The Clatterbridge Cancer Centre NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS MEETING

Agenda Item	013/17 (ii)	Date: 23rd January 2017
Subject /title	Quality Committee Performance Report	
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Responsible Director	Helen Porter, Director of Nursing & Quality	

Executive summary and key issues for discussion

This report provides an overview of quality at the trust; highlighting performance against key quality indicators and providing supporting detail.

This integrated quality performance report brings together the following documents into a single report:

- Infection Control Report
- Risk Report
- Workforce and Organisational Development Report
- Audit / Effectiveness Report

It is presented in the following sections:
- Quality Account: Improvement Priorities
- CQUINs
- Safe
- Effective
- Caring
- People Management and Culture

Strategic context and background papers (if relevant)

This proposed approach is driven by the findings of Deloitte's Well Led Review 2016.

Recommended Resolution

The Council of Governors note the report and the actions being taken to address highlighted areas.

Risk and assurance

The report is part of the overall Trust Performance Management System, ensuring oversight of quality across the trust and delivery of quality related KPIs and initiatives.

Link to CQC Regulations

Regulation 12: safe care and treatment
Regulation 17: good governance
Regulation 18: staffing

Resource Implications

None

Key communication points (internal and external)

Communicated with internal senior management team for information and action where appropriate.

Freedom of Information Status

FOI exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted. **Application Exemptions:** • **Prejudice to effective conduct of public affairs** • **Personal Information** • **Info provided in confidence** • **Commercial interests** • **Info intended for future publication**	Please tick the appropriate box below: [✓] **A. This document is for full publication** [ ] **B. This document includes FOI exempt information** [ ] **C. This whole document is exempt under FOI** IMPORTANT: If you have chosen B above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

Equality & Diversity impact assessment

Are there concerns that the policy/service could have an adverse impact because of:	Yes	No
Age		✓
Disability		✓
Gender		✓
Ethnicity		✓
Sexual Orientation		✓
Religion / Belief		✓
Pregnancy and maternity		✓
Civil Partnership and Marriage		✓

If YES to one or more of the above please add further detail and identify if full impact assessment is required.

Next steps

Appendices

Corporate Objectives supported by this report

Improving Quality	✓	Maintaining financial sustainability	
Transforming how cancer care is provided across the Network		Continuous improvement and innovation	✓
Research		Generating Intelligence	

Link to the NHS Constitution

Patients		Staff	
Access to health care		*Working environment* Flexible opportunities, healthy and safe working conditions, staff support	
Quality of care and environment	✓	*Being heard:* • Involved and represented • Able to raise grievances • Able to make suggestions • Able to raise concerns and complaints	✓
Nationally approved treatments, drugs and programmes			
Respect, consent and confidentiality			
Informed choice		Fair pay and contracts, clear roles and responsibilities	
Involvement in your healthcare and in the NHS		Personal and professional development	✓
Complaint and redress	✓	Treated fairly and equally	

January 2017

Quality Committee Performance Report

Introduction

This report provides an overview of quality at The Clatterbridge Cancer Centre NHS Foundation Trust; highlighting performance against key quality indicators and providing supporting detail.

It is presented in the following sections:

- Quality Account: Improvement Priorities
- CQUINs
- Key Performance Indicators and supporting information related to:
    - Safe
    - Effective
    - Caring
   - People Management and Culture

Quality Account: Improvement Priorities 2016/17 (as at 11/1/17)

A progress status RAG rating of 'Green' indicates either 'complete' or 'on track'.

Improvement Priorities	Detail	Progress Update	Progress status
Always Events	Always Events$^{©}$ focus on ensuring events that matter to patients happen every time for every patient.	A set of Always Events$^{©}$ at CCC are being developed using meaningful patient involvement. We will start to monitor compliance against these by Q4 2016/17.	
Model of Care	We will implement a model of Person Centered Care incorporating the frameworks developed by the Health Foundation and The King's Fund.	Refer to Strategic Plan actions.	
Serious Illness Conversation	Designed to improve the lives of all people with serious illnesses by increasing meaningful conversations about their values and priorities, we plan to cascade training throughout the trust so that all patients who might benefit, will be offered a serious illness conversation by the end of 2017.	The initiative has been piloted in 2 primary care sites (36 clinicians trained) and at CCC (19 clinicians trained) and a feasibility study for a bigger research project is underway. A project coordinator and data manager have been recruited, and a business case has been submitted to support further roll out and implementation of a 3 year strategy. There are discussions underway with NHSE re potential pilot sites for 2017/2018 and options for funding.	

CQUIN Summary (as at 11/01/17)

	Milestone met
🟩	Milestone met
🟧	Awaiting confirmation of achievement from NHSE / further data requested of CCC
🟥	Failed to achieve requirements
⬜	No requirements in the quarter
▢	RAG rated border indicates expected compliance; G = expected to meet, A = some concerns / awaiting confirmation, R = not expected to meet requirements.

CQUIN	Detail	Value	Q1	Q2	Q3	Q4	Progress Update
Staff Health and Wellbeing	Introduction of health and wellbeing initiatives	£561,579	🟩	⬜	⬜	⬜	No milestone in Q2 or Q3. Progress is routinely monitored at the Health and Wellbeing Committee and we expect to meet the Q4 requirements.
	Healthy food for NHS staff, visitors and patients		🟩	⬜	⬜	⬜	No milestone in Q2 or Q3. We have submitted information to NHSE regarding our progress and are awaiting feedback on whether this will meet Q4 compliance.
	Improving the uptake of flu vaccinations for frontline clinical staff		⬜	⬜	⬜	🟩	No milestone in Q2 or Q3. Q4 target met, as over 75% of frontline staff were vaccinated by 31/12/16
Sepsis	Timely identification and treatment for sepsis in acute inpatient settings	£187,193	🟩	🟩	⬜	⬜	In Q3 to date, the % of patients receiving antibiotics within 1 hour is 83% (Oct) and 86% (Nov). We expect a target of 85% to be agreed with NHSE, and will confirm if this has been met at the QC meeting.
Antimicrobial Resistance	Empiric review of antibiotic prescriptions	£56,015	🟩	🟩	🟩	⬜	Q3 95% of the antibiotic prescriptions audited had a review within 72 hours against a target of 75%
Clinical Utilisation Review	Installation and Implementation of software; reduction in inappropriate hospital utilisation and reporting of results	£442,757	⬜	🟩	⬜	⬜	No milestone in Q3.
Enhanced Supportive Discharge	Ensuring patients with advanced cancer are, where appropriate, referred to a Supportive Care Team, to secure better outcomes and	£200,000	🟩	🟧	⬜	⬜	Q2 progress update submitted to NHSE. Awaiting confirmation of achievement of milestone.

	avoidance of inappropriate treatments.		🟩	🟧	⬜	⬜	
Dose Banding	Standardise the doses of SACT in all units across England in order to increase safety, to increase efficiency and to support the parity of care across all NHS providers of SACT	£50,000	🟩	🟩	⬜	⬜	Q3 data not yet available. Confirmation of performance will be provided at the QC meeting.
	Local Drugs and Therapeutics committee has agreed and approved principles of dose banding, and dose adjustments required.		🟩	⬜	⬜	⬜	No milestone in Q2, Q3 or Q4.

The proposed CQUINs for 2017/18 (some extending to 2018/19) have now been published; the package that NHS England has offered the trust for 2017/18 is:

- Nationally standardised Dose Banding (CA2)
- Optimising Palliative Chemotherapy Decision Making (CA3)
- Clinical Utilisation Review (GE1)
- Medicines Optimisation (GE3)
- Enhanced Supportive Care (IM1)
- Locally Priced – service redesign and clinical practice benchmarking (GE4)

Further detail of each CQUIN is available at: https://www.england.nhs.uk/nhs-standard-contract/cquin/pres-cquin-17-19/

It is likely that we will also continue to be monitored against selected non-specialised CQUINs (e.g. staff health and wellbeing) in 2017/18, however the detail of this is yet to be agreed.

