



The Clatterbridge  
Cancer Centre  
NHS Foundation Trust

2017/18

# Quality Report

**Our Vision: To Provide The Best  
Cancer Care To The People We Serve**

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## Part 1: Statement on Quality from the Chief Executive

Quality is at the heart of what all our staff aim to achieve for all the patients in our care. I would like to thank the professionalism, expertise and commitment of our staff and volunteers which ensured that we are able to provide a high quality service.

We have clearly defined our Core Purpose as providing excellent care to people with cancer.

Our Vision is to provide the best cancer care to the people we serve. To deliver our vision we have made it our Mission to improve health and well-being through compassionate, safe and effective cancer care.

Our values, developed with our staff, demonstrate our commitment to how we work:

- Passionate about what we do
- Putting people first
- Achieving excellence
- Looking to the future
- Always improving our care

In 2016 we had our first comprehensive inspection by the Care Quality Commission. The Trust was delighted to receive an overall rating of 'Outstanding' which demonstrated the high standard of care and treatment delivered by our staff and provides reassurance to patients under our care. The Trust continues in its key aim to maintain its excellence in the delivery of high quality patient care.

The Trust Board continues to ensure that Quality and Safety is a key priority of and this is reflected in the new governance arrangements and the structures introduced in 2017. The Trust Board continues to oversee the delivery of the Trust's quality priorities and initiatives.

As a Foundation Trust we work closely with our Council of Governors to ensure that it supports the Trust Board in shaping the Quality Strategy and is kept apprised of progress in the delivery of the plans it contains. The Governors also receive the quarterly Quality Committee Performance Report.

We continue to work with our staff and our key stakeholders to continue to improve the quality of our services. This year has seen a number of key developments and challenges for the Trust including:

- The expansion of our services to now include the Haemato-oncology services from the Royal Liverpool & Broadgreen University Hospital Trust in July 2017.
- We have met all of the mandated waiting times targets
- I am particularly pleased to be able to report again that we have achieved against our clostridium difficile and MRSA targets. Whilst we had 6 cases of attributable clostridium difficile (c.diff) against a maximum of 5 cases, our Commissioners agreed that in all but 1 case there was not a lapse in care (1 decision pending).
- On the last day of 2017/18 it has been 6 years and 272 days since our last case of MRSA bacteraemia attributable to the Trust and 205 days since our last case of attributable c.diff.
- We have scored consistently in the top 20% performing Trusts in our most recent annual Staff and Patient Care Quality Commission surveys. Whilst all of the questions in these surveys are important one particular staff survey question provides me with assurance of the quality of care. When staff were asked 'if a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust' 93% replied yes.

- Our annual PLACE (Patient Led Assessment of the Care Environment) is scheduled to be undertaken on 29<sup>th</sup> May 2018. The actions from this assessment will be regularly reviewed throughout the year to ensure we continue to improve our patient experience.
- A high proportion of our healthcare support staff have now completed the Care Certificate. Since April 2015 to March 2018 of the 114 staff required to complete 71 staff have achieved the care certification with 31 in progress (ie 62% - as agreed at Trust level, includes all band 4 staff and above, existing and newly qualified).
- A key part of our Transforming Cancer Care initiative continues to be realised in the building of a new cancer centre in Liverpool. We are committed to working in partnership with our patients and the Royal Liverpool and Broadgreen University Hospital Trust.

As Interim Chief Executive I am confident that the Trust provides a high quality service and that these Quality Accounts demonstrate this. To the best of my knowledge the information in these accounts is accurate.

In summary, The Clatterbridge Cancer Centre has a good track record in delivering a quality service to our patients. As Interim Chief Executive I have a personal commitment to lead the drive for continual quality improvement. We will continue to deliver against the objectives we have set and will continue to improve quality in the challenging times ahead.

Ann Farrar  
Interim Chief Executive  
Date: xx<sup>th</sup> May 2018

## During the last year in our cancer centre:

We cared for  
7625 in-patients

We saw 11,712  
new out-patients

We delivered  
92,001 outpatient  
radiotherapy  
treatments

We delivered  
57,630 outpatient  
chemotherapy  
treatments

## During the last year we had:

0 cases of MRSA

6 cases of C diff  
(5 with no lapse in  
care 1 pending  
NHSE review)

26 formal  
complaints

20 attributable  
pressure ulcers (3  
lapse in care)

## Introduction

The Quality Report provides an overview of our performance in the key priorities we have set for improving the quality of the care we provide to our patients and to achieve our vision to provide the best cancer care to the people we serve. It outlines our future priorities for continuous quality improvement and reports on key quality measures.

Over the coming years the Trust will continue to keep a strong focus on continuing to improve the quality of the service it provides. This is primarily achieved through the delivery of the Quality Strategy. This strategy was refreshed in 2015 with a clear focus on defining the quality objectives that take us towards 'Transforming Cancer Care' which is our key strategic objective culminating in the build of a new state of the art cancer centre in Liverpool.

The strategy aims to improve:

- Patient Safety: *Always safe, always effective*
- Patient Experience: *Striving for excellent patient satisfaction*
- Outcomes / Effectiveness: *Efficient, effective, personalised care*

Part of our Quality Strategy is the ongoing review and monitoring of our local and national quality standards. We are also committed to ensuring transparency and we publish this information on our website 'High Quality and Safe Care'. We publish information in relation to the Care Quality Commission's (CQC) '5 key questions'.

**Are We Safe** includes:

- Open and Honest Care
- NHS Safety Thermometer
- Medicines Thermometer
- Healthcare associated infections
- Patient Led Assessment of the Care Environment (PLACE)
- Incident reports

**Are we Effective** includes:

- Compliance with patient risk assessments
- 30 day mortality post treatment

**Are we Caring** includes:

- Ward nursing staff levels
- Patient feedback

**Are we Responsive** includes:

- Compliance with cancer waiting times

**Are we Well Led** includes:

- Integrated performance report
- Staff feedback
- Nursing care indicators
- Quality accounts

<http://www.clatterbridgecc.nhs.uk/aboutcentre/highqualityandsafecare/>

Throughout the year we actively engage with our staff, governors (as elected representatives of our members), our Patient's Council and members of local Healthwatch and Overview and Scrutiny Committees. A public governor is a member of our Quality Board Committee which is the main forum for oversight of the delivery of the Quality Strategy and a governor also sits on the Trust Board. A Council of Governors Patient Experience Committee actively reviews patient experience measures and reports including detailed analysis of all patient complaints.

## Part 2: Priorities for Improvement and Statements of Assurance from the Board

The three main priorities for the Quality Strategy have been developed through an ongoing programme of engagement with the Trust Board, our Council of Governors, our Commissioners and with our local Healthwatch as well as our staff through our ongoing engagement processes throughout the year.

Due to the size of the population that it serves the Trust has endeavoured to engage with all Healthwatch and Overview and Scrutiny Committees (OSC) in developing the Quality Report and key priorities. In October 2017 and May 2018 the Trust held two engagement events to which it invited Healthwatch and OSC representatives from across Merseyside and Cheshire. At these events the Trust presented information on the delivery against its 2017/18 key priorities and discussed the priorities for 2018/19. The Trust will continue to use these engagement events to continue to improve engagement with Healthwatch over the coming year.

Representation from Healthwatch and OSC:

11.10.17
Healthwatch / OSC
6
9.5.18
Healthwatch
9

The Board continued to monitor performance against its Quality Strategy through its Quality Committee.

## 2.1 Priorities for Improvement

### Priority 1:

Safety:

Patient Safety: *Always safe, always effective*

#### Patient safety:

Implement a Human Factors Programme

#### Why have we chosen this priority?

The implementation of human factors is about enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings. Human Factors is an established scientific discipline used in many other safety critical industries. Human Factors approaches underpin current patient safety and quality improvement science, offering an integrated, evidenced and coherent approach to patient safety, quality improvement and clinical excellence.

#### How we did last year

The first Human Factors training programme was held in October 2017.

#### How will we monitor and measure progress of this priority

We will monitor progress of the programme through the Board Quality Committee. Progress to be measured against evidence to include staff training, incident review process and evidence of learning.

### Priority 2: Experience:

Patient Experience: *Striving for excellent patient satisfaction*

Implement reminiscence therapy (RITA) for dementia patients supported by volunteers.

#### Why have we chosen this priority?

Cancer is often described as a disease of older age. Many of our in-patients have many co-morbidities including dementia



which can increase risk of harms such as falls.

