in place:-

- Established documented procedures for the regular audit of clinical coding;
  An internal clinical coding audit programme within the last twelve months which was based on the requirements and standards within the latest versions of the NHS Clinical Coding Audit Methodology and must have been undertaken by staff on the registered list of clinical coding auditors

Clinical Coding IG 505 Internal Audit – November 2014

An audit looking at 100 FCE's (finished consultant episodes) was carried out on inpatient stays during the period of 1st April 2014 and 30th September 2014 by Accredited Clinical Coding Auditors from the Cheshire & Merseyside Data Quality and Clinical Coding Academy.

Summary of Findings

Coding Field	Percentage Correct	IG Req 505 Level 2	IG Req 505 Level 3
Primary diagnosis	95.00%	90%	95%
Secondary diagnosis	96.72%	80%	90%
Primary procedure	98.91%	90%	95%
Secondary procedure	96.36%	80%	90%

Coding Field	Percentage Correct 2011/2012	Percentage Correct 2012/13	Percentage Correct 2014/15
Primary diagnosis	95.00%	98.00%	95.00%
Secondary diagnosis	96.50%	96.96%	96.72%
Primary procedure	93.02%	97.85%	98.91%
Secondary procedure	96.24%	97.21%	96.36%

The coders have been commended on their dedication and achievements this year for exceptional outstanding performance in recognition of attaining the highest possible Level (level 3)

Recommendations

Action plans have been set up to follow up the recommendations to further improve performance:

- The policy and procedure document should be updated to ensure all information included is valid and reflective of the expected performance of the Department. In addition, all local policies should have a review date to ensure that the clinical coding that is being input as a result of the policy remains valid. The update to classifications as well as new standards being introduced means that there are occasions when clinical coding will change and may need to be reflected in the local policies. A review date will ensure this is not being missed.

- Soft tissue Ewing's sarcomas - the Trust should immediately draw up a local policy to ensure these diagnoses are not miscoded based on the description and index entry

or considered an error on audit from external sources. In addition, the Trust should raise this as an issue to be forwarded to the World Health Organization through the Clinical Classifications Service. Additional support can be provided by MIAA Clinical Coding Academy to progress this issue.

- In addition to all of the errors found on audit being fed back, the Department should organise in-house training to ensure that these particular errors in the application of newer concepts introduced into ICD-10 4th Edition are understood. The session should focus on the use of C97.X Malignant neoplasms of independent (primary) multiple sites and sequencing of dagger and asterisk codes in conjunction with the information provided in the National Clinical Coding Standards ICD-10 4th Edition (2014) reference book.

Payment and Tariff Assurance Framework Audit 2014-2015

The assurance framework's work programme for 2014/15 comprises audits at 75 acute trusts. The audits assess trusts' compliance with requirements for the creation of an accurate and effective national tariff and will help the audited organisations ensure its costs and payment data are accurate through:

- A review of a Trust's arrangements for producing accurate costs and payment information
- An assessment of the accuracy of the Trust's national cost submission (reference costs)
- An audit of clinical coding.

A Payment and Tariff Assurance Framework Audit was commissioned this year and included inpatient clinical coding looking at 200 records (100 HRG chapter FZ digestive system Procedures and Disorders, and 100 HRG Chapter Mouth, Head, Neck and Ears procedures and Disorders).

Summary of Findings

Coding audit findings

Area	Spells tested	% of spells changing payment	Clinical coding[1]						Other data items	
			% of spells changing HRG	% clinical codes incorrect	% diagnoses incorrect		% procedures incorrect		% spells with other data items incorrect	% other data items incorrect
					Primary	Secondary	Primary	Secondary		
FZ	99	1.0	1.0	1.7	1.0	0.6	0.0	6.5	0.0	0.0
CZ	100	1.0	1.0	0.4	1.0	0.4	0.0	0.0	0.0	0.0
Total	**199**	1.0	**1.0**	**1.0**	**1.0**	**0.5**	**0.0**	**3.6**	**0.0**	**0.0**