Key to performance metric tables

Titles key: Directive = rationale for inclusion (see detailed key below) | YTD = Year to date
Directive key: Department of Health (DoH), NHS Improvement (NHSI) | CQUIN (CQUIN) | Quality Report (QR) | Sign up to Safety campaign (SU2S) | Contract KPIs (C) | Open and Honest (OH)
General key: DC = Data capture system under development |TBA = To be agreed, QR = Quarterly Reporting | NYP = Data not yet published for this time period | NA = Not Applicable | ST = Safety Thermometer (this is a survey carried out on one day a month on all wards. The data relates only to the inpatients present on that day, rather than capturing all harm data for the month) | Grey shaded cells = Not applicable, data to be obtained for future reports, or data not available for this period | Yellow shaded cells = KPIs new to this report.

Work is on-going to develop targets and data flows for all KPIs and to enable forecasting.

Patient Safety

	Key Performance Indicator	Director	Target	Directive	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	YTD	12 month trend
Safe																		
Incidents	Total incidents resulting in harm to patients	HP		Internal	16	21	15	14	20	14	23	18	28	13	16	NYP	132	
	Serious Untoward Incidents (SUIs)	HP	TBA	TBC	0	0	0	1	0	0	2	0	0	1	0	0	3	
Harm free care	Percentage of Patients with no 'new' harms (ST)	HP	95%	C, SU2S, OH	98.0%	95.7%	98.2%	95.6%	94.9%	91.3%	96.2%	98.3%	91.2%	96.6%	96.6%	94.8%		
Never Events	Number of Never Events	HP	0	DoH, C	0	0	0	0	0	0	0	0	0	0	0	0	0	
Patient transfers	Number of patients transferred to another hospital	HP		TBC	3	1	5	10	14	6	6	9	10	6	5	9	65	
Falls	Number of falls per 1,000 admissions	HP	TBA	OH	23	28	28	22	25	25	58	31	11	27	31	28	236	
	Number of falls resulting in harm	HP	TBA	TBC	1	3	4	3	2	2	5	3	1	3	3	1	20	
	Falls assessment within 24 hours	HP	TBA	TBC	98%	99%	97%	98%	97%	97%	100%	100%	97%	100%	100%	99%		
Pressure Ulcers	Number of patients recorded as having a category 2-4 hospital acquired pressure ulcer	HP	13	OH	0	1	1	0	3	0	1	3	4	1	1	1	14	
	Number of patients recorded as having a category 2-4 hospital acquired pressure ulcer (CCC lapse in care)	HP	0	TBC	0	1	0	0	1	0	0	0	1	0	0	0	2	
	Waterlow assessment within 6 hours (pressure ulcer risk assessment)	HP	TBA	TBC	92%	99%	95%	95%	88%	90%	92%	92%	90%	96%	96%	97%		
VTE	Percentage of adult admissions with VTE Assessment (ST)	HP	95%	C	97.7%	98.3%	97.2%	96.5%	95.4%	97.6%	95.0%	93.8%	91.0%	94.7%	91.4%	93.8%		
	Percentage of patients at risk of VTE who have received prophylaxis	HP	100%	C	93.0%	92.0%	90.0%	96.0%	88.5%	88.5%	92.5%	88%	96.1%	81.5%	93%	93%		
Nutrition	Malnutrition assessment within 24 hours	HP	TBA	TBC	98%	99%	97%	98%	97%	97%	95%	94%	95%	96%	96%	97%		
Health Care Acquired Infections	Clostridium difficile infections (attributable)	HP	1	C, OH	0	0	0	1	0	1	1	1	1	0	0	0	4	
	MRSA infections (attributable)	HP	0	C, OH	0	0	0	0	0	0	0	0	0	0	0	0	0	
	MSSA bacteraemia (attributable)	HP	TBA	TBC	0	0	0	0	2	0	0	0	0	0	QR	QR	2	
	E. Coli bacteraemia (attributable)	HP	TBA	TBC	0	0	0	1	1	0	0	0	1	0	QR	QR	2	
	VRE bacteraemia (attributable)	HP	TBA	TBC	0	0	0	0	0	0	0	0	0	0	QR	QR	0	
	CAUTI (hospital acquired)	HP	TBA	TBC	0	1	3	0	0	0	1	1	4	1	QR	QR	7	

Key Performance Indicator	Director	Target	Directive	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	YTD	12 month trend
Medication (errors and improvement initiatives) — Chemotherapy Medication Errors per 1000 doses	HP	TBA	C, QR	0.17	0.18	0.35	0.16	0					0.82	0.67	0.99		
Number of Chemotherapy Medication Errors	HP	TBA	C, QR	1	1	2	1	0	2	3	4	3	5	4	6	27	
Radiotherapy Treatment Errors per 1,000 fractions (8 Total in May)	HP	TBA	C, QR	1.2	1.2	1.4	1.6	1.3		1.58	1.4	1.6	1	1.1	1.16		
Dose Banding Adult Intravenous SACT	HP	Q1 baseline, Q2 20%, Q3 55%, Q4 80%	CQUIN								Q1=0%		Q2=22%	QR	QR		
Empiric review of antibiotic prescriptions	HP	Q1 25%, Q2 50%, Q3 75%, Q4 90%	CQUIN, C								Q1=62%		Q2=83%	QR	QR		
Dementia — Composite Indicator for Dementia Screening	HP	90%	Internal	100%	100%	83.3%	77.8%	91.7%	70%	93.7%	100%	100%	100%	93%	92%		
AKI — Percentage completeness of the AKI data items (four per discharge)	HP	Q1 baseline, Q2 50%, Q3 75%, Q4 100%	Internal	85%	41.6%	43.8%	75%	25%	33%	0%	0%	67%	44%	NYP	NYP		
Sepsis — Percentage of patients requiring screening for sepsis, who have been screened as part of the admission process.	HP	Q1 baseline, Q2 TBA, Q3 TBA, Q4 TBA	CQUIN	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Percentage of patients presenting with severe sepsis, Red Flag Sepsis or Septic Shock, who have received IV antibiotics within an hour of presentation.	HP	Q1 baseline, Q2 TBA, Q3 TBA, Q4 TBA	CQUIN	75%	61.5%	82%	90%	100%	100%	83%	83%	83%	84%	83%	86%		
Safety culture — Number of breaches of duty of candour	HP	0	C	0	0	0	0	0	0	0	0	0	0	0	0	0	

Incidents

No incidents resulted in major or catastrophic harm/death during September and October and there were no never events. The 2 serious incidents reported in November's report occurred in August, not September – October as stated. 29 (5%) incidents resulted in minor harm and 4 incidents (0.6%) resulted in moderate harm. The moderate harms were due to a patient who fell on the ward and fractured their hip, 2 drug errors and a pressure ulcer. The majority of the minor harms were patient harms due to falls, patient condition which included moisture lesions, drug errors, VTEs and pressure ulcers.

Trends /areas of concern:

- Increase in radiotherapy workload/staffing incidents – ongoing issue regarding delays in pre-treatment due to workload. A review of pre-treatment pathways is underway.