Reminiscence therapy is defined by the American Psychological Association as "the use of life histories – written, oral, or both – to improve psychological well-being. The therapy is often used with older people."

We will implement the use of RITA (reminiscence interactive therapy activities) in our wards supported by dedicated, trained volunteers.

#### How we did last year

Reminiscence therapy will be a new workstream in our Dementia Strategy and will build on the work already implemented such as 'John's Campaign'.

#### How will we monitor and measure progress of this priority

We will monitor progress of the programme through the Board Quality Committee. Progress to be measured against evidence to include staff training, patient and carer feedback, reduction in falls/incidents and complaints.

#### Priority 3: Effective:

Outcomes / Effectiveness: *Efficient, effective, personalised care*

#### Patient Outcomes/effectiveness:

The development of an outcomes dashboard and KPI's aligned with Site Reference Groups (SRG's)

#### Why have we chosen this priority?

This is a quality metric for our patients and supports clinical leadership during transformation, improving the quality of care. The development of a digital outcomes dashboard will drive improvements in the quality of patient care.

#### How we did last year

Development of an outcomes dashboard and KPI's aligned with Site Reference

Groups (SRG's) will be a new workstream and will build on the work already implemented within the Trusts mortality and outcomes programme. This will support the new clinical model to be implemented in 2018/19.

#### How will we monitor and measure progress of this priority

We will monitor progress of the programme through the Board Quality Committee. Progress to be measured against dashboard development, improved outcomes and performance against key performance indicators.

In addition to the three priorities identified above the Trust is committed to the strengthening and improving of its safeguarding policies and processes. This is underpinned by a robust safeguarding improvement action plan which will be delivered by August 2018.

#### How we did last year: Progress made since publication of the 2016/17 report:

In our Quality Report last year (2016/17) we identified the following priorities:

**Patient Safety:** *Always safe, always effective*

Focus on falls. Development of a comprehensive falls prevention and management plan.

**Patient Experience:** *Striving for excellent patient satisfaction*  
Patient and Public Engagement Strategy

**Outcomes / Effectiveness:** *Efficient, effective, personalised care*  
Effective: Improving the Quality of Mortality Review and Serious Incident Investigation and Subsequent Learning and Action

**Priority 1: Safety:** Focus on falls.  
Development of a comprehensive falls prevention and management plan

Patient Safety: *Always safe, always effective*

**Patient safety:  
Falls**

We have a comprehensive falls prevention action plan. The green wrist bands were launched on the inpatient wards January 2018, patients will be allocated one to wear if they have had a history of falling or if they fall whilst an inpatient at CCC. The green wrist band is in addition to the white ID one provided on admission and is only to provide a visual alert that the patient is at risk of falling. The call don't fall signs is ongoing; the Quality Improvement Manager continues to work the COMMS team to source a 'call don't fall' sign to be placed in bathrooms/en suites as a prompt for patients. An image of the cord being pulled has been taken by the COMMS team and once approved by the falls group the signs will be ordered and will include Haemato-oncology. The sign has been to the designer a couple of times in order that the sign is right.

Following the successful trial and agreed funding of the Ramblegard falls monitors during November/ December. Conway and Mersey have now taken receipt of the new monitors and have completed ward based training. The directorate has now taken delivery of the 'digital reminiscence software' it received funding for at the end of last year, briefly the software consists of movies, music, old photographs, games etc that can cause a distraction to prevent patients wandering and increasing their risk of falling. One of the items is already being used across the trust by the clinical specialist for additional needs, 3 volunteers will be trained on how to use the device with the plan that they will start volunteering on the inpatients very soon.

A number of beds were trialed to allow relatives/carers to stay overnight in the

patients room, this is particularly significant for patients suffering with dementia and is a key part of John's Campaign. 2 Glideaway beds have now been delivered to CCC and are available for use.

Physiotherapists are part of in the falls incident panels, their plan was that they utilise the rotational band 5 post to provide exercise classes for inpatients to assist with strength and balance. This post has changed but they are still working on a plan for the exercise classes and aim to pilot the classes in the spring as part of physiotherapy teams quality improvement initiative.

**Why have we chosen this priority?**

Patient falls are the highest case of moderate patient harm and the second highest cause of minor harm incidents in the Trust.

**How we did last year**

2016/17 = 92 in-patient falls

2017/18 = 110 in-patient falls\*

\* Although there is a 19.57% increase it should be considered that from July 2017 the figures shown include the haemato oncology service which was transferred from Royal Liverpool and Broadgreen University Hospital Trust (RLBUHT). Falls prevention will remain a Trust priority and continue to be monitored.

**How will we monitor and measure progress of this priority**

Falls were monitored at the monthly falls incident panel and will be reported through to the Board Quality Committee.

**Priority 2: Experience:** Implementation of the Patient Experience Strategy

Patient Experience: *Striving for excellent patient satisfaction*



## Patient and Public Engagement Strategy

The Trust recognises the value of patient and public engagement in the planning and provision of care to deliver our mission and the development of services to deliver our vision. It also accepts its legal obligation to involve patients and the public in its work.

The Trust is undergoing considerable change and transformation over the coming months and years and it is imperative that we ensure that patients are fully engaged and involved in this journey and we use their involvement and feedback to provide the best cancer care to the people we serve. The Trust's Patient and Public Engagement Strategy sets out our ambitions for patient and public engagement and our plans to achieve these.

As the host of the Cheshire and Merseyside Cancer Alliance, CCC will also seek to influence the development of a C&M public and patient engagement strategy on cancer, which should be separate but complementary to this strategy.

### Why have we chosen this priority?

Over the coming years patient engagement will be critical to the ongoing development of our services and the continual improvement in patient care.

### How we did last year

The Trust undertook a variety of patient engagement activities such as:

- Continued to develop the Patient and Family Centred care nursing model
- Developed Always events
- Ensured patient and public representation on project groups
- Reviewed the internal Patient survey to ensure it is 'fit for purpose' and utilises available technology
- Continued to involve Governors in review of complaints

- Participated in national surveys and developed action plans to ensure improvement
- Involved patients the public and Governors in PLACE

### How will we monitor and measure progress of this priority

Progress will be reported to the Board Quality Committee.

**Priority 3:** Effective: Improving the Quality of Mortality Review and Serious Incident Investigation and Subsequent Learning and Action

Outcomes / Effectiveness: *Efficient, effective, personalised care*

### Patient Outcomes/effectiveness:

#### Mortality

The Trust continues to regularly evaluate, modify and improve the quality of its comprehensive mortality review processes. The Mortality Surveillance Group (MSG) maintains an effective strategic lead in the monitoring and promotion of mortality reduction, having oversight of all Trust related deaths, to include weekend deaths, via the Trust developed mortality dashboard. The MSG takes the lead in reviewing all high risk mortality areas, and reviews hard and soft intelligence in this regard, as well as internal and external clinical audit feedback. In-depth statistical analysis of chemotherapy and radiotherapy related deaths continues, providing a platform for the interrogation of individual Consultant performance, and continuous monitoring of chemotherapy regimens toxicities and variations in clinical practice.

Trust -wide monthly feedback and dissemination of learning from deaths from Mortality Review Meetings is in place. Structured Judgment Review methodology has been successfully introduced, with all Consultants expected to engage in such reviews, to highlight areas of good practice as well as identify any sub optimal care

provision and avoidable deaths. All Trust deaths in care are subject to one or more of five levels of scrutiny, to include a documented specialist Site Reference Group Review or Specialist Committee Review response to a mortality alert investigation process. The Trust continues to share this learning widely with external healthcare providers to include other hospital Trusts, GPs and Coroners.

The adoption of new national mortality guidance and policy has seen the Trust's closer liaison with national and regional partners and external agencies, to include CDOP (Child Death Overview Panel) and LeDER (NHSE Learning Disabilities Mortality Review Programme). Also, a focused emphasis on the early involvement of families, and continued open and honest communication with families and carers, in the event of Serious Untoward Incident investigations. In line with new statutory guidance in relation to the management of child (0-18yrs) deaths, the Trust now has an identified Key Worker for any families affected by the death of a child.

### **Why have we chosen this priority?**

Improved mortality review and review of serious incidents will:

- Be a driver for improved quality
- Improve patient safety
- Prevent avoidable deaths
- Reduce cost

### **How we did last year**

The Mortality Review Meetings resulted in a number of changes to clinical care such as changes to clinical practice, documentation and education and training.

### **How will we monitor and measure progress of this priority**

Mortality performance and progress is monitored at the Mortality Surveillance Group and reported to the Board via the Quality & Safety Sub Committee of the Board Quality Committee.

