The Clatterbridge Cancer Centre NHS
NHS Foundation Trust

2012 - 2013

Clinical & Information Governance - Annual Report

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Section 1

Introduction & Summary Report

NAME: **Kate Smith**
POSITION: **Head of Clinical & Information Governance:**

Clinical Governance, Practice Development & Information Governance:

Clinical Governance supports a systematic, sustained approach to quality improvement within the NHS and identifies the statutory duty for organisations to have in place arrangements for the monitoring and improving of quality in order to deliver safe and effective care.

The Clinical Governance Department continues to work to support and engage staff across the Trust in the development and delivery of Clinical Governance and Trust-wide quality improvement programmes, aligned with regulatory requirements and the Trust's Quality Strategy. For our patients undergoing cancer treatments, it is essential to provide high quality care which is safe, harm free, effective and patient centred, meeting both local and national expectations of the NHS quality agenda (Department of Health, 2012). With an increased emphasis on financial savings (Department of Health, 2012a), proactive management of regulatory compliant services is required, to achieve the best outcomes for cancer patients (Department of Health, 2010a) It is crucial also to promote safe working practices of all staff, both clinical and non clinical, reducing risk and avoidable harm.

Responding to the planned growth in demand across multiple sites, reflected in the Trust's strategic direction and objectives (CCC Trust Strategic Objectives, 2012) has been crucial. Staff capacity and resources have been reviewed to meet the regulatory requirements of training delivery and to improve both patient and staff experience within this values based culture (Davies & Nutley, 2000). The regular CCCL site visits by the Clinical Governance Support Team staff and mandatory training sessions, to include patient Moving & Handling, have provided invaluable liaison and support for the expansion of knowledge and skills, whilst Cancer Peer Review self assessment visits to satellite chemotherapy delivery services by the Head of Clinical & Information Governance and Delamere Day Case Unit Manager, has also secured a vital link to the Trust's core standards.

The Trust's legal responsibility in the continuous delivery of service and quality improvement, and the safe and effective delivery of care, has been set out in multiple key documents, to include the Health & Social Care Act 2012 (Department of Health, 2012b), Equity and Excellence (Department of Health, 2010c), and Putting Patients First (NHS England, 2013). The need for Trust public accountability has also been highlighted in the recently published Francis Report (Francis, 2013) and the Trust has responded proactively in successful early implementation of the new data collection for the Friends and Family test. Also compliance with NHS Safety Thermometer in patient data collection relating to harms, identified as Pressure Ulcers, Falls, Catheters with UTIs and VTE. (Department of Health, 2012a)

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 the Care Quality Commission, National Health Service Litigation Authority, Cancer Peer Review measures, ISO9001: 2008 Quality Management Standard and the Patient Information Standard.

Acknowledging that essential to the successful delivery of the Clinical Governance agenda is the achievement of a positive patient experience, many initiatives and projects have underpinned this continued improvement in the management of patient care, as set out in the Trust Quality Strategy. In addition to those detailed in the report, is the continued investment by the Trust in the successful delivery of national and local practice development Trust–wide initiatives. Clinical Governance and Practice Development are closely aligned in the development of staff training and educational opportunities within the Trust, in order to introduce and facilitate evidence- based practice as part of active change management and service improvement:

Non Medical Prescribing (NMP)
Introduced into the Trust in September 2010, the numbers of Non Medical Prescribers have continued to expand with 18 NMPs registered and actively prescribing. These include registered Nurses, Pharmacists and on treatment Radiographers (CCCL), with the Trust extending Independent Prescribing permissions to Pharmacists this year. CCC also participated for the first time in the North West Clinicians Audit which collectively established and assessed the value of NMP for our patient population with positive results. The annual North West Organisational audit saw CCC commended for its robust clinical governance arrangements and NMP strategy. The NMPs Personal Formularies continue to expand to include complex medications to enhance practice and some subsequent cycle chemotherapy prescribing.

Patient Group Directions
A method of supplying and administering named medications to patients without the need to see a doctor, this in house training programme, delivered by the Head of Clinical & Information Governance and the PGD Pharmacist, continues to enhance our patient experience. There are currently 201 PGD Practitioners trained and registered with 37 medications now available to be supplied under PGD, to include analgesics, anti-emetics, contrast media and treatment site related creams. Recent additions are topical anaesthetics and antibiotics for the immediate treatment of febrile neutropenia and sepsis. The PGD Practitioners were also actively involved in the delivery of the Trust ‘flu vaccination programme.

Productive Ward
This initiative to release time to care, through a modular programme of service improvement redesign and 5s activity, has been embraced by all inpatient wards with Productive Ward team leaders identified in all areas, with measurable outcomes through key process indicators chosen by ward teams. This initiative has been used to support the ward refurbishment programme and underpin workforce planning and skills auditing in theatre, as well as augmenting the falls prevention programme and central stores management initiative. Waste walks and spaghetti diagram activity has identified direct patient care percentages on all wards and CCC remains significantly above the national average with 53% .We are not complacent and continue to work to find new and creative ways to work in order to secure additional time for direct patient care. The Productive Ward also underpins the direction for achieving the successful delivery of the NHS Quality, Innovation, Productivity and Prevention (QIPP) agenda (Department of Health, 2010b), aiming to transform quality of care, whilst delivering significant efficiency savings for reinvestment into frontline care.

Numeracy Skills assessment
All new nurse starters to the Trust continue to undergo numeracy assessment at interview, identifying areas of weakness and any requirement for additional numeracy support to enhance knowledge and skills and provide safe harm free care.

Registered and HCA Nurse & Radiographer HCA Competency Framework
A competency framework has been designed based on Benner's Novice to Expert which will allow the above staff to develop their knowledge and skills in line with the KSF and provides a career progression pathway. This work will be expanded to include specialist and advanced competencies as well as those pertaining specifically to leadership roles

Mortality Review Programme
Following from the NCEPOD recommendations, a comprehensive mortality review programme has been successfully introduced into the Trust and is detailed in the report. Multidisciplinary Mortality Review Meetings (MRM) have also commenced and have been positively supported by the medical staff, with the appointment to the Clinical Governance Dept of a Consultant Clinical Audit Lead. The MRM has now been incorporated as an integral part of the Consultant's audit day for accessibility and promotes learning and best practice through constructive challenge and vibrant discussion.

Practice Development and Research Partnership
This CCC partnership with Chester University continues to promote learning in the skills of Evidence based practice, literature searching, undertaking 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 recently applied for funding both from the Trust and a Burdett grant in order to progress a nurse research project to investigate the communication needs of our patients and carers.

Work has also continued this year in the area of emergency and major incident planning. Also in the timely response to safety alerts and management and reduction of risk and clinical incidents, with a planned introduction of an electronic incident reporting system. The Clinical Governance Department has worked with staff to ensure compliance with a Trust–wide audit programme, supported through comprehensive document control systems, in line with Information Governance Toolkit requirements.

Providing safe and effective care is underpinned through the continued development of clinical audit within the Trust and the participation in national cancer audits. Additionally the expansion of clinical outcomes measures and monitoring processes, to include analysis of harm events in the inpatient population through the Trust adapted Global Trigger Tool based on research undertaken by Leape *et al* (1991), 30 and 90 day mortality rates in chemotherapy and radiotherapy patients and the expanded calculation of survival rates by tumour type. Ensuring accurate clinical coding and the recording of clinical and tumour specific data for analysis is key to the delivery of robust clinical governance and Trust remuneration for quality of care. Changes to national chemotherapy datasets, along with SACT chemotherapy dataset and the new COSD (Cancer Outcomes and Services Dataset) have been efficiently implemented and reported with commendation for completeness nationally.

July 2012 saw the integration of Information Governance into the Clinical Governance Department and an entire service review was commenced to assure compliance with the Information Governance Toolkit requirements. Achievement of level 2 and increased levels of compliance were achieved, with an ongoing plan directed towards level 3 attainment and invited

assessment by the MIAA. IG training needs have been reassessed for all staff with a commitment to work with the Information Commissioners Office for future auditing and assessment.

This Clinical Governance Annual Report aims to outline the key areas of work, aligned to the quality agenda, undertaken by all the Trust staff throughout 12/13, under the guidance and support of the Director of Nursing and Quality and the Clinical Governance Department

The Clinical Governance Department encompasses:

Head of Clinical & Information Governance

Clinical Governance Support Team (CGST)

Clinical Effectiveness Team (CET)

Clinical Coders

Volunteer Service, Volunteer Co-ordinator, Commissionaire

Information Governance Manager

Consultant Clinical Audit Lead

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Section 2

CLINICAL GOVERNANCE TRUST-WIDE REPORTS: CGST

NAME: **Karen Postlethwaite**
POSITION: **Clinical Governance Manager**
DEPARTMENT SUPPORTED: **Radiotherapy**

ANNUAL REPORT:

Consideration has been given to the following areas in compiling this report:

1. PATIENT EXPERIENCE

2. PATIENT SAFETY

3. CLINICAL OUTCOMES

4. CLINICAL EFFECTIVENESS

Compliance with the ISO9001: Quality Management Standard
CCC has maintained registration to the ISO9001: 2008 Quality Management Standard through 2012-2013. Although accreditation to a nationally recognized Quality Management Standard is only required for the Radiotherapy directorate CCC has chosen to extend this Quality framework across the Trust believing that accreditation to IS09001 provides valuable external validation of the effectiveness of the Trust's Clinical Governance and Risk Management systems. CCC still remains one of the only Trusts in the country to have achieved accreditation across all of its services.

Compliance with IS09001 requires twice yearly assessment by an external certification body. Our certification body, the British Standards Institute (BSI) has undertaken two such assessments in September 2012 and April 2013, conducting reviews of the processes and controls across several clinical and non-clinical departments including Radiotherapy, Radiotherapy Physics, chemotherapy and radiotherapy nursing provision, provision of chemotherapy at the mobile unit, medical devices management, Trials, CREST, Pharmacy, Finance and Human Resources.

Current management system controls such as incident reporting and action management, audit, assessment and control of risk and reporting of performance against internal and external standards were subject to assessment and found to be effective.

A minor non-conformity relating to control of documents was raised at the September visit. This was closed at the March visit with all corrective actions considered to have been satisfactorily implemented. A minor non-conformity relating to the lack of an effective Management Review process in some areas of the Trust had been raised at the visit in March 2012. This was not closed at the September visit as it was felt that actions taken had been insufficient to address the identified deficiency in this aspect of the quality system. Some progress had been made by the visit of April 13. There are now templates for agenda and minutes of the Directorate Performance Review meetings which are used to fulfill the requirements for a management review process and an SOP which clearly describes the objectives of the meetings and the responsibilities for ensuring they meet both Trust and ISO 9001 requirements. However the standard documentation has not yet been used effectively so resolution of the issue could not

be demonstrated. The non-conformity remains open with the aim of achieving closure at the next assessment in October 2013. The Radiotherapy department is excluded from this non-conformity as additional arrangements for Management Review within radiotherapy are effectively employed.

3 further non-conformities were raised at the September 2012 visit. These related to control of non-conforming product within radiotherapy (recording of machine faults), completion of patient chemotherapy records and control of nursing documentation. At the April visit the first of these was closed with effective action found to have been taken but the other 2 remain open as further examples of minor non-conformities in these areas were noted.

No new non-conformities were raised at the April visit and a number of examples of good practice were noted. The assessor noted that significant improvements had been made in the completion of the annual audit programme and in the management of medical devices. Document control and incident reporting processes were found to be effectively implemented and well managed across the Trust. The management review process in radiotherapy was commended, with comprehensive, well-maintained minutes of meetings showing evidence of review and re-setting of quality improvement objectives.

Compliance with Internal Process Audit Plan for 12-13

Department	Planned Audits	Completed Audits	Out-standing Audits
Clinical Effectiveness Team	**11**	7	4 (3 ongoing and 1 on hold)
Medical Records	**19**	19	0
Diagnostic Imaging	**12**	12	0
CReST	**23**	13	10
Pharmacy	**5**	5	0
Radiotherapy/Physics	**18**	16	2
Medical devices	**2**	0	2
Clinical Governance	**13**	11	2
In-patients	**16**	13	3
Out-patients	**5**	0	5
Delamere & satellite clinics	**10**	5	5
Theatre	**7**	2	5
Human Resources	**6**	6	0
Total	**147**	**109 (74%)**	**38 (26%)**

The following actions have been put in place to improve compliance in specific areas for the forthcoming year:

- A member of CGST has met with each member of CReST individually to ensure that an appropriate and useful audit has been identified and an achievable timescale allocated.

- Monthly audit meetings have been set up with the Out Patients Manager to monitor compliance with the Out Patient audit plan.

- Audit is an item on the standing agenda used for all clinical and non-clinical Directorate Performance Reviews. Comprehensive governance reports are completed for all Directorate Performance Reviews with levels of compliance with departmental audit plans included. A standard template is provided for the minutes of these meetings to ensure that audit compliance and significant actions from audit are discussed and recorded.

- The Process Audit Sub-committee has been established to monitor compliance with the audit plan and to ensure identified actions are carried through to completion. This committee meets monthly and reports to the Risk Management Committee.

Incident Reporting

'Towards Safer Radiotherapy' (TSRT) Royal College of Radiology Ref No BFCO (08) published in 2008 recommended changes to local and national incident reporting systems in order to facilitate the use of a national outcome-based severity classification and a pathway coding system.

TSRT requires that all radiotherapy departments adopt the same systems for grading and classification of errors and that all radiotherapy errors (at all levels, irrespective of whether they have led to radiotherapy incidents) should be reported to the NPSA (National Patient Safety Agency) through the NRLS (National Reporting and Learning System).

Radiotherapy errors at CCC have been graded and classified in accordance with TSRT recommendations since May 2009 and since April 2010 the introduction of a direct link from our local incident management database to the NRLS has meant that all patient safety incidents, including those within the TSRT classifications, are reported to the NRLS as recommended.

All incidents indicated as TSRT reported through the NRLS are picked up by the (HPA) Health Protection Agency which carries out analysis of the data. The HPA became part of Public Health England in April 2013.

The HPA have reported that during the most recent period for which data analysis is available 42 Radiotherapy departments in England and Wales had submitted incident reports to the NRLS using the TSRT coding system. This represents 79% of radiotherapy departments, enabling meaningful comparisons to be carried out between locally and nationally reported data.

Correlation with national reporting patterns

The most recent published TSRT data covers the period of 1 August – 31 December 2012. 1586 TSRT coded incidents were reported nationally during this time period. Comparison with CCC data shows that approximately 12% of these were reported by CCC.

There were 517 radiation incidents (treatment errors) reported nationally during the 5 month period in question. Comparison with CCC data shows that just under 4% of these (19) were

reported by CCC. 26 of the 465 radiation incidents reported were classed as level 1 incidents which means that they were reportable under IR(ME)R and 26 were level 2 incidents which means that they were not reportable under IR(ME)R but are of potential or actual clinical significance for the patient. All 19 radiation errors reported by CCC during this time were classed as level 3 errors which means that no harm was caused to the patient.

Further analysis shows a reassuring correlation with the types of incidents occurring at a local and national level, e.g. issues with imaging and moves from reference points are frequently the most common problems reported at both levels.

The HPA radiotherapy newsletter which should be published on a quarterly basis contains an "error of the month" section. The newsletter provides advice on actions to take to minimise the likelihood of the error of the month recurring. Review of this advice locally shows that all of the suggested actions have at least been considered at CCC and implemented whenever it has been possible to do so. This suggests that CCC should be justifiably confident in the strength of the systems that govern both the reporting and investigation of radiotherapy incidents.

During the whole of 12-13, 73 radiation incidents were reported at CCC. 67 were classed as level 3, 4 as level 2 and 2 as level 1. 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 two level 1 incidents have now been completed and closure by the IR(ME)R inspectorate is awaited.

Local learning from incidents has been improved by the introduction of annual mandatory training sessions for the therapy radiographers reviewing incidents reported and lessons learned. A bi-monthly summary of reported incidents is also now produced for radiotherapy staff.

It was expected that electronic incident reporting would be introduced during 2012, further improving the timely reporting and investigating of incidents. This project has been delayed due to technical difficulties and a new deadline for completion of October 2013 has been allocated.

Radiotherapy Workshop and Development Day 2013

CCC has been able to utilize a sum of money received from the Cancer Radiotherapy Innovation Fund to enable more patients to benefit from the use of Intensity Modulated Radiotherapy (IMRT), a radiotherapy technique that allows greater conformity of dose to the area requiring treatment and increased sparing of normal surrounding tissue. The funding has been used to enhance equipment, allow dedicated IMRT staff and provide access to relevant training and education for all disciplines involved in IMRT. In March 2013 CCC hosted an international workshop on advanced techniques in radiotherapy to share ideas and working practices around new technologies such as IMRT and IGRT (Image Guided Radiation Therapy). The workshop was held with the help of visiting experts from the VUmc Cancer Centre in Amsterdam and focused specifically on the implementation of new technologies in the tumour sites of lung and head and neck.

The ideas shared at the workshop were further explored at the Radiotherapy Development day in April. The audience of medical staff, radiographers, physicists, senior managers, Executive Directors and Non Executive Directors received presentations describing the highlights of the weekend, the use of the Novalis Tx at CCCL, an update on SABR lung treatments and anticipated developments and technologies.

Developments in Radiotherapy Planning and Treatment

The radiotherapy directorate continually strives to improve the quality of treatment available to patients. The use of Intensity Modulated Radiotherapy (IMRT) continues to expand in line with

the recommendation from the National Radiotherapy Advisory Group (NRAG) that IMRT should become the accepted standard of care between 2012-2017. IMRT is already the treatment of choice for a number of tumour sites including prostate and many in the head and neck region and protocols are currently being developed in other sites including cervix and lung. Consultants can request to use an IMRT plan for any patient's treatment if there is shown to be a clinical benefit to the patient in its use.

The use of Image Guided Radiotherapy (IGRT) also continues to grow and CCC staff have taken an active role in the review of IGRT facilities and pathways carried out by NRIG (National Radiotherapy Implementation Group) and have made significant progress in carrying out the recommendations for best practice contained in the subsequent report issued in August 2012.

A Varian TrueBeam Linear Accelerator was brought into clinical use in December 2012, further enhancing CCC'S IGRT facilities and enabling projects to be undertaken looking at the benefits of IGRT for oesophagus and bladder patients. Joint collaboration projects with Varian are planned for the forthcoming year.

