
June 2017

Quality Committee Performance Report



Introduction

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

It is presented in the following sections:

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

Quality Account: Improvement Priorities (as at 13/06/17)

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

2016/17

Improvement Priority	Detail	Progress Update	Progress status
Always Events	Always Events [®] focus on ensuring events that matter to patients happen every time for every patient.	Phase 1 completed with patient survey. Workshop held 29.9.16. Final validation by staff completed. Launch at Overview and Scrutiny Committee / Healthwatch Quality Accounts meeting on 25.4.17. Six Always Events were identified at these events and are now being finalised by testing them with staff against the criteria.	Green
Model of Care	We will implement a model of Person Centered Care incorporating the frameworks developed by the Health Foundation and The King's Fund.	Refer to Strategic Plan actions.	Green
Serious Illness Conversation	Designed to improve the lives of all people with serious illnesses by increasing meaningful conversations about their values and priorities, we plan to cascade training throughout the trust so that all patients who might benefit, will be offered a serious illness conversation by	The Phase One pilot was funded for one year by the NHS England New Models of Care Programme, which supported the development of the central programme infrastructure and the: <ul style="list-style-type: none"> - Development and pilot implementation in three sites across England in 2016/17: Airedale, Southend and Clatterbridge Cancer Centre - Adaptation of the US programme for the UK context through a robust applied research methodology - Development of a robust evaluation and research programme - Safe and effective system-wide roll out. 	Green

	the end of 2017.	<p>The pilot will end in June 2017 and evaluation data from the pilot will be analysed, with results expected in autumn 2017.</p> <p>Learning from the evaluation will then inform the specification for phase two of the programme, for which funding will then be sought. In the interim, plans for further development within CCC include extension of training to other members of the MDT such as specialist nurses.</p>	
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2017/18

The following Improvement Priorities have been developed and agreed for 2017/18:

- Safety: Focus on falls. Development of a comprehensive falls prevention and management plan
- Experience: Implementation of the Patient Experience Strategy
- Effective: Improving the Quality of Mortality Review and Serious Incident Investigation and Subsequent Learning and Action

CQUIN Summary (as at 09/06/17)

Key:

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

2016/17 CQUINs

CQUIN	Detail	Value	Q1	Q2	Q3	Q4	Progress Update
Staff Health and Wellbeing	Introduction of health and wellbeing initiatives	£561,579					All 2016/17 milestones met
	Healthy food for NHS staff, visitors and patients						All 2016/17 milestones met
	Improving the uptake of flu vaccinations for frontline clinical staff						2016/17 milestone met
Sepsis	Timely identification and treatment for sepsis in acute inpatient settings	£187,193					All 2016/17 milestones met
Antimicrobial Resistance	Empiric review of antibiotic prescriptions	£56,015					All 2016/17 milestones met
Clinical Utilisation Review	Installation and Implementation of software; reduction in inappropriate hospital utilisation and reporting of results	£442,757					All 2016/17 milestones met
Enhanced Supportive Discharge	Ensuring patients with advanced cancer are, where appropriate, referred to a Supportive Care Team, to secure better outcomes and avoidance of inappropriate treatments.	£200,000					All 2016/17 milestones met

CQUIN	Detail	Value	Q1	Q2	Q3	Q4	Progress Update
Dose Banding	Standardise the doses of SACT in all units across England in order to increase safety, to increase efficiency and to support the parity of care across all NHS providers of SACT	£50,000					All 2016/17 milestones met
	Local Drugs and Therapeutics committee has agreed and approved principles of dose banding, and dose adjustments required.						2016/17 milestone met

2018/19 CQUINs

The CQUINs for 2017/18 (some extending to 2018/19) have now been published and we have agreed with NHS England (NHSE) / Liverpool CCG to implement the following:

CQUIN	Detail	Value	Q1 milestone	Q2 milestone	Q3 milestone	Q4 milestone
Staff Health and Wellbeing	Introduction of health and wellbeing initiatives REVISED FOCUS FOR 2017/18	£46,000				Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress
	Healthy food for NHS staff, visitors and patients					Maintaining 2016/17 improvements and attainment of 2017/18 targets
	Improving the uptake of flu vaccinations for frontline clinical staff					70% compliance target

CQUIN	Detail	Value	Q1 milestone	Q2 milestone	Q3 milestone	Q4 milestone
Holistic Needs Assessment and Care Planning NEW CQUIN	Holistic Needs Assessment	£333,448 (NHSE) £46,000 (Liverpool CCG)	Trust to baseline current delivery of HNA and care planning by trust and by in-scope tumour types	Develop protocol for measurement and reporting (via agreed regional approach). Trust to baseline current delivery of HNA and care delivery for Haemato-oncology.	% improvements agreed upon baseline. Year 2 targets set.	Improvements delivered by trust and tumour type/ team
	Supportive Care Planning		Trust to baseline current delivery of treatment summaries and care planning by trust and by treatment type	Develop protocol for measurement and reporting (ideally via regional dashboard)	% improvements agreed upon baseline.	Improvements delivered by trust and treatment type/ team
Clinical Utilisation Review	Implementation of software; reduction in inappropriate hospital utilisation and reporting of results	£442,757	85% - 95% of inpatients reviewed Reduction of bed usage where patients don't meet CUR criteria: Baseline	85% - 95% of inpatients reviewed Reduction of bed usage where patients don't meet CUR criteria: target to be agreed	85% - 95% of inpatients reviewed Reduction of bed usage where patients don't meet CUR criteria: target to be agreed	85% - 95% of inpatients reviewed Reduction of bed usage where patients don't meet CUR criteria: target to be agreed
Enhanced Supportive Discharge	Ensuring patients with advanced cancer are, where appropriate, referred to a Supportive Care Team, to secure better outcomes and avoidance of inappropriate treatments.	£300,000	Continuing 2016/17 patient cohorts and adding additional cohorts for 2017/18 Details of milestones for 2017/18 are being negotiated with NHSE			
Dose Banding	Standardise the doses of SACT in all units across England in order to increase safety, to increase efficiency and to support the parity of care across all NHS providers of SACT	£176,772	The list of included drugs has increased for 2017/18 Details of milestones for 2017/18 are being negotiated with NHSE.			
	Local Drugs and Therapeutics					

CQUIN	Detail	Value	Q1 milestone	Q2 milestone	Q3 milestone	Q4 milestone
	committee has agreed and approved principles of dose banding, and dose adjustments required.					
Optimising Palliative Chemotherapy NEW CQUIN	To ensure systematic review of further-chemotherapy decisions for patients with poor clinical response, and to improve mortality review processes.	£182,218	Details of milestones for 2017/18 are being negotiated with NHSE			
Medicines Optimisation NEW CQUIN	Funded pharmacist change programme to optimise use of high cost drugs: adoption of bio-similars and generics; improved drug data quality; utilising most cost-efficient dispensing cost channels; compliance with policies/guidelines, so to tackle variation & waste	£117,539	Details of milestones for 2017/18 are being negotiated with NHSE.			

Key Performance Indicators and supporting information

Amendments to the KPIs for 2017/18

New KPIs:

- Clinical Utilisation Review (CQUIN): % of patients not meeting the 'Clinical Utilisation Review' criteria. This initiative aims to prevent unnecessary hospital admissions and reduce length of stay for patients by determining the most suitable level of care according to clinical need. CCC is aiming to reduce the % of patients not meeting the criteria and is working with NHSE to develop targets for 2017/18.
- % of patients waiting 30 minutes or fewer for outpatient peripheral clinics (Data now available)

Amendments:

- Amended targets for AKI, sepsis and dementia. These have been retained as KPIs due to the importance to patient care, with more stretching targets now set internally as they are no longer CQUINs for CCC.

Removed KPIs:

- Only pressure ulcers resulting from a lapse in care at CCC, rather than all pressure ulcers will now be reported.
- Following the successful implementation of the Antibiotic Prescription Review CQUIN, this data will no longer be reported.