Oversight of Trust mortality data summary is now included in the Trust's Quality Accounts from June 2018

## **2.2 Statements of Assurance from the Board**

During 2017/18 The Clatterbridge Cancer Centre NHS Foundation Trust provided and/or sub-contracted three relevant NHS services.

The Clatterbridge Cancer Centre NHS Foundation Trust has reviewed all the data available to them on the quality of care in three of these NHS services.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by The Clatterbridge Cancer Centre NHS Foundation Trust for 2017/18.

### **Information on participation in clinical audits and national confidential enquiries**

During 2017/18, 13 national clinical audits and 1 national confidential enquiry were relevant to the health services provided by The Clatterbridge Cancer Centre NHS Foundation Trust.

During that period The Clatterbridge Cancer Centre NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries for which it was eligible to participate.

The national clinical audits and national confidential enquiries that The Clatterbridge Cancer Centre NHS Foundation Trust was eligible to participate in during 2017/18 are as follows.

- National Bowel Cancer Audit
- National Lung Cancer Audit

- National Oesophago-Gastric Cancer Audit
- National Head and Neck audit (HANA)
- Cancer Outcomes and Services Dataset (COSD)
- National Audit of Breast Cancer in Older patients
- Female Genital Mutilation
- NCEPOD – Cancer in Children, Teens and Young Adults
- RCR National Prostate Cancer Audit - Radiotherapy Data
- RCR National Muscle Invasive Bladder Audit
- National Audit of the management of patients at risk of Transfusion Associated Circulatory Overload
- Non-Interventional Study Protocol - AMN107A2001
- National Study of Late Effects after Hodgkin Lymphoma
- National Small Cell Bladder Audit
- RCR National Prostate Cancer Audit - Radiotherapy Data
- RCR National Muscle Invasive Bladder Audit
- National Audit of the management of patients at risk of Transfusion Associated Circulatory Overload
- Non-Interventional Study Protocol - AMN107A2001
- National Study of Late Effects after Hodgkin Lymphoma
- National Small Cell Bladder Audit

The national clinical audits and national confidential enquiries that The Clatterbridge Cancer Centre NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry are contained in the following table.

- National Bowel Cancer Audit
- National Lung Cancer Audit
- National Oesophago-Gastric Cancer Audit
- National Head and Neck audit (HANA)
- Cancer Outcomes and Services Dataset (COSD)
- National Audit of Breast Cancer in Older patients
- Female Genital Mutilation
- NCEPOD – Cancer in Children, Teens and Young Adults

**Table 8a: Audits: cases submitted**

National Clinical Audit and NCEPOD eligible studies	Cases submitted
National Bowel Cancer Audit	571/726 (79%) treatment records submitted by CCC. Unable to upload 100% of records as referring hospitals have not uploaded the patient's demographic and diagnosis data.
National Lung Cancer Audit	Data submitted via COSD monthly
National Oesophago-Gastric Cancer Audit	262/331 (79%) treatment records uploaded as at 20/02/2018. Partial upload achieved awaiting data completion by referring hospitals.
National Head and Neck audit (HANA)	Data collection in progress, no deadline
Cancer Outcomes and Services Dataset (COSD)	XML files were sent monthly to NCIN
National Audit of Breast Cancer in Older patients	Patient data will be extracted from COSD monthly submission
Female Genital Mutilation	Zero return for 2017-18
NCEPOD – Cancer in Children, Teens and Young Adults	1/1 In-patient clinician questionnaire completed (100%). 4/4 SACT case clinician questionnaires completed (100%). 1/1 organisational questionnaire completed (100%). 5/5 case note extracts returned to NCEPOD
RCR National Muscle Invasive Bladder Audit	20/20 cases submitted (100%).
National Audit of the management of patients at risk of Transfusion Associated Circulatory Overload	40/40 records completed (100%)
RCR National Prostate Cancer Audit - Radiotherapy Data	Files are sent monthly to NCIN

Non-Interventional Study Protocol - AMN107A2001	Due to commence. Deadline date 31/12/2018.
National Study of Late Effects after Hodgkins Lymphoma	28/188 records completed (11%). Deadline for completion of the national study has been extended until 31/10/18
National Small Cell Bladder Audit	9/9 records completed (100%).

The reports of 4 national clinical audits were reviewed by the provider in 2017/18 and The Clatterbridge Cancer Centre NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

**Table 8b: Audits: actions**

National Clinical Audit	Actions to improve quality of care
NBOCAP (Bowel Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2018-19
NLCA (Lung Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2017-18. SRG members reviewing action plan.
NOGCA (Oesophago-Gastric Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2017-18. SRG members reviewing action plan.
NPCA (Prostate Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2017-18

\*SRG – Site Reference Group

The reports of 33 local clinical audits were reviewed by the provider in 2017/18 and The Clatterbridge Cancer Centre NHS Foundation Trust intends to take the following course of action to improve the quality of healthcare provided.

**Table 8c: Local Audits**

Local Clinical Audit	Actions to improve quality of care
The development, implementation and impact of a nurse-led complex needs clinic for metastatic breast patients, promoting patient centred care	Confirmed Good Practice
Blood Product Transfusion Times (QUIP)	<p>Action Plan:</p> <ul style="list-style-type: none"> <li>Teaching/refresher session, for prescribers and for nurses, particularly regarding rules around group and save labelling. Could be given at Drs induction</li> <li>Factsheet/intranet guidelines re process, especially importance of timely transfusions</li> <li>Identify which HCP sends relevant fax and mitigate for delays to expedite transfusion decisions.</li> <li>Agree fax and introduce fax policy with WUTH to indicate time of blood product arrival. Nurses could then be aware of a time to expect when the blood should be going up.</li> <li>Re-audit for assurance of compliance with policy and process.</li> </ul>
Compliance of Docetaxel in treating breast cancer cancer patients in adjuvant setting using FEC-T (Fluorouracil/ Epirubicin/ Cyclophosphamide/ Docetaxel)	<p>Action Plan:</p> <ul style="list-style-type: none"> <li>Audit expanded to look at St Helens &amp; Knowsley</li> </ul>
Assessing the needs of patients with previously treated primary high risk, uveal melanoma undergoing regular liver surveillance using the Macmillan Holistic Needs Concerns Checklist.	<p>Action Plan:</p> <ul style="list-style-type: none"> <li>Work with Liverpool Ocular Oncology Centre (LOOC) to develop further psychological and emotional support at diagnosis</li> <li>Patient portal for self-supported management</li> <li>Assess impact of prognostication results on patients emotional well being</li> <li>Improve delivery of prognostication results</li> </ul>
Monitoring of weight post first line treatment for ovarian cancer	<p>Action Plan:</p> <ul style="list-style-type: none"> <li>Project Expanded (Reduce weight gain and improve quality of life)</li> </ul>
Holistic Needs Assessment (HNA)	<p>Action Plan:</p> <ul style="list-style-type: none"> <li>Training workshops being delivered to support staff in completing the HNA.</li> </ul>
Re-Audit – Follow-up of patients receiving adjuvant therapy for breast cancer	Sustaining Improvement

An audit to establish if aflibercept (available via the Cancer Drug Fund) is improving patient outcomes	Confirmed Good Practice
Audit of mid treatment CBCT (Cone Beam CT) image results for SABR (Stereotactic ablative radiotherapy) Lung Cancer Patients	Confirmed Good Practice
An empirical study to investigate the intra fraction motion of biologically optimised radiotherapy treatments for prostate cancer	Confirmed Good Practice
The incidence of febrile neutropenia and impact on hospital admissions in testicular cancer patients receiving chemotherapy: A re-audit	Sustaining Improvement
Pressure Ulcer ReAudit - April 2017	Sustaining Improvement
National Re-audit of Breast Radiotherapy Practice	Sustaining Improvement
Toxicity and outcome after radical pelvic/prostate radiotherapy	Confirmed Good Practice
(QUIP) To understand how to improve the diagnosis and treatment of suspected Neutropenic Sepsis	Confirmed Good Practice
Assessing the value of the Specialist Breast Nurse Practitioner in the outpatient	Action Plan: <ul style="list-style-type: none"> <li>Present at SRG/CNG meetings</li> <li>Re-design/re-structure patient questionnaire- aim to encourage all patients to respond</li> <li>Repeat Audit</li> </ul>
(Re-audit) Decision-making and documentation of CPR status for acute admissions to CCC	Sustaining Improvement
Evaluation of the accuracy of current 2D MV treatment verification imaging protocol for standard two-field breast radiotherapy in the department	Confirmed Good Practice
Peripheral neuropathy in taxanes	Confirmed Good Practice
Secondary Breast Cancer Pledge	Action Plan: <ul style="list-style-type: none"> <li>NICE Guidance on Keyworker assignment</li> </ul>