Total incidents by incident type (1/9/16 – 31/10/16):
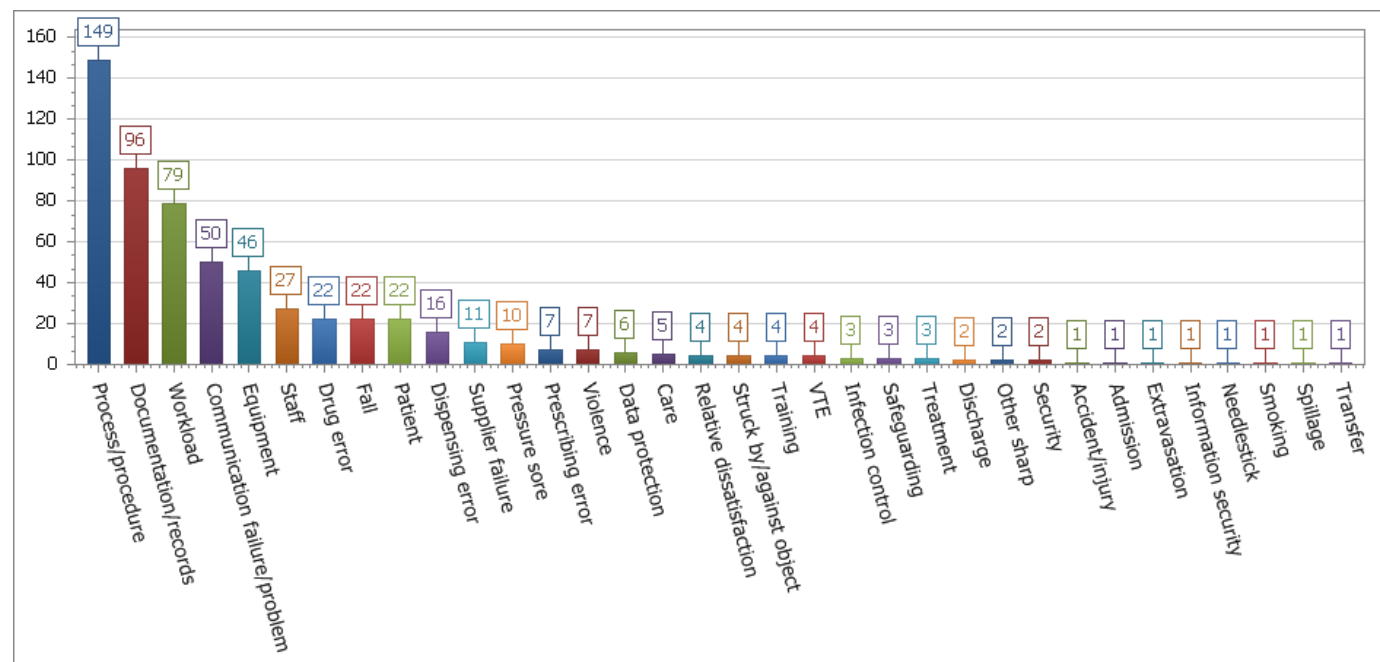
Externally reportable incidents per year and by reporting type:

External body	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
HSE (RIDDOR) **Note: from April 2012, over 3 day injuries changed to 7 days**	2	2	3	2	4	1*
HSE - other			2			
MHRA						
SHOT	2					
CQC (IRMER)	2	2	1	2	5	1***
STEIS	1	2	3		6	6**
CQC local inspector (all STEIS incidents reported from 1/2/16)					2	
NRLS	1237	1623	1392	1668	2401	1900
SIRS	20	17	19	14	23	16
Information Commissioner		1	1	1	1	
DOLS (applications)				13	5	7

*(12642) Manual handling- non patient

** Chemo Meditech errors (12865, 12864), 2 C diffs

*** (12973) Orthovoltage

Patient transfers to an acute trust: November and December 2016

Number of patients transferred = **14**

Reason for transfer	% of patients
Medical review	43
Cardiac event / arrest	7
Respiratory event / compromise	21
Gastro-intestinal event	7
Sepsis	15
Renal failure	7

MEWS score prior to transfer	% of patients
0	7
1	7
2	7
3	14.66
4	7
5	7
6	7
7	14.66
8	
9	7
10	14.66
No MEWS documented	7

Time of transfer:

- o In hours (09.00hrs – 17.00hrs) – 50%
- o Out of hours (17.00hrs – 09.00hrs and weekends) – 50%

Acute trust patients transferred to:

- Wirral University Foundation Teaching Hospital 93%
- Royal Liverpool Hospitals NHS Trust 7%

Was treatment stopped or delayed?

- o Yes – 43%
- o No – 28.5%
- o N/A – 28.5%

Harm free care

NHS Safety Thermometer (ST)

This table shows the ST survey data for December 2015 to December 2016. All figures are % except the sample which is the total number of patients included each month.

		Dec15	Jan16	Feb16	Mar16	Apr16	May16	Jun16	Jul16	Aug16	Sep16	Oct16	Nov16	Dec16
Harm Free		96.00	95.65	90.74	94.12	94.92	91.30	94.23	94.74	85.96	87.93	93.22	93.10	94.64
Pressure Ulcers - All		2.00	0.00	7.41	1.47	3.39	2.17	3.85	3.51	8.77	10.34	3.39	3.45	0.00
Pressure Ulcers - New		0.00	0.00	0.00	0.00	3.39	2.17	1.92	0.00	1.75	1.72	0.00	1.72	0.00
Falls with Harm		0.00	0.00	0.00	0.00	0.00	2.17	0.00	0.00	1.75	0.00	0.00	0.00	0.00
Catheters & UTIs		0.00	2.17	0.00	1.47	0.00	2.17	0.00	0.00	1.75	0.00	1.69	3.45	0.00
Catheters & New UTIs		0.00	2.17	0.00	1.47	0.00	2.17	0.00	0.00	1.75	0.00	0.00	3.45	0.00
New VTEs		2.00	2.17	1.85	2.94	1.69	2.17	1.92	1.75	3.51	1.72	3.39	3.45	5.36
All Harms		4.00	4.35	9.26	5.88	5.08	8.70	5.77	5.26	14.04	12.07	6.78	6.90	5.36
New Harms		2.00	4.35	1.85	4.41	5.08	8.70	3.85	1.75	8.77	3.45	3.39	5.17	5.36
Sample		50	46	54	68	59	46	52	57	57	58	59	58	56

VTE: Percentage of patients being assessed and percentage of 'at risk' patients receiving prophylaxis
The percentage of patients being assessed rose to 91.4% for October and 93.8% for November, and administration of prophylaxis for those at risk, increased to 93% for both months. This was raised as a 'key line of enquiry' at the Q2 Integrated Care Directorate performance review. Ward staff have now started to include a check of the drug card within the morning handover, with the aim of updating any cards where

prophylaxis has been given but not recorded, and also to highlight the importance of giving every dose. This new process should support the reduction of all omitted drugs, not only prophylaxis. Following this action we hope to see a rise in compliance in December.

Infection Control

Our patients have had the following infections in Quarter 2 2016/17:

- MRSA bacteraemia: 0
- MSSA bacteraemia: 1
- E. Coli bacteraemia: 5 (all cases)
- Vancomycin-resistant Enterococci bacteraemia (VRE): 2
- Clostridium difficile infection (CDI) attributed to the Trust: 4 (+ 1 not attributable)
- MRSA Screening - data not available

Clostridium difficile
Unfortunately, we have already exceeded our allocated objective with five cases of CDI, four of which are attributed by definition to CCC. NHS England has reviewed all of the attributed cases and determined that, in line with our own MDT findings, there was no lapse in care relating to our management of the patients. The table below provides further detail of the cases.