Financial impact of errors

Area	FZ	CZ	Overall
Spells tested	99	100	**199**
% spells changing payment[2]	1.0	1.0	**1.0**
Pre audit payment	£193,515	£241,366	**£434,881**
Post audit payment	£191,257	£239,734	**£430,991**
Gross change	£2,258	£1,632	**£3,890**
% gross change	1.2	0.7	**0.9**
Net change[3]	-£2,258	-£1,632	**-£3,890**
% net change	-1.2	-0.7	**-0.9**
Episodes unsafe to audit	0.0	0.0	**0.0**

As in previous years the quality of clinical coding based on last year's national performance:

- performance that would place the trust in the best performing 25% of trusts (lower quartile; 5.2% and below) is judged to be good
- an error rate that would the trust in the worst performing 25% of trusts (upper quartile; 10.5%) is poor
- otherwise performance is judged to be adequate (last year's average was 7.0%).

The Trust was placed in the best performing 25 % of Trusts

Recommendations

Ensure that the Trust produces coded data that accurately reflects the care delivered.

- Amend the local policy and procedure document to ensure it is consistent with national standards.
- Review audit and training provided to the team to determine if programmes are sufficient to identify and reduce coder errors.
- Work with clinicians to improve the level of information for coding, especially on recording infusion cycles.

Action plans have been set up to follow up the recommendations to further improve performance:

- 29 April 2015 All coding errors fed back to clinical coders
- 18 May 2015 Amendment to Clinical Coding local policy to include guidance on the ordering of general anaesthetic codes to be assigned directly after site codes in line with national standards
- Validation spot checks undertaken to ensure national standards are being met

- Audit on general anaesthetic codes to be included in monthly audit programme
- A regular monthly programme is in place to review different aspects/areas of clinical coding, reports completed and fed back to the clinical coding team. Policies and help-sheets updated where applicable and reinforcement of national standards and coding rules imparted to reduce coder errors. Monthly clinical coding meetings are also in place to discuss queries and errors resulting from validations and audits. All coders currently follow the standards for training and attend regular refresher clinical coding courses held by MIAA Clinical Coding Academy and those who are not yet accredited work towards the qualification within 2 years.
- A programme to be implemented to improve the level of information for coding. Collaborating with clinicians, targeting accurate chemotherapy documentation in line with national standards e.g. chemotherapy cycle numbers are documented on occasions differently in the case notes. A planning meeting to be set up in September 2015 Actions arising will form an established implementation plan to progress forwards with this issue. The advent of a new EPR system in February 2016 will almost definitely help towards solving this issue.
- An audit programme to be implemented to look at outpatient procedures

Overall the Trust has continued to improve its coding accuracy with a further significant improvement in both diagnosis and procedure coding rates. The coders have been commended on this.

Programme of Clinical Coding Internal Audits scheduled for 2015

The Clinical Coding Team will continue to support and monitor compliance with the Trust's audit programme. In addition internal monthly audits will be performed, targeting both complex and non-complex clinical coding throughout 2015/2016. The team will continue to develop and build on achievements already made in 2014/15 and develop, through workshops and training, a clearer understanding of the clinical coding process. An audit programme will be devised to look at outpatient procedures.

Section 6

Information Governance Report

Executive Summary

Safe and Effective

- Ensure that the Data Protection and Information Security incidents are dealt with appropriate with lessons learned.
- Ensure that the Data Protection and Information Security risks are recorded and monitored.
- Ensure that any changes in legislation are included within Trust policies and staff are informed via Trust wide communication methods.
- Ensure that the mandatory HSCIC Information Governance Toolkit annual self-assessment has the relevant updated evidence and is reviewed and approved by appropriate members of staff and managers.
- Well Lead
- Review the Information Governance Board Terms of Reference annually to ensure that the group is fit for purpose.

Annual Report

Information Governance – Overview

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for systems and development of guidance for NHS and partner organisations. Information Governance at The Clatterbridge Cancer Centre

Following the appointment of a dedicated Information Governance Manager in October 2012, the Trust has made a number of improvements taking the evolving Information Governance agenda forward to embed legislation by creating documentation and improving working practices within the Trust.