	<ul style="list-style-type: none"> <li>Staff and patient representatives to consider this report and its implications/ solutions.</li> <li>The Pledge Partnership will chair this meeting and, as appropriate, contribute ideas or changes which have been adopted by other hospitals in response to similar issues. Together staff and patients will then develop a set of improvement goals which are appropriate to the hospital's resources but maintain an ambition on achieving the highest possible standard of care for patients with secondary breast cancer.</li> </ul>
Case series of breast carcinosarcoma	Confirmed Good Practice
Introduction, development and evaluation of nurse-led video link consultation as a potential replacement for outpatient clinic visits	Confirmed Good Practice
Baseline review of level 1 psychological interventions provided by staff to patients attending CCC.	Confirmed Good Practice
Evaluation of Enhanced Supportive Care Service (ESC)	<p>Action Plan:</p> <ul style="list-style-type: none"> <li>Patients from all tumour groups should be eligible to access ESC. This will require service investment.</li> <li>Wide dissemination of results from this study and the forthcoming qualitative evaluation to raise awareness, encourage engagement and promote patient referral to the service. Results from this study should be presented to participating SRGs to encourage higher ESC referral rates. ESC referral should be an integral part of the patient pathways for all cohorts</li> <li>Secure appropriate funding to embed ESC within cancer services beyond the end of March 2019</li> <li>Engage with local Cancer Alliance and the STP to explore a system wide approach to ESC implementation</li> <li>Develop robust procedures to measure and collect data for unplanned admissions within the cancer centre and</li> </ul>



	<p>local hospitals.</p> <ul style="list-style-type: none"> <li>Undertake further longitudinal studies of ESC patients with a larger sample size and additional power to demonstrate advantages of ESC and highlight areas for further improvement.</li> </ul>
An Evaluation of The Implementation and Impact of The Carers' Alert Thermometer (CAT-CCC) Tool At Clatterbridge Cancer Centre	<p>Action Plan:</p> <ul style="list-style-type: none"> <li>Explore earlier use:</li> <li>Integrate with existing processes to include carers</li> <li>Explore use by other teams</li> <li>Additional pilot with other teams</li> <li>Involvement of Maggie's Centre staff</li> <li>Have online version of CAT available on Meditech and install on IPAD for self-completion</li> </ul>
Use of jaw tracking to reduce dose to organs at risk for early stage non small cell lung cancer (NSCLC) treated using Volumetric Arc Therapy (VMAT)	<p>Action Plan:</p> <ul style="list-style-type: none"> <li>Implement Jaw tracking</li> </ul>
The outcome of Duke's C2 Colon Cancer	Confirmed Good Practice
Highlighting blood results on the ward	<p>Action Plan</p> <ul style="list-style-type: none"> <li>As only verbal prompts were used throughout this project consideration is being given to having having a visual prompt to remind staff taking bloods to use the blood board.</li> <li>Consider better positioning of the blood notice board</li> </ul>
Number of cycles of first line platinum combination chemotherapy and patient survival in advanced small cell lung cancer (SCLC) 4v6	<p>Action Plan:</p> <ul style="list-style-type: none"> <li>Guidelines should limit the recommended cycle number to 4 until the superiority of a longer regime is identified in a randomised study</li> </ul>
Review of High Dose Radiation (HDR) surface mould radiotherapy	<p>Action Plan:</p> <ul style="list-style-type: none"> <li>Create Meditech proforma for prospective completion of follow up data</li> <li>Present at General CCC Audit Meeting Feb 2018</li> <li>Write article for Green Journal in collaboration with Physics Department</li> <li>Re-Audit from Feb 2014 to present</li> </ul>
Pilot Project For Evaluation of Pre-appointment Telephone Consultation For Patient Under Follow-	<p>Action Plan:</p> <ul style="list-style-type: none"> <li>Expansion of the project in this specific upper GI oncology patient population would continue to allow for timely investigations when</li> </ul>

up For Upper Gastrointestinal Tumours	necessary
Prophylactic daily G-CSF - is it cost effective?	<ul style="list-style-type: none"> <li>To facilitate efficient clinic disposal future development includes a formal arrangement for rescheduling of clinic appointments</li> </ul>
Collecting Outcome Measures for The Rehabilitation and Support Team	Confirmed Good Practice
Local NICE Guidance Audit	Actions to improve quality of care
TA378 - Ramucirumab for treating advanced gastric cancer of gastro-oesophageal junction adenocarcinoma previously treated with chemotherapy	Fully Compliant
TA411 - Necitumumab for untreated advanced or metastatic squamous non-small-cell lung cancer	Fully Compliant
TA414 - Cobimetinib in combination with vemurafenib for treating unresectable or metastatic BRAF V600 mutation-positive melanoma	Fully Compliant
TA403 - Ramucirumab for previously treated locally advanced or metastatic non-small-cell lung cancer	Fully Compliant

### Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by The Clatterbridge Cancer Centre NHS Foundation Trust that were recruited during that period to participate in research approved by a Research Ethics Committee was 526.

	Q1	Q2	Q3	Q4	Total
Clatterbridge Cancer Centre	98	101	145	182	526

## Research and Innovation

R&I has achieved a lot in the last five years and we are now entering a new and exciting time of transition. We remain totally committed to the Trust objectives of providing the best cancer care to the people that we serve. The Team have put in place robust governance arrangements, invested in the delivery teams and supported gaining Experimental Cancer Medicine Centre status with strong early phase trial portfolio and established the CCC Biobank for cancer research. We recognise and embrace the need to develop and move forward with a weather eye to the expansion into Liverpool and the opportunities for the enhancement of our research agenda for patient benefit that this affords. We look to develop our areas of strength, continue our collaborations with strategic partners and deliver access to research to our patients to provide excellent evidence based care through a strong refreshed research portfolio.

### Key Developments

#### Continuing the development of academic oncology

The Trust continues to recognise the importance of academic oncology to further facilitate CCC's aim to foster Clinician-led research and research development at the Trust. We have now appointed a new Director of Academic Research. There will be a new Research Strategy to refresh and develop our research agenda. Our next focus will be on 'making every patient's experience count.' We aim to build an inclusive and dynamic research portfolio focused on patient benefit and excellence, by reviewing the trial portfolio, capitalising on research strengths and expanding the qualitative research agenda. We will also flex our workforce to assure continued support for research across all sectors. Additionally we will be looking to expand IT infrastructure to facilitate inclusion of our patients into trials. We will also increase our research visibility for our patients across the Trust and through a new website.

We have continued to support study delivery at CCC. We have increased commercially funded studies year on year (from 15% of our portfolio in 2010-11 to over 60% to date) through close working and quality delivery. The R&I Team have been at the forefront of supporting key strategic studies, upskilling staff to undertake First in Human, Phase I, Immunotherapy and First in Class Drug studies. There has been an increase in the number of studies for which CCC act as Sponsor with two large grants secured within the Hepatobiliary (led by Prof. Palmer with a grant of £4, 005, 017) and Head and Neck (led by Dr Sacco, grant of £981, 503) portfolios and two new Lung Cancer studies in the pipeline led by Dr Escriu; all the studies are for patients with unmet needs in difficult disease areas. The CCC Biobank has grown the targeted sample collections and is releasing quality samples to support bench to bedside research.

### Notable Achievements

- CCC in collaboration with the University of Liverpool has supported the ECMC through its first year and assuring that deliverables have been met. There has been a 75% increase in early phase studies in the last year to support the ECMC strategy and agenda. Importantly this gives patients access to novel agents. We also attended the ECMC North showcase and delivered presentations and research posters showcasing CCC and our research.
- We welcomed the Haemato-oncology Team and have successfully integrated their research studies under CCC governance and into our portfolio. We are continuing to support the research agenda, cross cutting and assuring Haem-onc representation at all levels of R&I study meetings and governance.
- There has been significant development of the CCC Edge

platform. CCC is one of the first Trusts to use this system for reporting on trial recruitment. The system has been further developed within R&I to be used as the main research governance platform with bespoke reporting on all aspects of study management enabling streamlining of processes. As the system is web-based, this has aided the smooth integration of the Haemato-oncology team into the CCC research governance processes. CCC Edge has also been modified to underpin all reporting requirements to support the ECMC and has been recognised by CRUK as a Liverpool positive.