Clostridium *difficile* data	Jul-16	Aug-16	Sep-16	Total 2016/17
Monthly Actual Post 72 hr	1	1	0	**4**
Monthly Actual Pre 72 hr	0	0	0	**1**
Lapse in care	0	0		**0**
Ribotype	014			

Rates of Clostridium difficile Infection

The table below shows the rate of infection per 100,000 beds for Clatterbridge, Christie and the Royal Marsden.
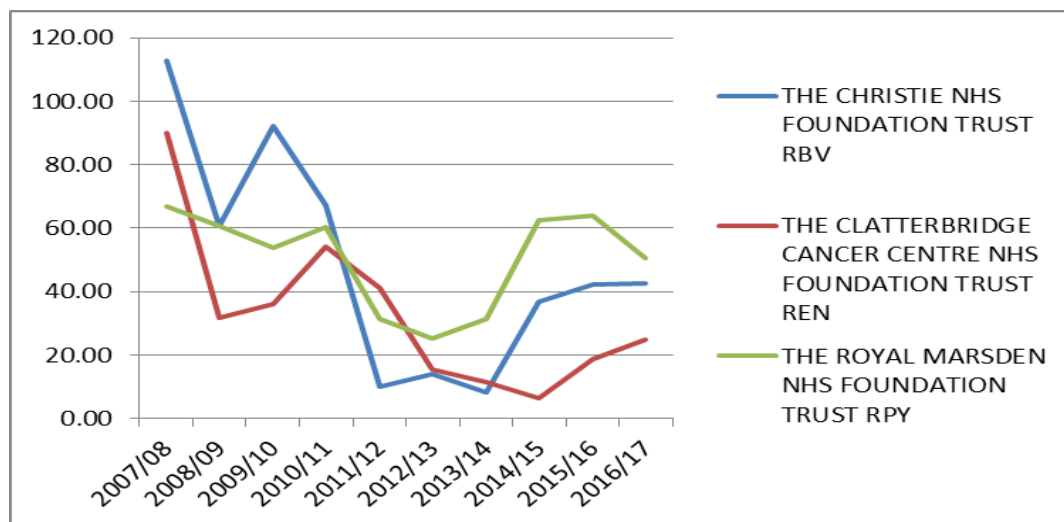
Our rate of infection is slightly lower at 48 cases per 100,000 occupied bed days compared with the previous quarterly rate (50.21) and remains comparable to other specialist cancer Trusts. However this remains concerning for us as it is the highest sustained increase we have seen since 2010/2011.

Summary of Infection Control Priorities for 2016-2017

- Continue water testing and ensure safe water for patients through IPC and engineering controls.
- Continue to participate in Transforming Cancer Care meetings and raise awareness of the need to include Infection Prevention and Control in SLA negotiations.
- Continue work in line with the new annual programme.

- o Particular focus on improving standards of Bare Below The Elbows among all staff groups
- Review SOPs and surveillance protocols to ensure IPC practices can continue with the new EPR system
- Continue to focus on urinary catheterisation and documentation (including HOUDINI and surveillance) during the new Level 2 Core Skills infection prevention and control training to promote best practice.
- Compile a protocol to support appropriate use of the new UV-C emitter.

Claims

No new Letters of Claim or Letter Before Action (2016/05) have been received since the previous report previous report.

Inquests

One new inquest file has been opened since the previous report and one remains open:

Inquest Number	Date of Request	Coroner	Reports sent	Date of Inquest	Staff requested to attend	Conclusion
2016/02	12/10/16	Liverpool & Wirral	1/11/16			
2016/03	14/11/16	Liverpool & Wirral	28/11/16			

Clinical Effectiveness

	Key Performance Indicator	Director	Target	Directive	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	YTD	12 month trend
Effective																		
Mortality	Total number of in-hospital deaths	HP/PK		Internal	10	11	5	14	10	12	9	7	6	6	7	4	61	
	30 day mortality rate (radical chemotherapy)	HP	TBA	QR	0.3%	0.3%	0.4%	0.4%	0%	0.4%	0.4%	0.3%	0.3%	0.4%	0.3%	NYP		
	30 day mortality rate (palliative chemotherapy)	HP	TBA	QR	2.8%	2.4%	2.0%	2.6%	2.5%	1.4%	1.1%	1.5%	1.5%	1.7%	2.3%	NYP		
	30 day mortality rate (radical radiotherapy)	PK	TBA	QR	1.0%	0.8%	0.5%	0.5%	0.3%	0.3%	2.2%	3.5%	2.4%	2.1%	2.5%	NYP		
	30 day mortality rate (palliative radiotherapy)	PK	TBA	QR	10.1%	9.7%	13.4%	12.0%	19.6%	14.4%						NYP		
	Additional mortality KPIs - to be confirmed	PK																
Time to Consultant Assessment	Percentage of patients admitted as an emergency by A&E or directly from the community, who have a documented assessment from a consultant within 14 hrs of arrival at hospital.	HP	75%	Internal	65.0%	61.0%	65.0%	79.0%	90.0%	81.0%	77.0%	80%	78%	69%	68%	86%		
Length of Stay	Length of Stay Elective Care (Average number of days on discharge)	HP	5	Internal	3.46	2.16	2.56	2.46	2.97	2.02	1.81	2.40	2.1	2.79	2.6	4.61		
	Length of Stay Emergency Care (Average number of days on discharge)	HP	10	Internal	10.97	7.20	8.88	9.20	10.38	9.68	9.76	10.61	6.67	12.14	13.15	10.04		
Linac Utilisation	Linac Downtime	PK	2%	Internal	2.0%	2.3%	1.8%	4.2%	3.3%	1.8%	6.4%	2.42%	3.45%	3.25%	3.90%	2.72%	3.44%	
	Linac Utilisation	PK	85%	Internal					84.8%	80.2%	82.8%	81.2%	77.9%	83.5%	86.5%	89.0%		
Care hours per patient day	Care hours per patient day: Conway Ward	HP	Awaiting Provision of 'Model Hospital' Portal	NHSI						5.8	6.4	6.2	5.4	5.2	DC	DC		
	Care hours per patient day: Sulby Ward	HP		NHSI						4.0	4.6	3.6	3.7	3.4	DC	DC		
	Care hours per patient day: Mersey Ward	HP		NHSI						5.6	5.4	5.3	4.8	4.5	DC	DC		
Staff Recruitment	Time to recruit staff (days)	AC	60	Internal	23	30	24	19	26	30	31	31	43	59	61	59		
Clinical Trials	Number of patients enrolled into clinical trials	PK	400 per annum	Internal		75		101	Q1=64			Q2=59 (subject to change)			QR	QR		

Mortality

The table below shows the number of deaths on each ward per month, whether the death was expected and if the patient was receiving end of life care.

Ward	No. of inpatient deaths			No. of expected deaths			No. of patients receiving End of Life Care		
Month	Oct	Nov	Total	Oct	Nov	Total	Oct	Nov	Total
Conway	2	3	**5**	2	3	**5**	1	2	**3**
Mersey	5	1	**6**	5	1	**6**	4	1	**5**
Sulby	0	0	**0**	0	0	**0**	0	0	**0**
Total	**7**	**4**	**11**	**7**	**4**	**11**	**5**	**3**	**8**

To further develop our existing mortality review processes, the trust is collaborating with other cancer treatment providers to agree a standard definition of an avoidable / unavoidable death. This will help us to benchmark against peers and identify any areas for improvement.

NICE Guidance

There are 17 pieces of guidance (including 7 Quality Standards), published between May 2012 and April 2016 which have not yet been fully assessed. There are 20 pieces of guidance published between April 2011 and April 2016 which have outstanding actions.

Clinical Audit

The following table shows which National/Regional clinical audits the trust is participating in (no change from previous report):

Audit	National/Regional	Deadline	Criteria	Status and details
Head and Neck (HANA)	National	TBC		
Lung (LUCADA)	National	30th May 2016	Patient diagnosed in 2015	Data would be submitted via COSD monthly
Bowel (NBOCAP)	National	2nd November 2016	Oncology treatment records for patients diagnosed 01/04/2015 to 31/03/2016	
Oesophago-gastric cancer	National	2nd November 2016	Oncology treatment records for patients diagnosed 01/04/2015 to 31/03/2016	
RCR National Prostate Cancer Audit - Radiotherapy Data	National	On-going audit	Radiotherapy treatment planned from April 2016	Data is submitted monthly to CNIN

The following tables provide an overview of the trust and departmental management of clinical and process audits.