Other developments taken forward this year include the use of deep inspiration breath hold treatments for left sided breast tumours, the use of SABR (stereotactic ablative radiotherapy) for paraspinal tumours, increased use of enhancing contrast in simulator planning and a review of the planning pathway for patients who require planning and treatment on the same day.

Papillon centre
The Papillon technique is a form of contact radiotherapy that uses low energy x-rays to treat certain types of rectal cancer. CCC has been delivering treatment using this technique for many years in a room used to deliver superficial therapy. During 2012-13 CCC has developed a dedicated Papillon Suite containing clinic rooms, preparation rooms and a treatment facility which has radically improved the facilities and environment for patients undergoing Papillon treatment.

Radiotherapy and Imaging
Further work has been undertaken in 2012 to continue the integration of the Radiotherapy department and Diagnostic Imaging department which now operate under one Radiotherapy and Imaging directorate. A state of the art MRI scanner has recently been installed and is expected to be brought into clinical use in June 2013. This will significantly increase the capacity for undertaking diagnostic MRI scans and also allow greater use of MRI scans for the planning of radiotherapy.

Clatterbridge Cancer Centre- Liverpool
The desire to reduce the often draining travelling time for patients north of the River Mersey led to the development of Clatterbridge Cancer Centre- Liverpool (CCCL) which opened to the public on the Aintree hospital site in February 2011. The centre operates under the same well established and successful clinical governance structure as the radiotherapy department at CCC and along with the whole of CCC has maintained compliance with the IS09001: 2008 Quality Management System Standard

The Novalis Tx is used to deliver a stereotactic radiosurgery service. Patient numbers had been slow at first but are now increasing. The service continues to treat arteriovenous malformations and trigeminal neuralgia as well as brain metastases and acoustic neuromas. This year has seen the continued development of the frameless mask system of immobilization thereby removing the need for a treatment frame to be temporarily fixed to the patient's skull.

2012-13 has seen the introduction of a stereotactic service for treatments of spinal tumours (spinal SABR), with 3 patients having been treated with this technique to date. This treatment is normally given over fewer treatment sessions than standard radiotherapy and allows high doses of radiation to be given to the tumour whilst minimizing the dose to normal tissues.

The centre continues to treat mostly breast, prostate, lung and lymphoma patients. Treatments with palliative intent for patients of any tumour site are considered on a case-by case basis once the needs of the individual patient have been assessed. The safety of patients is our first priority and any changes to the clinical model are not made until the systems to ensure appropriate clinical support have been put in place.

In February 2013 CCCL was awarded the highest score possible in the Macmillan Quality Environment Mark (MQEM), highlighting the exceptional comfort, accessibility and design of the centre.

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 94 radiotherapy measures applicable to CCC – 23 of these are assessed at a network level and 71 at departmental level. The department measures are split into 4 categories. There is a set of generic measures which are relevant to all treatment modalities and focus on the overall management and organisation of the service and then there is a set of measures specific to each of the following treatment modalities:

- EBRT (External beam radiotherapy)
- IMRT (Intensity modulated radiotherapy)
- Brachytherapy

The results of the self-assessment carried out by the Radiotherapy service at CCC in September 2012 are as follows.

Measure	**Compliance CCC 12/13**
Generic	92% (24/26)
EBRT	96% (23/24)
IMRT	100% (7/7)
Brachytherapy	93% (13/14)

The same compliance levels were reported for CCCL with the exception of Brachytherapy as this service is only delivered at the main Clatterbridge site.

The compliance for the network radiotherapy measures, for which CCC as the only radiotherapy provider in the network bears the main responsibility, was assessed at 96%.

Compliance with the departmental measures should be further improved this year with the planned implementation of In Vivo Dosimetry which allows real time measurement of dose to the patient and the fulfillment of the training and education strategy for radiotherapy staff.

NAME: **Nadine Higgins**
POSITION: **Clinical Governance Manager (Regulation)**
DEPARTMENTS SUPPORTED: **Nursing, Chemotherapy, CREST, and Pharmacy**

ANNUAL REPORT:

Consideration has been given to the following areas in compiling this report:

1 PATIENT EXPERIENCE

2 PATIENT SAFETY

3 CLINICAL OUTCOMES

4 CLINICAL EFFECTIVENESS

Registration against Care Quality Commission Essential Standards for Quality and Safety
The trust continues to comply against all 16 quality and safety standards (see table below) standards and remains registered without condition.

Regulation	Outcome	Title and summary of outcome
9	**4**	**Care and welfare of people who use services** People experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.
10	**16**	**Assessing and monitoring the quality of service provision** People benefit from safe, quality care because effective decisions are made and because of the management of risks to people's health, welfare and safety.
11	**7**	**Safeguarding people who use services from abuse** People are safeguarded from abuse, or the risk of abuse, and their human rights are respected and upheld.
12	**8**	**Cleanliness and infection control** People experience care in a clean environment, and are protected from acquiring infections.
13	**9**	**Management of medicines** People have their medicines when they need them, and in a safe way. People are given information about their medicines.

14	**5**	**Meeting nutritional needs** People are encouraged and supported to have sufficient food and drink that is nutritional and balanced, and a choice of food and drink to meet their different needs.
15	**10**	**Safety and suitability of premises** People receive care in, work in or visit safe surroundings that promote their wellbeing.
16	**11**	**Safety, availability and suitability of equipment** Where equipment is used, it is safe, available, comfortable and suitable for people's needs.
17	**1**	**Respecting and involving people who use services** People understand the care and treatment choices available to them. They can express their views and are involved in making decisions about their care. They have their privacy, dignity and independence respected, and have their views and experiences taken into account in the way in which the service is delivered.
18	**2**	**Consent to care and treatment** People give consent to their care and treatment, and understand and know how to change decisions about things that have been agreed previously.
19	**17**	**Complaints** People and those acting on their behalf have their comments and complaints listened to and acted on effectively, and know that they will not be discriminated against for making a complaint.
20	**21**	**Records** People's personal records are accurate, fit for purpose, held securely and remain confidential. The same applies to other records that are needed to protect their safety and wellbeing.
21	**12**	**Requirements relating to workers** People are kept safe, and their health and welfare needs are met, by staff who are fit for the job and have the right qualifications, skills and experience.
22	**13**	**Staffing** People are kept safe, and their health and welfare needs are met, because there are

		sufficient numbers of the right staff.
23	**14**	**Supporting workers** People are kept safe, and their health and welfare needs are met, because staff are competent to carry out their work and are properly trained, supervised and appraised.
24	**6**	**Cooperating with other providers** People receive safe and coordinated care when they move between providers or receive care from more than one provider.

Robust systems are in place across the trust to ensure the trust maintains it registration with the CQC. Each of the CQC Essentials Standards of Quality and Safety Outcome has an assigned lead/s who complete a Provider Compliance Assessment on a quarterly basis, the PCA describes how the Trust is compliant with each essential standard and 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 unannounced inspection. An online data base is in use to record PCAs.

Each PCA is scrutinised twice yearly by the Scrutiny Committee to ensure it is appropriate and fit for purpose. This is supported by a program on mock inspection 2 of which were completed in 2012/13

The Trust also receives a Quality and Risk Profile 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 2012/13

The Care Quality Commission inspected The Clatterbridge Cancer Centre in October 2012 and found the trust met the fooling standards:

- Consent to care and treatment
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Supporting Workers
- Assessing and monitoring the quality of service provision

The Trust was assessed by the Merseyside Internal Audit Agency Framework to Assure Achievement of CQC outcomes which showed high assurance.

Development of Robust System for managing mental capacity and deprivation of Liberty Issues and consent to treatment processes

Consent training in now included as part of mandatory training for all clinical staff and this includes sections on deprivation of liberty and mental capacity.

Face to consent and capacity training was included in the consultants manadatory training day and session have been held as part of the SPR teaching program and clinical champions.

New consent form have been developed and launched to help simplify the processes.

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 2 years at CCC. In 2012/13 8 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 ant there has been improvement across the trust in nearly all areas

The key areas identified are detailed below:

Definition of risk area
Incidence of in-patient falls
Quality of Documentation of Nursing Care may lead to risk
Pressure Ulcers
Patient receive Nutrition / Hydration
Discharge / Transfer planning
Medicines Management / Pain Relief
Management of Patients at risk of VTE
Referral of patients with Suspected Dementia

A QINC audit tool has been developed for use in Day Case Chemotherapy and is due to be piloted in July 2013

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 2012/13 Peer Review cycle the service attained the following levels of compliance:

Team undergoing Peer review	2012/13 Performance
Brain CNS	90% on self assessment
Sarcoma	100 % on self assessment
Complementary Therapies	100 % on self assessment

Chemotherapy Service	95 % on self assessment
Oncology Pharmacy Service	100% on self assessment
Intrathecal chemotherapy	100% on self assessment
Radiotherapy Generic – CCC	92% on self assessment
Radiotherapy Generic – Aintree	92% on self assessment
Radiotherapy External Beam – CCC	96% on self assessment
Radiotherapy External Beam – Aintree	96% on self assessment
Radiotherapy IMRT- CCC	100% on self assessment
Radiotherapy IMRT- Aintree	100% on self assessment
Radiotherapy Brachytherapy	93% on self assessment
Specialist Acute Oncology	100% at Peer Review
General Acute Oncology	55% at Peer Review
Acute Oncology In Patient	67% at Peer Review
TYA PTC Core	37.5% at Peer Review 1 serious concern was identified at Peer Review: • There is no acute leukaemia specialist in the core membership of the TYA MDT. This has now been resolved and a leukaemia specialist has been in place since Jan 2013
TYA PTC MDT	56% at Peer Review
Specialist Palliative Care	80% at Internal Validation 1 serious concern was identified at Internal Validation: • The lack of a second palliative care consultant

New measures have been introduced for the 2012/13 Peer Review cycle against which the trust will have to demonstrate compliance. These are:

- Specialist Palliative Care Measures

NAME: **Sue Relph**
POSITION: **Patient Experience Manger**

NAME: Sue Relph
POSITION: Patient Experience Manager

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.

Complaints Analysis 2012/13

Date Received	Complaint no/	Brief narrative	Response date	Comments	Grade/ Upheld
02/04/2012	01/2012	Patient has questions relating to how diagnosis was made	03/05/2012	NFA	2 med Yes
14/04/2012	02/2012	Patient unhappy with Consultant feels they are too negative.	05/05/2012	NFA	1 med yes
30/04/2012	03/2012	Family unhappy with secretary- didn't feel she acted in a timely manner	17/05/2012	NFA	2 med No
04/12/2012	04/2012	Complainant unhappy with Trust's handling of a complaint made earlier in the year	25/05/2012	Meeting with ICAS	2 med No
21/06/2012	05/2012	Patient unhappy that metastatic disease was not diagnosed earlier.	24/09/2012	Now a claim	2 Med Yes
15/08/2012	06/2012	Relative unhappy with care/support during patient's last few days at home	28/09/2012	PHSO requested further	2 Med No

				questions responded 05/04/2013	

07/08/2012	07/2012	Relative has questions relating to radiotherapy of deceased patient	15/10/2012 (via STH&K)	NFA	2 Med No
19/11/2012	08/2012	Relative unhappy with consultant breaking bad news.	29/11/2012	Further letter recvd14/12/12. responded 20/12/12	2 Med No
28/11/2012	09/2012	Family unhappy with care and attitude of consultant	04/02/2013	NFA	2 Med yes
29/01/2013	10/2012	Bereaved wife has questions relating to trials	14/03/2013	NFA	2 Med No
25/02/2013	11/2012	Patient complaint about drug error	08/04/2013	NFA	2 Med Yes

Summary 2012/13

Total complaints received 11

Subject matter of complaint:

Treatment and Care	**5**
Communication	**3**
Staff attitude	**2**
Complaints handling	**1**

PALS

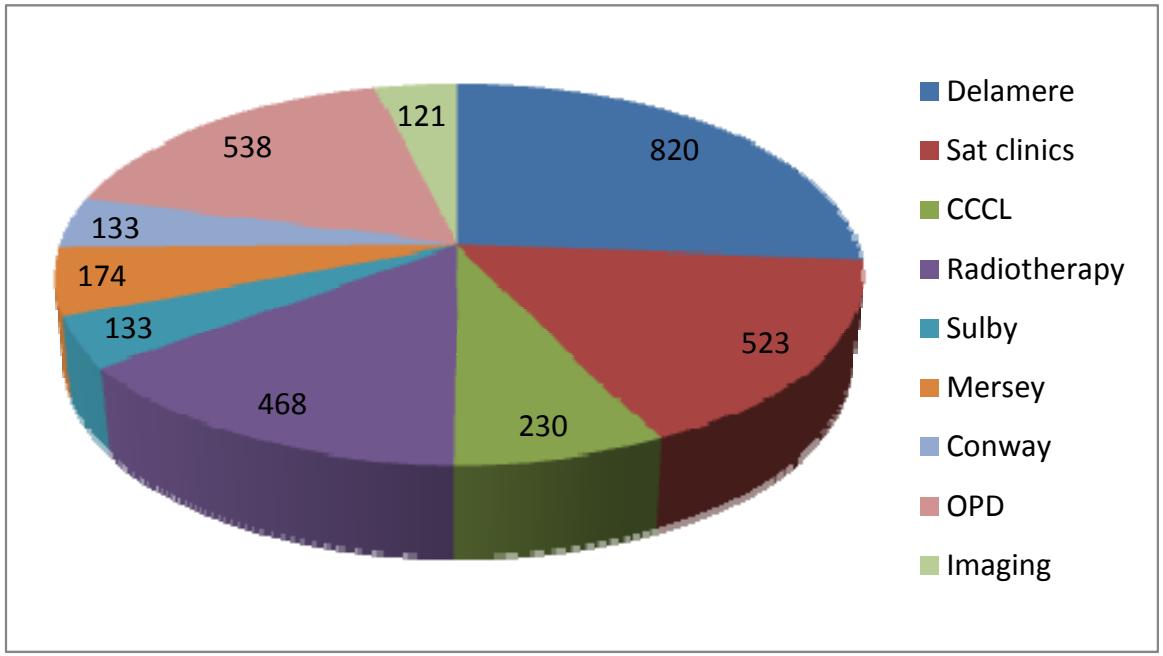
Concern	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Advice/info	6	2	3	4	8	11	8	15	7	10	15	10
Delays/(waiting times)	3	1	2	1	7	2	1	2	1	1	1	5
Staff attitude		1			2		3		2	1	1	1
Communication	3	13	2	3	2		8	1	4	6	5	5
Car Parking	2		1	1	1		1	2	2			
Environment			1	1	2	1				3	4	1
T&C		4	5	5	3	1				1	2	
Transport	3		1	1	3		2	3	2			
Other	1				1	2		3	2		3	2
Thank you	3	1	1	3	3	1	6	2	6	1	3	2
Totals	**21**	**22**	**16**	**19**	**31**	**18**	**29**	**28**	**26**	**23**	**34**	**25**

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. Occasionally contact is made by e-mail and responded to by e-mail.

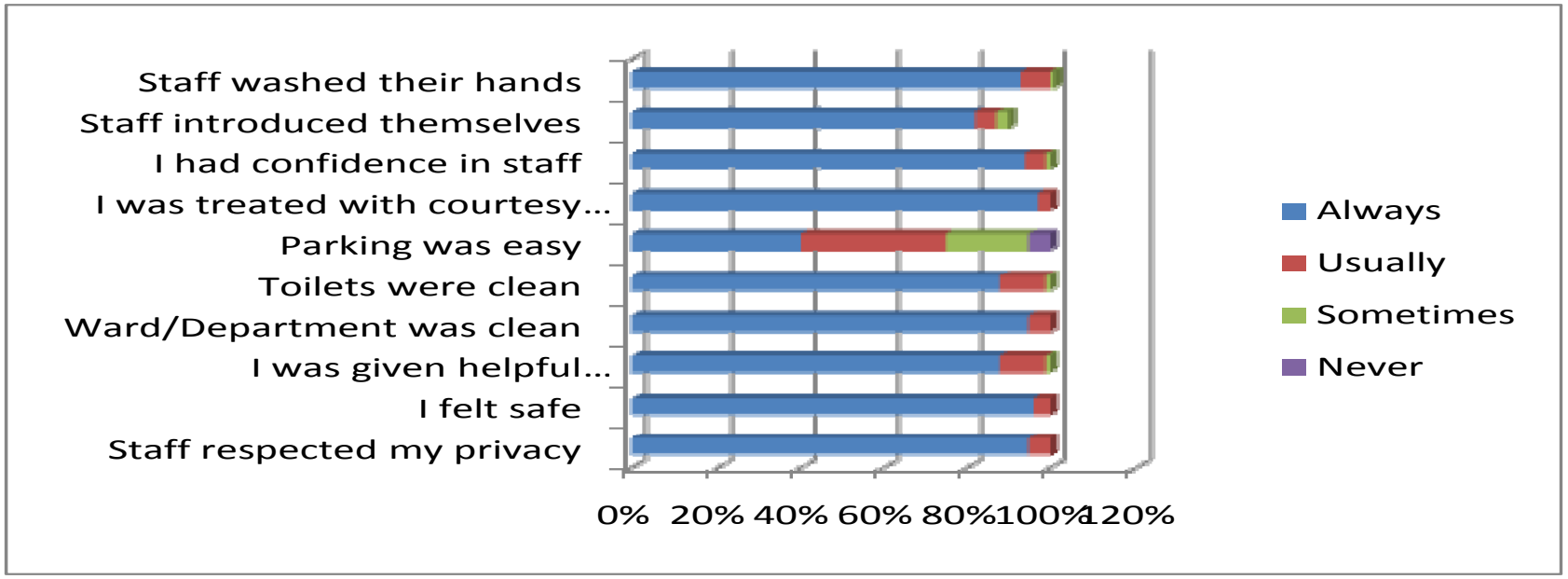
Patient Feedback Survey

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 17,000 feedback forms during this time.