Key to performance metric tables

Titles key: Directive = rationale for inclusion (see detailed key below) | YTD = Year to date

Directive key: Department of Health (DoH) | NHS Improvement (NHSI) | Single Oversight Framework (SOF) | CQUIN (CQUIN) | Quality Report (QR) | Sign up to Safety campaign (SU2S) | Contract KPIs (C) | Open and Honest (OH)

General key: DC = Data capture system under development | TBA = To be agreed, QR = Quarterly Reporting | NYP = Data not yet published for this time period | NA = Not Applicable | ST = Safety Thermometer (this is a survey carried out on one day a month on all wards. The data relates only to the inpatients present on that day, rather than capturing all harm data for the month) | Grey shaded cells = Not applicable, data to be obtained for future reports, or data not available for this period | Yellow shaded cells = KPIs new to this report.

Patient Safety

	Key Performance Indicator	Director	Target	Directive	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	YTD	12 month trend
Safe																		
Incidents	Total incidents resulting in harm to patients	HP		Internal	14	23	18	28	13	16	10	11	11	5	2	NYP	NYP	
	Serious Untoward Incidents (SUIs)	HP	TBA	Internal	0	2	0	0	1	0	0	0	1	0	0	1	1	
Harm free care	Percentage of Patients with no 'new' harms (ST)	HP	95%	c, suas, OH	91.3%	96.2%	98.3%	91.2%	96.6%	96.6%	94.8%	94.6%	95.1%	96%	98%	94%		
Never Events	Number of Never Events	HP	0	DoH, C, SCF	0	0	0	0	0	0	0	0	0	0	0	0	0	
Patient transfers	Number of patients transferred to another hospital	HP		Internal	6	6	9	10	6	5	9	9	6	12	8	10	10	
Falls	Number of falls per 1,000 admissions	HP	TBA	OH	25	58	31	11	27	31	28	20	15	19	12	19	19	
	Number of falls resulting in harm	HP	TBA	Internal	2	5	3	1	3	3	1	4	2	2	1	2	2	
	Falls assessment within 24 hours	HP	TBA	Internal	97%	100%	100%	97%	100%	100%	99%	99%	99%	100%	99%	99%		
Pressure Ulcers	Number of patients recorded as having a category 2-4 hospital acquired pressure ulcer (CCC lapse in care)	HP	0	OH	0	0	0	1	0	0	0	1	1	1	0	2	2	
	Waterlow assessment within 6 hours (pressure ulcer risk assessment)	HP	TBA	Internal	90%	92%	92%	90%	96%	96%	97%	93%	96%	96%	95%	96%		

	Key Performance Indicator	Director	Target	Directive	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	YTD	12 month trend		
Safe																				
VTE	Percentage of adult admissions with VTE Assessment (ST)	HP	95%	C, SOF	98.6%	98.5%	96.4%	95.7%	98.2%	97.7%	97.9%	95.0%	99.0%	96.9%	95.5%	97.2%				
	Percentage of patients at risk of VTE who have received prophylaxis	HP	100%	Internal	88.5%	92.5%	88%	96.1%	81.5%	93%	93%	93%	90%	96%	89%	93%				
Nutrition	Malnutrition assessment within 24 hours	HP	TBA	Internal	97%	95%	94%	95%	96%	96%	97%	99%	96%	98%	98%	97%				
Health Care Acquired Infections	Clostridium difficile infections (attributable)	HP	1	C, OH, SOF	1	1	1	1	0	0	0	0	0	0	0	0	0			
	MRSA infections (attributable)	HP	0	C, OH, SOF	0	0	0	0	0	0	0	0	0	0	0	0	0			
	MSSA bacteraemia (attributable)	HP		Unity submission	0	0	0	0	0	0	0	0	0	0	0	0	NYP	NYP		
	E. Coli bacteraemia (attributable)	HP		Unity submission	0	0	0	1	0	0	0	0	0	0	0	0	0	NYP	NYP	
	VRE bacteraemia (attributable)	HP		Unity submission	0	0	0	0	0	0	0	0	0	0	0	0	0	NYP	NYP	
	CAUTI (hospital acquired)	HP		Internal	0	1	1	4	1	3	1	0	0	1	0	0	0	NYP	NYP	
Medication (errors and improvement initiatives)	Chemotherapy Medication Errors per 1000 doses	HP	TBA	C, QR					0.82	0.67	0.99	0.69	0.46	0.17	0.14	1.43				
	Number of Chemotherapy Medication Errors	HP	TBA	C, QR	2	3	4	3	5	4	6	4	3	1	1	9	9			
	Radiotherapy Treatment Errors per 1,000 fractions (8 Total in May)	HP	TBA	C, QR		1.58	1.4	1.6	1	1.1	1.16	1.2	1.6	1.1	0.76	0.62				
	Dose Banding Adult Intravenous SACT	HP	Q1 baseline, Q2 - Q4 TBA based on Q1 baseline	CQUIN	Q2=22%			Q3=76%			95%			QR						
Dementia	Composite Indicator for Dementia Screening	HP	R: <95%, A: 95%-99%, G: 100%	Internal	70%	93.7%	100%	100%	100%	93%	92%	82%	84%	100%	100%	89%				
AKI	Percentage completeness of the AKI data items (four per discharge)	HP	R: <95%, A: 95%-99%, G: 100%	Internal	33%	0%	0%	67%	44%							92%				
Sepsis	Percentage of patients requiring screening for sepsis, who have been screened as part of the admission process.	HP	100%	Internal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				
	Percentage of patients presenting with severe sepsis, Red Flag Sepsis or Septic Shock, who have received IV antibiotics within an hour of presentation.	HP	R: <95%, A: 95%-99%, G: 100%	Internal	100%	83%	83%	83%	84%	83%	86%	100%	100%	90%	96%	76%				
Safety culture	Number of breaches of duty of candour	HP	0	C	0	0	0	0	0	0	0	0	0	0	0	0	0			

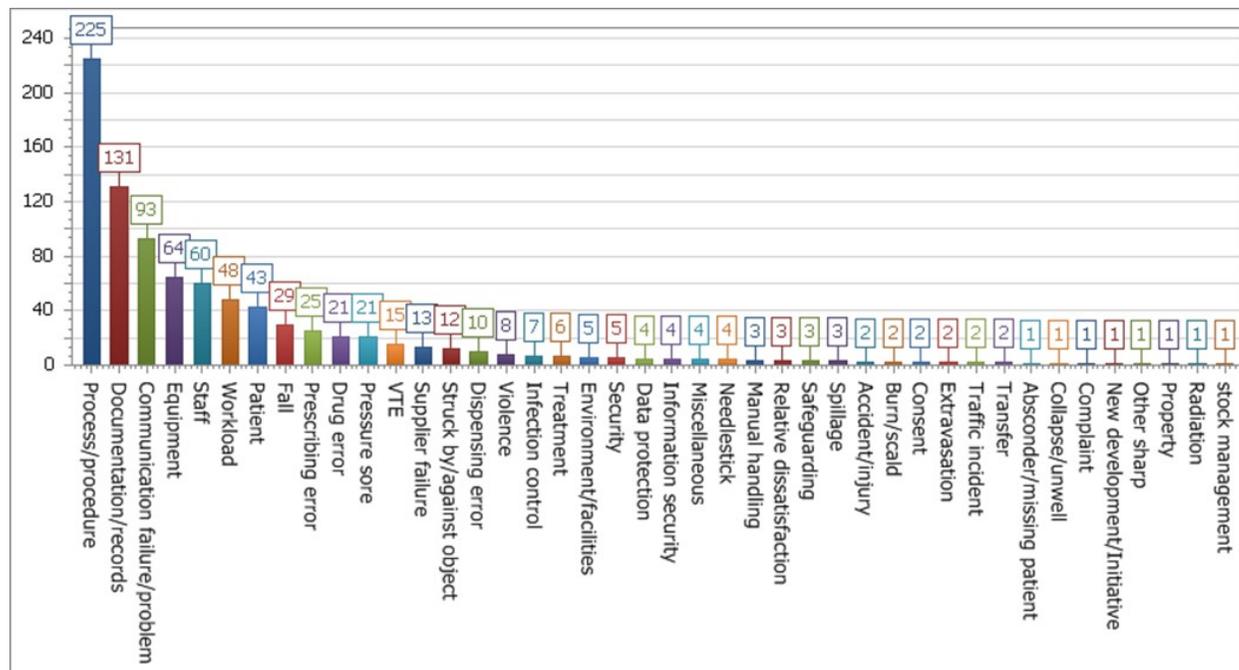
Incidents

No incidents resulted in severe harm or death between 1/12/16 – 30/4/17. 52 (5%) incidents resulted in low/minor harm, with the majority being patient harms. 4 (0.4%) patient incidents resulted in moderate harm, details are provided below:

1. INC 14959 - Patient was sat in the cannulation chair in PET/CT waiting for her FDG tracer injection. When the staff returned to her with the injection she was sat in the chair but had somehow fallen during the time that the staff were out of the room. She had a gash and bleeding on her forehead and had banged her nose. Husband has since advised that wife fainted as she is prone to do when faced with an injection. NEWS score taken and contacted SHO to assess the patient. Patient assessed and advised to go to A and E which she did. Patient's husband has subsequently contacted the department (approx 6 weeks after the fall) and stated that patient has an fracture of the pelvis diagnosed by x-ray and CT - no active treatment necessary. Patient did not complain about hip/leg pain to radiographers or doctor here. Patient attended local A&E as advised but no x-rays or scans were undertaken there. Patient's husband claims that, although he was not present, his wife always advises those caring for her that she is liable to faint when injected. Radiographer here states that the patient did not state this and only commented that she does not like needles. Incident has also highlighted the fact that, because patient only attended for imaging and is not one of our patients, there is no record in which the SHO can annotate details of the assessment. NEWS assessment provided with incident form. Amended harm to moderate on presumption that fracture caused by fall. However, must be minor fracture as patient has continued to be mobile even after diagnosis.
2. INC 15122 -Fall - Conway - SR5 - Patient was found on the floor in room, fall not witnessed. Escorted back to bed. Observations taken. Patient initially reported being pain free. Was unable to transfer out of bed to chair to attend radiotherapy. Unable to have treatment as unable to lie flat. On call SHO informed and reviewed patient. Patient had fractured hip. Patient given further education regarding nurse call bell. Patient highlighted in safety huddle. Falls RCA completed. Falls Care plan was in place. Discussed with ward manager to determine if the fall was preventable in any way to determine if reportable under RIDDOR. Informed Health & Safety advisors. Reviewed by ward manager and agreed this was not preventable so not reportable to HSE.
3. ID 294 – Serious incident: Chemotherapy weight, detailed below.

4. ID 128 - Patient called triage asking for advice on taking his capecitabine. It was soon evident that for the last 21 days he had been taking only the 150mg tablets x2 in the morning and x2 in the evening. After completing the 21 day cycle he noticed the remaining boxes of capecitabine were 500mg tablets. Staff member explained that they should have been taking together daily in the morning and evening and that he had only been taking 300mg am and pm instead of the intended dose of 1300mg. He explained that he was just given the boxes and told to follow the instructions on the boxes and not advised how to take them. Delamere do counsel patients but no documentation regarding TTH advice. Delamere has highlighted to staff and a new process is being devised to incorporate a TTH button on Meditech.

Total incidents by incident type (1/12/16 – 30/04/17):



Serious Incidents (all to date)

- **ID 389 – Ketamine wrong dose:**

Patient given an overdose of Ketamine – prescribed 100mg and 1000mg was administered due to a calculation error. The patient died and a police/coroner investigation is underway. Serious Incident Panel held 5/6/17. Incident reported to NRLS (CQC), Steis, HSE and MHRA.

- **ID 294 – Chemotherapy Weight:**

Weight entered as 87kg instead of 59.5kg and as such patient received a higher dose than would have been intended on 21/04/2017. Dose of Cisplatin should have been in the region of 124mg (which would have been dose banded to 128mg) rather than the 145mg given. Was also given 100mg Vinorelbine rather than 90mg. Patient reported for day 8 and the error was identified by nurse conducting the assessment of the patient who found that the patient had not coped well with treatment and had weighed the patient and found out the patient was 59kg which was a marked change. Patient experienced increased side effects and although the higher dose was tolerated, clinician decided to change regime to Carboplatin and Vinorelbine. Human Error - transcribed into Meditech from case notes incorrectly. (note the correct weight was annotated in the paper notes by the clinician correctly).

Actions: Staff have been reminded of the importance of recording patient height and weight at every appropriate interaction. In addition, a review of the process for taking weights and recording them accurately – limit opportunities for transcription error wherever possible.

- **Radiotherapy ID**

Two patients with the same surname were to be treated consecutively with external beam photons on 18.4.17. The first patient was receiving palliative prostate treatment to a dose of 36Gy/6#/1 per week, so a daily dose of 6Gy. The second patient was receiving radical radiotherapy to the prostate to a dose of 60Gy/20# giving a daily dose of 3Gy. The 3Gy per day plan was used to treat the 6Gy per day patient. The operator had pulled up the correct Encounter for the patient called into the treatment room but had then pulled up the incorrect patient, and therefore plan, from the Aria queue. The plan and the Encounters document are not automatically linked

so a manual check that the plan pulled up from the queue matches the Aria Encounters document must be carried out at this point. This check was not done. The patient is ID'd in the treatment room against the Encounters document, which in this case was correct. Patient was set up. Isocentre height was approx. 1cm out so staff acquired all bed parameters at this point. Images were taken and matched despite the fact that the image attached to the plan indicated fiducial markers and the patient being treated did not have any. A small move was made and treatment delivered. The error was picked up when 2 different staff took the next patient into the room and attempted to load the plan. It was then realised that the plan had already been delivered that day and further investigation showed that it had been delivered to the previous patient with the same surname.

Actions: Physics have calculated that the patient treated incorrectly received an isocentre dose of 2.93Gy instead of the intended 6Gy, so an underdose of 3.07Gy for 1 fraction. The Consultant has chosen not to apply compensation. The patient will still receive just short of 33Gy in total and local protocol allows 30-36Gy. Apology and explanation has been given to the patient. A reminder of the correct process for checking Encounters against plan has been given to all staff. Staff involved have been given additional support on set as deemed appropriate on discussion with Section Manager. An incident panel was held on 30.5.17 and additional actions identified including a review of how we book and alert staff to same or similar name patients and how we check and acknowledge that documents match. Varian will again be approached to clarify whether there is any way of linking Encounters and the plan.

Externally reportable incidents per year and by reporting type:

4 new incidents have been reported externally since the last report, the new RIDDOR manual handling incident (INC 15545) and the 3 serious incidents detailed above.