Clinical & Process Audit 2016/17

- Completed: 60
- In Progress: 47
- On hold: 7
- Not Started (Total): 134
- Not started (Beyond deadline): 76
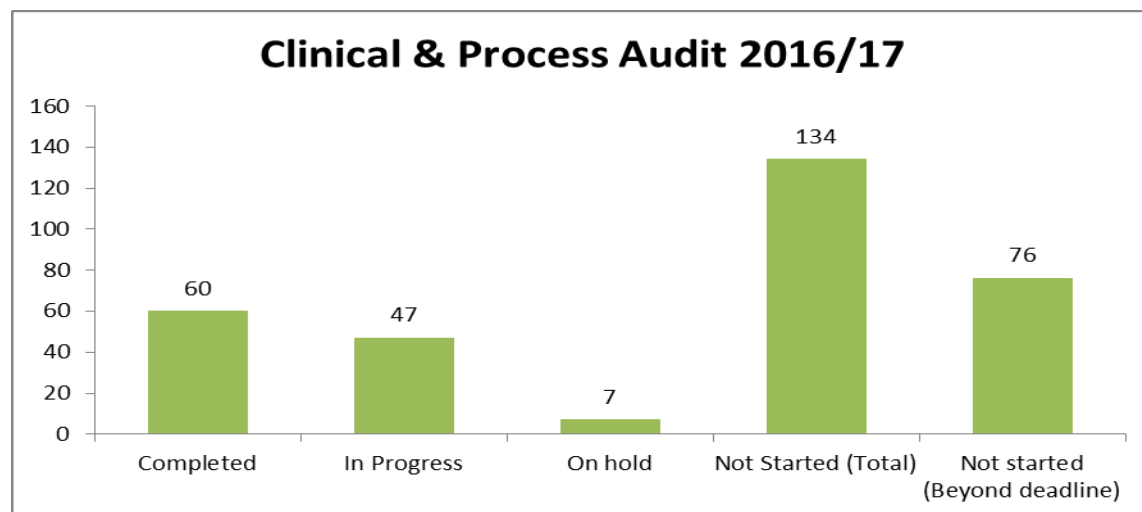
Clinical & Process Audit 2016/17 per Department
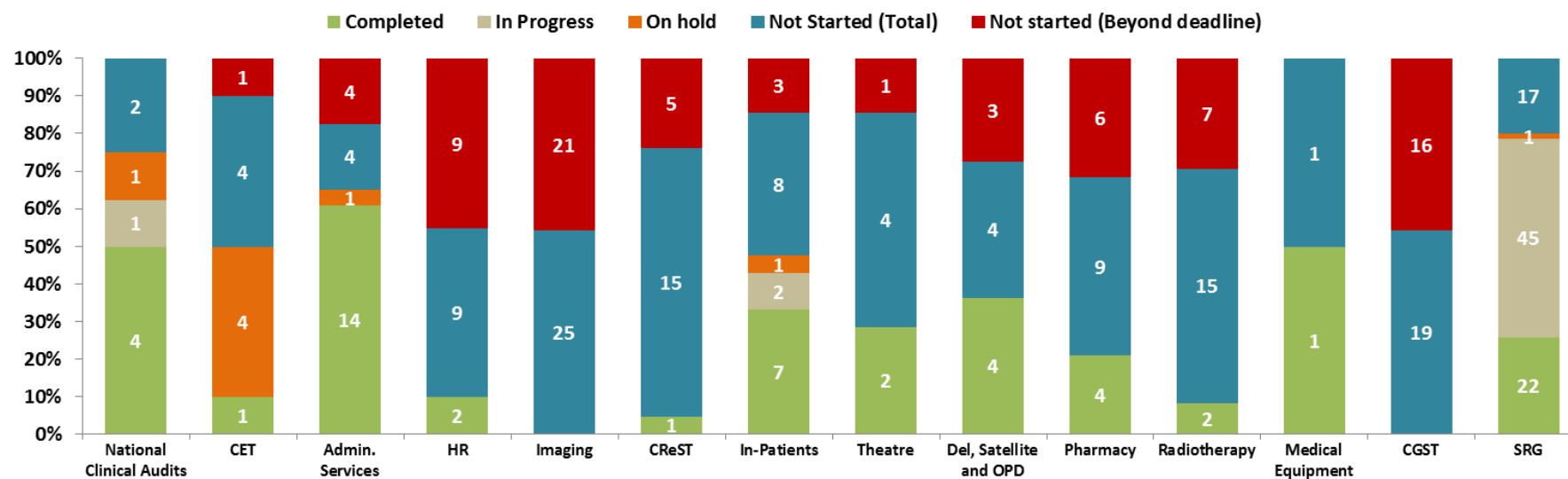
Patient Experience

	Key Performance Indicator	Director	Target	Directive	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	YTD	12 month trend
Caring																		
The NHS Friends and Family Test (FFT): Inpatients	Total responses as a percentage of those eligible to respond.	HP	30%	C, O&H	12.5%	13.5%	25.5%	23.9%	19.1%	30.9%	27%	12.9%	11.80%	19.10%	19.10%	23.10%		
	Percentage of respondents who were either likely or extremely likely to recommend to friends and family.	HP	<90: R, 90-94: A, =>95: G	C	100.0%	97.1%	100.0%	98.6%	94.3%	95%	95%	100%	95%	98.20%	94.10%	97.01%		
The NHS Friends and Family Test (FFT): Outpatients	Percentage of respondents who were either likely or extremely likely to recommend to friends and family.	HP	<90: R, 90-94: A, =>95: G	C	97.6%	96.2%	96.8%	96.3%	93.9%	96.7%	94.0%	97.7%	96.60%	94.80%	96.68%	96.36%		
The NHS Friends and Family Test (FFT): Staff	Percentage of respondents who were either likely or extremely likely to recommend to friends and family as a place to work.	AC	<90: R, 90-94: A, =>95: G	External	100.0%			100.0%			90.0%			91%	QR	QR		
	Percentage of respondents who were either likely or extremely likely to recommend to friends and family as a place for treatment or care.	AC	<90: R, 90-94: A, =>95: G	External	100.0%			71.0%			100.0%			95%	QR	QR		
Waiting Time	Percentage waiting 30 minutes or less	HP	TBA	Internal									DC	DC	DC	DC		
	Percentage waiting 31 - 60 minutes	HP	TBA	Internal									DC	DC	DC	DC		
	Percentage waiting over 60 minutes	HP	TBA	Internal									DC	DC	DC	DC		
	Percentage waiting 30 minutes or less in a CCC outpatient clinic	HP	65%	Internal	69.4%	71.6%	74.7%	71.7%	72.2%	75.3%		79.1%	79.96%	78.29%	79.23%	77.48%		
	Percentage waiting 30 minutes or less for Radiotherapy	PK	80%	Internal	61.7%	70.1%	66.7%	68.7%	72.6%	78.6%		DC	DC	DC	DC	DC		
	Percentage waiting 30 minutes or less for Delamere	HP	80%	Internal	85.2%	81.1%	85.0%	83.4%	86%	83%		91.1%	92%	91%	90%	91%		
Complaints	Number of Complaints	HP	0	C	2	0	2	1	1	2	0	4	0	1	2	2	12	

Patient Surveys

Friends and Family Test

The following charts show the total surveys completed and the % of patients who would recommend the service, by directorate.