During the time period April 2012 to March 2013 we have received 3179 forms compared to 3416 from the previous year. The following chart identifies the source of the forms during this year:

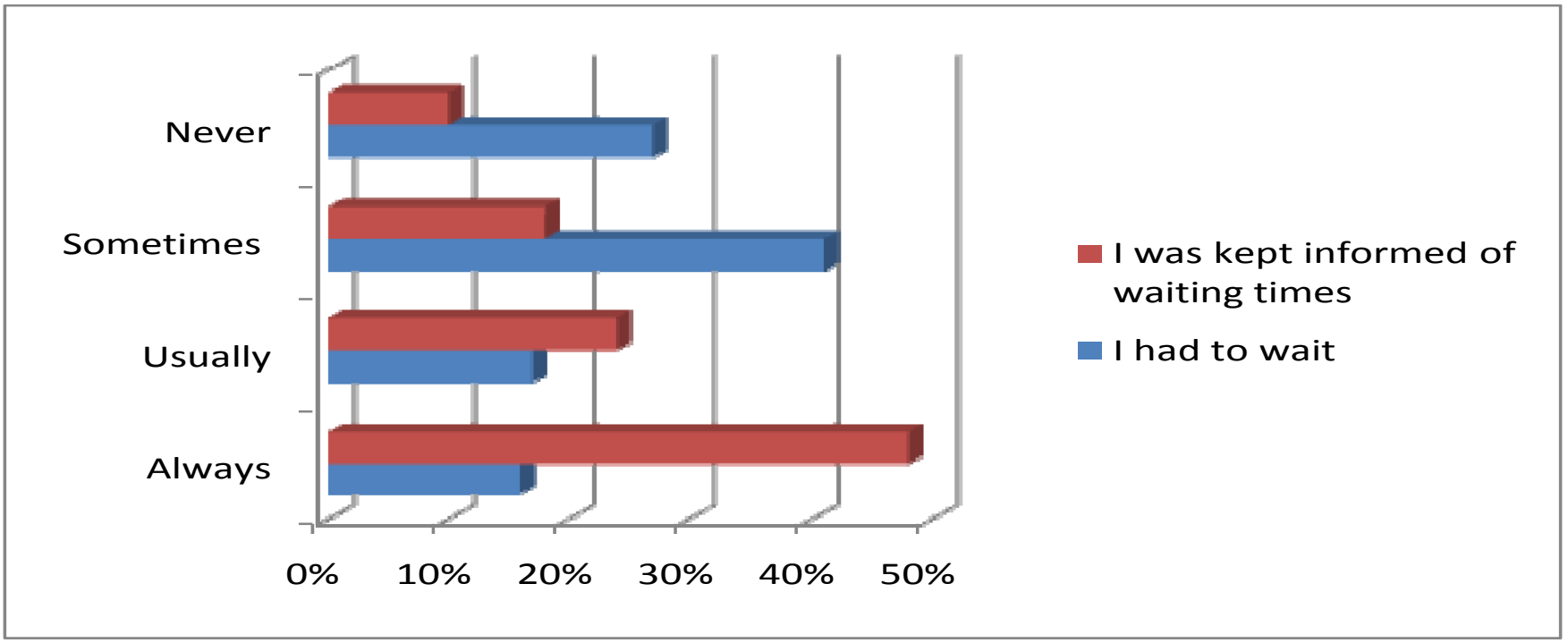


The chart below gives an example of some of the 30 questions we ask and their results for the last 12 months



It is relevant that our internal scores mirror the results of the CQC survey.

Waiting times remain the main cause for concern within CCC, staff are encouraged to keep patients informed of the length and reason for the delay.



The Friends and Family Test

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:

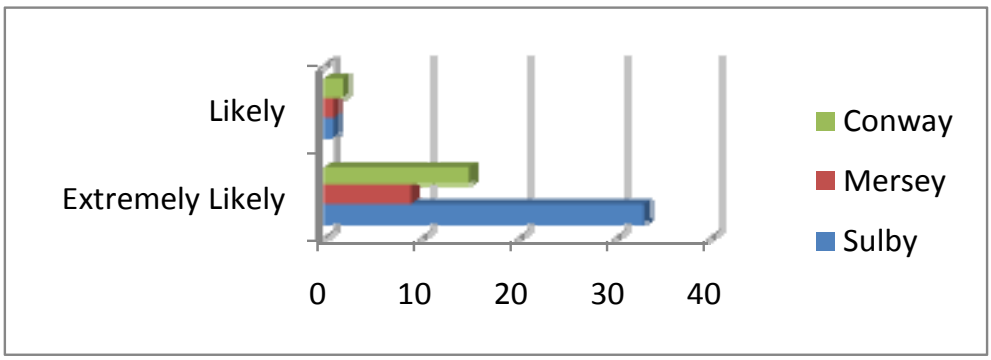
> How likely are you to recommend our ward to friends and family if they needed similar care or treatment?
> [] Extremely likely
> [] Likely
> [] Neither likely or unlikely
> [] Unlikely
> [] Extremely unlikely
> [] Don't know

From April 1st 2013 it will be 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.

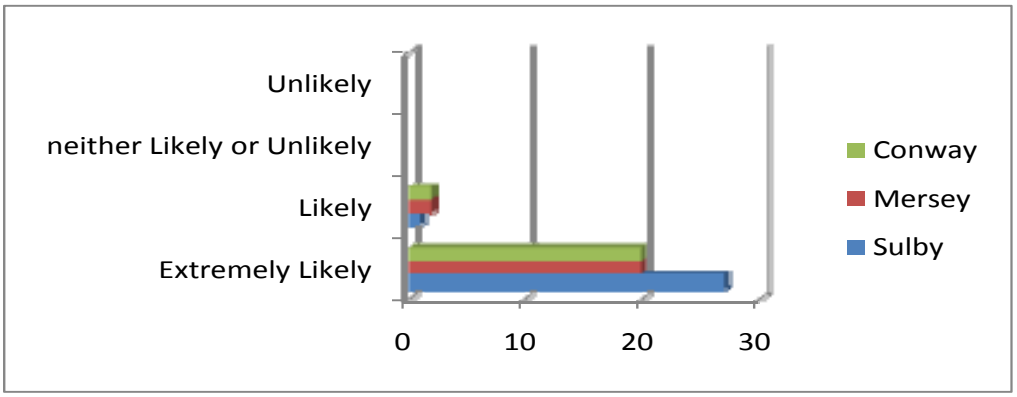
We opted to try a paper based system in the form of postcards. The guidelines state that the patient must be asked the question at discharge or within 48 hours of discharge. The aim is at least a 15% response rate. We have distributed collection boxes on the wards and at the main desk. The postcards have a freepost address to enable patients to return them once they get home.

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.

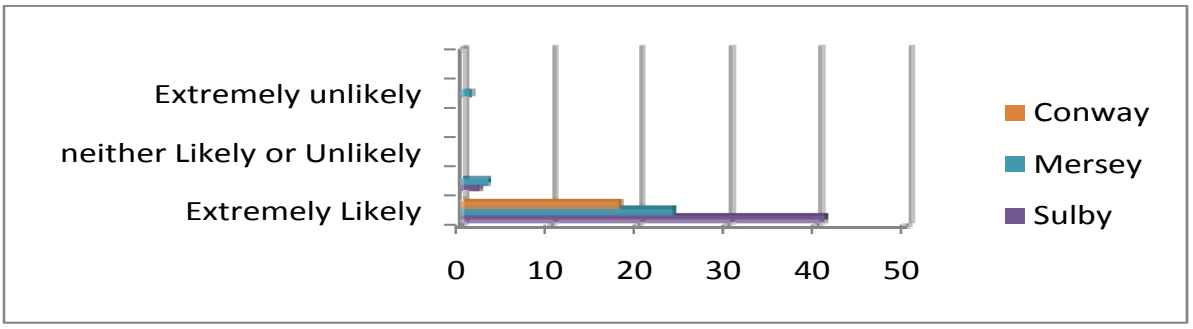
December 2012
The response rate overall was 19.4%
97% of respondents scored 'extremely likely'
3% respondents scored 'likely'



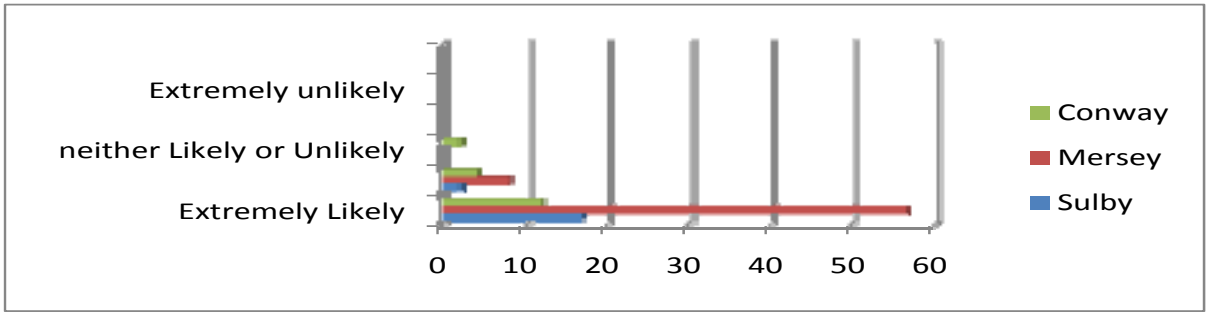
January 2013
Overall response rate 24%
95.5% 'extremely likely'
4.5% 'Likely'



February 2013
Overall response rate 35%
93% extremely likely
6% likely
1% (extremely unlikely)



March 2013
Overall response rate 41%
83% patients were extremely likely to recommend our services
14% patients were likely
2% were neither likely or unlikely
1% was unlikely



Patient and Public Involvement Activity

During 2012/13 the Trust has engaged with patients and stakeholders to further develop its services.

Activities have included:

- The third open day for LINKS (Local Involvement Networks- now Healthwatch), 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

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
- Continue to engage with varied groups (Wirral deaf Society, , Clwyd patients council, John Holt Cancer Foundation).

External Surveys

During this year CCO participated in the 2012 national inpatient survey

<u>NHS Inpatient survey 2012</u>:

The Care Quality Commission 2011inpatient survey involved 156 acute and specialist NHS trusts and received responses from 64,500 patients, with a response rate of 51%.

Once again, Clatterbridge Cancer Centre has scored amongst the best performing NHS Trusts across England.

The survey asked questions on admission to hospital, the hospital and ward, doctors, nurses,

care and treatment, operations and procedures and leaving hospital.

Results rate the Centre within the country's 20% best performing trusts in 92% of the questions.

We received the highest national score in twelve (ten in 2011) questions:

- Hand Washing
- Cleanliness of rooms/wards
- Hand wash gel available
- Given enough emotional support
- Given enough privacy
- Call button responded to
- Involved in decisions about care
- Staff informed me of side effects
- Staff took family and home into consideration before discharge
- Carers received necessary information
- Staff informed who to contact on discharge
- Letters were written in a way I understood

In the overall section scores, CCC scored in the top 20% of 8 of the 8 sections:

- Waiting lists and planned admissions
- The Hospital and Ward
- Doctors
- Nurses
- Care and Treatment
- Operations and procedures
- Leaving hospital
- Overall views and experiences

In comparison to last year we were:

Significantly better on 1 question
Significantly worse on 0 questions
The scores show no significant difference on 53 questions

Compared to other trusts we were:

Significantly better than average on 54questions
Significantly worse than average on 2 questions
The scores were average on 6 questions

NAME: **Luke Scott**

POSITION: **Clinical Governance Manager – Patient Safety**

DEPARTMENTS SUPPORTED: **Diagnostic Imaging and Research & Development**

ANNUAL REPORT:

Consideration has been given to the following areas in compiling this report:

1. PATIENT EXPERIENCE
2. PATIENT SAFETY
3. CLINICAL OUTCOMES
4. CLINICAL EFFECTIVENESS

Patient Information

Throughout 2012/13 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 underway to ensure that all relevant leaflets meet the criteria of the Information Standard within the next year.

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. Each proposed intervention has an underpinning evidence base that identifies the need for change and how its elements can help on a journey that will make a real impact on rates of patient harm and death.

The proposed elements, suggested changes and associated measures provide a basis on which to start making a difference in the given area. It also provides a sound methodical approach that can be applied repeatedly in other improvement efforts.

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 2012/13 there were 63 Patient Safety Leadership Walkrounds successfully completed across almost all areas and staff groups.

So far, within the first five rounds of Walkrounds 474 Walkround have been completed, from these, 271 issues have been raised by staff and have been taken forward. 31 issues remain outstanding at the end of 2012/13. Each issue is assigned to an Executive and/or staff member to take forward and is tracked until completion by the Clinical Governance Manager for Patient Safety, action plans are lodged with the department that the issue concerns via the Departmental Review Meetings. Agreed actions are followed up and progress reported to the area at regular intervals.

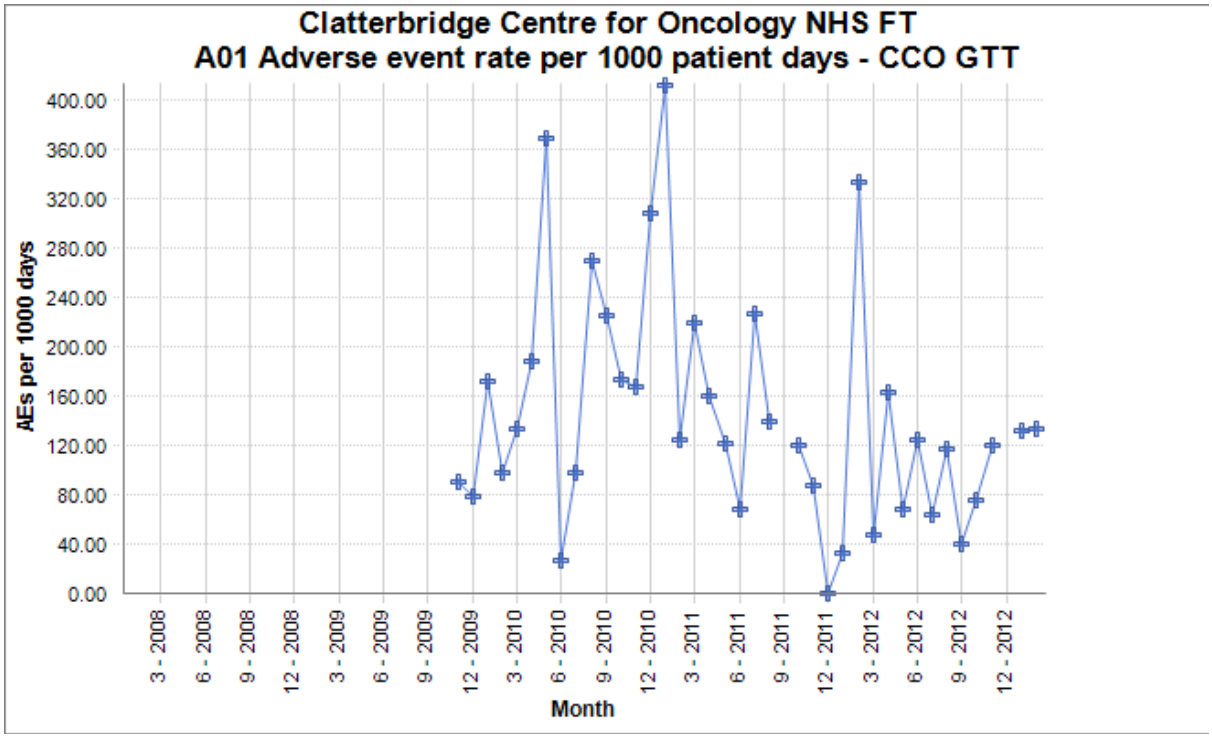
The cumulative number of Walkrounds conducted is recorded on the Institute for Healthcare Improvement (IHI) Extranet through the Patient Safety First Campaign.

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.

The number of adverse events identified per 1000 days of patient stay in hospital is recorded on the Institute for Healthcare Improvement (IHI) Extranet through the Patient Safety First Campaign.



During 2012/13 there were no harm events classified above an F (*Temporary harm to the patient and required initial or prolonged hospitalisation*).

The overall percentage of admissions with an Adverse Event averages at 43% therefore just under half of all patients 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.

Deterioration

CCC started recording and reporting on this intervention in January 2010. Data was collected for the four deterioration measures (D01, D02, D05 and D06) and recorded on The Institute for Healthcare Improvement (IHI) Extranet through the Patient Safety First Campaign. Data collection for measures D01 & D02 (Number of Cardiac Arrest and Rapid Response Calls) stopped in April 2011, however data is still recorded for measures D05 & D06.

D05 - Percentage of Patients With Observations Complete: percentage of patients in the sample where all the relevant clinical observations were recorded in the patient notes.

Using the Patient Safety First Campaign Chart Checker adapted for CCC, 30 sets of patient observations/mews records for each of the three in-patient wards are reviewed (*by the wards*) per month. In addition, each set of patient records reviewed during the monthly Global Trigger Tool review are assessed against the CCC Chart Checker.

D06 - Trigger Patients Receiving an Appropriate Response: using the data collected from the chart checker assessments (*detailed above*) this measure is calculated by dividing the number of patients who triggered and received an appropriate response '*If MEWS raised (above 4) was the patient referred appropriately'* by the total number of patients who triggered.

NHS Safety Thermometer

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, or a round 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.

NAME: **Vicky Davies**
POSITION: **Risk Management Facilitator**
DEPARTMENT SUPPORTED: **Trust - Wide**

Consideration has been given to the following areas in compiling this report:

1. PATIENT EXPERIENCE

2. PATIENT SAFETY

3. CLINICAL OUTCOMES

4. CLINICAL EFFECTIVENESS

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 2012/13 there were 547 risks on the register. The table below shows the grading of the open risks on the register and compares them across the last 3 years.

Risk Grade	**Number on Register end of 2009/10**	**%**	**Number on Register end of 2010/11**	**%**	**Number on Register end of 2011/12**	**%**	**Number on Register end of 2012/13**	**%**
1-3 (Very Low)	99	14%	69	10%	68	12%	63	12%
4-7 (Low)	355	49%	347	50%	286	51%	277	51%
8-12 (Moderate)	267	37%	261	38%	203	36%	203	37%
13-25 (High)	7	1%	13	1.8 %	5	0.9 %	4	0.7 %
Total	**721**		**690**		**562**		**547**	

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 10/11**	**%**	**Total 11/12**	**%**	**Total 12/13**	**%**
Risk Assessment	486	70%	398	71%	378	69%
Board Assurance	75	11%	38	7%	34	6%

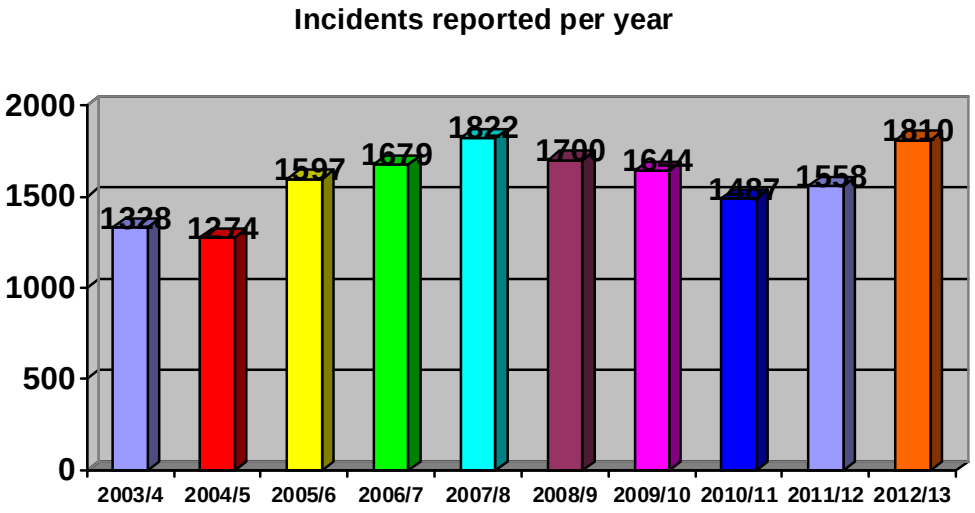
Framework						
Incidents	7	1%	14	2%	26	5%
NICE Guidance	5	0.7%	5	1%	7	1%
Audit	1	0.1%	1	0.2%	3	0.5%
Board identified risks/Annual Plan	15	2%	12	2%	11	2%
Complaints	0		0		0	
Safety alerts	0		0		0	
Claims	0		0		0	
Departmental assurance framework	101	15%	94	17%	88	16%

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.