Information Governance Board

The IG Board is Chaired by the Head of Quality and Information and supported by the IG Manager. The IG Board is responsible for providing information and assurances to the Trust Board that The Clatterbridge Cancer Centre is safely managing all issues relating to Information Governance including:

- Supporting the Caldiott and SIRO functions

- Planning and carrying out Audits
- Approve an annual work plan
- Review Incidents and Risks of confidentiality
- Review and approve documentation for the IG Toolkit requirements

ICO Reported Incidents for 2014/15

The Trust has reported data breach incidents to the Information Commissioner's Office during 2014/15 who agreed with the Trust's decisions on each occasion and no further action was taken. The Trust takes all incidents seriously and is continuously working to improve data protection awareness amongst staff.

Documentation created /reviewed for 2014/15

The documentation below has been developed and reviewed to show that the Trust recognises the importance of reliable information, both in terms of clinical management of individual service users and the efficient management of services and resources. The documentation forms part of the development and implementation of a robust Information Governance Framework covering all aspects of Information within the Trust:

• 20 Year Rule Project	• Information Governance Policy
• A Guide for Patients booklet	• Information Governance Strategy
• Authorisation of Electronic Data Transfer Procedure	• Information Governance Toolkit Action Plan
• Bespoke Information Governance Training	• Information Lifecycle Management Policy
• Caldicott Approval Procedure	• NHS Number Audit Procedure
• Caldicott Function Work Programme	• NHS Number Policy
• Confidentiality Audit Procedure	• Patient Leaflet
• Corporate Records Audit	• Privacy Impact Assessment Template
• Data Flows	• Radiotherapy Audit
• Data Processing Template	• Risk Assessments

• Data Sharing Template	• Save Haven Policy
• Fair Processing Notices	• Senior Information Risk Owner (SIRO) Report
• Information Asset Plan & Register	• System Level Security Policies
• Information Asset System Questionnaires	• Transferring Person Identifiable Data Overseas
• Information Governance Board Terms of Reference	
• Information Governance Communications and Training Strategy	

Mersey Internal Audit Agency (MIAA)

Each year Mersey Internal Audit Agency conduct an internal review of the Trust's evidence to measure what the Trust has provided against the criteria set out in the Information Governance Toolkit. For the year 2014/15, the Trust received Significant Assurance for the second year which is a huge achievement and an indication of the improving awareness and support from staff involved in the assessment process co-ordinated and facilitated by the Information Governance Manager.

IG Toolkit Version 12 – 2014/15 Submission

The Trust submitted the overall evidence and scores on the 31st March 2014. The scores for all requirements of the Toolkit are between 0-3 and all Trusts must score a minimum of level 2 to maintain their IGSoC. All 45 requirements were completed with a total of 26 scoring at level 2 and 19 at level 3 achieving the overall target score of 80%.

The information below is a comparison between the Versions 11 and 12 Toolkit evidence submitted:

IG Toolkit Assessment Summary Report

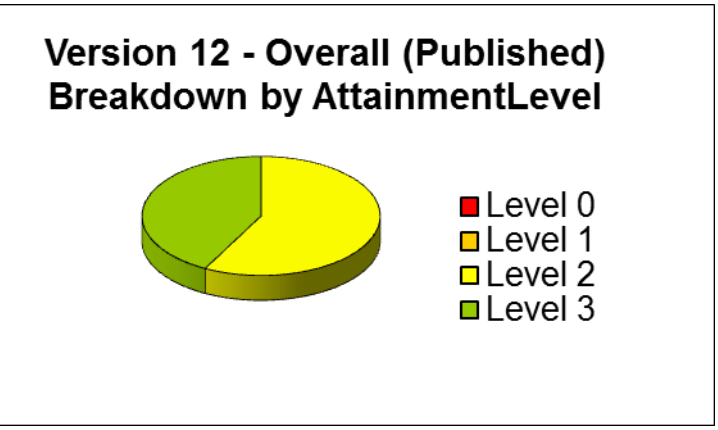
CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST

(Acute Trust)

Prepared on 06/08/2015

Overall

Assessment	Stage	Date	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Self-assessed Grade
Version 12 (2014-2015)	Baseline	31/07/2014	0	0	45	0	45	66%	Satisfactory
	Performance Update	31/10/2014	0	0	42	3	45	68%	Satisfactory
	Published	31/03/2015	0	0	26	19	45	80%	Satisfactory
	Target		0	0	26	19	45	80%	Satisfactory
Version 11 (2013-2014)	Baseline	31/07/2013	0	0	41	4	45	69%	Satisfactory
	Performance Update	31/10/2013	0	0	36	9	45	73%	Satisfactory
	Published	31/03/2014	0	0	26	19	45	80%	Satisfactory
	Target		0	0	27	18	45	80%	Satisfactory