- The CCC Biobank continues to collect samples for high quality research, where possible targeted to assure highest research resource.
- R&I has improved study delivery not only increasing the number of studies opened this year but also increasing patient recruitment. We will use this as a platform to continue to give our patients across the region access to novel agents and to participate in research.

#### **CQUINS:**

A proportion of The Clatterbridge Cancer Centre NHS Foundation Trust's income (2017/18) was conditional on achieving quality improvement and innovation goals agreed between The Clatterbridge Cancer Centre NHS Foundation Trust and its commissioners, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 are available electronically at <http://www.clatterbridgecc.nhs.uk/about-centre/high-quality-and-safe-care>

#### **Information relating to registration with the Care Quality Commission and periodic/special reviews**

The Clatterbridge Cancer Centre NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions for the treatment of disease, disorder or injury and for diagnostic and screening procedures. The Care Quality Commission has not taken enforcement action against The Clatterbridge Cancer Centre NHS Foundation Trust during 2017/18

The Clatterbridge Cancer Centre NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

#### **Information on the quality of data**

The Clatterbridge Cancer Centre NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was: 99.8% for admitted patient care and 99.9% for outpatient care. The Trust does not provide accident and emergency care.
- which included the patient's valid General Practitioner Registration Code was: 100% for admitted patient care and 100% for outpatient care. The Trust does not provide accident and emergency care.

The above figures are in line with the SUS data quality dashboard methodology:

- Where there is an NHS number this is classed as valid.

- The General Practitioner Registration Code figures include the default not known/not applicable codes as valid.
- The General Practitioner Registration Code figures class any GP Practice that was closed prior to the beginning of the financial year as invalid.

The Clatterbridge Cancer Centre NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 83% and was graded green.

The Clatterbridge Cancer Centre was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

The Clatterbridge Cancer Centre NHS Foundation Trust will be taking the following actions to improve data quality:

The Trust has an active Data Quality Group in place, with membership from all key areas of the Trust, and a remit to ensure good data quality processes and procedures are in place, both for internal and external assurances. Regular Data Quality Audit reports are produced in line with Department of Health IG toolkit requirements, with level 3 achieved in 2017/18.

With the implementation of a new EPR system in 2016, and the continued essential requirement for accurate, timely and complete data to support statutory reporting, activity performance and service development, data quality remains a priority. The Trust has expanded its Business Intelligence function with the introduction of a new Data Validation Team, to continue to revise, monitor, evaluate, and strengthen data entry and quality for further assurances. Additional external scrutiny of Trust data quality and key validation processes has been invited and secured from MIAA and Quintiles IMS in March 2017. The need for targeted, local ownership of data quality within Directorates has been progressed.

Areas of continued focus include:

- Reviewing, analysis and improving data quality, including timeliness of data entry in the EPR system, as per the Trust Data Quality Policy
- Produce and review Data Quality Audit reports in line with guidance from the Information Governance toolkit
- Ensure procedures are in place to support data collection, validation and training needs
- Respond to any recommendations resulting from the external scrutiny
- Continue to embed localised ownership of data quality within Directorates.

## Implementation of the Priority Clinical Standards for Seven Day Hospital Standards

To address the requirement standard 2,6 and 8 for regular and consistent senior input to inpatient care the concept of the “Consultant Of The Week” (COW) has been developed. The clinical oncologists have been working a COW rota since April 2014, and Medical Oncologists since February 2016.

The “COW” rota has provided regular and reliable senior medical decision making to the inpatient areas, this providing the required support and training to doctors in training and improves patient safety.

To acknowledge changes arising from 7 day services guidance the COW responsibilities have been extended to being available on site to review unplanned admissions until 9- 8pm Monday to Friday, 9-5pm at weekends (standard 2) . Admission rate at CCC drops significantly at weekends due to concerns about access to diagnostic tests, while plain Xrays are available on site, patients must be transferred to Wirral University Teaching Hospital, Arrowe Park site for most other investigations. Blood tests are available but transfer of the sample to Arrowe Park hospital is required. Patients at CCC have access to investigations but not on site at CCC at weekends. Urgent radiological investigations required out of hours (eg head CT) will require transfer of the patient to Arrowe Park hospital (standard 5) CT and MRI are available on site Monday – Friday 9-5.

There is a consultant ward round from a medical oncologist and a clinical oncologist 7 days a week. All patients in escalation group D or more on the basis of the early warning score (Escalation group D = NEWS 5 where no exemption has been identified) are reviewed by a consultant within 24 hours on the daily ward rounds.

Patients in the step facility are reviewed at 9 and 4pm Monday to Friday (standard 6).

Emergency radiotherapy is available 7 days a week (standard 8).

### **COW Ward Responsibilities**

- Attend morning multidisciplinary team handover (see handover policy). 9 am.
- Review all patients in step-up immediately following morning handover and evening handovers
- Consent patients admitted for emergency radiotherapy for cord compression (if not already consented) if a Clinical Oncology trainee is not available for consenting i.e. Both Day SpR is a Medical Oncology Trainee
  - A patient should not leave the ward for radiotherapy planning before consent has been obtained
- Review all emergency admissions admitted since last ‘COW ‘ ward round. 7 days/week.
  - 90% of admissions to be reviewed with 14 hours of admission by consultant( Keogh standard)
- On admission for all patients COW will formulate the integrated management plan with **estimated** discharge date and criteria for discharge



- patients who are admitted to hospital and are who are considered likely to require community care for discharge should be highlighted at admission not when considered medically fit for discharge (Trust responsibility under the Care Act 2014)
- COW ward rounds will be supported by a Ward Nurse. COW ward rounds take priority over weekly rounds by individual consultants for both nursing and junior doctor support.
  - On the daily ward rounds the consultant will determine the patients status as medically active, medically optimized, Medically discharged or End of Life Care
- Monday – Sunday perform ward round to review all patients identified as **medically active**
  - All patients identified as medically active which include the below:
    - Deteriorating patients
    - Uncertain diagnosis
  - Awaiting consultant input prior to discharge
  - Patients In Step – Up (review twice daily 9.30 and 4 pm)
  - All patients admitted as unplanned admission within past 48 hours not managed on a care pathway
  - All patients discharged from step up within past 48 hours All patients not responding to treatment as expected
  - All patients in escalation policy groups D (medium risk) and E (High risk) within past 24 hours
    - Guidance by escalation group allows for flexibility and variances but maintains robust direction for nursing staff
    - All patients about which the Junior Medical Trainees, Oncology Trainees or Nursing Staff have concerns
  - Patients identified as medically optimized patients may be reviewed as a board round/discussion with ward teams. This includes:
    - Patients who are physiologically stable
    - Have a confirmed diagnosis or have appropriate tests under way
    - Are managed on a care pathway or following a prescribed plan of care
    - In a stable condition
- Discuss and review as appropriate all patients with high risk NEWS score or those patients where the risk of mortality is greater than 10% (ie venous lactate level >2 in patients with sepsis), or where a patient is unstable and not responding to treatment as expected within 1 hour
- Provide a source of expert advice to the Oncology SpR's and Junior Medical trainees supporting the Triage and assessment team
- Be available for planning for emergency/urgent radiotherapy.
- Discuss all transfers for emergency radiotherapy with SpR prior to transfer of the patient (clinical oncology COW only)
- Prioritise admissions if Bed Status – Red or Amber bed status
- Prioritise admission to Step – up
- Source of advice for Doctors in Training
- Education of Doctors in Training – e-portfolio ACAT, CBD, MiniCeX etc (as appropriate)

## Following the daily COW ward rounds

- The COCOW will be available for review of patients on Mondays, Wednesdays and Fridays until 8pm or until the last expected patient for review has been seen.
- The MOCOW will be available for review of patients on Tuesdays and Thursdays until 8pm or until the last expected patient for review has been seen.
- If the COCOW is busy with emergency radiotherapy the MOCOW will be available to support the doctors in training and Advance Nurse Practitioners and review all admissions or deteriorating patients on the wards irrespective of the speciality of the usual managing consultant until 5pm Monday – Friday.

## Learning From Deaths

During 2017/18 **85** of The Clatterbridge Cancer Centre NHSFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 17 in the first quarter; 17 in the second quarter; 19 in the third quarter; 32 in the fourth quarter.

By 31.3.18 65 case record reviews (phase I: consultant case record review of own cases) and 55 investigations (phase II: pre mortality multi-disciplinary meeting review, to include structured judgement review (SJR) have been carried out in relation to 85 of the deaths included in item 27.1.3 out of the 55 investigations were further selected for discussion at the Trusts Mortality Review Meeting (phase III: Trust –wide formal multi-disciplinary mortality & learning from deaths review meeting).