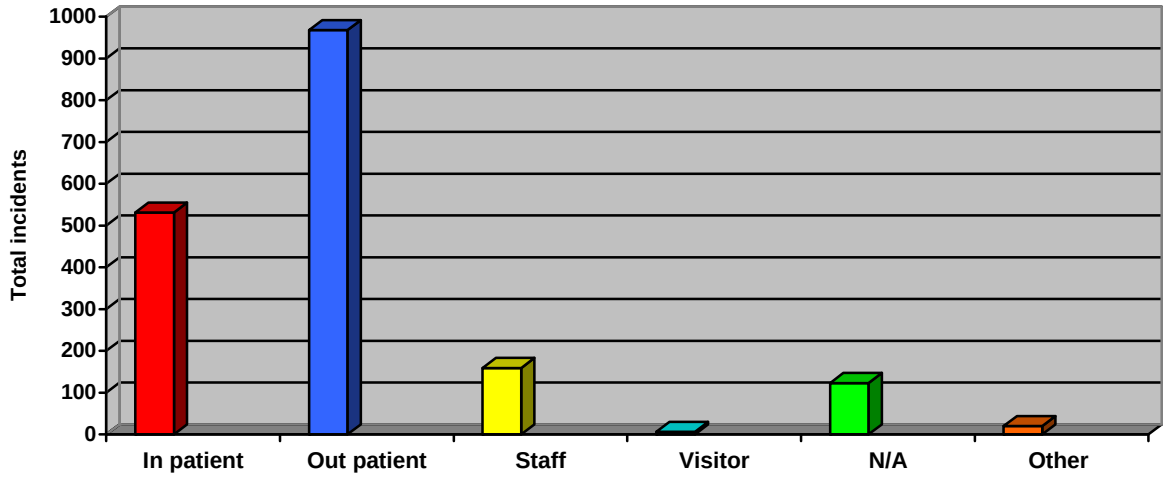
1810 incidents were reported from 1/4/12-31/3/13 and this was an increase compared to the 1558 the year before. The chart below shows the total number of incidents reported in previous years.



Person concerned

The majority of incidents were patient incidents (83%) followed by staff incidents (9%), with the remaining involving visitors, volunteers, agency staff or not involving a specific person as shown in the table below.

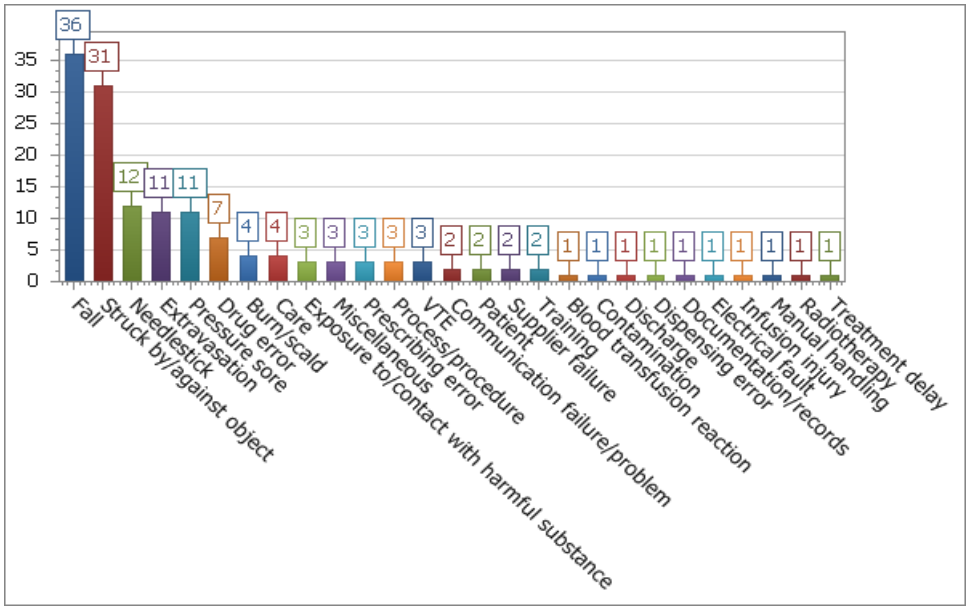
Table to show incidents by person involved



Levels of Harm

Of the 1810 incidents reported, 151 (8%) resulted in harm. Of the 151, 149 (99%) resulted in low harm and 2 (1%) resulted in moderate harm. The two moderate harm incidents both involved inpatient falls which had resulted in a dislocated shoulder and a pathological hip fracture. Of the minor harm incidents 73% were patient incidents, 24% were staff incidents and 3% were visitor incidents.

The causes of minor harm



The table above shows that the majority of minor harm is a result of a fall, being struck by or against an object, needlestick injury, a pressure ulcer or an extravasation.

Externally Reported Incidents

External body	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
HSE (RIDDOR) **Note: from April 2012, over 3 day injuries changed to**	4	7	3	2	2	2*

7 days						
MHRA	0	3	1 (CT)	1		
SHOT	2	0	0	0	2	
CQC (IRMER)	2	2	1 (CT)	0	2	2****
STEIS	2	4	1	0	1	2**
NRLS	13	3	13	1283	1237	1623
SIRS	0	0	1(PARS)	18	20	17
Information Commissioner						1***

*RIDDOR = over 7 day manual handling injury (INC3343) and patient fall resulting in shoulder dislocation (INC4548)
**STEIS= Herceptin incident (INC3167), Electronic Prescribing (INC3659)
*** Info Com = Missing camera memory card (INC 3775)
**** IRMER= Radiotherapy wrong side treated (INC 4373), Radiotherapy wrong area (INC4501)

1623 patient incidents were reported via the National Reporting and Learning System and 17 incidents were reported to the Security Incident Reporting System.

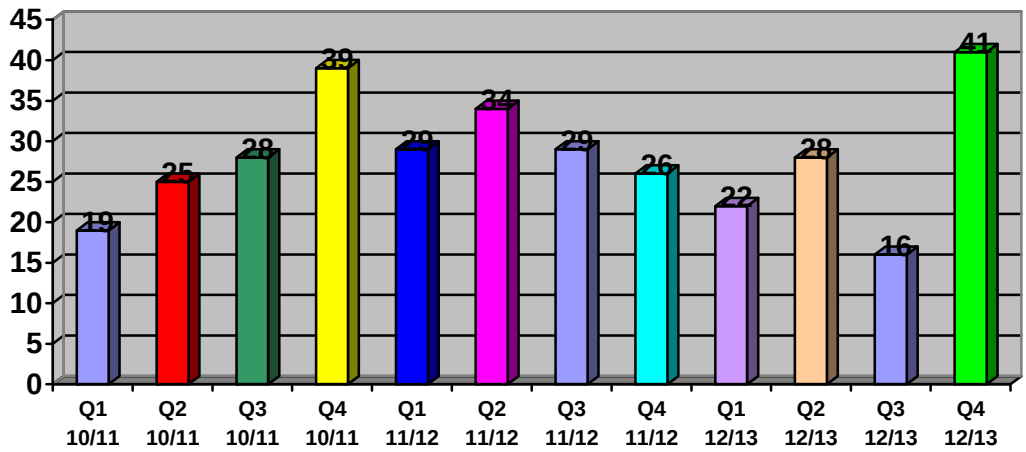
Trust performance against selected quality metrics 2012/13:

	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sept 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
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	0	0	0	0	0	0.59	0	0	0	0	1.28	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)	0	0	0	0	0.77	0.17	0.15	0.31	0.17	0.16	0.17	0
Radiotherapy treatment errors (number of errors per 1,000 fractions)	0.93	0.26	0.69	0.94	0.27	0.28	0.5	1.3	1.2	0.78	1.5	0.82
Falls / 1,000 inpatient admissions	23.4	22.7	6.7	23.5	31.3	16.8	12.5,	16.4	9.3	41.8	33.1	26.8

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 for 2010/11, 2011/12 and 2012/13

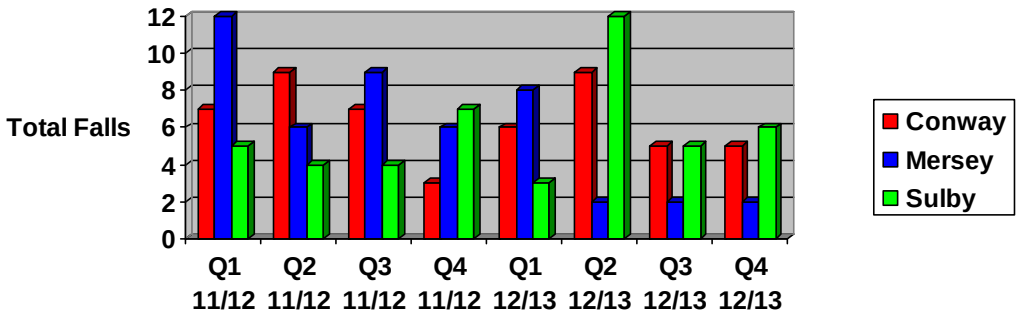


Falls reported by person concerned

Person concerned	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13
Inpatient	17	23	12	31
Staff	2	1	3	5
Outpatient	2	3	1	5
Visitor		1		
Volunteer	1			

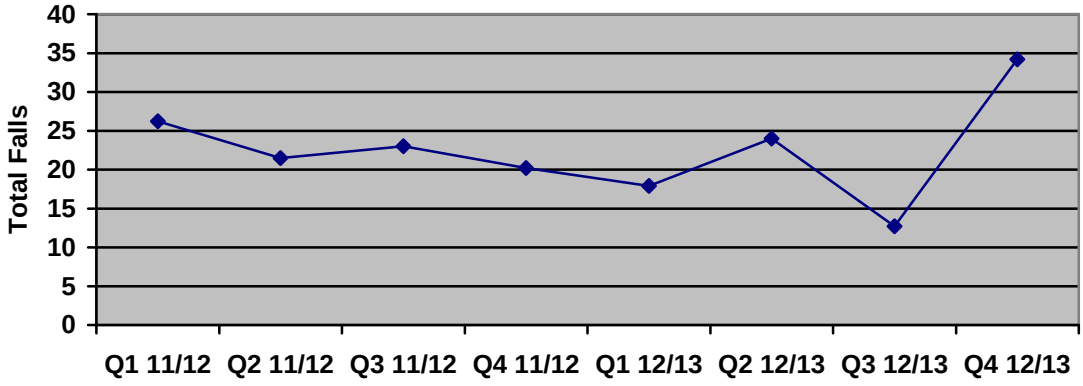
The tables above show that the majority of falls are due to inpatient falls. Falls reports are monitored at the Manual Handing/Falls Prevention Group which meets quarterly. All inpatients receive a falls risk assessment on admission and if assessed as 'at-risk of falls', a falls care plan is implemented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

Inpatient Falls on Ward per quarter



Ongoing work at ward level is taking place to improve the monitoring of falls and falls prevention, including the introduction of a root cause analysis to be completed following a fall.

Chart to show total inpatient falls per 1000 inpatient admissions per quarter for 2011/12 and 2012/13



Serious Incident Panels

No serious incident panels were held in 2012/13.

Incident Reviews

21 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.

Please see Risk Management Annual Report for further details.

Incident Number	Date of incident	Date of review	Incident
3099	1/5/12	2/7/12	Dietetic service
3167	15/5/12	25/6/12	Herceptin error
3291	20/6/12	2/7/12	Nurse registration
3670	3/9/12	9/10/12	IMS unauthorised Configuration
3639	11/6/12	16/10/12	Maxims implementation
3659	17/8/12	2/10/12	EP – Irinotecan/Temozolomide
3775	25/9/12	18/10/12	Radiotherapy missing memory card
3653/3657	10/8/12 29/8/12	20/9/12	Pharmacy Environmental Control
3853	19/10/12	18/12/12	Misplaced box from SBS
3963	7/11/12	19/12/12	EP - VIDE
4366	3/1/13	15/1/13	Radiotherapy Near Miss – Removal of MLC from Treatment Field
4373	11/1/13		Reportable incident – wrong side treated
4127	7/9/12	14/12/12	Trial ST03, incorrect dose
4501	7/2/13		Incorrect area scanned
4259	5/9/12	18/3/12	Herceptin
4471	11/2/13	19/3/13	Herceptin
4471/4259	2012/13	9/5/13	Herceptin overview review
4803	8/4/13	1/5/13	Bed Order
4588	21/2/13	23/4/13	Failure to follow up completion of chemotherapy
4679	13/2/13	8/5/13	Early cessation of Chemotherapy and removal of PICC

Claims

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

New Claims/Potential Claims

5 new clinical claims/potential claims were received in 2012/13, as detailed in the table below. A Letter of Claim was received for one of them and the other 4 are still at the pre-action stage. No new non clinical claims were received in 2012/13.

New claims/potential claims 2012/13

Claim Number	Claim Date	Incident date	Nature of Claim	Status of Claim
CNST				
2013/03	25/3/13	2012	Chemotherapy treatment but no details given	Letter before Action
2013/02	14/2/13	Oct 2010	Radiotherapy treatment but no details given	Letter before Action
2013/01	21/1/13	July 12	Gantry came into contact and pressed patients elbow due to wrong fields being auto set	Letter of Claim and Letter of Response
2012/03	15/12/12	2008	Failure to heed reported symptoms of thoracic pain, failure to order MRI scan	Letter before Action
2012/01	23/4/12	2010	Failure to advise of terminal condition	Letter before Action

Ongoing claims from previous years

A number of files have been closed in 2012/13 due to no progress and will not be opened again unless a Letter of Claim is received; however the following claim is still ongoing:

Claim Number	Claim Date	Incident date	Nature of Claim	Status of Claim
2011/01	1/4/11	2008	Failure to monitor/ act and transfer following deterioration. Previous complaint – joint claim with Wirral.	Damages agreed at £40k (50% share), costs to be finalised.

Safety Alerts

There have been 92 alerts issued by the Central Alerting System over the period 1st April 12 - 31st March 2013.

Originator	Total	%
MHRA Medical Devices Alerts	89	97%
DH Estates and Facilities	3	3%

All alerts were acknowledged and assessed to determine whether action was required. Action was not required for 77 (84%) of the alerts. For the 15 (16%) 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 Trust was last formally assessed against Level 3 of the NHSLA Risk Management Standards on 30/11/10-1/12/11 and was successful in maintaining Level 3. The next formal assessment was due in November 2013, however due to a review of the standards and assessment process by the NHSLA, this assessment has been postponed until the new standards are in place. An informal visit took place on 28/1/13 when the assessor visited the Trust to discuss potential changes to the assessment process in the future and how the Trust planned to continue to assess compliance against the original standards. It was agreed that the Trust would continue to monitor compliance with the original standards as this provided a good risk management framework and structured audit plan.

The NHSLA audit plan has continued to be monitored, with the development of the new Risk Management Audit Sub Committee which meets monthly to review audits. The new sub committee was set up to enable audits to be reviewed in more detail due to the agenda at the Risk Management Committee continuing to grow.

For further details please see Risk Management Annual Report 12/13

NAME: **Dee-Anne Bentley**
POSITION: **Document Control Manager & Freedom of Information Lead**
DEPARTMENTS SUPPORTED: **Trust Wide**

ANNUAL REPORT:

Consideration has been given to the following areas in compiling this report:

5. PATIENT EXPERIENCE
6. PATIENT SAFETY
7. CLINICAL OUTCOMES
8. CLINICAL EFFECTIVENESS

DOCUMENT CONTROL

The Document Management Policy was reviewed and updated in September 2012 ensuring continued compliance with NHSLA regulations and to make certain that clear and current processes are set out to assist CCC staff in the review and development of Trust documents and that formal document ratification and document control processes are followed. This in turn ensures that all controlled CCC documentation utilised in patient care is current and up to date.

Three audits are carried out annually as part of the monitoring process of the Document Management Policy and to ensure compliance with the policy's requirements. At the time of the audit there were 221 current policies. 5% (11) of the documents were audited which were selected at random.

The Following audits were completed in January 2013 focussing only on Trust Policies:-

1. Audit To Show The Control of Documents
The main issue arising from this audit was in relation to policies containing the required sub headings as a minimum. A small number of the policies audited did not include one or more of the following sections "Laws & Regulations", "Definitions" or "References". The documents identified at the time of the audit were coming up for review and the action for the Document Control Manager/Freedom of Information Lead was to raise this with the document author upon review.

2. Audit to Show The Ratification of Documents
No issues or actions were identified. All documents audited had been suitably ratified in accordance with the Trust's Document Management policy.

3. Audit to Show the Archive of Documents:
Out of the eleven documents audited, one of the documents audited was a first version. Three documents had all previous versions available in both the paper and electronic archive files. Two policies had all previous versions available in both paper and electronic archive files. One had all previous hard copy versions held in paper file and only some available electronically. Three had some previous versions available in the hard copy folder with all previous versions available electronically. Four had limited availability both electronically and in hard copy.

In all instances of limited availability, this applied to much earlier versions of the document.

The Document Control Manager/Freedom of Information Lead will continue to follow the correct archiving procedure to make sure the availability of previous versions are available electronically and in paper format in accordance with the appropriate retention timescales and to re-audit in one year.