Grade Key

Not Satisfactory	Not evidenced Attainment Level 2 or above on all requirements (Version 8 or after)
Satisfactory with Improvement Plan	Not evidenced Attainment Level 2 or above on all requirements but improvement actions provided (Version 8 or after)
Satisfactory	Evidenced Attainment Level 2 or above on all requirements (Version 8 or after)

Section 7

Clinical Governance Report: Document Control & Freedom of Information

Executive Summary

Safe, Effective & Well Lead

- Introduction of a Document Control Procedure providing all staff with a step by step guide on the requirements for developing new or reviewing/updating existing documents and the consultation and ratification requirements.
- Modifications to various aspects of the document control procedure, which have significantly improved the timeframe from which a document is approved to being fully document controlled and issued as a live document.
- Significant decrease in the number of out of date policies in the Trust. 60% decrease compared to 2014.
- Compliance with the Information Governance Toolkit Requirements

Annual Report

The Trust's "Document Control Policy" was reviewed, updated and approved in October 2014. The changes incorporated a new practice for the way in which Trust documents are ratified. The Document Control Manager (DCM) had been trialling the acceptance of electronic approvals, rather than physical signatures and this proved to be a more effective and practical method. Accepted electronic methods of approval include meeting minutes, email approvals from the document's allocated author or a signed copy of the document which would be scanned and emailed to the Document Control Manager who would file it electronically as evidence. This process has significantly improved the timeframe from which a document is approved to being fully document controlled and issued as a live document on the Trust's system for staff access.

A new procedure was also introduced and implemented in October 2014 titled "Document Control Procedure (Producing Trust Documents & Performing Reviews Updates of Existing Trust Documents)". This document aims to provide staff a step by step guide on the requirements for developing new or reviewing/updating existing documents published in the name of the Trust (with the exception of patient and staff information leaflets which are controlled under a different regime), together with the consultation and ratification requirements before a document is submitted for document control.

Each step of the procedure must be followed before submission for document control. If one or more of the steps have not been followed staff are informed within the procedure that their document would not be ready for submission.

The procedure has been disseminated to staff via Senior Managers, E-Bulletin and Team Brief. The procedure has also been provided to individual staff upon document review reminders or staff queries with regard to document creation/updates.

The introduction of this procedure has improved staff understanding and the fluency in which documents are submitted.

In June 2015 a further change to the Document Control process was introduced. All documents are now only accessible to staff via the Trust's intranet, whereas previously documents were also available on the Trust's T: drive. Reducing the access to documents on the intranet ensures that documents are available from one central point. This change in process has also improved the timeframe in which documents are controlled and published for staff access and ensure there is no duplication. The Trust were informed of this change in practice via both E-bulletin and Team Brief. The Trust's Document Control Policy is currently being updated to reflect this change.

The Document Management Policy continues to ensure compliance with the original NHSLA Standards and monitoring audits are submitted to the Risk Management Audit Sub Committee and also the Information Governance Board. The policy will also comply with the allocated Information Governance Toolkit requirements.

Historically, three audits were carried out annually as part of the monitoring process of the Document Control Policy to ensure compliance. The audits each focussed on control, ratification and archiving of documents. In March 2015 one single audit to cover all three of these areas was carried out by the Document Control Manager.