In 55 cases a death was subjected to both a case record review and an investigation (phase I & II). The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 3 in the first quarter;
- 15 in the second quarter;
- 15 in the third quarter;
- 20 in the fourth quarter.

2 patients were reviewed in 2018/2019 Q1.

SJR avoidable death scoring mechanism locally agreed March 2018 for inpatient deaths, data collection ongoing from April 2018. Delay in recording inpatient avoidable deaths due to recommendation by Royal College of Physicians to clinicians and lack of national agreement.

39 out 55 cases had SJR completed. Out of the 39, 2 cases were further selected for discussion at the Trust's Mortality Review Meeting. SJR was not 100% completed due to implementation phase at early stage.

2 representing 5% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 1 representing 33% for the first quarter; 0 representing 0% for the second quarter; 1 representing 7% for the third quarter; 0 representing 0% for the fourth quarter.

These numbers have been estimated/calculated using the RCP Structured Judgement Review methodology.

8 case record reviews and 13 investigations (phase II) were completed after 31.03.2017 which related to deaths that took place before the start of the reporting period. 3 SJR were completed.

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated/calculated using the RCP Structured Judgement Review methodology.

Overall, 2 representing 3% of the patient deaths during October 2016-March 2018 who were reviewed during April 17 – March 18 period are judged to be more likely than not to have been due to problems in the care provided to the patient. ”

### Outpatient Deaths

In addition to review of inpatient deaths, The Clatterbridge Cancer Centre NHSFT also is committed to review outpatient deaths for patients within our care which meet the mortality review criterion; deaths within 30 days of chemotherapy or radiotherapy treatment, and within 90 days of radical radiotherapy treatment. Radiotherapy for spinal cord compression or bone metastases cases are not required for review, on the condition that the dose and fractionation given was as per Trust protocol. Therefore the corresponding figures for the **outpatient** deaths are;

During 2017/18 **484** of The Clatterbridge Cancer Centre NHSFT patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period: 110 in the first quarter; 115 in the second quarter; 123 in the third quarter; 136 in the fourth quarter.

Of the 484 deaths, 386 cases required a review. By 31.3.18 **301** cases out of the 386 cases were reviewed (phase I) and 289 investigations (phase II) have been carried out in relation to 301 of the deaths included in item 27.1. 28 out of the 289 investigations were then selected for further discussion at the Trusts Mortality Review Meeting (phase III).

In 289 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 8 in the first quarter;
- 47 in the second quarter;
- 106 in the third quarter;
- 79 in the fourth quarter.

49 patients were reviewed in 2018/2019 Q1

2 representing 7% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 0 representing 0% for the first quarter; 1 representing 2% for the second quarter; 1 representing 1% for the third quarter; 0 representing 0% for the fourth quarter.

These numbers have been estimated/calculated using the RCP Structured Judgement Review methodology.

110 case record reviews and 121 investigations (phase II) completed after 31.03.2017 which related to deaths which took place before the start of the reporting period.

3 representing 2.5% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been estimated/calculated using the RCP Structured Judgement Review methodology.

5 representing 1.2% of the patient deaths during November 2015-March 2018 who were reviewed during April 17 – March 18 period are judged to be more likely than not to have been due to problems in the care provided to the patient.

#### **Summary of learning from case record reviews and investigations conducted in relation to the deaths (inpatient and outpatient deaths)**

1. Accurate recording of cause of death can be complex which could involve multiple organisations and professional discussion and agreement.
2. Able to learn from and share good practice with other hospitals to strengthen the quality of care provided to patients.
3. Accessing patient's scans, pathology reports and blood test results carried out in other hospitals is a crucial part of safe service delivery.
4. Timely and electronic documentation of the chemotherapy assessment using standardised tools at each administration point is important. This enables other health professionals involved in delivering the care to remain informed about the condition of the patient.
5. Robust communication platform between health professionals is vital for continuation of care, at time when clinical staff number can be restricted.
6. A need to review treatment pathways for Small Cell Lung cancer patients admitted for emergency chemotherapy.
7. A need to review clinical trial data to ensure local protocol for Non-Small Cell Lung cancer is robust.

## Learning from SUI investigations

8. Accurate documentation and access to up to date scan results and MDT notes are essential for timely delivery of patient care. Processes to support this in the event of IT failure are crucial.
9. Ensuring all staff are competent, aware of, and following the correct processes and protocols prior to SACT administration to prevent medication being administered without bloods being checked.
10. Reduced mobility, spinal involvement, marked paraparesis, poor nutrition post chemotherapy due to severe mucositis and faecal incontinence must be carefully and regularly assessed and monitored to prevent pressure ulcer deterioration.
11. Unfamiliar and infrequently prescribed drugs require targeted medicines management training to include correct dosage and labelling. Clinical staff must be assessed for numerical competence.
12. Patient height and weight must be accurately recorded at every appropriate interaction.

## Description of the actions taken in the reporting period, and proposed to take following the reporting period, in consequence of what the provider has learnt during the reporting period

1. Contacted the coroner office expressing concern that inaccurate cause of death had been recorded on a patient's death certificate. Coroner agreed to issue an updated patient's death certificate with correct cause of death.
2.
  - a. Review and implement The Christie's hospital's diabetic pathways.
  - b. Sharing learning from previous death review cases to the Isle of Man Noble's hospital when dispensing oral chemotherapy to patients. There were a few incidents in the past whereby patients were continuing to take oral chemotherapy when admitted to other local hospitals. Now all oral chemotherapy packages carry a yellow label advising patient/other health professionals to stop treatment when feeling unwell and to contact the Trust via a 24 hour phone number.
3. Due to the geographic location of the Trust and reducing the travel time of patients, patients are seen at their local hospital by the clinical team. Therefore the Trust's medical staff is equipped with local hospital login to access the local hospital's clinical systems, ensuring the latest information/results are available for review. Likewise, patient's blood test results that were carried out in other hospitals are now electronically transferred into Meditech (EPR) system for review.
4.
  - a. Oral chemotherapy will not be dispensed by PharmaC when no chemotherapy assessment has been documented by the out-patient clinic.
  - b. Clear documentation if treating against protocol. There has been a worksheet created in Meditech asking if the treatment is per protocol, if the nurse answers "No" a comment is added to document as to why/who discussed with etc.



- c. A worksheet was created for the band 5 & 6 chemotherapy nurses to complete which includes case studies where they need to work out the patient's performance status. There are some further refinements to be made to improve the worksheet.
- d. Moving to use UKONS version 2 for our SACT assessment, ensuring all patients are assessed in a standardised way, whether inpatient, outpatient or triage patient.
5. An electronic handover document is in development, which will be accessible by all and contained within Meditech.
  6. An audit is being undertaken to review Small Cell Lung cancer patients admitted for emergency chemotherapy.
  7. Lung Specific Reference Group is reviewing the available clinical trial data and the local chemotherapy protocol for Non-Small Cell Lung cancer ensuring the local chemotherapy protocol is robust and in line with clinical trial recommendation.
  8. Processes have been developed and are in place to support clinicians' access to required clinical information in the event of IT failure.
  9. Processes and practices have been changed to ensure patients do not receive their medication until the blood results have been checked .The process for dissemination of protocol updates has been formalised to ensure doctors are aware of the current versions. A pilot has been implemented of involving the patient by giving them a copy of the protocol.
  10. Monthly multidisciplinary harms review meetings are now in place with external challenge from tissue viability nurse.
  11. Medicine Management training has been reviewed to include more specific training on the interpretation of medication strengths. All staff must complete numeracy testing. Additional warning labels and information posters produced. On line information available in clinical rooms.
  12. A review of the process for taking patient weights and recording them accurately has been undertaken.

**Assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period**

- Ref point 2: Since the Trust's introduction of yellow labels to oral chemotherapy packages, there has been no further incidence of patients being unwell and continuing to take oral chemotherapy while admitted to other local hospitals in Cheshire and Merseyside.
- Since the action of point 3, patient's result are now easily assessable by the care team.
- Since the action of point 4, chemotherapy assessment is now more completed timely and improved documentation.

- Since the action of point 9, all patients do not receive their medication until the blood results have been checked.
- Since the action of point 10, no further grade 4 pressure ulcers have occurred. Harms review meetings provide an essential reflection and learning platform to prevent future occurrences.
- Since the action of point 11, clinical staff has more accessible medicines dispensing information in clinical rooms. All clinical staff have been formally assessed for numeracy competency.
- Since the action of point 12, there are now limit opportunities for transcription errors of height and weight.