Following the Trust's name change in May 2012 all standard document templates have been changed to display the Trust's new logo and corporate branding. Current controlled documents are gradually being amended to incorporate this and amend any reference to the old Trust name throughout.

All controlled CCC documents are currently monitored via the All Documentation Alphabetical List spreadsheet on the T: drive and Q-Pulse (Document Management System). A new Electronic Document and Records Management System (EDRMS), Meridio, is currently being rolled out throughout the Trust. Once this system is available Trust wide all CCC documents will be accessed by staff via this system and monitored and accessed by the Document Control Manager to make certain that all information is updated in accordance with their review requirements and all obsolete documentation are archived and retention requirements are met. The Document Management Policy will be amended accordingly once Meridio is in place Trust wide.

A spreadsheet report detailing all outstanding CCC policies is submitted on a bi-monthly basis to the Risk Management Facilitator to present to the Risk Management Committee. The report also includes a four month comparison of all outstanding policies to monitor review progress.

All controlled CCC documents are published on CCOComms on the T: drive and the staff intranet for staff access Trust-wide and also the Trust's website for public access where appropriate. Fortnightly update reports of all newly added/updated documents are added to the staff intranet and are reported monthly via Team Brief.

A report is submitted to the Information Governance Board on a monthly basis detailing all new/updated CCC documents together with a regular report on all Freedom of Information Requests and requests made under the Environmental Information Regulations 2004. This information is also disseminated to CCC staff monthly via Team Brief.

FREEDOM OF INFORMATION

The Freedom of Information Policy was reviewed and updated in September 2012 and the procedure document titled "Freedom of Information Requests (Including Guidance on Environmental Information Requests and Requests under the Data Protection Act)" was updated in conjunction.

The Document Control Manager/Freedom of Information Lead is primarily responsible for co-ordinating and responding to Freedom of Information and Environmental Information requests. However, all CCC staff are responsible for ensuring that any information requests are directed appropriately and within an appropriate timeframe. This requirement is clearly set out in the Trust's mandatory Information Governance yearly training and in the aforementioned Freedom of Information policy and procedure documents.

The number of information requests made under either the FOI or EIR regime between 1st January 2012 to 31st December 2012 are as follows:-

TIMELINE OF FOI RESPONSES	
Requests Received	**174**
Requests processed within legal timescales	**162**
Requests processed within agreed extended timescales	**6**
Late responses	**4**
No response sent	**1**
Requests withdrawn by the applicant	**1**
TIMELINE OF EIR RESPONSES	
Requests Received	**12**
Requests processed within legal timescales	**8**
Requests processed within agreed extended timescales	**2**
Late responses	**1**

The total number of information requests received in 2012 was 186 which is an increase of 7% compared to the 174 received in 2011.

The number of requests received so far in 2013 compared to 2012 has increased. By the end of May 2013 a total of 91 requests had been received compared to 82 by the end of May 2012.

An Annual Report has been produced by the Document Control Manager/Freedom of Information Lead fully analysing the number of requests received (with a three year comparison), exemptions, appeals, response times, the type of disclosure and the departments targeted. This was submitted to the Information Governance Board in February 2013.

NAME: **Derry Sinclair / Steve Povey**
POSITION: **Health and Safety Advisor/LSMS/Emergency Planning Liaison Officer**
Department Supported **Trust Wide**

Health, Safety & Security Annual Report: 2012/2013

Introduction

The Clatterbridge Cancer Centre NHS Trust is a Specialist Hospital with over 850 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 and security. In addition, advice is available from radiation protection, infection control and occupational health.

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

Regular reports on all accidents, dangerous occurrences and ill health are presented at our bimonthly health and safety committee and action plans are implemented. The purpose of the 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".*

At 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.

Fire

The main Fire Safety development has been the policy change from Merseyside Fire & Rescue Service (MFRS) regarding unwanted fire signals. From October 2012, daytime response was withdrawn with the Trust expected to investigate any fire alarm activation and contact MFRS if assistance is required. This resulted in both procedural and resource implications for the Trust. Further change has been notified and it is expected that on October 2013, overnight response cover will be withdrawn. This will have further and more far reaching implications as automatic fire alarm activations will only be responded to by the Nurse Bleep holder, Security and Shift Engineer. The Fire Risk Assessment for the Trust will need to be reviewed before the arrangements come into effect.

A comprehensive program of fire drills has been developed to ensure that the Trust is compliant with Fire legislation. All fire drills and unwanted fire alarms are recorded and any actions raised

are addressed at the 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 2013/2014 and all fire marshals complete a monthly checklist within their area.

Fire Safety training is provided to all staff as part of new starter Induction and is repeated bi-annually as part of the Bi—Ennial Mandatory Update (BEMU) package.

Fire evacuation equipment training has continued to take place over the last year. During December the opportunity to utilise the empty downstairs ward following the refurbishment of Mersey arose for training in the use of the evacuation equipment/when and how to vertically evacuate a person. Further training has been made available for 2013/2014.

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 lapses in compliance with relevant Health and Safety Legislation.

The document is divided into different sections and if hazards are identified, the Trust's risk assessment forms must be completed. Each area develops an action plan and ensures that any risks are controlled.

The findings of these are reported to the Health & Safety Committee on annual basis.

Areas covered b y 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 is now being provided in a more frequent and structured format to enable compliance with H&S legislation. Particular emphasis has been placed on Management training to ensure Health & Safety responsibilities are understood and departmental commitment is required.

Health & Safety, Risk Management and Inanimate Load Training is provided to all new staff on Induction with Health & Safety and Inanimate Load training provided within the BEMU package on an ongoing basis.

In the early part of 2013 a comprehensive package of training was published for staff at all levels, this included:

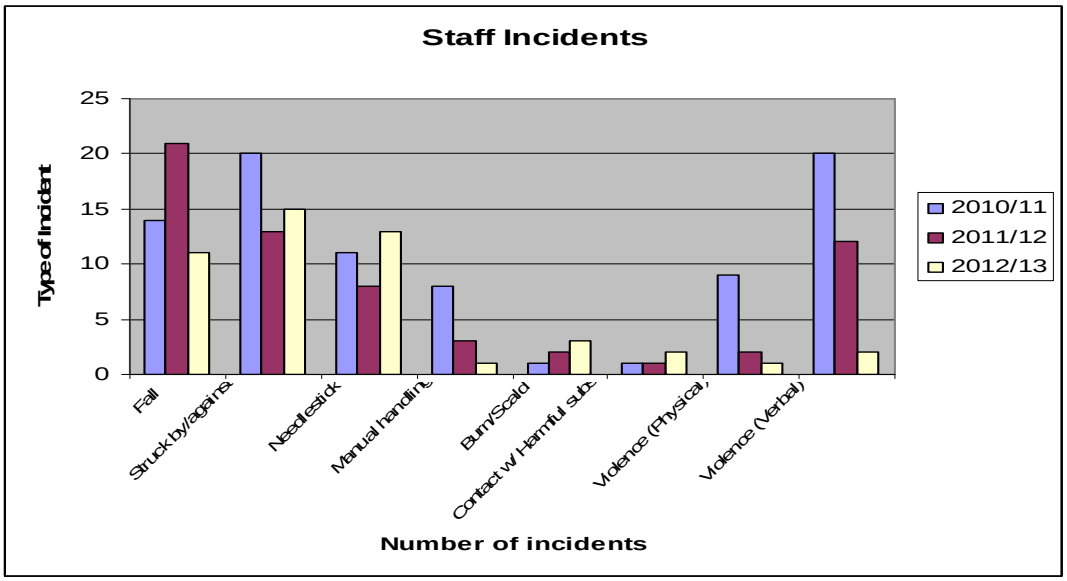
- On Call training for Senior Managers
- Display Screen Equipment Assessor Training
- Fit Testing (correct fitting of masks)
- Health & Safety for Managers
- Fire Marshall
- First Aid training (provided by an external company and all non-clinical areas have first aiders and equipment to ensure compliance).

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

Musco-skeletal Injuries

During the course of the year Health and Safety, in conjunction with Human resources have analysed musco-skeletal injuries which have occurred. This has been achieved by looking at both injury type and length of absence and has been cross referenced against area of work, job type, shift and also looked at repeat absences. A number of interesting correlations became apparent and further study to drill down to the root causes are ongoing. The initial findings were reported to Health and Safety Committee and a project area for the incoming Manual handling Trainer was identified.

Health and Safety Incidents



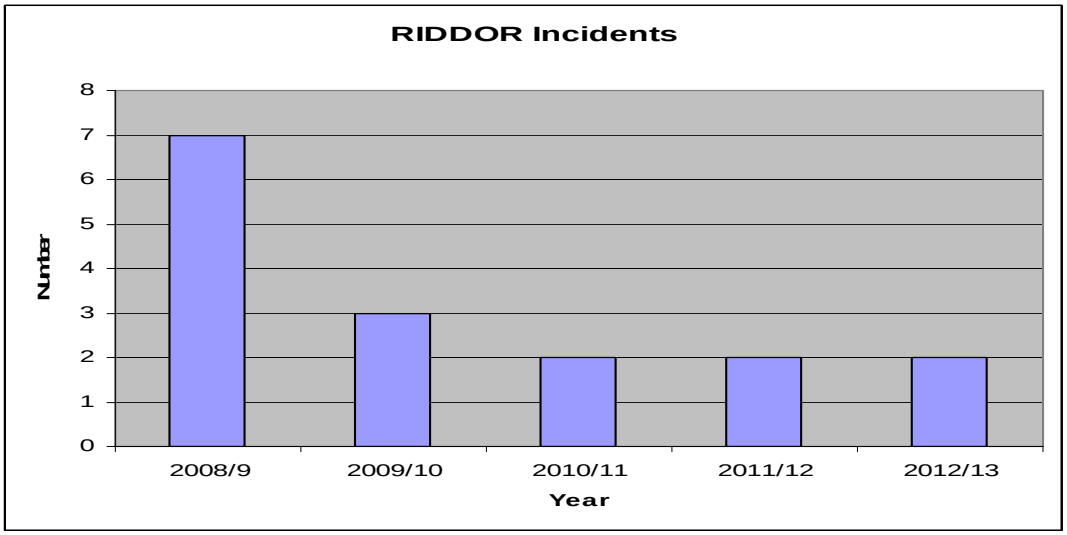
The graph shows falls in a number of areas over 2011/2012, however there were a couple of areas of increase.
The needlestick injuries sustained are of concern but the transfer to Safety Needles should remedy this.

Of particular note are the reductions to violence, both physical and verbal and Manual Handling which is traditionally a high incidence subject.

The Trust is now working towards compliance with the European Council Directive 2010/32/EU on preventing sharp injuries in the hospital and healthcare sector and has been in the process of trialing safety needle devices since February and plan to have compliance by June 2013.

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 a period of time. This period of time under the regulations was originally more than three days but changed to more than seven days in April 2012. The chart below shows the number of reported incidents over the last five years and shows an initial reduction down to consistency. It should be noted that in the last year, 2012/13 whilst two incidents were reported, one of them was included as precautionary as the criteria within the regulations was not clear.



Flu

The 2012/13 Flu Vaccination Campaign was the most successful the Trust has had. The Department of Health set a target of 70% vaccination of Front Line Staff with the Trust achieving 70.3% and being one of a small number of Trust's to exceed the target in the North of England.

The Trust will continue to encourage flu vaccination uptake amongst staff and will launch the next campaign in September 2013 which has a target of 75% front line staff uptake.

Security

The following policies are reviewed and updated in a recurring cycle and are due within the next 12 months in line with the new 'Standards for Providers'.

- Security physical assesses and property
- Lone workers
- The prevention and management of Violence and Aggression

All departments have completed risk assessments in the above areas and the audit report was presented with appropriate action plan to the health and safety committee.

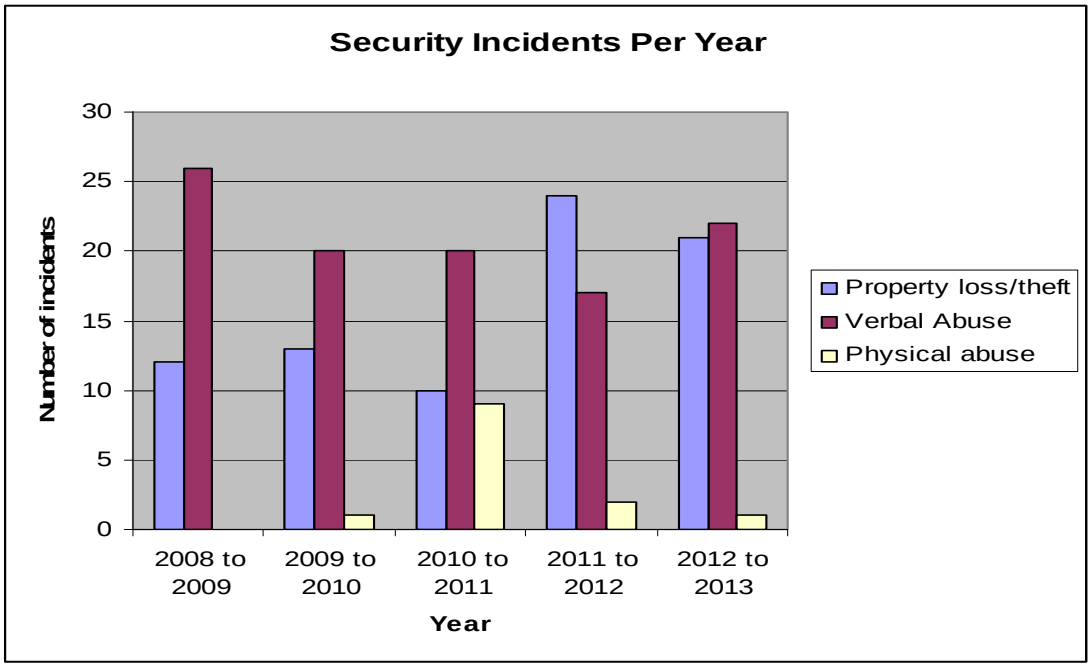
The Trust has reviewed and upgraded the CCTV system throughout and is now in the process of reviewing security guard cover from service level agreement provider and external companies.

From 2013/14 the Trust will have to complete an annual Organisation Crime Profile and adhere to standards set by NHS Protect.

From April 2013 all Trust's will have to adhere to the HealthWRAP initiative, which is a workshop to raise awareness of PREVENT. This aims to reduce the risk from radicalisation of vulnerable individuals and is compulsory for all staff.

In line with the nationally agreed security management principles the LSMS and Head of Technical Services undertook a site security risk assessment and an action plan has been developed which will be continuously reviewed and monitored through the Health and Safety committee.

As part of Security awareness for staff, a training presentation is delivered to all new and existing staff as part of the BEMU process. 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.



The comparison does not show a significant increase in security incidents over the 4 year period.

There is however an increase in the number of property/loss/theft mainly being stock from the wards. This may be due to improved reporting by staff and regular stock taking. A full review of security measures have been introduced including upgrading of CCTV, reducing access to supplies and currently reviewing security personnel .Within the last 12 months the Trust has improved working relationships with Merseyside Police for advice and information.

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

In October 2012 the LSMS and Local Fraud Officer for the Trust held an Anti Crime Month to raise awareness of security/fraud in the Trust, a Roadshow was set up in the Hospital foyer with information, handouts and small items for staff to take away, this also allowed staff the opportunity to ask questions and raise any concerns directly with the Trust Local Security Management Specialist (LSMS) and the Local Fraud Officer.

Lone Worker Devices

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

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.

Additional devices have been purchased to cover staff working in the Mobile Chemotherapy Unit.

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 in to 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.

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. These sessions will be commencing from June 2013.

An annual security work plan and report has been developed and been approved by the Trust Board and a copy sent to the NHS Protect to ensure compliance.

Section 4

CLINICAL GOVERNANCE TRUST-WIDE REPORT: CLINICAL EFFECTIVENESS TEAM (CET)

NAME: **Helen Wong**
POSITION: **Clinical Governance Manager (Audit) & Statistician**
DEPARTMENTS SUPPORTED **(as Clinical Governance Manager): CET/Trust Statistician**

ANNUAL REPORT:
CET consists of 3 teams: Clinical Officers, Clinical Coding and Clinical Audit. The service provides inputting and validation of clinical data, provision of administration support to TSGs, facilitation of clinical audit, clinical coding for HRGs and medical statistics support.

1. NICE COMPLIANCE

There were 96 sets of new NICE guidance published during 12/13, details as follows:

Category	Number published	Number applicable to CCC	Compliance
CG	19	3	2 x partially, 1 x awaiting local lead response
DG	4	-	
IP	27	-	
MT	2	-	
MTG	2	-	
PH	6	-	
QS	11	3	3 x awaiting local lead response
TA	25	11	
Total	**96**	**11**	

Clinical guidelines CG144 Venous thromboembolic diseases and CG151 Neutropenic sepsis were partially compliant and an implementation plan has been developed for both which are in the process of being actioned.

During 12/13, 5 NICE Technical Appraisals Audits were carried out. The Trust proved to be fully compliant with no out-standing actions for 3 sets of guidance.

For TA 250 Breast cancer (advanced) – Eribulin, NICE does not recommend Eribulin based on cost effectiveness. CCC do not offer Eribulin for this cohort of patients through the CCC chemotherapy protocol process. The patients identified were received Eribulin were approved by the Cancer Drug Fund, hence there is no concern with compliance with NICE guidance as funding was secured elsewhere.

For TA 192 Lung cancer (non-small-cell, first line) – Gefitinib, 18 NSCLC patients were identified as having commenced Gefitinib. All 18 patients were EGFR mutation positive. All 18 patients received Gefitinib as first-line treatment. 16 patients were identified as having locally advanced or metastatic disease. For the remaining 2 patients, 1 did not have stage recorded in Maxims, their clinical notes or LUCADA therefore we could not ascertain compliance and 1 patient was recorded as T1b N0 M0 in LUCADA which would make us non-compliant as this is

not locally advanced or metastatic disease. HW contacted pharmacy regarding checking stage of disease for future patients.

During 12/13 all NICE audit reports were reported to the Integrated Governance Committee.

2. 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 Studies:

NCEPOD
- Cardiac Arrest Procedure Study
- Subarachnoid 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, Nursing, Allied Health professionals and audit department, etc.) During 2012/13, the sub-committee have met 7 times and approved 39 clinical audit proposals. 3 audit events took place in 12/13 – (Breast, Upper GI & Colorectal and Lung TSGs) an overall of which was presented to the group.