Previously, the three separate audits would only monitor Trust policies. The single audit covered 12 documents from each document category:-

- Policies
- Procedures
- Guidelines
- Forms
- Competencies
- Letter Templates
- Patient Group Directions
- Protocols
- Strategies
- Terms of Reference
- Work Instructions

The documents were then monitored against a list of requirements within the Document Control Policy:

- The document has been produced in the correct format;
- Ratification/Approval evidence has been obtained from the appropriate authorisor(s);

- If the document is a first version policy; Has an Impact Assessment been completed;
- Current electronic version (PDF or Read Only) is available on the T: drive;
- Current electronic version (PDF or Read Only) is available on the intranet;
- Current electronic version (PDF or Read Only) is available on the website (where applicable);
- Current electronic version (PDF or Read Only) is available on Q-Pulse;
- Hard master copy is held by the Document Control Manager (DCM);
- Current version registered on the All Document – Alphabetical Lists spreadsheet with an up to date hyperlink;
- Current Word version is held by the DCM;
- Have any authorised copies been distributed? If yes, has a distribution note/register been signed by the person responsible;
- Have the authorised distributed copies been marked in red with an allocated copy number;
- Old version been archived.

142 documents were audited in total. All were selected at random using an alphabetical list of all live Trust documents. Under some of the above categories there were less then 12 documents and therefore all available documents under that category were audited.

Patient and staff information leaflets were not included in this audit. These documents are monitored separately under the "Development of Patient Information Policy" by the Clinical Governance Manager; Patient Safety.

Given the scale of the audit a number of actions were identified but the majority were addressed and completed during the course of the audit, these actions included:-

- Ratification evidence for some documents had not been filed. The evidence had already been obtained and submitted but had not yet been filed by the Document Control Manager. This was mainly due to the document only recently being document controlled. This action was completed at the time of the audit.
- Some of the links to the documents on the intranet were not working properly. All identified links were reinstated at the time of the audit.
- A number of out of date documents identified. The relevant authors were notified at the time of the audit for them to conduct a review and update the document. Some authors advised that upon review some documents were no longer in use or had been replaced by other existing documentation. These documents have since been archived.
- Some of the Trust policies audited were identified as being out of date/due for review and all authors were informed at the time of the audit and the policies have since been updated or are currently going through the final approval process prior to being submitted for document control.

At the time of the March 2015 audit the number of out of date policies compared to March 2014 have decreased greatly. In March 2014 108 policies were identified as being out of date and only 43 identified in March 2015 which is a decrease of 60%. The number of out of

date policies continues to decrease and part of this progress is due to the recent change in the document control process and the introduction of the Document Control Procedure.

The Trust is currently looking to introduce a new Document Management System which in the future is hoped to further improve the document control process. The aim is for all documents to be managed, stored, updated, ratified and accessed within the one system.

Freedom of Information

Safe, Effective & Well Lead

- The total number of information requests received in 2014 has increased by 24% compared to 2013 and 78% compared to 2012.
- Continued compliance with the Freedom of Information Act 200 and Environmental Information Regulations 2004.
- Formal complaint received in 2013 escalated to the Information Commissioner's Office (ICO) in 2014. The Decision Notice issued by the ICO confirmed that the Trust had correctly complied with its obligations under the FOI Act and that it was not required to take any further steps as a result of the Decision Notice.
- Compliance with the Information Governance Toolkit Requirements.

The total number of requests made under the Freedom of Information Act 2000 (FOI) and Environmental Information Regulations 2004 (EIR) are as follows:-

FOI RESPONSE TIMESCALES	
Requests Received	**322**
Requests processed within legal timescales	**279**
Requests processed within requested extended timescales	**22**
Late responses	**8**
No response sent	**0**
Requests withdrawn by the applicant	**1**
Clarification requested from applicant with no further response from applicant	**12**
Other	**0**