External body	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
HSE (RIDDOR) Note: from April 2012, over 3 day injuries changed to 7 days	2	2	3	2	4	3	1*
HSE - other			2				
MHRA							
SHOT	2						
CQC (IRMER)	2	2	1	2	5	1	1**
STEIS	1	2	3		6	6	2***
CQC local inspector (all STEIS incidents reported from 1/2/16)					2		
NRLS	1237	1623	1392	1668	2401	2579	
Information Commissioner		1	1	1	1	1	
DOLS (applications)				13	5	7	

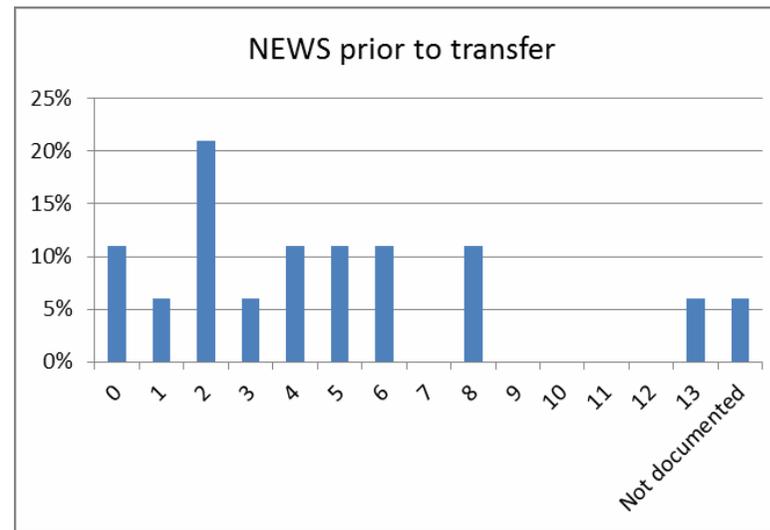
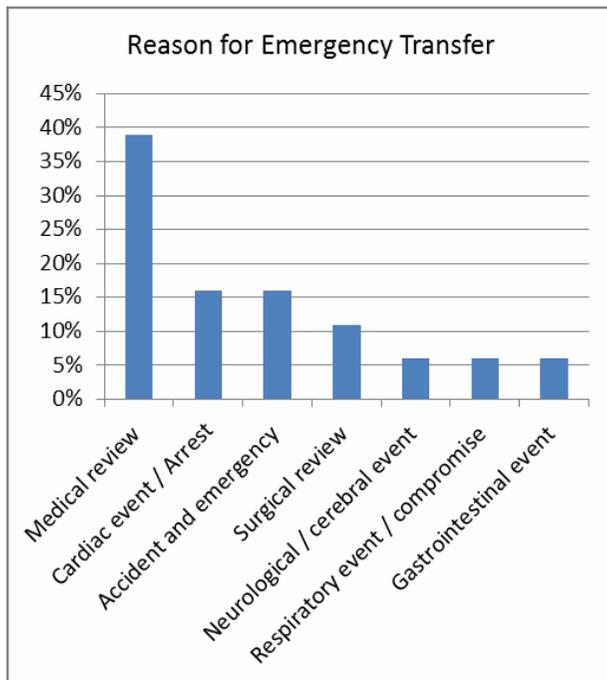
*389 Ketamine ID389

** Radiotherapy ID 228

*** ID389 Ketamine, ID294 Chemo Weight

Patient Transfers to an Acute Trust: March and April 2017

Number of patients transferred = **18**



Time of transfer:

- In hours (09.00hrs – 17.00hrs) – 39%
- Out of hours (17.00hrs – 09.00hrs and weekends) – 61%

Acute trust patients transferred to:

- Wirral University Foundation Teaching Hospital 94%
- Liverpool Heart and Chest 6%

Was treatment stopped or delayed?

- Yes – 61%
- No – 33%
- N/A Staff Member 6%

Harm free care

VTE (Venous Thromboembolism): Percentage of patients being assessed and percentage of 'at risk' patients receiving prophylaxis

Since the last report, an issue with the VTE assessment data has been identified, namely that we have been including only nursing assessments, rather than nursing or medic assessments, in our figures. We have re calculated the compliance based on the latter, and these updated figures are now displayed. This has been approved by several key clinical members of staff including the Clinical Director for Integrated Care and senior nurses as an appropriate change to the KPI logic. We have been compliant throughout 2016/17 and continue to be in April at 97.2%.

Administration of prophylaxis has risen slightly on the previous month; however this has been static at around 90% for the last 7 months. Improvements to address this are on-going; the medical VTE is now mandatory on the unplanned admissions pathway, and work is underway to extend this to planned admissions. The nursing and medical assessments are being combined on Meditech, with the required system

changes likely to be completed in Q1 2017/18. VTE occurrence is monitored closely at CCC with incident forms completed and Root Causes Analyses undertaken for those which developed at CCC.

Pressure Ulcers:

There were 3 hospital acquired pressure ulcers in April 2017, with root cause analyses finding that 2 were potentially due to a lapse in care by CCC:

- Although all interventions were in place, including equipment and dietician referral, there was poor documentation regarding comfort checks and an initial delay in providing an air mattress. There were also contributing factors for this patient who had a previous history of pressure ulcers and was receiving end of life care.
- An air mattress was provided on admission and the patient was encouraged to sit out of bed, however there was no evidence that a chair cushion was provided prior to the development of a grade 2 ulcer. There was however no evidence to suggest that this would have prevented the development of the ulcer. At the RCA meeting it was noted that the area had healed and all appropriate interventions were in place.

Acute Kidney Injury (AKI)

A significant shift in compliance from between 33% - 67% recorded in early 2016/17, to 92% in April 2017 is the result of developing the Meditech system to allow recording of information relating to our diagnosis and treatment of AKI. We have not yet reached the internally developed target of 100%, however this development should support us to achieve this.

Sepsis

In 2016/17, the targets for this CQUIN (Percentage of patients presenting with severe sepsis, Red Flag Sepsis or Septic Shock, who have received IV antibiotics within an hour of presentation) were Q1= baseline; Q2 80%, Q3 85%, Q4 90%. Although not a CQUIN for 2017/18, we

recognise that this is a vital standard for our patients and will therefore be continuing to record this and monitor our compliance against our internally developed target of 100%. Despite achieving over 82% in 2016/17, with 3 months at 100%, our compliance fell to 76% in April 2017; 2 patients' drug cards could not be located at the time of the audit (they had been discharged prior to the audit), so without proof, these cases were recorded as non-compliant. 2 patients did not have any documentation to support why they had missed antibiotic target time. 1 patient had missed target by several hours; the ward manager has been asked to investigate this particular incident and to ensure that a clinical incident is raised.

NHS Safety Thermometer (ST)

The table below shows the ST survey data for May 2016 to April 2017. All figures are % except the sample which is the total number of patients included each month. This is a snapshot on one day of every month, rather than total occurrence of harm.

		May16	Jun16	Jul16	Aug16	Sep16	Oct16	Nov16	Dec16	Jan17	Feb17	Mar17	Apr17
Harm Free		91.30	94.23	94.74	85.96	87.93	93.22	93.10	94.64	91.80	92.73	96.49	94.44
Pressure Ulcers - All		2.17	3.85	3.51	8.77	10.34	3.39	3.45	0.00	4.92	3.64	1.75	1.85
Pressure Ulcers - New		2.17	1.92	0.00	1.75	1.72	0.00	1.72	0.00	1.64	0.00	0.00	1.85
Falls with Harm		2.17	0.00	0.00	1.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Catheters & UTIs		2.17	0.00	0.00	1.75	0.00	1.69	3.45	0.00	0.00	0.00	1.75	3.70
Catheters & New UTIs		2.17	0.00	0.00	1.75	0.00	0.00	3.45	0.00	0.00	0.00	1.75	3.70
New VTEs		2.17	1.92	1.75	3.51	1.72	3.39	3.45	5.36	3.28	3.64	0.00	0.00
All Harms		8.70	5.77	5.26	14.04	12.07	6.78	6.90	5.36	8.20	7.27	3.51	5.56
New Harms		8.70	3.85	1.75	8.77	3.45	3.39	5.17	5.36	4.92	3.64	1.75	5.56
Sample		46	52	57	57	58	59	58	56	61	55	57	54

Quality at The Clatterbridge Cancer Centre (Q@CCC)

Delivering high-quality, safe and clean care to patients is of paramount importance, however measuring the quality of nursing care delivered by individuals and teams can be a challenge. In an effort to achieve this, we implemented Q@CCC, a comprehensive performance assessment framework which is based on key clinical indicators, High Impact Actions for Nursing and Midwifery and NICE guidance. Following a re-launch of this assessment process in July 2016, we decided to focus on the Care Quality Commission's 5 key lines of enquiry (Safe, Effective, Well Led, Caring and Responsive).