## 2.3 Reporting Against Core Indicators

In July 2017 the Trust took over the management of the haemato-oncology service from the Royal Liverpool and Broadgreen NHS Trust. Where the information below contains data after this period it will include the haemato-oncology patients and staff which impacts on the ability to compare with previous year's performance.

Commentary provided on all relevant domains to the Trust as below.

### Domain 3: Patients readmitted to a hospital within 28 days of being discharged aged 16 or over

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
2016/17	Data not available			
2015/16	Data not available			
2014/15	Data not available			
2013/14	Data not available			
2011/12	0.00	8.84	0.00	17.15
2010/11	0.00	9.04	0.00	17.10
2009/10	0.00	9.10	0.00	15.26
2008/09	0.00	9.43	0.00	15.27

Data source: NHS Digital Comparator group: Acute Specialist organisations

The Clatterbridge Cancer Centre NHS Foundation Trust considers that this data is as described for the following reasons:

- It is consistent with our previous performance
- The data source is governed by a standard national definition and results are reported from a statistical data set on the Health and Social Care website.

The Clatterbridge Cancer Centre NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Continual monitoring of our internal quality indicators

**Domain 4: Ensuring that people have a positive experience of care – responsiveness to inpatients' personal needs.** The Trust's responsiveness to the personal needs of its patients during the reporting period.

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
2017/18	Data not yet published			
2016/17	84.9	68.1	60.0	85.2
2015/16	86.3	77.2	70.6	88.0
2014/15	85.9	76.6	67.4	88.2
2013/14	86.7	76.9	67.1	87
2012/13	87.2	76.5	68	88.2
2011/12	86.7	75.6	67.4	87.8
2010/11	85.5	75.7	68.2	87.3
2009/10	86.0	75.6	68.6	86

Data source: NHS Digital

The Clatterbridge Cancer Centre NHS Foundation Trust considers that this data is as described for the following reasons:

- It is consistent with our previous performance
- It is consistent with our internal real time patient survey program
- The data source is governed by a standard national definition and results are reported from a statistical data set on the Health and Social Care website.

The Clatterbridge Cancer Centre NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Developing an action plan to address any issues identified in the patient survey results
- Continual monitoring of our internal real time survey results and the Friends and Family results
- Rolling out our 'patient video story' programme.

**Domain 4: Ensuring that people have a positive experience of care:** The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

Period	Trust Performance	National Average (specialist Trusts)	National Range (specialist Trusts) (lowest)	National Range (specialist Trusts) (Highest)
2017	93%	89%	79%	93%
2016	92%	89%	76%	93%
2015	91%	89%	82%	93%
2014	96%	87%	73%	93%
2013	93%	86%	68%	94%
2012	93%	86%	68%	94%
2011	96%	86%	66%	96%

Data source: NHS Digital Comparator group: Acute Specialist organisations

The Clatterbridge Cancer Centre NHS Foundation Trust considers that this data is as described for the following reasons:

- It is consistent with our previous performance
- The data source is governed by a standard national definition and results are reported from a statistical data set on the Health and Social Care website.

The Clatterbridge Cancer Centre NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Continual monitoring of our internal quality indicators
- Ensuring staff views are heard directly by the Board through Patient Safety Leadership Rounds
- The data source is governed by a standard national definition and results are reported from a statistical data set on the Health and Social Care website.
- Developing an action plan to address any issues identified in the staff survey results.

**Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm:** The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
Q3 17/18	94.14%	95.25%	76.08%	100%
Q2 17/18	96.36%	95.19%	71.88%	100%
Q1 17/18	97.25%	95.09%	51.38%	100%
Q4 16/17	97.10%	95.54%	63.02%	100%
Q3 16/17	90.67%	95.7%	76.48%	100%
Q2 16/17	96.64%	95.65%	72.14%	100%
Q1 16/17	98.33%	96.01%	80.61%	100%
Q4 15/16	96.26%	95.87%	78.06%	100%
Q3 15/16	98.1%	95.8%	61.5%	100%
Q2 15/16	98%	96.2%	75%	100%
Q1 15/16	97.8%	96.04%	86.1%	100%
Q4 14/15	99.08%	96.31%	79.23%	100%
Q3 14/15	98%	96%	81%	100%
Q2 14/15	98.1%	96%	86.4%	100%
Q1 14/15	98.2%	96%	87.2%	100%

Data source: NHS Digital

The Clatterbridge Cancer Centre NHS Foundation Trust considers that this data is as described for the following reasons:

- It is consistent with our internal audit program
- It is consistent with our Safety Thermometer results.
- The data source is governed by a standard national definition and results are reported from a statistical data set on the Health and Social Care website.

The Clatterbridge Cancer Centre NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Ongoing clinical audit including management of the whole VTE pathway
- Daily review of compliance with all clinical risk assessments

**Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm:** The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
April 2016 to March 2017	39.9	35.9	0	147.5
April 2015 to March 2016	30.5	40.1	0	111.1
April 2014 to March 2015	6.1	15.1	0	62.2
April 2013 to March 2014	11.6	39	0	85.5
April 2012 to March 2013	35.7	42.7	0	79.1

Data source: NHS Digital Comparator group: Acute Specialist (including acute specialist (children)) organisations

The Clatterbridge Cancer Centre NHS Foundation Trust considers that this data is as described for the following reasons:

- It is consistent with our internal reporting
- The data source is governed by a standard national definition and results are reported from a statistical data set on the Health and Social Care website.

The Clatterbridge Cancer Centre NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

- Continuing to improve our infection control practices and case reviews of all incidences of Clostridium Difficile

**Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm:** The number of patient safety incidents reported within the Trust during the reporting period (acute specialist).

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
October 16 to March 17	771	1444	295	3872
April 16 to September 16	1342	1357	286	2527
October 15 to March 16	1217	1312	334	2666
April 15 to September 15	916	1138	347	2137
October 14 to March 15	849	1114	300	2672
April 14 to September 14	776	993	85	2619

Data source: NHS Digital Comparator group: Acute Specialist (including acute specialist (children)) organisations



## Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm:

The rate (per 100 admissions) of patient safety incidents reported within the Trust during the reporting period (acute specialist)

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
October 16 to March 17	85.3	51.6	13.7	149.7
April 16 to September 16	150.6	59.5	16.3	150.6
October 15 to March 16	141.9	56.7	16.1	141.9
April 15 to September 15	117	48.5	15.9	117
October 14 to March 15	108.5	43.3	3.6	170.8
April 14 to September 14	94.8	40.2	17.6	94.8

Data source: NHS Digital Comparator group: Acute Specialist (including acute specialist (children)) organisations

## Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm:

The number that resulted in severe harm or death (acute specialist)

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
October 16 to March 17	0	3	0	11
April 16 to September 16	0	2	0	7
October 15 to March 16	0	2	0	9
April 15 to September 15	0	2	0	9
October 14 to March 15	0	4.17	0	23
April 14 to September 14	0	6	0	24

Data source: NHS Digital Comparator group: Acute Specialist (including acute specialist (children)) organisations

## Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm: The percentage of such patient safety incidents that resulted in severe harm or death

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
October 16 to March 17	0.00%	0.21%	0.00%	1.37%
April 16 to September 16	0.00%	0.12%	0.00%	1.05%
October 15 to March 16	0.00%	0.10%	0.00%	0.59%
April 15 to September 15	0.00%	0.10%	0.00%	0.62%
October 14 to March 15	0.00%	0.31%	0.00%	0.90%
April 14 to September 14	0.00%	0.57%	0.00%	4.19%

Data source: NHS Digital Comparator group: Acute Specialist (including acute specialist (children)) organisations

The Clatterbridge Cancer Centre NHS Foundation Trust considers that this data is as described for the following reasons:

- It is consistent with our internal reporting processes

The Clatterbridge Cancer Centre NHS Foundation Trust has taken the following actions to improve the quality of its services (the rate of severe harm incidents is 0 and therefore cannot be improved on.)

- Continued delivery against our Risk Management Strategy
- Continued delivery against our Quality Strategy
- Continued monitoring of our incident reporting levels via the NRLS (National Reporting and Learning System)
- Improved feedback to staff who report incidents

NB: Our rate of incidents reported is at the highest level. According to the NRLS / National Patient Safety Agency organisations that report more incidents usually have a better and a more effective safety culture. You can't learn and improve if you don't know what the problems are.