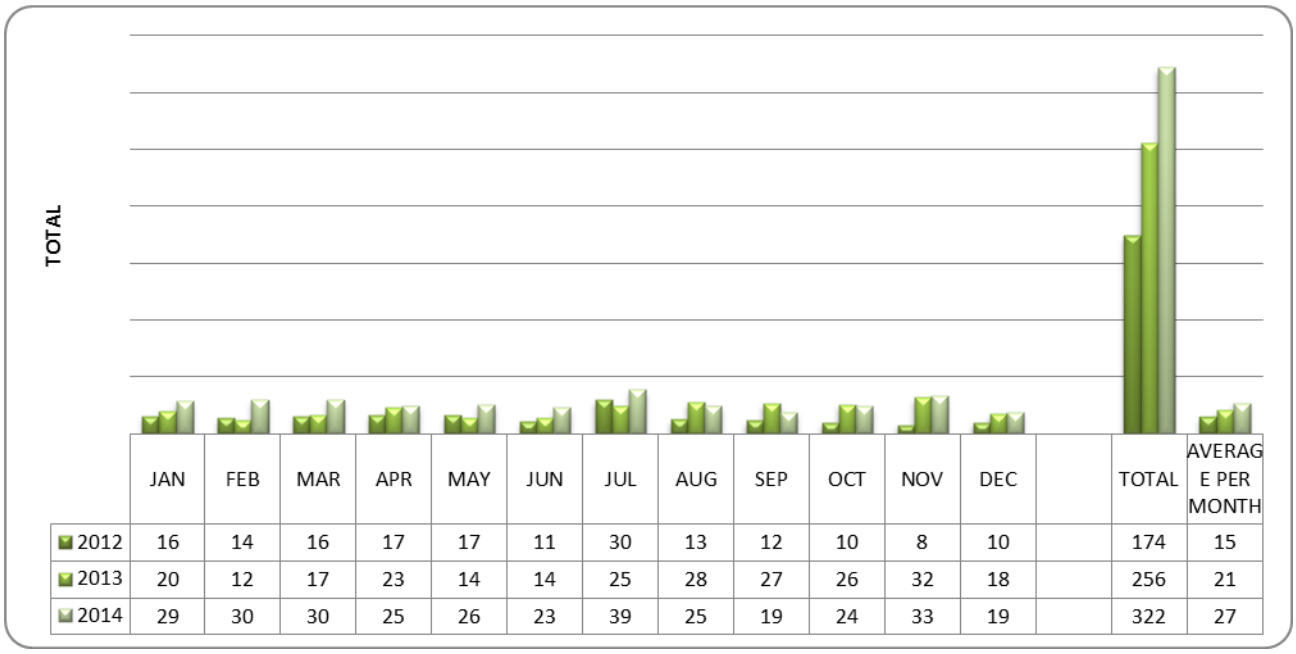
EIR RESPONSE TIMESCALES	
Requests Received	**9**
Requests processed within legal timescales	**9**
Requests processed within requested extended timescales	**0**
Late responses	**0**
No response sent	**0**
Requests withdrawn by the applicant	**0**
Clarification requested from applicant with no further	**0**

response from applicant	
Other	**0**

The total number of information requests received in 2014 is 331 which is an increase of 24% compared to 2013 and 78% compared to 2012.

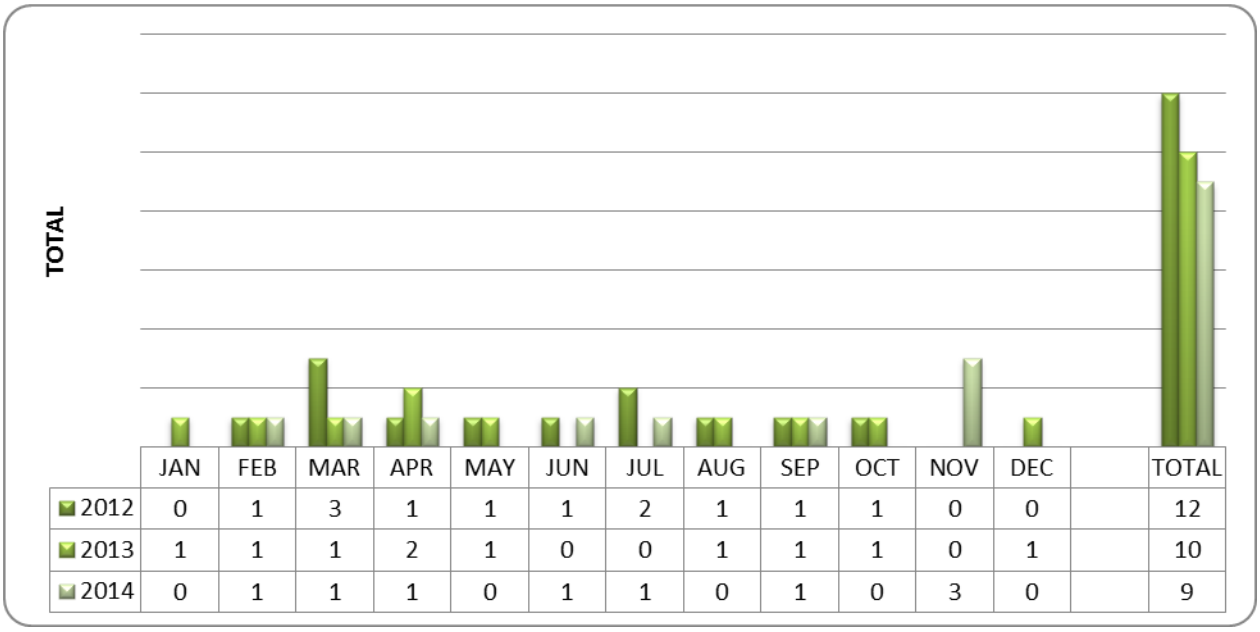
The below table gives an indication of the increase of requests over the past three years (2012, 2013 and 2014):-