Each time we assess an area, we use five different methods;

- Interviewing inpatients on the wards
- Interviewing ward nursing staff
- Interviewing ward managers
- Auditing nursing documentation (both bedside and electronic notes)
- Observing the ward environment

The Q@CCC tool is not only used to effectively monitor aspects of care and provide evidence of the care we deliver, it is also designed to provide feedback to the nursing staff that will allow them to improve their understanding of how they deliver care, identify what works well, and establish where further developments may be needed.

The overall results achieved by each ward at each assessment are as follows:

	Q3 2016/17	Q4 2016/17	Q1 2016/2017	Jan/Feb 2017
Conway				
Mersey				
Sulby				

Detailed action plans are in place for each ward and these are monitored at their quality meetings.

Clinical Effectiveness

	Key Performance Indicator	Director	Target	Directive	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	YTD	12 month trend
Effective																		
Mortality	Total number of in-hospital deaths	HPIPK		Internal	12	9	7	6	6	7	4	8	7	8	7	5	5	
	30 day mortality rate (radical chemotherapy)	HP		QR	0.4%	0.4%	0.3%	0.3%	0.4%	0.3%	0.0%	0.0%	0.1%	0.2%	0.3%	NYP		
	30 day mortality rate (palliative chemotherapy)	HP		QR	1.4%	1.1%	1.5%	1.5%	1.7%	2.3%	1.7%	1.4%	1.2%	1.1%	1.3%	NYP		
	30 day mortality rate (radical radiotherapy)	PK		QR	0.3%	2.2%	3.5%	2.4%	2.1%	2.5%	3.4%	3.2%	3.6%	2.9%	1.8%	NYP		
	30 day mortality rate (palliative radiotherapy)	PK		QR	14.4%													
Time to Consultant Assessment	Percentage of patients admitted as an emergency by A&E or directly from the community, who have a documented assessment from a consultant within 14 hrs of arrival at hospital.	HP	75%	Royal College of Physicians	81.0%	77.0%	80%	78%	69%	68%	86%	80%	72%	71%	70%	93%		
Length of Stay	Length of Stay Elective Care (Average number of days on discharge)	HP	5	Internal	2.02	1.81	2.40	2.1	2.79	2.6	4.61	2.25	4.40	3.82	2.59	1.78		
	Length of Stay Emergency Care (Average number of days on discharge)	HP	10	Internal	9.68	9.76	10.61	6.67	12.14	13.15	10.04	6.91	9.61	8.96	8.94	7.42		
Appropriate bed usage (CUR CQUIN)	% of patients not meeting the 'Clinical Utilisation Review' criteria	HP	TBC with NHSE	CQUIN												40%		
Linac Utilisation	Linac Downtime	PK	2%	Internal	1.8%	6.4%	2.42%	3.45%	3.25%	3.90%	2.72%	1.53%	4.04%	2.74%	2.34%	2.36%	3.44%	
	Linac Utilisation	PK	85%	Internal	80.2%	82.8%	81.2%	77.9%	83.5%	86.5%	89.0%	80.9%	83.3%	95.5%	94.8%	86.7%		
Care hours per patient day	Care hours per patient day: Conway Ward	HP	Awaiting Provision of 'Model Hospital' Portal	NHSI	5.8	7.6	7.0	6.2	5.8	5.6	6	6.3	5.9	6	6	6.2		
	Care hours per patient day: Sulby Ward	HP		NHSI	9.1	9.9	6.7	8.2	6.6	9.4	8.5	10.8	7.3	7.4	7.3	9		
	Care hours per patient day: Mersey Ward	HP		NHSI	8.1	6.9	7.1	7.1	6.3	6.1	6.8	6.7	6.6	6.7	6.3	7.3		
Staff Recruitment	Time to recruit staff (days)	AC	60	Internal	30	31	31	43	59	61	59	63	41	67	66	26		
Clinical Trials	Number of patients enrolled into clinical trials	PK	400 per annum	Internal				83			87			71		QR		

Consultant Assessment within 14 hours of admission

Consultant cover is now provided between 5pm and 8pm, and a split handover has been introduced at the weekend to enable more timely assessment of patients who arrive after midday. This has had a significant impact on the timeliness of assessments; with 93% of patients having an assessment within 14 hours in April 2017, the highest in the last 12 months.

Mortality

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

Ward	No. of inpatient deaths				No. of expected deaths				No. of patients receiving End of Life Care			
	March	April	May	Total	March	April	May	Total	March	April	May	Total
Conway	5	0	4	9	5	0	3	8	4	0	2	6
Mersey	2	5	2	9	2	4	2	8	1	4	1	6
Sulby	0	0	0	0	0	0	0	0	0	0	0	0
Total	7	5	6	18	7	4	5	16	5	4	3	12

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

NICE Guidance

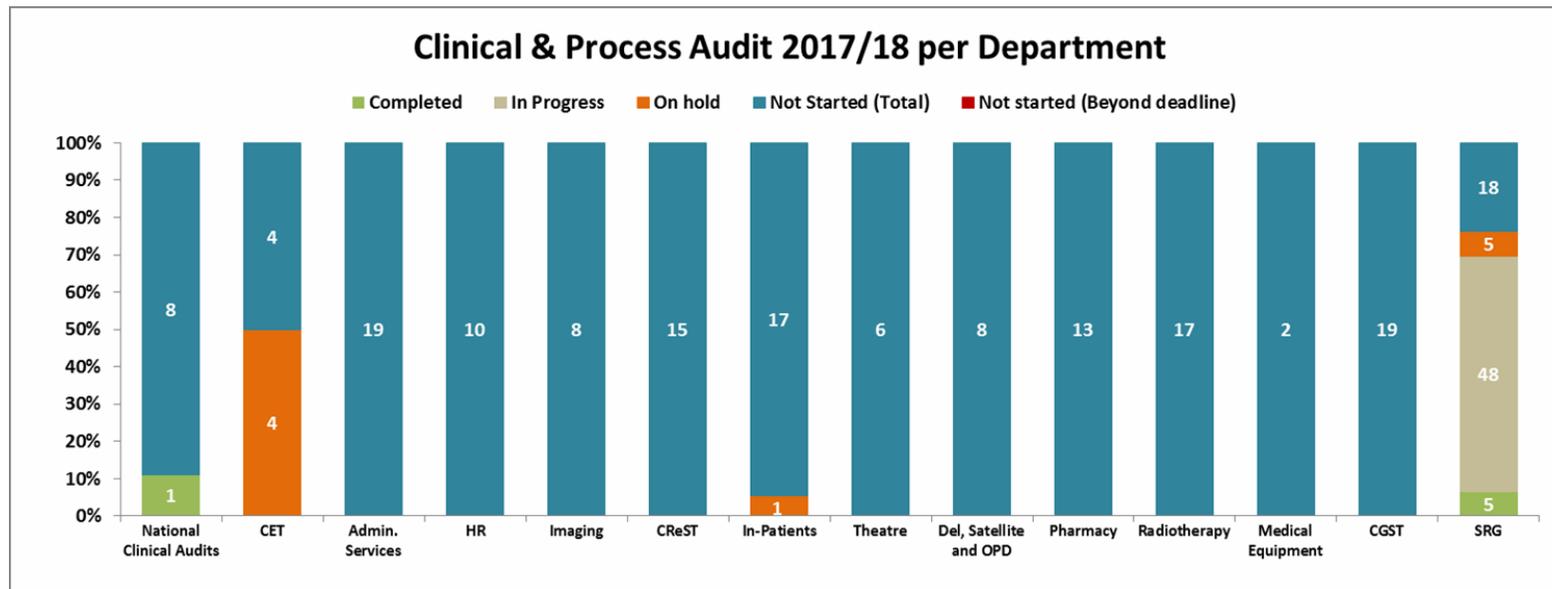
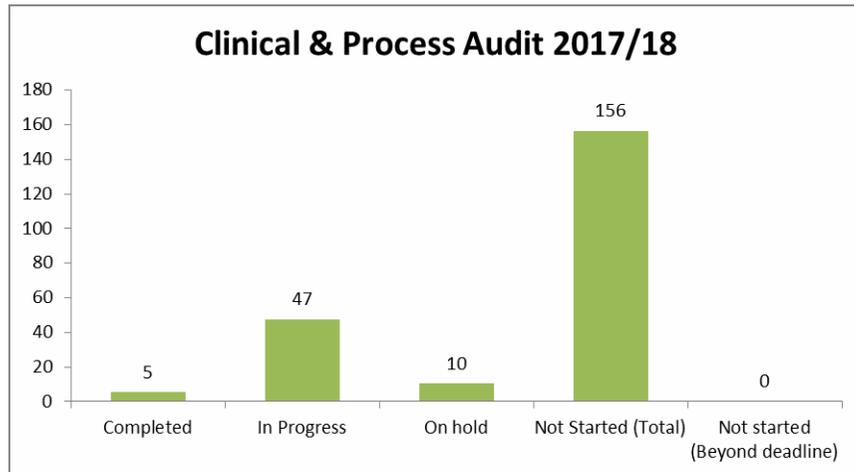
There are 12 pieces of guidance (including 7 Quality Standards), published between May 2012 and February 2017 which have not yet been fully assessed.