Local Clinical Audit
During 12/13, 40 new clinical audits were commenced. Also there were 26 completed local clinical audits during 2012/13, of which 14 confirmed good practice, 8 made improvements and 4 sustained improvement.

Trust Mortality Review Meetings
The CET Governance Manager (Audit) and CET Coordinators facilitate and coordinate the monthly Mortality Review Meetings.

Examples of Changing Clinical Practice due to Audit Findings

Audit 1) Clinical Experience in Mersey of the use of the Cancer Drug Funded Eribulin to support Breast Cancer Treatment– Dr S O'Reilly & Matthew Denham

Audit Objectives:

1) To assess efficacy and tolerability of the Eribulin accessed through the North West Cancer Drugs Fund in 2011

Actions:

- Clinicians to check LFTs the day before treatment and be mindful of patients with liver abnormality and dose reduce if in doubt.
- Looking into an algorithm to identify when dose reduction is required.
- This audit was identified as a good model for CDF drugs and will be used for other drugs.

Audit 2) Re-audit of Local Neutropenic sepsis audit – Dr E Ahmed & Dr N Hannaway

Audit Objectives:

1) To measure % of patients with neutropenic sepsis receiving 1st antibiotics < 1 hour.
   Audit standard: 100%
2) To assess % of patients sampled with MEWs and MASCC score checked on admission.
   Audit standard: 100%

Actions:

- Run a weekly report for all discharged patients to identify if they were coded as having NS during their admission.
- EA, NH and TG to review case notes and undertake a root analysis. An incident form should be completed for all non-compliances.
- JE and NH to meet with ED and SR to discuss where the triage role fits with these patients.
- Posters to be put up on the Wards.
- JB and TG to look at ways to improved documentation of recording of times.

Audit 3) Outcome in poor Performance Status (PS) patients with Small Cell Lung Cancer (SCLC) and to identify predictive factors for Extensive Disease (ED) SCLC – Dr E Marshall & Dr F Azam

Audit Objectives:

1) Identify predictive factors for extensive disease (ED) SCLC.
2) 30 days, 3 months, 6months and 12 months survival

Actions:

The recommendation, based on this audit and on the data of published clinical trials, is that oral Etoposide for poor PS SCLC patients has been removed from the CCC chemotherapy protocol book.

Audit 4) An audit of locally advanced rectal adenocarcinoma with operable liver metastases at presentation – Dr J O'Hagan

Audit Objectives:

1) To assess what treatments are administered in what order in locally advanced rectal adenocarcinoma

Actions:

- Proposed pathway for fit patients with locally advanced rectal adenocarcinoma and
- synchronous operable liver metastases.
- Develop a Treatment Protocol to be discussed with Liver surgeons.
- Look into a prospective audit.

Sharing Audit Findings
Trust audit leads are encouraged to share their audit findings at the TSG Audit Presentation events, Regional Meetings and/or Thursday Registrars Teaching Session. 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:

National Cancer Research Institute Poster Presentations
1) Suntinib Therapy for Metastatic Renal Cell Carcinoma : The Mersey Experience – Dr A Mullard, Dr S Purcell, Dr J Carser and Dr R Griffiths
2) Effect of public holidays causing interruptions and prolongation of radiotherapy in breast cancer patients - Dr B Jyoti, Dr H Wong, Dr N Thorp
3) Adjuvant therapy of small HER2 positive Breast cancer: A single UK centre experience – Dr F Azam, Dr M Latif, Dr S Yousif, Dr E Ahmed

British Journal of Ophalmology
1) Magnetic Resonance Imaging in the detection of hepatic metastases from high risk uveal melanoma: a prospective study in 188 patients – Dr E Marshall, Dr C Romaniuk, Dr M Chopra

European Society of Gynaecological Oncology
1) The toxicity of chemotherapy in older ovarian cancer patients – Dr D Shaw, Dr R Lord

British Gynaecological Cancer Society
1) Platinum sensitivity and brain metastases from ovarian cancer. Single centre study – Dr F Azam, Dr M Latif, Dr K Hayat, Dr J O'Hagan, Dr J Green, Dr R Lord

British Neuro-Oncology Society
1) Long term survival in glioblastomas treated with chemo radiotherapy; a single institution study – Dr B Haylock, Dr D Husband, Dr A Shenoy, C Walker
2) Primary central nervous system lymphoma (PCNSL) – the long term experience of a single UK centre - Dr M Saipillai, Dr S Khakoo, Dr M Anthonypillai, Dr B Haylock

Audit Training / Awareness Session
We continue to provide information to SHOs on their induction day 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 271 clinical data ad-hoc requests during the period of 2012/13, some of which provide support to the freedom of information request and to the decision making process for Trust strategies and clinical service developments.

3. CLINICAL EFFECTIVENESS

Accuracy of Clinical Data
The CET officers are currently taking part in the annual data accuracy audit which checks the data input into Maxims by the officers. The audit looked is looking at 90 patients that had received chemotherapy and radiotherapy during 2012.

Fourteen data items were picked to be audited as they were known to have more errors occurred in previous CET accuracy checks audits.

Systemic Anti-Cancer Therapy Dataset (SACT)
In order to support the SACT dataset the chemotherapy data that the CET officers input into Maxims has increased to include drugs, dosage, method of administration, etc.

Cancer Service Outcomes Database (COSD)
We are responsible for uploading information from the Unknown Primary and Teenage & Young Adults MDTs into the COSD.

The COSD is a compiled dataset which provides the standard for secondary uses information required to support implementation and monitoring of Improving Outcomes: a Strategy for Cancer.

The COSD replaces the existing National Cancer Dataset and the Cancer Registration Dataset. It incorporates the National Cancer Waiting Times Monitoring Dataset and items from the SACT and the Radiotherapy Dataset.

Maxims Web Launch
CET provided a key role in testing the functionality of the new Maxims Web and a vital part in the data migration process.

Supporting TSGs
Tumour Specific Groups (TSGs) 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 and Officer are assigned to the Breast, Central Nervous System, Upper GI & Colorectal, Gynaecological, Skin, Lymphoma, Lung, Sarcoma, Unknown Primary, Acute Oncology and Urology TSGs to promote and support clinical audit activity and to input into issues relating to the completeness and accuracy of clinical data in Maxims.

4. REFERENCES
Audit Policy (PTWDAUDT)
NICE National Clinical Guidance Policy (Dissemination, Review, Implementation & Monitoring of National Clinical Guidance) (PCGONICE)
CET Operational Policy (CET-01)
Clinical Audit Sub Committee – Terms of Reference

Section 5

CLINICAL GOVERNANCE TRUST-WIDE REPORT: CLINICAL OUTCOMES

NAME: **Kate Smith/ Helen Wong**
POSITION: **Head of Clinical & Information Governance/Clinical Governance Manager (Audit) & Statistician**

Clinical Outcome Form
The pilot of the clinical outcome form with 8 consultants at their out-patients clinics is continued. The Gynaecology TSG group consultants also took up the clinical outcome form to capture recurrence data. 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 days treatment mortality
The 30 days chemotherapy and radiotherapy mortality performance are reported to the Trust Board as part of the Quality Report. Individual consultants are also being notified of their chemotherapy and radiotherapy mortality performance monthly. At the year end, an individualised performance report was distributed to all consultants presented in the format of control charts which allowed performance comparison between consultants and observed trends over time.

From the analysis completed for 2012, four additional chemotherapy regimens were identified associating with high mortality and added to the monitoring list, total of 8 regimens.

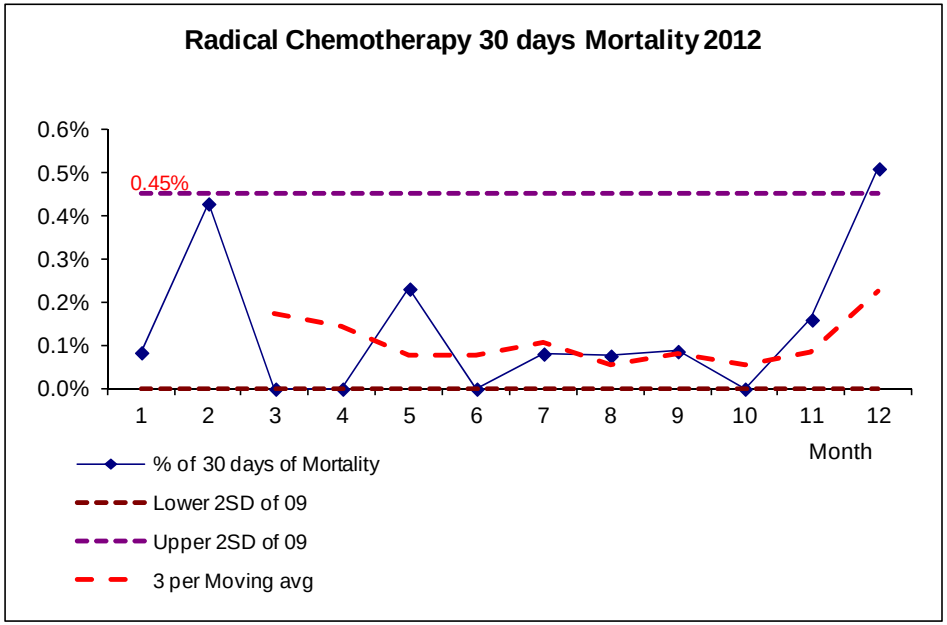
The overall CCC performance for Chemotherapy and Radiotherapy 30 day mortality is as follows:

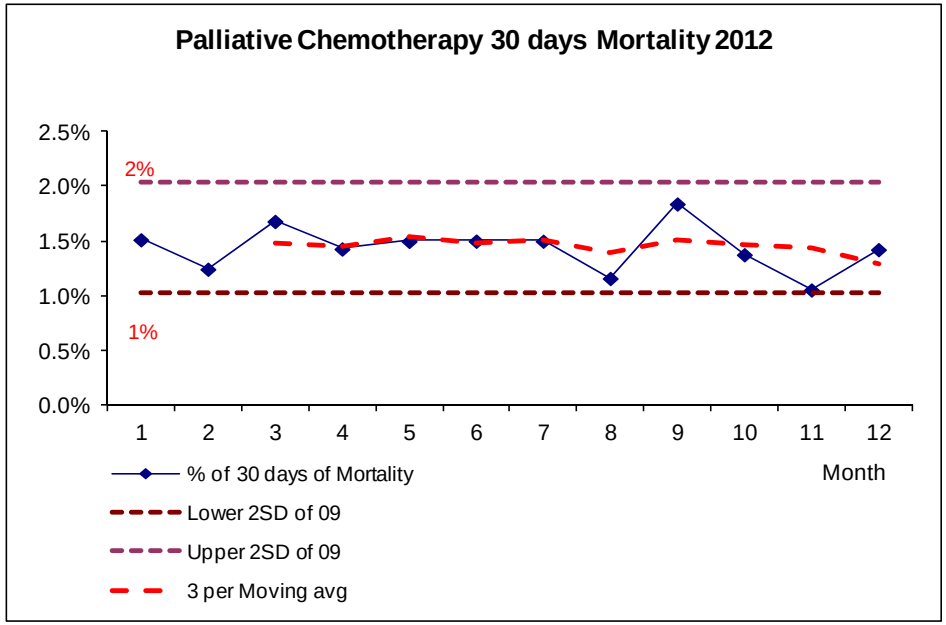
Radical Chemotherapy - overall

Month	1	2	3	4	5	6	7	8	9	10	11	12	Overall at cycle level	Overall at patient level
No. of patient die in 30 day of a chemotherapy cycle	1	5	0	0	3	0	1	1	1	0	2	6	20	20
%	0.1%	0.4%	0.0%	0.0%	0.2%	0.0%	0.1%	0.1%	0.1%	0.0%	0.2%	0.5%	0.1%	0.75%
Total per Month	1190	1165	1206	1115	1295	1092	1235	1308	1151	1311	1248	1176	14492	2669

Palliative Chemotherapy - overall

Month	1	2	3	4	5	6	7	8	9	10	11	12	Overall at cycle level	Overall at patient level
No. of patient die in 30 day of a chemotherapy cycle	19	15	21	16	20	18	19	16	24	20	15	18	221	221
%	1.5%	1.2%	1.7%	1.4%	1.5%	1.5%	1.5%	1.2%	1.8%	1.4%	1.1%	1.4%	1.4%	7.95%
Total per Month	1252	1201	1246	1116	1330	1196	1263	1374	1301	1448	1416	1261	15404	2779



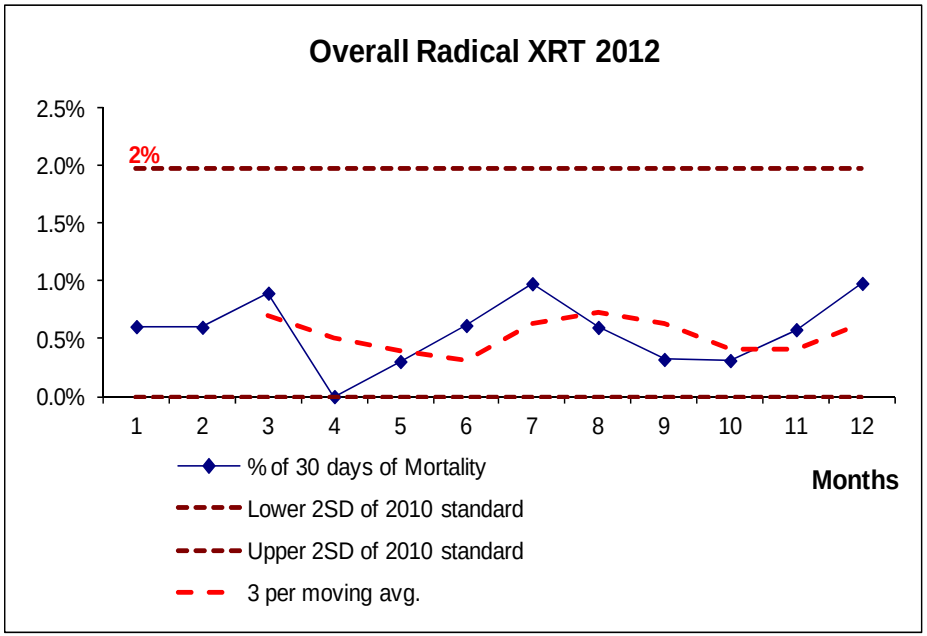


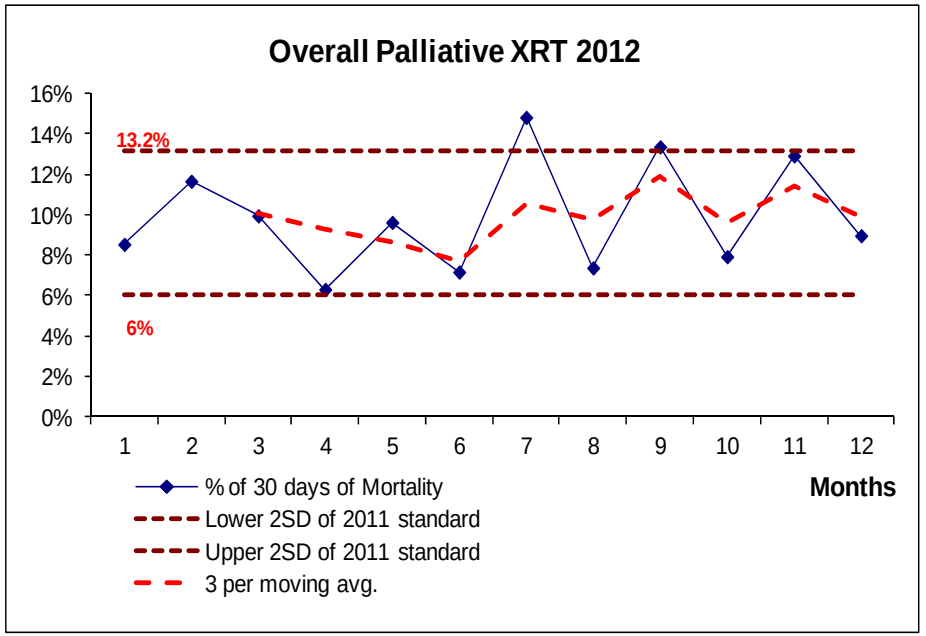
Overall Radical Radiotherapy

Month	1	2	3	4	5	6	7	8	9	10	11	12	Overall at RT level	Overall at patient level
No. of patient die in 30 day of a course of XRT	2	2	3	0	1	2	3	2	1	1	2	3	22	22
%	0.6%	0.6%	0.9%	0.0%	0.3%	0.6%	1.0%	0.6%	0.3%	0.3%	0.6%	1.0%	0.6%	0.62%
Total per Month	330	333	335	308	329	325	307	334	311	320	345	306	3883	3528

Overall Palliative Radiotherapy

Month	1	2	3	4	5	6	7	8	9	10	11	12	Overall at RT level	Overall at patient level
No. of patient die in 30 day of a course of XRT	17	28	23	14	26	16	35	18	25	20	30	21	273	273
%	8.5%	11.7 %	10.0 %	6.3%	9.6%	7.2%	14.%	7.4%	13.4 %	7.9%	12.9 %	9.0%	9.9%	14.8%
Total per Month	199	240	231	222	270	223	236	244	187	252	232	234	2770	1850



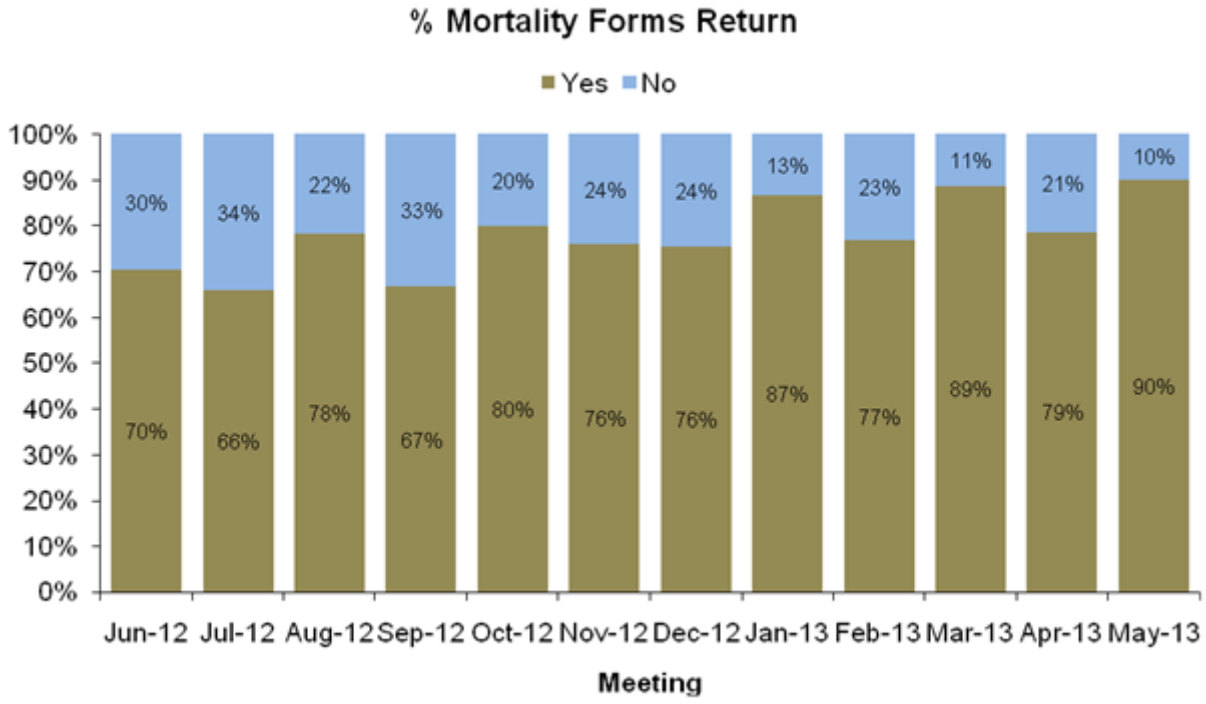


Mortality Review Programme

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.