- **Freedom of Information Requests:-**



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC		TOTAL	AVERAGE PER MONTH
2012	16	14	16	17	17	11	30	13	12	10	8	10		174	15
2013	20	12	17	23	14	14	25	28	27	26	32	18		256	21
2014	29	30	30	25	26	23	39	25	19	24	33	19		322	27

- **Environmental Information Regulations Requests:-**



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC		TOTAL
2012	0	1	3	1	1	1	2	1	1	1	0	0		12
2013	1	1	1	2	1	0	0	1	1	1	0	1		10
2014	0	1	1	1	0	1	1	0	1	0	3	0		9

Despite the significant increase in requests being submitted to the Trust, staff who are approached for information by the DCM in order to answer the requests remain diligent in their efforts to answer requests appropriately and within the requirements of the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

The DCM produces a yearly report on the FOI and EIR requests that are received by the Trust which is made publicly available on the Trust's website. The report provides a detailed analysis of the requests received between January and December of that year to include the number of requests received, response times, level of disclosure, exemptions and the department(s) targeted. The Annual Report is presented to the Information Governance Board yearly upon completion prior to publication.

The Trust received its first formal complaint in 2013 in relation to a response to an FOI request. This was also detailed in the Clinical Governance Annual Report 2012-2013. In accordance with the Code of Practice under Section 45 of the Freedom of Information Act 2000 the Trust carried out an internal review into the request and the panel concluded to that the Trust's original decision be upheld. The applicant expressed further dissatisfaction and escalated their issue to the Information Commissioner's Office (ICO) who then conducted a full investigation. In July 2014 the ICO issued an official Decisions Notice which confirmed that the Trust had correctly complied with its obligations under the FOI Act and that it was not required to take any further steps as a result of the Decision Notice.

The Decision Notice issued in this matter is available publicly via the ICO's website under case reference number FS50535326: https://search.ico.org.uk/ico/search/decisionnotice

Section 8

Information Management Report

Executive Summary

Safe, Effective, Responsive, Well-led:

- **Data Warehouse build/development/test** The Information Team have been assigned 14 of the 19 Object Model purchased for the Trust Data Warehouse to build, develop and test. We achieved 1 Object Model sign off in 14-15 plus ongoing work for the remaining 13 in progress. This project has been a 40% increase in the Team's workload which has been absorbed on top of an already busy and deadline driven workload, with only additional resource provided in 14-15 from Natcansat which did not support any deliverables. It has been a challenge to balance Routine and Development work and continues to be.

- **EPR Project Reporting requirements** Information Team were involved in the procurement part of the project during 14-15.

- **Contract Monitoring requirements** The increase in requirements from NHS England, NHS Wales and IOM has meant additional Reports developed by the Information Team to support the Finance Dept. For example, Standard Drugs, Cancer Drug Fund, Drugs and Devices, Aggregate Contact Monitoring, RAS testing, Long stay pts and Diagnostic Imaging Direct Access MRI Service Balanced Scorecard. All Reports were developed and delivered in line with Commissioner and National timetable in 14-15. Finance also requested 20 additional Adhoc reports to be developed to support the Trust's Commissioning and Business planning requirements in 14-15

- **NHS Statutory Reporting requirements** Information Team completed all NHS statutory reporting requirements in 14-15 within the mandatory timetable. During this period, additional Reports have been developed such as Friends and Family Tests, Female Genital Mutilation and Safe Staffing Return. The Information Team spend a lot of their working week supporting the National Waiting Times reports to ensure data is accurate and complete including tracking functionality.