Clinical Audit

The following table shows the National/Regional clinical audits in which the Trust is participating:

	National / Regional	Deadline	Criteria	Status and details
Head and Neck (HANA)	National	28 th February 2017	Patient diagnosed 2014 to 2016 into DAHNO	Complete 787 patient records uploaded 799 treatment records uploaded
Lung (LUCADA)	National	30 th May 2016	patient diagnosed in 2015	Data would be submitted via COSD monthly
Bowel (NBOCAP)	National	2 nd November 2016	Oncology treatment records for patients diagnosed 01/04/2015 to 31/03/2016	579 treatment records uploaded (as at 23/12/2016)
Oesophago-gastric cancer	National	February 2017	Oncology treatment records for patients diagnosed 01/04/2015 to 31/03/2016	295 treatment records uploaded. 52 treatment records not uploaded due to patient/primary not being registered.
RCR National Prostate Cancer Audit - Radiotherapy Data	National	On-going audit	Radiotherapy treatment planned from April 2016	Data is submitted monthly to CNIN
Female Genital Mutilation	National	On-going audit		0 cases identified as at 13/12/2016
RCR National Muscle Invasive Bladder Audit	National	22 nd May 2017	Patients who commenced XRT between 06/12/16 and 27/03/17	
National Audit of Breast Cancer in Older patients	National	Due to commence	Deadline for completion of organisational questionnaire by the breast cancer MDT clinical lead was 13/12/2016	Data would be submitted via COSD
National Audit of the management of patients at risk of Transfusion Associated Circulatory Overload	National	May 2017	Maximum of 20 inpatient and 20 outpatients, 60 years old or over who are transfused during the months of March and April 2017	

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



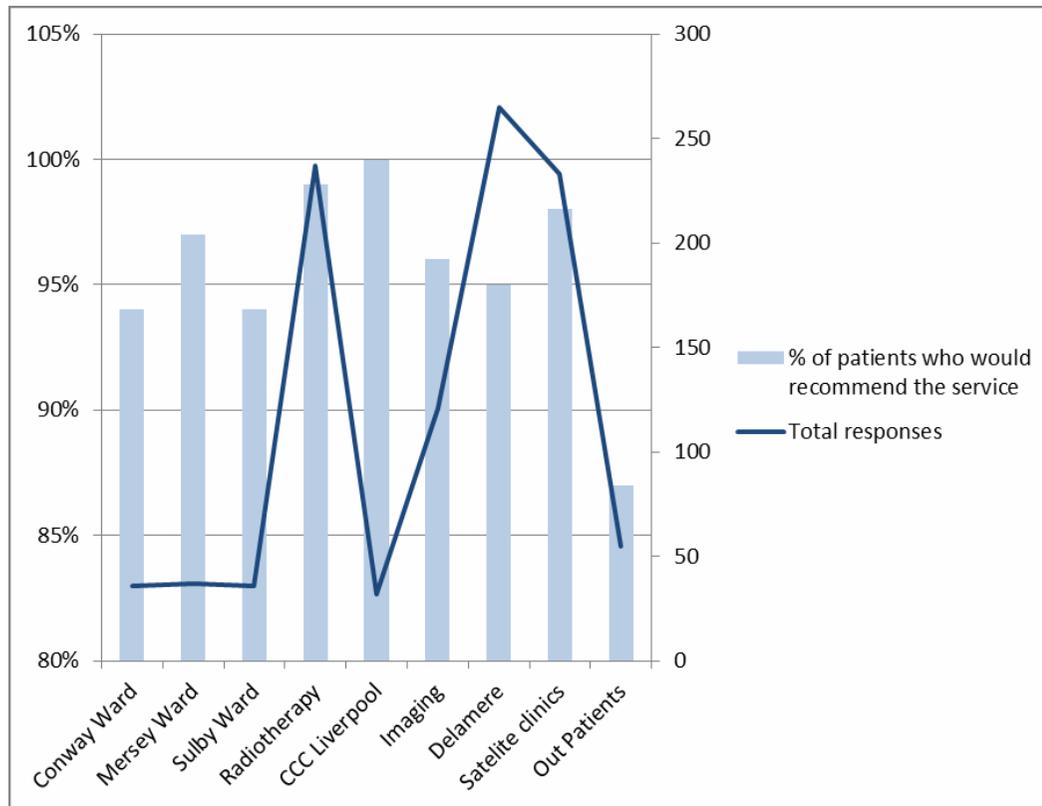
Patient Experience

Key Performance Indicator		Director	Target	Directive	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	YTD	12 month trend
Caring																		
The NHS Friends and Family Test (FFT): Inpatients	Total responses as a percentage of those eligible to respond.	HP	30%	C	30.9%	27%	12.9%	11.80%	19.10%	19.10%	23.10%	10.80%	10.95%	13.80%	15.00%	15.80%		
	Percentage of respondents who were either likely or extremely likely to recommend to friends and family.	HP	<90: R, 90-94: A, >95: G	C, Q&H, SOF	95%	95%	100%	95%	98.20%	94.10%	97.01%	96.88%	100.00%	94.11%	93.30%	100%		
The NHS Friends and Family Test (FFT): Outpatients	Percentage of respondents who were either likely or extremely likely to recommend to friends and family.	HP	<90: R, 90-94: A, >95: G	C	96.7%	94.0%	97.7%	96.60%	94.80%	96.68%	96.36%	96.88%	96.44%	96.92%	95.07%	89.52%		
Waiting Time	Percentage waiting 30 minutes or less in a CCC outpatient clinic	HP	65%	Internal	75.3%		79.1%	79.96%	78.29%	79.23%	77.48%	73.24%	77.46%	72.74%	77.27%	74.07%		
	Percentage waiting 30 minutes or less for Radiotherapy	PK	80%	Internal	78.6%		DC	DC	DC	DC								
	Percentage waiting 30 minutes or less for Delamere	HP	80%	Internal	83%		91.1%	92%	91%	90%	91%	87%	86%	87%	86%	86%		
	Percentage waiting 30 minutes or less for outpatient peripheral clinics	HP	65%	Internal					96%	96%	93%	94%	93%	88%	86%	86%		
Complaints	Number of Complaints	HP	0	C, SOF	2	0	4	0	1	2	2	4	0	2	3	4	4	

Patient Surveys

Friends and Family Test (Patients)

The following chart shows the total surveys completed and the % of patients who would recommend the service, by department, for Q4 2016/17.