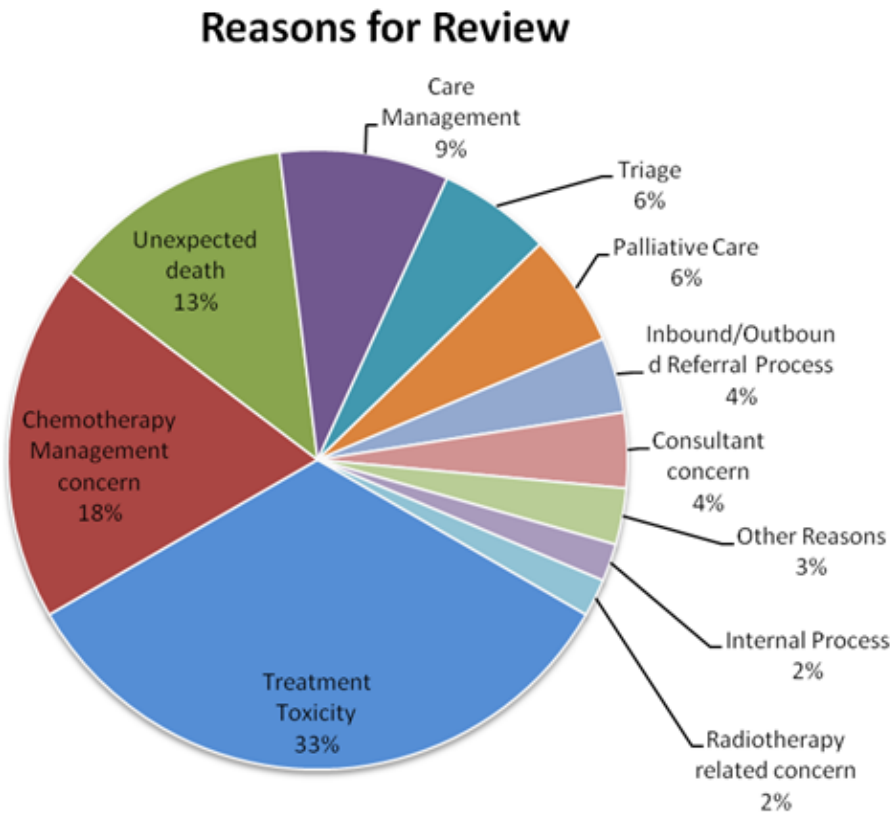
No. of mortality forms completed

During June 12 – May 13, 591 forms were sent to consultants to complete, 461 (78%) returned.



Review reason distribution

Out of 461 returns, 99 were selected and discussed at the mortality review meeting.



Recommendations and Actions

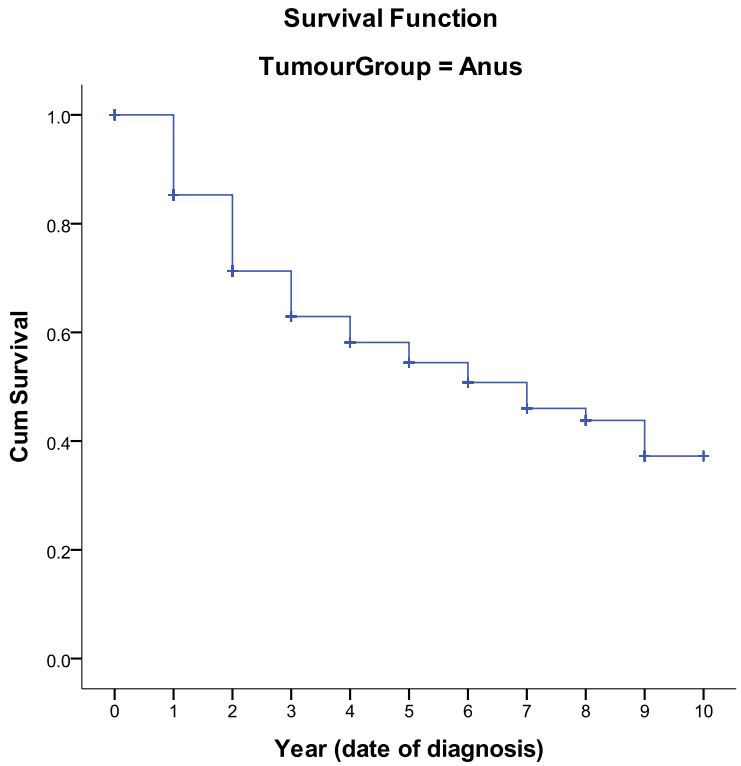
Actions Summary:

- Initiated Amber care Bundle
- 4 clinical audits were initiated. 1) Audit Triage advice for patient die within 30 day of treatment (Dr. Sullivian) 2) Audit Spinal Cord Compression inpatients pathway (Dr. Littler) 3) Audit Palliative Bone Metastases Radiotherapy (Dr. Tolan) 4) Chemotherapy nurse documentation (Head of Day-Case & Out-Patient)
- Improve Documentation & Communication of CPR decision
- Improve patient medical records documentation by chemotherapy nurses and clinicians.
- Communicate any concerns to other health professionals (i.e. GP, DGH)

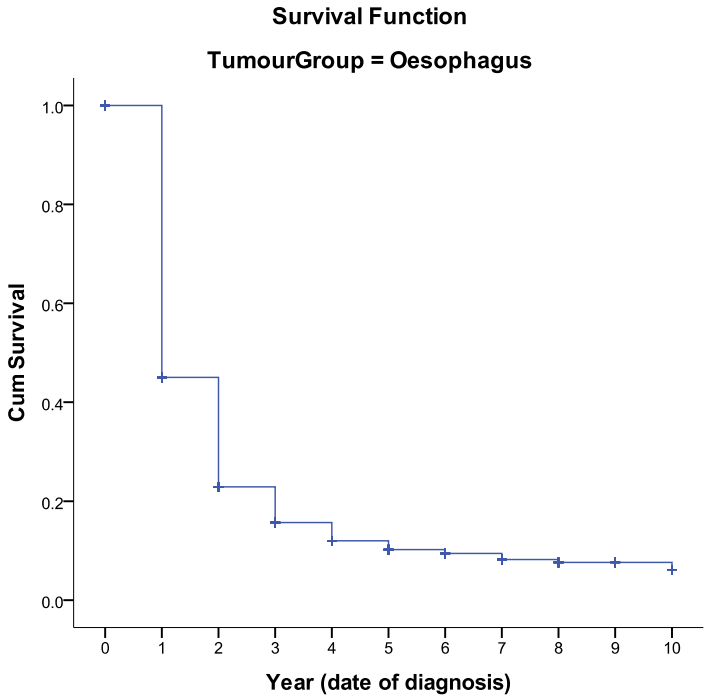
Section 2: CCC Cancer patient survival rate by Specific Tumour Group
This section presents the overall survival for patients referred to CCC who were diagnosed with one of the following 7 cancers (Anus, Oesophagus, Opthalmic, Skin Melanoma, Soft Tissues, Stomach and Testis) during 2003 –June 2012 with at least 12 months follow up.

Time Period: Newly diagnosed cancer between 2003- June 2012.

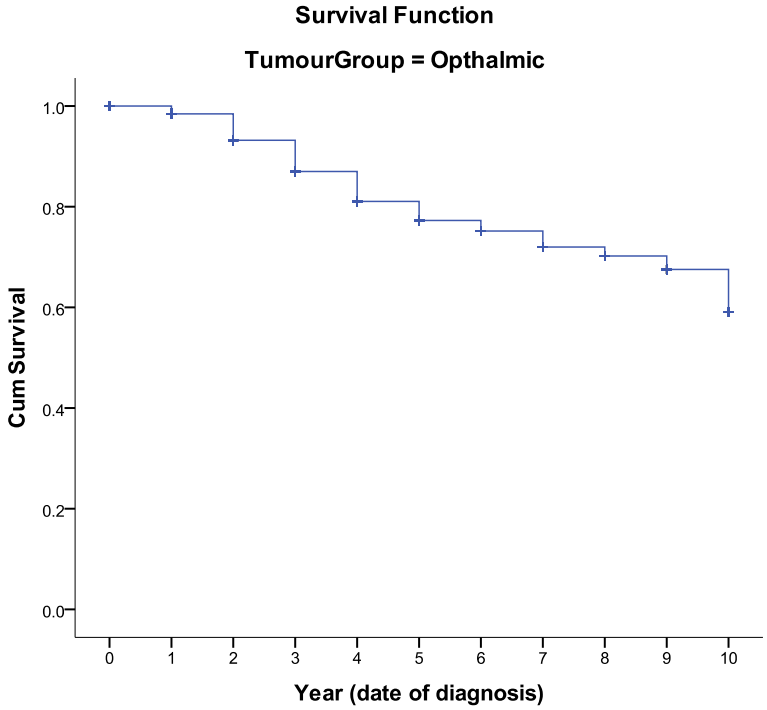
Tumour Group	ANUS
Number of patients	379
1 year survival	85%
5 years overall survival	54%



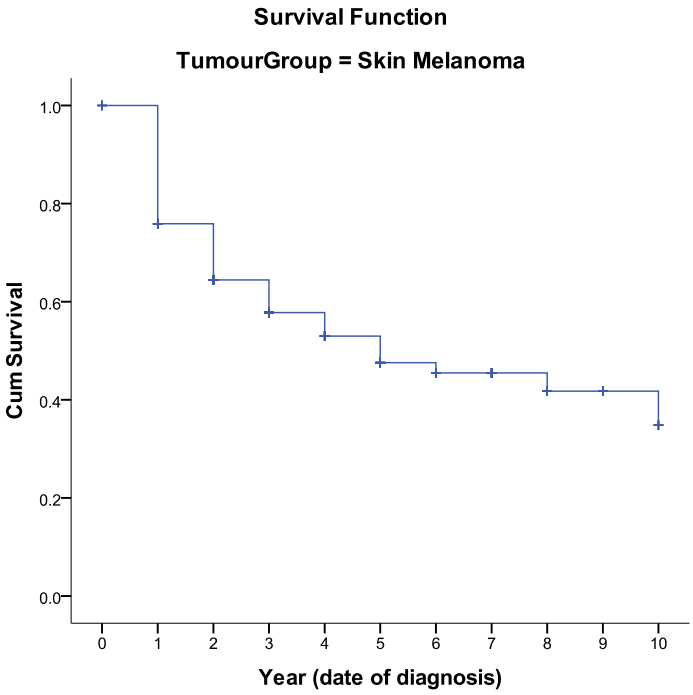
Tumour Group	Oesophagus
Number of patients	2097
1 year survival	45%
5 years overall survival	10%



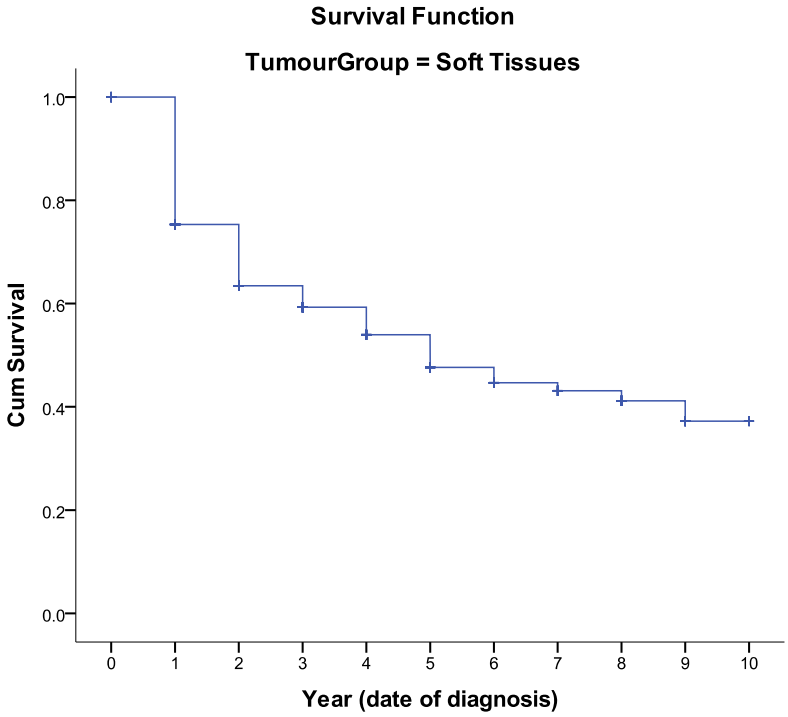
Tumour Group	OPTHALMIC
Number of patients	1218
1 year survival	98%
5 years overall survival	77%


Survival Function
TumourGroup = Opthalmic
Cum Survival
1.0
0.8
0.6
0.4
0.2
0.0
0
1
2
3
4
5
6
7
8
9
10
Year (date of diagnosis)

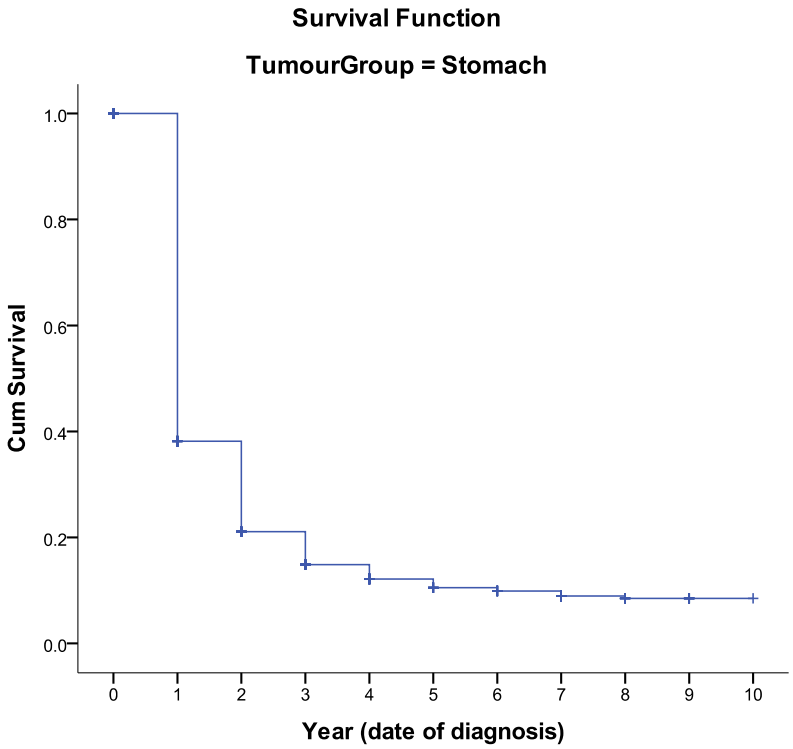
Tumour Group	SKIN MELANOMA
Number of patients	369
1 year survival	76%
5 years overall survival	48%



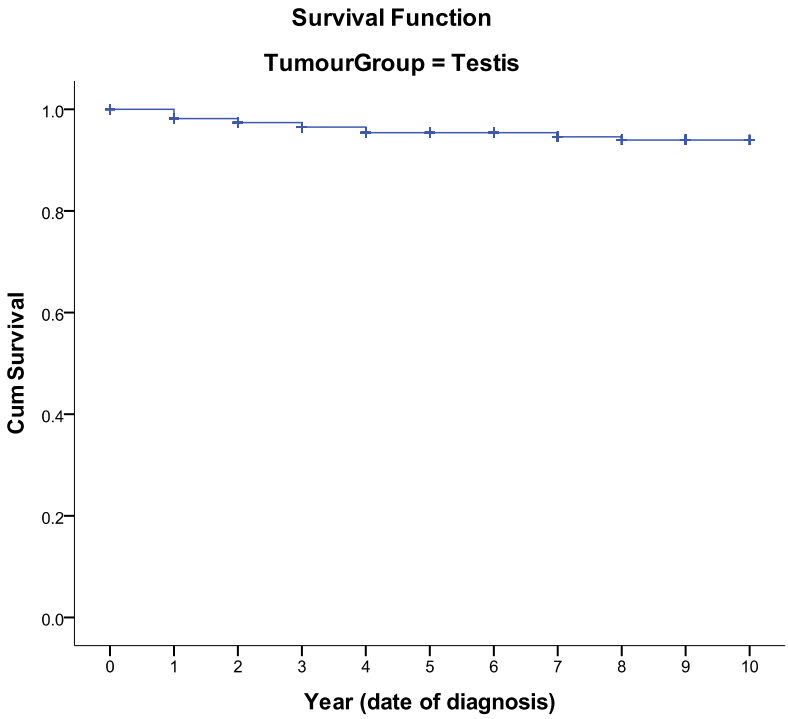
Tumour Group	SOFT TISSUES
Number of patients	380
1 year survival	75%
5 years overall survival	48%


Survival Function
TumourGroup = Soft Tissues
Cum Survival
1.0
0.8
0.6
0.4
0.2
0.0
0
1
2
3
4
5
6
7
8
9
10
Year (date of diagnosis)

Tumour Group	STOMACH
Number of patients	1457
1 year survival	38%
5 years overall survival	11%