Integrated Care

Chemotherapy Services

Q3 October 2016

Radiation Services

Q3 FFT 2016 (Oct & Nov only)
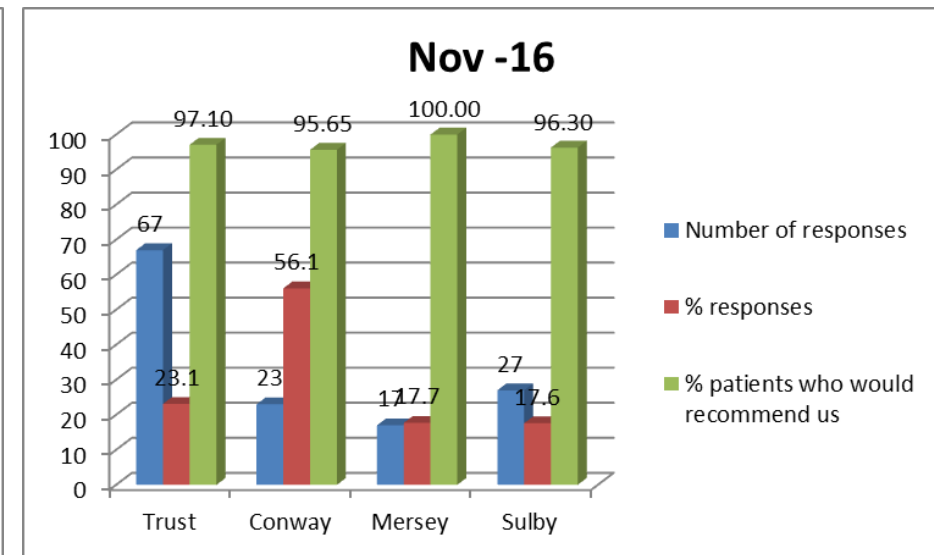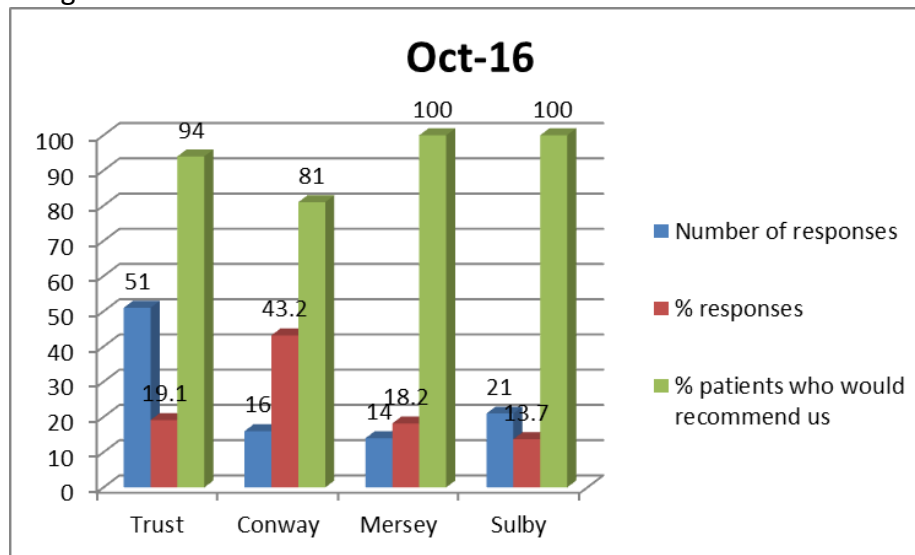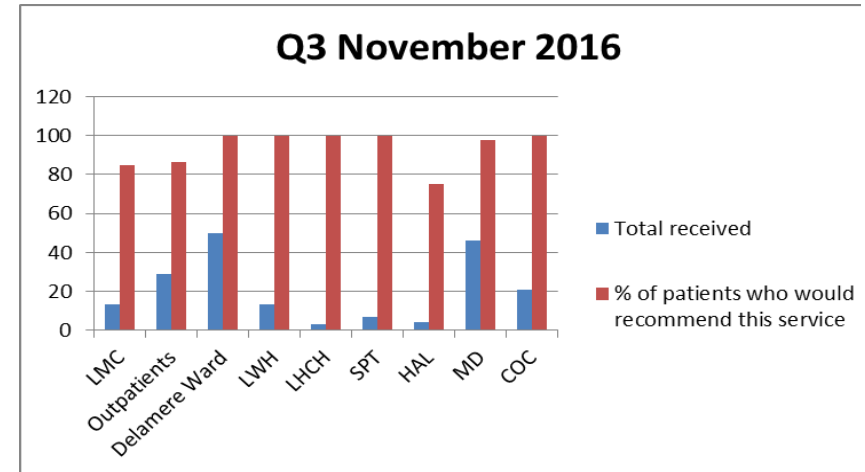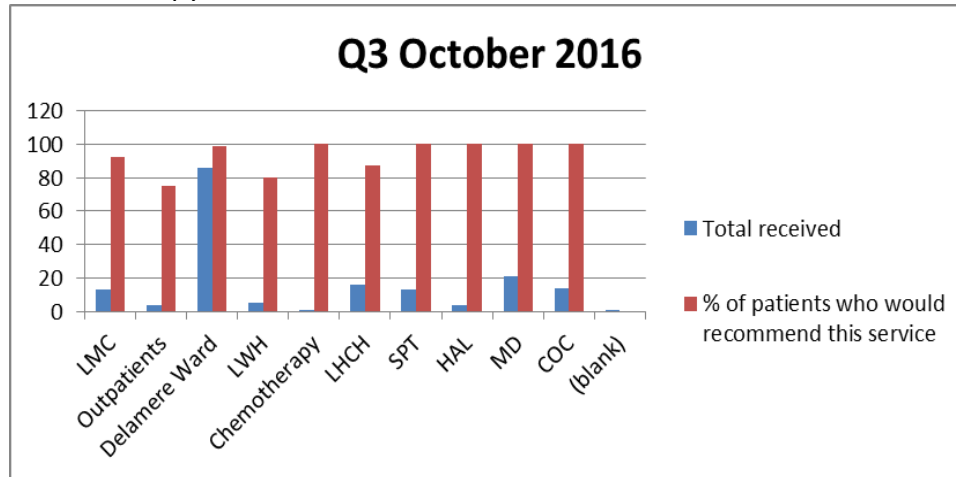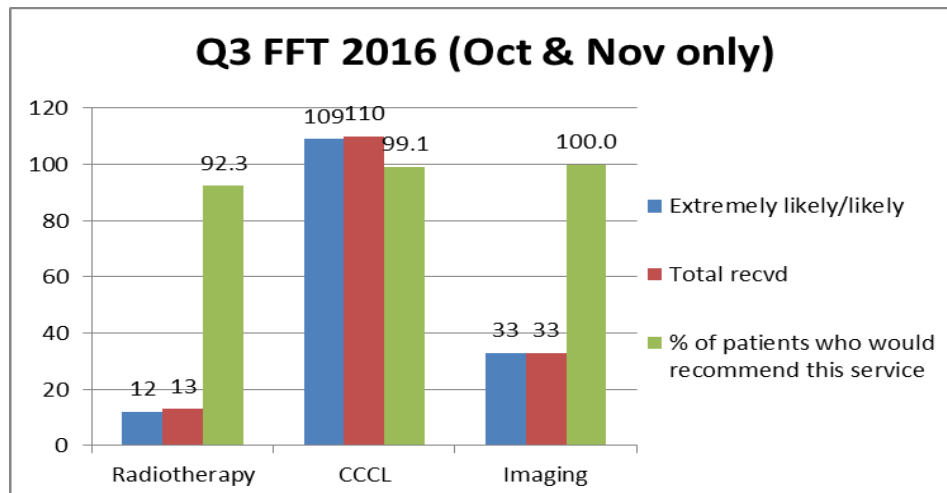
Further Patient Experience Metrics and Sources of Information

Latest Initiatives
Since Monday 28th November the main reception in CCC Wirral has been staffed by two new receptionists, from 8am to 8pm Monday to Friday and 8am to 2pm Saturday. The volunteers are now located at the alternate end of the reception desk to assist in helping patients/visitors find their way around the centre. This will help to standardise the level of service provided to all patients and visitors and ensures that we have sufficient resource to both staff the desk, and take people to where they need to be.

Percentage of patients waiting 30 minutes or less
The % of patients waiting 30 mins or less for Delamere and outpatients remains stable at 91% and 77% respectively for November 2016. There has however been a recent increase in patient dissatisfaction with the length of time they've had to wait. These figures are therefore being reviewed to ensure accuracy.

Patient experience indicators – The 'Always Events' are being agreed and will be reported here once monitoring begins.