Further Patient Experience Metrics and Sources of Information

Percentage of patients waiting 30 minutes or less

The % of patients waiting 30 mins or less for Delamere and outpatients is 86% and 74% respectively for April 2017.

Patient experience indicators – The ‘Always Events’ are being agreed and will be reported here once monitoring begins. Further detail is provided in the Quality Account - Improvement Priorities section at the start of this report.

National surveys

Our latest inpatient survey, released 31st May 2017 is available here: <http://www.cqc.org.uk/provider/REN/survey/3>

Our aggregate scores were rated as ‘better’ than other trusts in all sections of the survey, with 9.1 out of 10 for ‘overall experience’.

Patient story programme

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

NHS Choices/Patient opinion

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

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

Complaints

The Trust has a formal complaints policy which adheres to national NHS guidance. In addition to the policy the Trust has a system whereby the Council of Governor's Patient Experience Committee reviews all complaints received (with patient identifiable information removed) and responses sent which provides the COG with assurance that the Trust adheres to its complaints process and that they are apprised of any patient concerns. An overview of complaints in April and May 2017 is provided below:

April 2017	May 2017
01/17 relative has questions about chemotherapy 02/17 relative unhappy with staff attitude 03/17 relative has questions about treatment and care 04/17 patient unhappy with consultant	05/17 relative has questions about treatment and care 06/17 Staff attitude 07/17 relative has questions about treatment and care

Claims

3 new Letters of Claim have been received (bold text) since the previous report as detailed in the table below:

Claim Number	Claim Date	Incident date	Nature of Claim (Alleged failure)	Progress/Action
2015/07	1/6/17	15/12/14	Misdiagnosis of brain metastases resulting in unnecessary radiotherapy	LOC received. Previously reported to NHR who had closed file due to no progress. LOC reported and files re-opened. Hill Dickinson previously instructed.
2017/14	31/5/17	24/4/17	One claim received (staff)	Reported to NHSLA. Incident forms completed at the time by WUTH and CCC.
2016/14	27/4/17	17/4/17	Contractor slipped on wet floor in RVS in Aintree.	All documented uploaded to NHR.
2016/11,	24/2/17	3/3/16	Three claims received (staff)	Portal Claims. All documents completed and uploaded to the NHSLA. 2

12, 13		27/4/16 11/5/16		incident forms received and investigated previously.
2016/10	LOC 13/2/17	5/12/16	One claim received (staff)	Reported to NHSLA. Acknowledgement sent to claimant solicitors. All documents obtained and uploaded to NHSLA. Allegations to be denied. Further information requested and disclosed.
2016/03	LOC 21/6/16	20/10/13	Failure to warn of the risks of falling- fall on ward	Previous PALS and incident reported at the time of the fall in 2013. Reported to NHSLA, HD instructed. Preliminary external medical and nursing reports have been supportive and therefore there is sufficient evidence to deny liability. Letter of Response sent repudiating the claim. File was closed and CNST closure form received from the NHSLA. Particulars of Claim now received and Defence drafted denying allegations. Further information requested- photos of bathroom. Witness statements being obtained.
2016/02	LOC 23/6/16	4/5/16	Patient fall in toilet in radiotherapy dept	Incident previously reported and review held. LOC received and reported to NHSLA. HD instructed. Liability denied. Closure form received from NHR, file closed.
2016/01	LOC 19/4/16	23/2/16	One claim received (staff)	Incident reported INC 12369. Portal claim – response pack completed and sent to NHSLA.
2015/05	LBA 11/6/15 LOC 31/3/16	July 13	Negligent insertion of cannula resulting in skin grafts and physio – failure to offer a Picc	LOC received and request for extension of limitation agreed. Reported to NHSLA and HD instructed. Letter of Response served. Part 36 offer received of £52,540, NHR offer of £20,000.
2015/03	LOC 11/5/15	July 14	Joint claim with Wirral -Did not treat neutropenia, bloods not checked, not reviewed by oncology team and discharged by Wirral with a severe infection. Previous inquest Oct 14	Letter of Response served, specific allegations relating to CCC denied. No further progress

Inquests

No new inquest files has been opened since the previous report and all previous inquest files have been closed with no staff being called to attend an inquest.

People Management and Culture

Key Performance Indicator		Director	Target	Directive	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	YTD	12 month Trend	
People Management and Culture: Well Led																			
Staff Attendance and Turnover	Attendance (Sickness Level)	AC	R: => 4%, A: 3.8% - 3.3%, G: =< 3.5%	SOF	4.8%	4.6%	4.07%	3.34%	3.85%	4.49%	4.28%	3.79%	4.84%	4.14%	4.14%	4.05%			
	Stress related absence	AC	TBC	Internal					0.77%	1.21%	0.83%	0.53%	0.67%	0.65%	0.97%	0.91%			
	Staff Turnover (Leavers divided by average staff in post FTE)	AC	1% per month	SOF	0.84%	1.56%	0.88%	1.39%	1.43%	0.48%	0.86%	1.29%	0.76%	0.41%	1.12%	0.12%			
Staff Development	Statutory Mandatory Training (Rolling 12 months)	AC	R: <75%	Internal	83%	82%	82%	82%	83%	82%	83%	83%	85%	85%	80%	80%			
	Mandatory Role Essential Training (Rolling 12 months)	AC	A: 75% - 94%, G: =>95%	Internal	79%	78%	79%	78%	78%	75%	70%	71%	68%	81%	73%	79%			
	Performance Development Reviews (PADR) (Rolling 12 months)	AC		Internal	62%	57%	46%	46%	54%	57%	60%	61%	75%	76%	73%	70%			
	Nurse Revalidation complete	AC	TBC	C					100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Medical Revalidation complete	AC	TBC	GMC					100%	100%	97%	N/A	N/A	100%	100%	100%	100%		
Staff Experience	Medical Appraisal complete	AC	TBC	Internal					53%	54%	48%	54%	54%	40%	25%	29%			
	Staff FFT: Recommend CCC as a place to work	AC	R: <90, A: 90-94, G: =>95	SOF, O&H		90.0%			91%			No report due to National Staff Survey			22%	Q/R			
Employee Relations	Staff FFT: Recommend CCC for treatment	AC		SOF, O&H		100.0%			95%			No report due to National Staff Survey			83%	Q/R			
	Formal Bullying & Harassment cases	AC	0	Internal					0	1	0	0	0	0	0	0	0		
Risks	Investigations completed within 8 weeks	AC	100%	Internal					75%	100%	100%	100%	100%	100%	100%	100%			
	High risk as a % of all risks	HP	TBA	Internal	2%	2%			2%		2%	2%		3%		2%			
	% of risks reviewed within agreed timescale	HP	TBA	Internal	68%	97%			67%		58%	59%		48%		48%			

Attendance & Stress Related Absence:

Absence across the Trust has decreased slightly by 0.09%. The highest reason for absence in April 2017 was gastrointestinal (20.06 FTE) followed by anxiety/stress/depression (12.6 FTE) and cold, cough, influenza (9.1 FTE).

Stress related absence has also decreased in April 2017. The figure of 0.91% relates to 14 episodes in total of stress related absence. Absences relating to personal stress have decreased however, work related stress has increased to 6 episodes.

Turnover

The Trust's turnover rate has increased in April 2017 with 15 leavers compared with 7 in March 2017. 'Unknown' as a reason for leaving is continuing to appear on leaver reports and the Workforce Team have developed a new leaver form that has a drop down menu which directs the user to complete a valid reason for leaving. There were 5 individuals recorded as 'unknown' this month however, via confirmation from the

line manager and exit interview surveys the actual reasons for leaving are recorded as follows: Promotion (2), Work life balance (1), Health (1), Retirement (1).

The HR Business Support Team are continuing to work with managers to ensure that temperature checks are completed by new starters and exit interviews by leavers to ensure we understand our turnover rates and these will be reported on in Junes report.