Tumour Group	TESTIS
Number of patients	739
1 year survival	98%
5 years overall survival	95%


Survival Function
TumourGroup = Testis
Cum Survival
1.0
0.8
0.6
0.4
0.2
0.0
0
1
2
3
4
5
6
7
8
9
10
Year (date of diagnosis)

Section 6

CLINICAL GOVERNANCE TRUST-WIDE REPORT: CLINICAL CODING

NAME: **Anne Bedford**
POSITION: **Systems Training Manager, Clatterbridge Cancer Centre**
DEPARTMENT SUPPORTED: **Clinical Coding**

CLINICAL CODING

The Trust currently employ two qualified Accredited Clinical Coders with an outstanding vacancy for a whole time novice coder

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:-

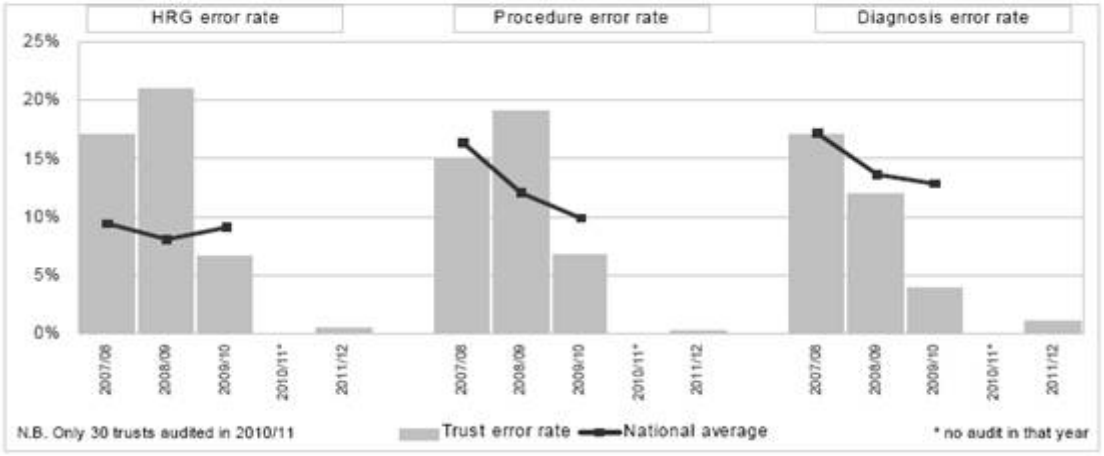
- Established documented procedures for the regular audit of clinical coding;
  An internal clinical coding audit programme within the last twelve months which was based on the requirements and standards within the latest versions of the NHS Clinical Coding Audit Methodology and must have been undertaken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

A PbR audit was not commissioned this year due to very favourable results in the previous year

Payment by Results (PbR) Data Assurance Framework

The Payment by Results (PbR) Data Assurance Framework supports the improvement of data quality by auditing admitted patient care (inpatient) and outpatient data which underpins payments and financial flows within the NHS. The assurance framework is carried out on behalf of the Department of Health (DH) and is a key component of the PbR system.

Figure 1: **HRG, procedure and diagnosis error rate**



A PbR audit was not required at CCC during 2012/2013. However, Figure 1 shows that during the last five years the Trust's **HRG error rate has substantially reduced in line** with the national trend.

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.

Clinical Coding IG Internal Audit – Feb 2012

An audit looking at 100 FCE's (finished consultant episodes) was carried out on inpatient stays during the period of 1st April 2012 and 31st August 2012 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	98.00%	90%	95%
Secondary diagnosis	96.96%	80%	90%
Primary procedure	97.85%	90%	95%
Secondary procedure	97.21%	80%	90%

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

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:

- Ensure the Clinical Coding Policy and Procedure document which although conforms fully to national standards, has review dates on all contained documents.
- Review the procedure codes for Papillon radiotherapy which is now classed as intraluminal brachytherapy and update the policy accordingly.
- Ensure the coders are referring to the latest version of the Department of Health Chemotherapy Regimens list when coding the delivery of chemotherapy.
- Provide feedback and training to coders on the issues found in the audit.

Programme of Clinical Coding Internal Audits scheduled for 2013

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 2013/2014. The team will continue to develop and build on achievements already made in 2012, and develop, through workshops and training, a clearer understanding of the clinical coding process.

The PbR Assurance Programme with NHS England, Monitor and Capita for 2013/14. is in the process of being finalised. The expectation is that this will include some form of targeted, risked based clinical coding audit of admitted patient care activity and that these will continue to be co-ordinated locally by commissioners.

Section 7

INFORMATION GOVERNANCE

NAME: **Jo Fitzpatrick**
POSITION: **Information Governance Manager**
DEPARTMENT SUPPORTED: **Trust Wide**

ANNUAL REPORT:

Information Governance – Overview

Information Governance is to do with the way organisations 'process' or handle information. It covers personal information, ie that relating to patients/service users and employees, and corporate information, eg financial and accounting records.
Information Governance provides a way for employees to deal consistently with the many different rules about how information is handled, including those set out in:

- The Data Protection Act 1998.
- The common law duty of confidentiality.
- The Confidentiality NHS Code of Practice.
- The NHS Care Record Guarantee for England.
- The Social Care Record Guarantee for England.
- The international information security standard: ISO/IEC 27002: 2005.
- The Information Security NHS Code of Practice.
- The Records Management NHS Code of Practice.
- The Freedom of Information Act 2000.

The IG Toolkit

The Information Governance Toolkit is a performance tool produced by the Department of Health (DH). It draws together the legal rules and central guidance set out above and presents them in one place as a set of information governance requirements. The organisations described below are required to carry out self-assessments of their compliance against the IG requirements.

The Information Governance requirements

There are different sets of information governance requirements for different organisational types. However all organisations have to assess themselves against requirements for:

- management structures and responsibilities (eg assigning responsibility for carrying out the IG assessment, providing staff training, etc);
- confidentiality and data protection; and
- information security

The Purpose of the Information Governance assessment

The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Where partial or non-compliance is revealed, organisations must take appropriate measures, (eg assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

The ultimate aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information. This in-turn increases public confidence that 'the NHS' and its partners can be trusted with personal data.
Assessments must be completed by all organisations that fall under the responsibility of the DH, these are:

- NHS organisations (acute trusts, ambulance trusts, mental health trusts, primary care trusts and strategic health authorities) including foundation trusts
- adult social care
- community pharmacies
- dental practices
- eye care services
- general practices
- DH arms' length bodies (ie executive agencies such as the Medicines and Healthcare products Regulatory Agency; special health authorities such as the NHS Business Services Authority; and non-departmental public bodies such as the Health Protection Agency).

There are additional categories of organisations that must also carry out IG assessments to provide an 'assurance' that they are adhering to good information governance practices.

Examples of these are organisations that:

- have access to NHS patients and/or to their information;
- provide support services directly to an NHS organisation; or
- have either direct or indirect access to NHS Connecting for Health services, including N3 - the NHS National Network.

As stated, these are examples of typical organisations and there may be other categories that are also required to provide IG assurance.

Depending on the services etc provided, these organisations are referred to in the IG Toolkit as either a Commercial Third Party or an NHS Business Partner.
A Commercial Third Party is an organisation external to the NHS, that contracts with an NHS establishment to provide goods, services or business that directly or indirectly support the care provided to patients by that establishment. For example this will include organisations that provide information services to the NHS (eg IT support), and also those that host or manage the N3 connection on behalf of another non-NHS organisation.

An NHS Business Partner is an organisation that, whilst remaining independent, works closely with NHS organisations and shares common goals for providing high standards of healthcare directly to patients. The category includes DH Arms Length Bodies (DH ALBs), referred to above, and Independent Treatment Centres. The term Independent Treatment Centre encompasses Independent Sector Treatment Centres (ISTCs), private hospitals, hospices, charitable foundations etc.

NHS Business Partners are distinct (in IG terms) from Commercial Third Parties, as the nature of their service(s) suggest that they are more likely to have a need to actively process patient or personal data on a regular basis. Commercial Third Parties should not under normal circumstances have such a requirement, although in exceptional cases (eg incident investigations) this may be required.

Time of completing IG assessments

An assessment can be started at any time after a new version of the IG Toolkit is released (June/July each year) but in all cases the final submission must be made online by 31st March each year. NHS organisations are also required to complete interim assessments during the year - deadlines for interim submissions are publicised when a new version of the Toolkit is released.

The work necessary to make improvements or to maintain compliance should be an on-going process and not left till the year end.

Final submission assessment scores reported by organisations are used by the Care Quality Commission to risk assess outcome 21 - records (and other standards as appropriate) of Essential standards of quality and safety (PDF, 2429 Kb) - see page 170.

IG Statement of Compliance (IGSoC)

The Information Governance Statement of Compliance (IG SoC) is the process by which organisations enter into an agreement with NHS CFH for access to the NHS National Network (N3). The process includes elements that set out terms and conditions for use of NHS CFH systems and services including the N3, in order to preserve the integrity of those systems and services.

The steps in the IG SoC process set out a range of security related requirements which must be satisfied in order for an organisation to be able to provide assurances in respect of safeguarding the N3 network and information assets that may be accessed.

The Information Governance Statement of Compliance process is agreed once for each organisation i.e. per legal entity. Continuing compliance is reconfirmed through the annual submission of the Information Governance Toolkit and acceptance of the IG Assurance Statement.

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 in the following areas:

Information Governance Strategy

This Strategy was developed 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 strategy describes the development and implementation of the robust Information Governance Framework covering all aspects of Information within the Trust including:

- Patent Information
- Personnel Information
- Organisational Information

Information Governance Communications and Training Strategy

The subject of Information Governance awareness is a key issue for all NHS organisations and their staff, agents and third party contractors who should consider it to be fundamental to the effective delivery of health services.
It was important to identify key staff groups that would require additional IG Training ie; Human Resources, Medical Records, Information Technology as well as individuals with key roles. This additional training is to be completed in conjunction to the basic annual IG Training every three years and specific modules for those groups and individuals can be found in the Training Needs Analysis within the Strategy.

Data Protection & Confidentiality Policy

The Trust has a legal obligation to comply with all appropriate legislation and guidance when processing personal data about patients, employees and other individuals. The Policy follows the Principles and requirements set out in the Data Protection Act 1998 that is the key piece of Legislation covering security and confidentiality of personal information.

Information Life Cycle Management Policy

The Information Life Cycle Management Policy describes the approach that the Trust has adopted in managing the information under its control. This Policy is the overarching Information Life Cycle Management Policy for the Trust that forms part of a wider set of Records Management Policies and guidelines.

Photography and Video Policy

Following an incident involving the loss of a memory card from a camera at the Trust in October 2012, there was a subsequent thorough investigation and voluntary reporting to the Information Commissioner's Office.Whilst no penalty was imposed by the ICO,a need for guidance for staff around cameras and the use of removable media and digital images subject to numerous legal requirements, resulted in policy changes.

Information Security Forum

The Information Security Forum has been initiated and is Chaired by the Information Governance Manager which reports to the Information Governance Board, the same as the well-established Data Quality Group. This Group is responsible for:

- Promotion of Information Security throughout the Trust
- The review and recommendation for the approval of all information security policies and procedures.
- Reviewing and monitoring information security risks and incidents
- Monitoring and auditing compliance with standards and policies
- Reviewing and recommending for approval the information security elements of the annual IG Toolkit submission.

Improved Project Documentation

In order to satisfy the requirements and guidance from the Information Commissioner's Office, a set of documents has been produced to be used for any Trust Project that contains data on our patients and staff. An example of the following templates must be completed by the Project Manager with assistance from the IG Manager:

- Privacy Impact Assessment
- Data Protection Act Compliance Assessment
- Risk Assessments
- Data Sharing / Data Processing Agreements
- Data Mapping

For any projects that are deemed to be new or existing IT Systems, the following documentation is required:

- System Questionnaire
- System Level Security Policy
- Risk Assessment
- Business Continuity / Disaster Recovery Plans
- SIRO Report - This is when the SIRO (Senior Information Risk Owner) for the Trust approves the documentation for Trust systems and either accepts the risks identified or requests further work to make improvements thus minimising and mitigating risks of any potential data security breaches.

Information Governance Board

The IG Board is now Chaired by the Head of Clinical and Information Governance 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 function
- Audits

- Approve an annual work plan
- Review Incidents and Risks of confidentiality

Cheshire and Mersey Information Governance Group

This Group was established several years ago in an attempt to create a consistent approach to working collaboratively with all IG Leads across the Patch. With The Clatterbridge Cancer Centre Manager now Chairing this Group, there are stronger links between the Trust and the Cheshire and Mersey community. This group meets quarterly to discuss the main IG topics identifying political and legislative changes as well as structural NHS changes that impact on all. There is also a newly established Freedom of Information operational meeting that meets quarterly and a separate operational meeting to discuss key topics more in depth as required.

Tiered Information Sharing Agreement

Whilst there was a Tiered Sharing Agreement in place across Wirral, it was important to understand the need for an overarching Tiered Sharing Agreement across the wider Cheshire and Mersey Community which Trusts are beginning to understand the importance of through the work of the Cheshire and Mersey IG Group and are starting to sign up. All Trusts in the Wirral including Clatterbridge are signed up to this commitment to follow best practice and legislation.

Training

The Information Governance Workbook was updated and improved to ensure that at least 95% of staff received basic IG Training for the year 2012/13 ensuring training compliance figures with the IG Toolkit.

There is also identified additional training within the approved Training Needs Analysis for key staff to be complete IG e-Learning training 3 yearly.

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 2012/13, the Trust received Limited Assurance from the overall report with a list of actions to address shortfalls.

IG Toolkit Version 10 - 2012/13 Submission

The Trust submitted the overall evidence and scores on the 31st March 2013. 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 27 scoring at level 2 and 18 at level 3 giving an overall score of 80% which is slight improvement on last year's submission of 79%.

The Trust is committed to continually improve Information Governance across the Trust and embed a culture of accepting and understanding that all staff have a responsibility to comply with the Data Protection Act and the IT Security Policies and guidelines in their day to day duties.

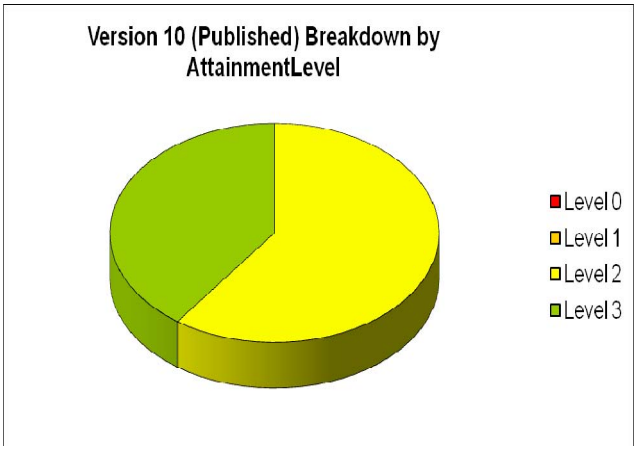
The information below is a comparison between the Versions 10 and 9 Toolkit evidence submitted:

IG Toolkit Assessment Summary Report

CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST

Prepared on 17/05/2013

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Initial Grade	Current Grade
Version 10 (2012-2013)	Baseline	0	0	28	17	45	79%	Satisfactory	Satisfactory
	Performance Update	0	0	38	7	45	71%	Satisfactory	Satisfactory
	Published	0	0	27	18	45	80%	Satisfactory	Satisfactory
Version 9 (2011-2012)	Baseline	0	0	29	16	45	78%	Satisfactory	Satisfactory
	Performance Update	0	0	30	15	45	77%	Satisfactory	Satisfactory
	Published	0	0	28	17	45	79%	Satisfactory	Satisfactory



Not Satisfactory	Not achieved Attainment Level 2 or above on all requirements (Version 8 after)
Satisfactory	Achieved Attainment Level 2 or above on all requirements (Version 8 or after)

CLINICAL GOVERNANCE TRUST-WIDE REPORT: VOLUNTEER SERVICE

NAME: **Sue Relph**
POSITION: **Patient Experience Manager**

ANNUAL REPORT:
CCC Volunteer Team

- **Number of hours of voluntary service given**. The total number of recorded hours of voluntary work coordinated by the CCC Volunteer Coordinator was 12983.75 hours, slightly less than last years figure of 13553. This figure is for the Volunteer Team only and excludes the independent organisations such as the WRVS and League of Friends, the chaplaincy volunteers and the Patients' Council. The number of active volunteers on the Volunteer Team has slightly reduced from last year to 95 from 105 volunteers attending at least weekly for at least three hours per week.

- **Recruitment** recruitment has been limited due to the retirement of the Volunteer Co-ordinator

- **Training** for new volunteers has continued, however an update in mandatory training is required across 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 **WRVS** 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 over £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 £90,000 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.

  Many of the volunteers are nurses or other professionals and CCC patients benefit from their considerable professional experience. For example, among the 7 HeadStrong volunteers are 3 senior nurses. Volunteering at CCC affords them the opportunity to apply their skills in direct patient care without the concomitant supervisory or managerial responsibilities which accompany their paid roles. They are prepared to sacrifice the status, recognition and financial rewards that go with their paid roles in exchange for the satisfaction that volunteering directly with patients affords them.

Volunteer Roles

Volunteer roles at CCC are 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

Volunteer Role
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' Craft Activities
Patients' Entertainment
Patients' Library
Befriender – Welsh and Isle of Man patients
Pets as Therapy Visitor
Liaison with local firms (e.g. Sainsburys) to solicit donations in kind (e.g. mince pies).

At CCC, the Volunteer Coordinator directly manages most of the volunteer services. This is different from most NHS Volunteer Coordinator roles elsewhere. Normally a hospital Volunteer Coordinator 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, Outpatients Clinic. All other volunteers are directly managed by the Volunteer Coordinator.

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 is uniformly excellent. Recruitment of volunteers has been undertaken to extend the service and further recruitment is planned.

Hand and Foot Massage Service Development

Massages are provided to patients in the Radiotherapy Treatment Area, all inpatient wards and Delamere Day Case Unit. The Massage Volunteers also attended external events such as the Lung Cancer Support Group, Lymphoedema Support Group and Teenagers and Young Adults Support Group to provide massages.

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 2012 – 2013 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, but is not currently able to accommodate these requests, which are passed to Human Resources. The age profile of the volunteers shows that the majority of volunteers are retired from full time employment with almost two thirds of the volunteers aged between 50 and 75. CCC Volunteer Team now has 15 volunteers over the age of 75 with 6 active volunteers over the age of 80.