National surveys
Our latest inpatient survey, released 8th June 2016 is available here: http://www.cqc.org.uk/provider/REN/survey/3

Patient story programme
Each month we publish a patient story as part of our Open & Honest Care Programme, these are available on our website in The High Quality and Safe Care section. http://www.clatterbridgecc.nhs.uk/aboutcentre/highqualityandsafecare/safe/openandhonestcare/

NHS Choices/Patient opinion
The links to the latest comments are below. There are currently seven ratings on the website. The latest review is below. The last comment was added in June. http://www.nhs.uk/Services/hospitals/ReviewsAndRatings/DefaultView.aspx?id=105001

Link for Patient Opinion https://www.patientopinion.org.uk/opinions?nacs=REN20

Complaints

The Trust has a formal complaints policy which adheres to national NHS guidance. In addition to the policy the Trust has a system whereby the Council of Governor's Patient Experience Committee reviews all complaints received (with patient identifiable information removed) and responses sent which provides the COG with assurance that the Trust adheres to its complaints process and that they are apprised of any patient concerns.

The Trust received 2 complaints in October and 2 in November:

- Communication and concerns regarding treatment options
- Relating to extravasation
- Treatment delays – Delamere and Southport Clinic. Treatment either delayed (patient highlighted that on one occasion they waited over 7 hours for treatment at CCC-Wirral arriving at 11am and not leaving until 18:15) or not available at all.
- Patient unhappy with how their previous complaint was handled.

People Management and Culture

	Key Performance Indicator	Director	Target	Directive	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	YTD	12 month Trend
People Management and Culture: Well Led																		
Staff Attendance and Turnover	Attendance (Sickness Level)	AC	3.5%	Internal	4.3%	4.2%	4.5%	4.2%	4.3%	4.8%	4.6%	4.07%	3.34%	3.85%	4.49%	4.28%		
	Stress related absence	AC	TBC	Internal										0.77%	1.21%	0.83%		
	Staff Turnover (Leavers divided by average staff in post FTE)	AC	1% per month	Internal	1.63%	0.83%	0.96%	1.26%	1.33%	0.84%	1.56%	0.88%	1.39%	1.43%	0.48%	0.86%		
Staff Development	Statutory Mandatory Training (Rolling 12 months)	AC	95%	Internal			88%	85%	87%	83%	82%	82%	82%	83%	82%	83%		
	Mandatory Role Essential Training (Rolling 12 months)	AC	95%	Internal	86%	86%	74%	76%	78%	79%	78%	79%	78%	78%	75%	70%		
	Performance Development Reviews (PADR) (Rolling 12 months)	AC	95%	Internal	88%	82%	83%	79%	70%	62%	57%	46%	46%	54%	57%	60%		
	Nurse Revalidation complete	AC	TBC	TBC										100%	100%	100%		
	Medical Revalidation complete	AC	TBC	TBC										100%	100%	97%		
	Medical Appraisal completed within the last 12 months	AC	TBC	TBC										53%	54%	48%		
Staff Experience	Staff FFT: Recommend CCC as a place to work	AC	TBA	TBC									91%		QR	QR		
	Staff FFT: Recommend CCC for treatment	AC	TBA	TBC									95%		QR	QR		
Employee Relations	Formal Bullying & Harassment cases	AC	0	TBC										0	1	0		
	Investigations completed within 8 weeks	AC	100%	TBC										75%	100%	100%		
Risks	High risk as a % of all risks	HP	TBA	TBC	2%	2%	3%	3%	2%	2%	2%			2%		2%		
	% of risks reviewed within agreed timescale	HP	TBA	TBC				42%			68%	97%		67%		58%		

Workforce and Organisational Development (WOD)

Retention:
The Trust target for retention is 12%, however the Trust has been unable to achieve this target for the last 12 months with retention rates consistently remaining between 12.5% and 14%.
• Over the last twelve months the majority of leavers for the Trust, by staff group, have been admin and clerical staff followed by nursing and midwifery.
• 56.8% of leavers within the last twelve months had less than 3 years' service with the Trust.
• The majority of leavers were AfC Band 2 admin and clerical and band 5 nurses within the last year
• Doctors leaving the Trust cite reasons for leaving as career decisions, re-location and concerns with regards to changes in clinical practice
• Exit Interview data suggests that the majority of leavers leave the Trust for other roles within the NHS, followed by other roles outside the NHS and retirement
Corporate action plan in place to reduce turnover which will be presented to TMG in January with regular updates as agreed.

Recruitment and Retention Strategies:
Recruitment: All recruitment adverts contain proactive and positive messages about the Trust's future plans in Liverpool. Managers are encouraged to ask interviewees, especially clinical staff, about their future aspirations with Liverpool being a prime factor at recruitment stage.

Over recruitment: Directorates have adopted over recruitment strategies to ensure that vacancy gaps are miminised. This means that workforce establishments have been increased although budgets remain the same. It allows the service to minimize gaps in service within high turnover areas such as nursing and radiation services. The service is currently looking at a similar solution for the Admin and Clerical workforce to reduce the reliance on agency spend in this area.

Retire and return Policy: A Trust policy was recently reviewed to ensure it enabled members of staff to access their pension and return to work with minimum delay. The policy encourages managers to look creatively at step down and wind down options for staff wishing to continue working at a lower grade or working fewer hours whilst drawing their pension or in the run up to their retirement.

Retention Agreement: A retention bonus scheme was agreed in partnership with the Trade Unions in December 2015, which sets out how staff will be protected and rewarded over the immediate 12 months before and after the transfer of services to Liverpool. This included travel protection, bonus retention payment, payment of the foundation living wage and pay protection. There are eligibility criteria within this agreement.

Medical Recruitment towards new clinical model: As a result of several consultant oncologist vacancies, the Medical Director and Clinical Directors have designed 6 new posts that reflect the principles of the new clinical model and new ways of working. An innovative approach to advertising these posts was taken with the aim of attracting new and innovative talent to the Trust, using a targeted approach and social media. The appointment process is currently underway.

Clinical Workforce Strategy: A Clinical workforce strategy has been in place for a year, with specific projects in place to support workforce redesign. It is intended to create new and innovative roles, provide opportunity for greater development amongst different staff groups, such as advanced nurse practitioners, clinical fellows etc, and therefore support the longer term succession planning and retention of key staff across the Trust.

Recruitment Process Improvement and Training: A new recruitment system (TRAC) was introduced in Q1 2016 with the aim of reducing the time to hire. All recruiting managers have been trained in the system. Feedback has been positive and there are early indications that the time to hire is being reduced. A full review of progress will be presented to the Quality Committee in March 2017.

Nursing Recruitment Strategy: A fortnightly strategy meeting has been established by the General Manager for Integrated Care, supported by the Workforce & OD Department. The aim of this group is to widen the recruitment pool for nurse recruitment, raising the profile of CCC within the recruitment market, designing innovative approaches to advertising campaigns, block recruitment days and developing a flexible workforce linked to the internal nurse bank to support vacancy management.

PADR: It has been agreed that for the 2017/18 PADR process, all staff will be asked a set of core questions relating to their intentions regarding Liverpool. The responses will be fed into the workforce planning process and culture work stream for further reflection / action.

Career Pathways: The Director of Nursing and Quality is currently leading a review of nursing careers at CCC. This work will identify the different levels of competency at each level of nursing to inform future career pathways and subsequent succession planning approaches.

Staff Benefits: A review of staff benefits is due to take place in Q1 2017, with the aim of ensuring that CCC has a competitive reward and benefits package in preparation for increased competition for recruiting staff once CCC Liverpool is in place.

Streamlining: The streamlining programme is designed to reduce the time to hire, though improved systems and processes to enable a more flexible workforce across the local health economy, through processes such as faster pre-employment checks and reduced duplication of effort of time for the new starter. In addition, streamlining will improve the recruitment experience as new recruits will not have to repeat unnecessary training or checks as part of the recruitment process.