Employee Relations:

There were no formal employee relations investigations on-going in April 2017 however, two previous cases where open, awaiting a formal disciplinary hearing to be conducted. These were both completed and the cases were closed in April.

A grievance was received in April 2017 but an investigation was not deemed necessary, this was heard and completed in April 2017.

An appeal was received at the end of April 2017 against a decision to dismiss. This will be heard in May 2017.

Agency Rules

The agency use continues to reduce month on month. With the change to the IR35 rules in April 2017 (making public sector bodies liable for ensuring tax is paid by a worker) there have been a number of challenges to the status of workers and whether or not they can continue to be used. The Workforce Redesign Group monitors this on a weekly basis and WOD are working closely with Finance colleagues and managers to ensure that the Trust is compliant in this area.

Time to hire

Following the introduction of the Workforce Redesign Group in January we are now starting to see some of the benefits of the changes introduced and the tightening of timescales throughout the process. Although Time to Hire has been reported as high over the past few months the mitigation has been around the Consultant recruitment activity and how vacancies are managed within the Trac system. The process has now been addressed, audited and additional training provided within the Team which has had a positive effect on this months reported timescales reducing it from 65.7 days to 25.81 days.

Job Evaluation

The KPI for Job Evaluation has decreased again to 50% however, this related to only 4 posts in the process with 2 being out of KPI.

Mandatory Training

Following the presentation on progress of the Mandatory Training review the revised Training Matrix has now been circulated to all senior managers for comment. IM&T have also tested CCC systems for ESR E-Learning compatibility. It is anticipated that a Trust wide systems update will be completed in the next few weeks after which L&D will be working with departments to ensure staff are able to use ESR to complete their mandatory training. A training implementation plan will be commence once IM&T have confirmed that the Internet Explorer, Java and Flash player updates have taken place.

Policies & Procedures

There has been a slight decrease in the KPI for polices this month which relates to 3 policies that are out of date. These are currently in process with two going to SPF in June and 1 to OPF in May.

PADR's

Compliance for PADRs is expected to improve during April to July following the recent decision by the Board to change the period that PADRs must be completed by in line with the Trusts Business Planning cycle. All senior managers have been contacted with information regarding the change of reporting and also updated paperwork regarding collation of information to inform the development of a Talent Management strategy.

Statutory Mandatory Training:

Following the presentation on progress of the Mandatory Training review the revised Training Matrix has now been circulated to all senior managers for comment. IM&T have also tested CCC systems for ESR E-Learning compatibility. It is anticipated that a Trust wide systems update will be completed in the next few weeks after which L&D will be working with departments to ensure staff are able to use ESR to complete their mandatory training. A training implementation plan will be commence once IM&T have confirmed that the Internet Explore, Java and Flash player updates have taken place. Regular discussions with managers regarding compliance are now taking place within the monthly HR Surgeries.

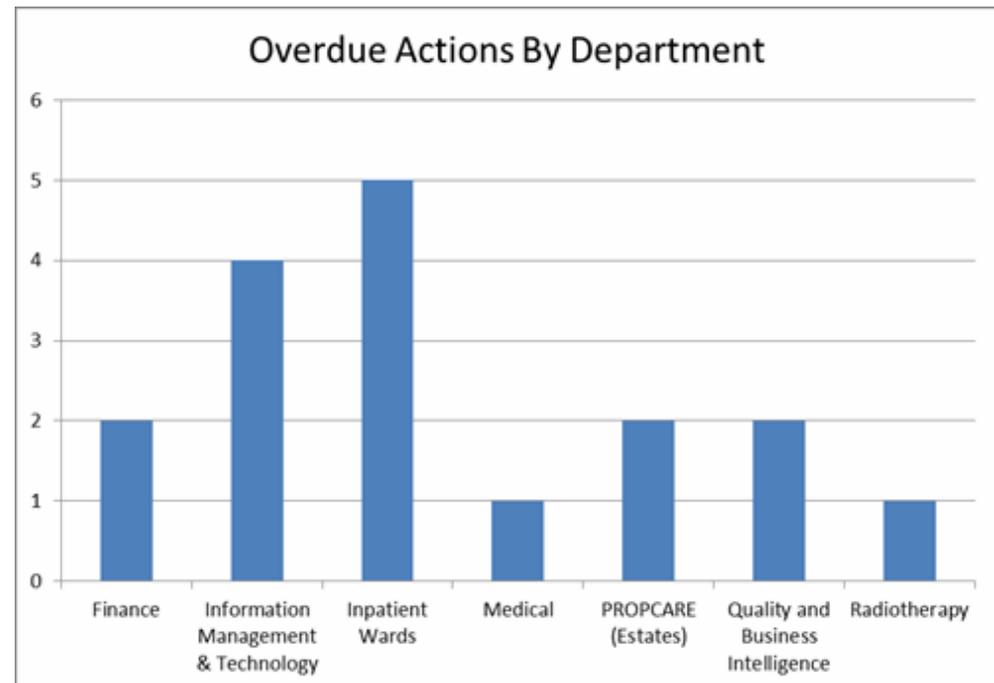
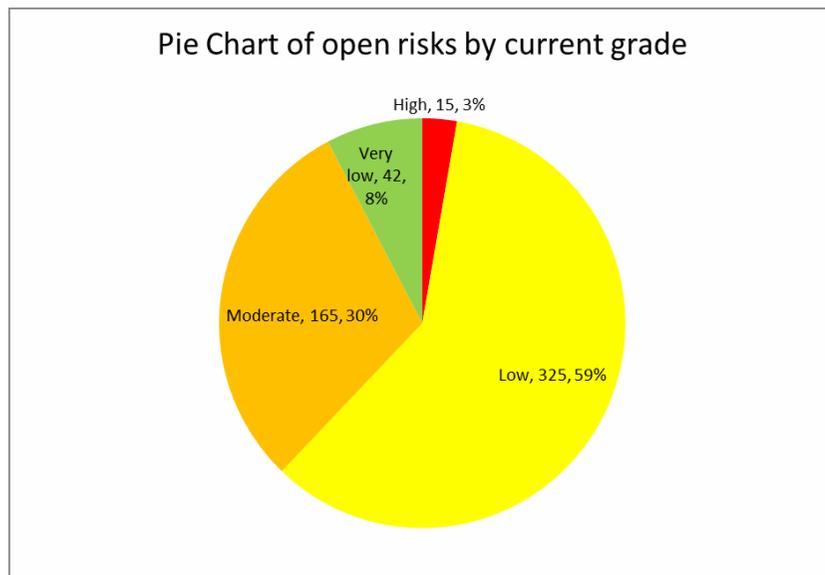
Staff Friends & Family Test

Following the results from the last survey an analysis of the data received has been conducted. Whilst the survey is confidential it is recognised that there are some challenging workforce issues taking place across the Trust, including workforce redesign. The submission of the surveys

shows that out of 18 responses there were 14 comments stating that the respondents would not recommend the Trust as a place to work. Of these, 8 were submitted on the same date, at or around the same time of day, a further 2 were again submitted on the same day at or around the same time, this could suggest that the survey was being completed in teams or groups of employees at the same time. Overall there were consistent themes such as communication and relationships that were commented on. This data will continue to be monitored and plans have been put in place to improve the engagement process for the survey in the short term whilst longer term opportunities are currently being explored. For information, a breakdown of the responses is provided in the Staff Experience section.

Management of Risk

The chart on the left shows the number of risks within each category, and the chart on the right shows the departments with overdue actions as at 2/6/17. The action owners will have received notification that these actions are overdue and that updates are required.



Risk Review status by grade:

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

Risk Grade	Overdue Review Date at 19/12/16	Overdue Review Date at 5/4/17	Overdue Review Date at 2/6/17
1-3 (Very Low)	14	15	10
4-8 (Low)	183	172	112
9-12 (Moderate)	66	102	78
13-25 (High)	5	4	7
Total	268 (41%)	293 (52%)	207 (38%)