Annual Report

The Information Team's main objective within the Trust is to provide a Business Intelligence Service to facilitate Clinical decision making, Service development, Data quality, Commissioning and Performance management of Health Care Services.

The Team has 6.5 WTE staff which consists as follows:

Information Manager

Information Intelligence Analyst
2 x Senior Information Analysts
2 x Information Analysts
Information Quality Analyst (part time)

The Information Team currently extract data from 7 Clinical Information systems within the Trust's Electronic Patient Record system and present Analysis as required using Crystal Reports, Microsoft office and SPSS technologies that have been in place for over 13 years. A number of National changes are issued throughout the year by HSCIC in the form of SCCI Notices which requires the Information Team to work with the EPR Supplier and other staff to implement new statutory Reports within set deadlines. This covers the Quality and Information Directorate Reporting requirements such as Female Genital Mutilation, Friends and Family for Staff and Outpatients and Infection Control etc.

As part of the Trust's IM&T Programme, the Information Team is a key player as all Clinical Systems require skills and knowledge of relational database and data extraction to support statutory and operational requirements.

The Trust purchased a Data Warehouse, Dashboard and Patient Level Information Costing system in April 2014 which the Information Team are currently building and testing the majority of the 19 Object Models required. This has involved the Information Team learning new skills such as Business Objects and QLIK View to re develop all existing Reports, plus absorbing a fundamental part of the development requirements for the Project. This continues to be a challenge balancing this and the routine deadline workload.

The Team is involved in a number of Projects including the replacement EPR Project which is due for implementation in February 2016. The 19 Object Models in the Data Warehouse will require re development based on the Meditech System to support consistency in Reporting requirements.

The Team provides up to one day a week on the TCC Project for an Analyst to support the Capita Activity Model based on data used across the Trust.

The Information Team provide support for upgrades to existing Clinical Information Systems which may involve re writing Reports or re developing processes.

The Information Team is responsible for producing the Trust Contract Monitoring, Drugs, Reference Costs and Cancer Drug Fund Reports to support the needs of NHS England. The requirements have increased over the years including the Team using the SLAM system on behalf of Finance and Contracting Team to support the requirements of the Commissioners.

The development of Directorate and Executive Dashboards was achieved in 2013-14, with the aim to use new technologies such as QLIK View and Business Objects to improve functionality to the end users in 15-16. The Information Team will play a key role in re developing the trust Integrated Performance Report for the Board meetings enabling drill down functionality to identify reasons for breach of key indicators at source for members.

A total of planned 150 statutory, operational and data quality reports are produced by the Information Team over a variety of frequencies such as daily, weekly, monthly, quarterly or annual to support the Trust's requirements for Commissioning and Performance Management. Each Report has a documented Procedure and is covered with the Team that enables all statutory reports to be delivered within set NHS deadlines and as part of the Trust's Contract with NHS England. The Team achieved 100% compliance with this timetable in 14-15.

The emphasis on tracking and monitoring all patients on pathways has involved the Team developing work around to support the business needs and assurance of delivery for key targets such as Cancer Waiting Times and Referral to Treatment.

The increase in Activity and Services across the Trust has made additional work for the Information Team such as the Pharmacy Subsidiary, The Clatterbridge Clinic and Transforming Cancer Care, which have been absorbed within current resources.

A total of 222 unplanned report requests were received and delivered in 2014-15 by the Information Team from both external and internal users. The timeframe on average to deliver approximately 1 unplanned report request per day is within 10 working days.

The Information Team also manage an Annual Data Quality Audit Programme to which 9 Reports are produced to support the Information Governance toolkit standards and External Audit Agency requirements as agreed by the Executive Team. A Data Quality Group is Chaired by the Information Manager to enable monitoring of activity and quality, plus support standardisation and discussion for Statutory reporting and Information Governance requirements. The Team produce lists of blank or incomplete data entry in the EPR system which is sent to the relevant Departments to correct in line with the Data Quality Policy requirements.