Workforce Planning: As part of the workforce planning cycle this year, the HR Business partners will be carrying out a flexible working review. This will support the retention of staff as there is a perceived lack of equity within existing work patterns due to long standing historical requests for flexible working and the need to review them. It will also form part of the culture work stream work, which will focus on the concept of workforce mobility.

Exit and Entry Interviews: In order to identify the reasons for joining the Trust, entry interviews at induction for new starters have been introduced. In addition, a further pulse survey is completed at the 90 day employment date as the highest turnover rate appears in leavers with less than 3 years' service. Furthermore, the exit interview process has been revised to attempt to capture employees' intentions to leave the Trust to support early intervention and to fully understand the reasons for leaving.

Attendance & Stress Related Absence:
Reduction in the overall sickness absence figures for November by 0.21%, however absence remains 0.78% above the Trust's target. There has been a reduction in long term sickness absence, however short term absence has been increasing since August 2016.

Stress across the Trust continues to be a concern and it consistently remains one of the three highest reasons for absence each month. Work related stress remains above the Trusts target and as such there have been a number of action plans developed in departments where work related stress has been highlighted. These include; Mersey Ward, Radiotherapy, Sulby, and Conway.

Employee Relations:
All KPIs in regards to Employee relations have been met. There have been a significant reduction in Employee relations cases since August 2016 and this trend continues as in January 2017 there are currently no suspensions and only one ongoing case which is currently within KPI.

Agency Usage
Agency use reduced in November and breaches of the NHSI rules also reduced. Work continues to reduce agency usage and this will be further supported with the introduction of the Workforce Redesign Group in January 2017 who's remit will include the authorisation and monitoring of all agency bookings across the Trust further improving challenge around the use of agency workers and improving existing data quality and compliance.

PADR's
In response to challenge at the Board in relation to current poor PADR compliance figures, a review of the PADR process and how it contributes to the trust's overall strategic purpose has been undertaken. It is believed that the appraisal process requires greater alignment to the corporate objectives and business planning process across the trust and that a concentrated period of time should be identified for all staff to complete their PADR following the annual agreement of the Trust corporate objectives. This is to ensure that all staff are clear how their performance directly relates to the business performance of the trust (creating the 'golden thread') and that all managers are given clear direction on what is expected of them and the importance of undertaking PADRs.

It is then intended that managers will be held to account by ensuring that all staff are appraised between April and June each year which will enable objectives to be set at Directorate, team and individual level that align back to the corporate objectives. Managers will have to provide evidence of this as part of the quarterly performance review process and information from PADRs will be collated to inform an annual trust learning and training needs assessment by September each year (the educational start of the year).

In addition, it is proposed that compliance rates that fall below the trust target of 95% from 2017 Quarter 2 onwards will be reviewed as part of the trust's Incremental progression Policy, which could result in the non-progression of pay for staff and managers who are not compliant.

The Workforce & OD team is currently working with the Head of Performance and Planning to agree the operational detail required to introduce this proposed way forward from April 2017. The proposed way forward is also being discussed with Trade Union colleagues to ensure a partnership approach to implementation.

Mandatory Training

Compliance for Mandatory training has increased slightly since the last report with the majority of departments being at between 76% and 92% compliant. Doctors' compliance continues to be the lowest. They have been invited to participate in the STAR Chambers review of the training matrix to enable them to provide feedback regarding issues impacting on their compliance. The action plan to resolve factors impacting on compliance targets is underway and on track for completion for end of March 2017.

Compliance for PADRs has increased since last month. No further feedback from departments regarding non-compliance has been received by the L&D team. Following feedback from Board in December, there is a proposal to change the reporting period for PADRs to fall in line with the Business Planning cycle. This is a change to the policy and process which is currently being discussed with the Head of Performance & Planning in readiness for discussion with the Trade Unions.

Management of Risk

The chart on the right shows the departments with overdue actions as at 19/12/16. The action owners will have received notification from the system that these actions are overdue to remind them that updates are required.

Pie Chart of open risks by current grade

Overdue Actions By Department
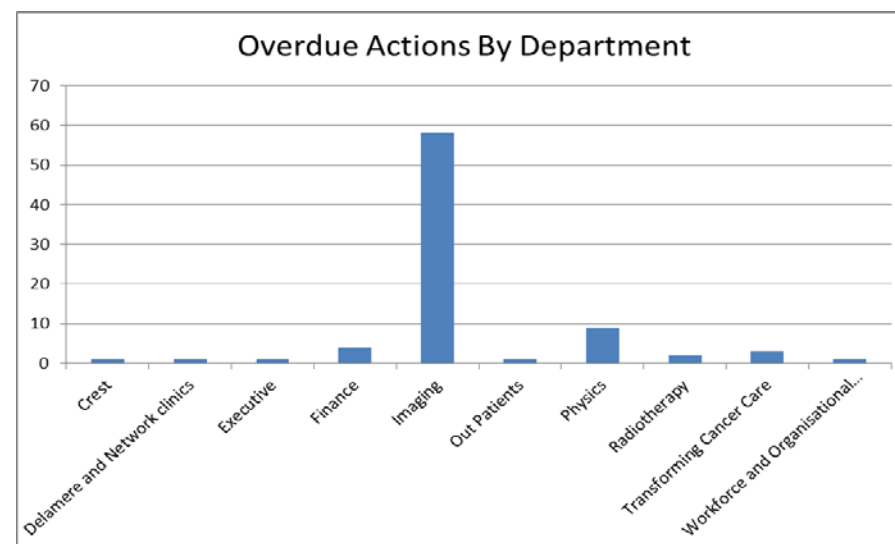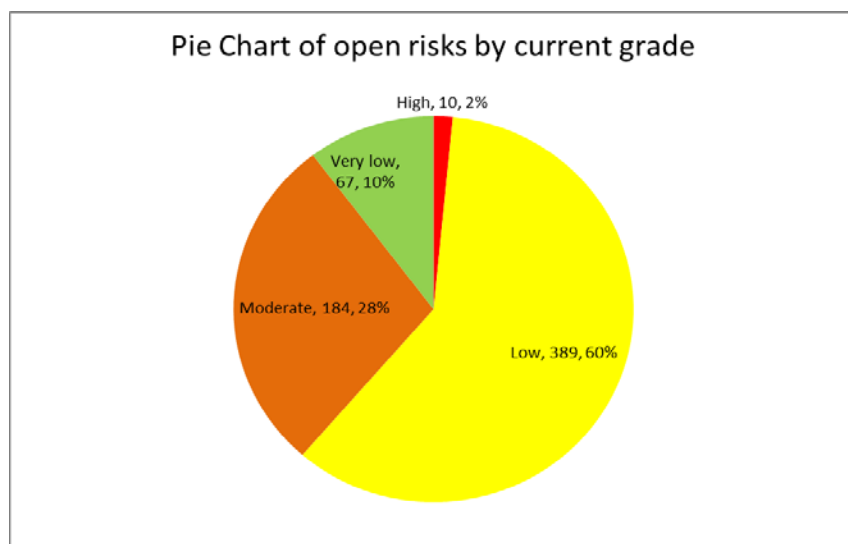
Risk Review status by grade:

The following table shows that there are a significant number of risks which have not been reviewed within the due dates. Managers have been reminded of the need to review their risks and update Datix, monitoring reports detailing overdue reviews and actions are submitted for review at the directorate review meetings. The Risk Management Committee also monitors which departments have overdue risk reviews and actions.

Risk Grade	Overdue Review Date at 20/9/16	Overdue Review Date at 7/11/16	Overdue Review Date at 19/12/16
1-3 (Very Low)	7	8	14
4-8 (Low)	132	169	183
9-12 (Moderate)	78	102	66
13-25 (High)	2	6	5
Total	**219 (33%)**	**285 (42%)**	**268 (41%)**