We will therefore continue to encourage staff to report all incidents and near misses as we see this as indicative of a proactive risk management and patient safety culture.

## 2.4 The Friends and Family Test



**Friends & Family Test**  
Inpatient

1. What is your sex?  
☐ Male ☐ Female

2. What age are you?  
☐ 0-15 ☐ 16-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65-74 ☐ 75-84 ☐ 85+

3. What is your ethnic group?  
☐ White ☐ Mixed/Multiple ethnic groups ☐ Asian/Asian British ☐ Black/Black British ☐ Other ethnic group

4. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? (include any acute problems related to old age)  
☐ Yes, limited a lot ☐ Yes, limited a little ☐ No ☐ Prefer not to say



We would like to ask patients to answer the following questions so that we can gain valued feedback on the services we provide. Your responses will enable us to ensure that we are providing the best possible care to our patients. Your help in answering this question would be much appreciated.

We would like you to think about your recent experiences of our service.

How likely are you to recommend our service to friends and family if they needed similar care or treatment? please tick one of the following:

☐ Extremely likely ☐ Likely ☐ Neither likely nor unlikely ☐ Unlikely ☐ Extremely unlikely ☐ Don't know

What would have made your visit better?

Date: / / Service: the outpatient

Please return this postcard to the 'Friends and Family Test' post box on the reception desk. For further information please contact Sue Phipps, Patient Experience Manager on 0151 482 7927 or email sue.aphipps@clatterbridge.nhs.uk

Please tick this box if you did NOT visit with your carers to be made aware.

Thank you.

The Clatterbridge Cancer Centre  
NHS Foundation Trust

The goal of The Friends and Family Test is to improve the experience of patients. It aims to 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?

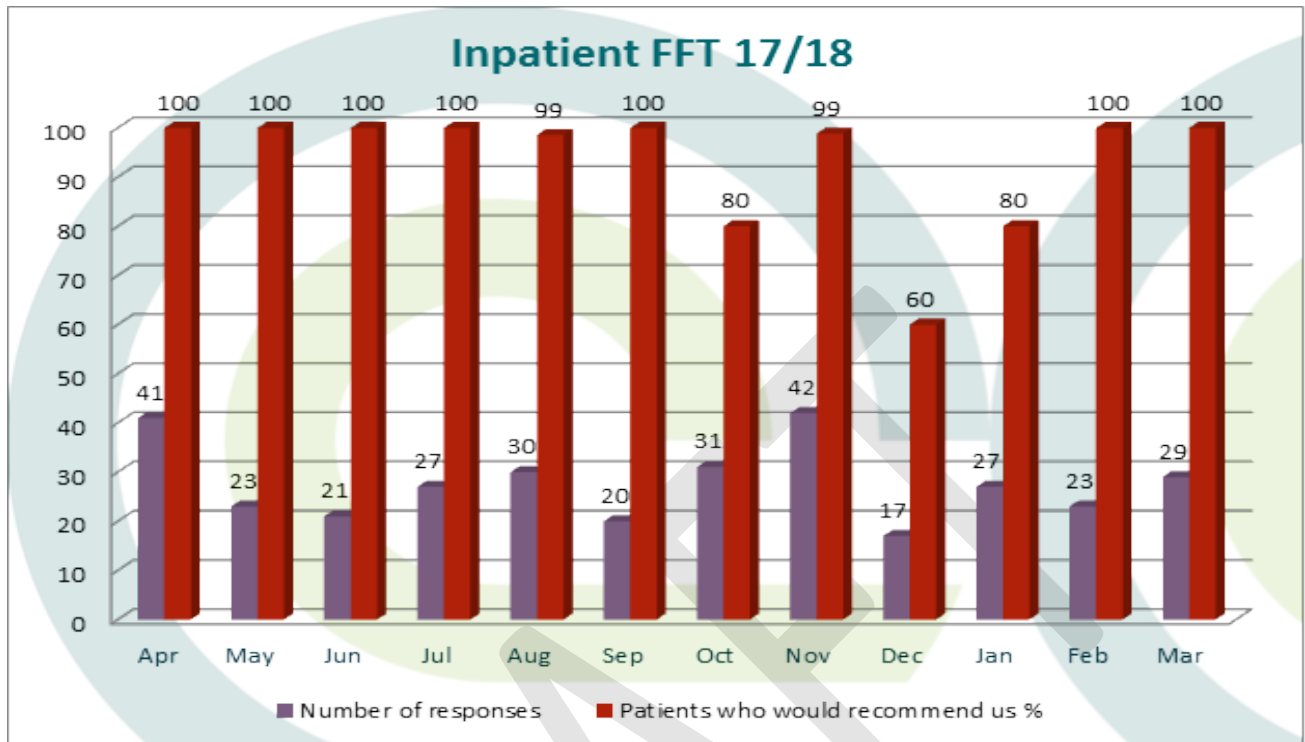
- Extremely likely
- Likely
- Neither likely or unlikely
- Unlikely
- Extremely unlikely
- Don't know

The following graphs show the percentage of patients that would recommend our services to the Friends and Family. The number of responses received for each month is also indicated.

The Trust recognises that the Friends and Family response rate is lower than desired due to a number of circumstances to include the disease status of the patient population and timing of distribution of the response cards. To address this matter the Trust has invested in digital software which will be piloted in 2018 to facilitate ease of response.

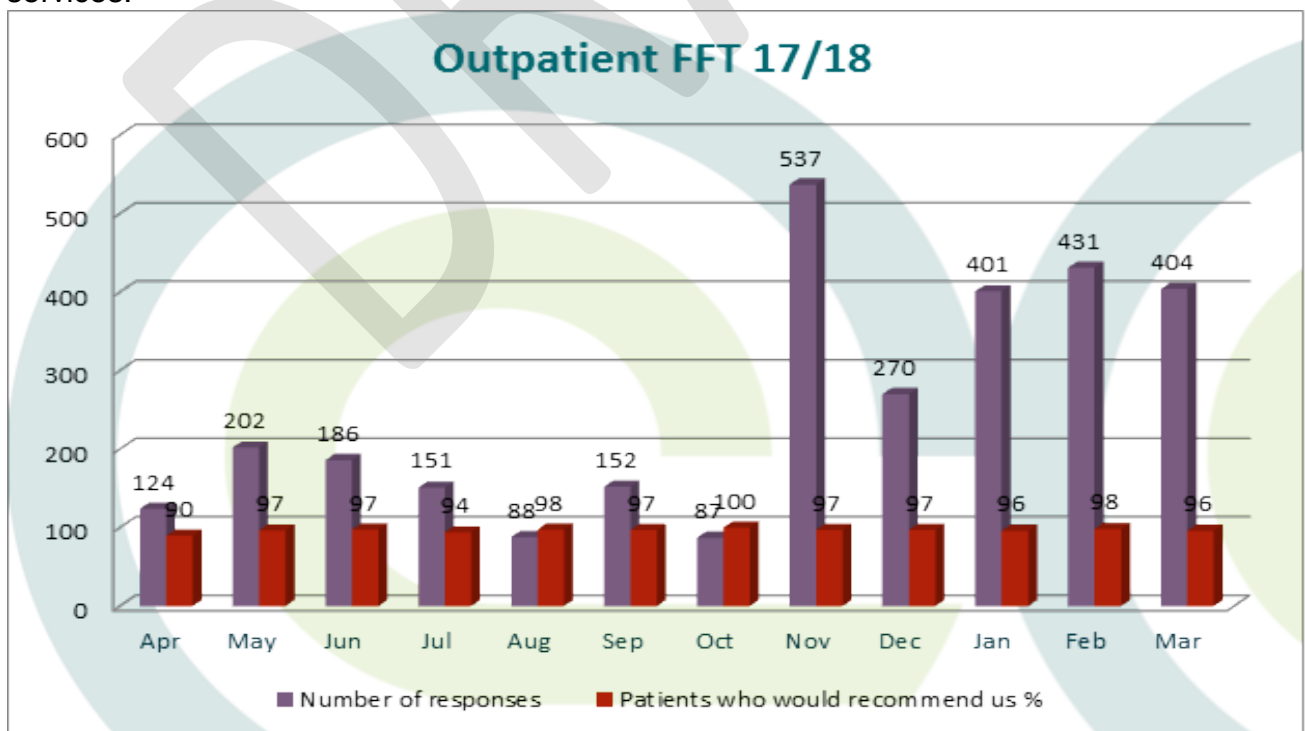
## Inpatient Friends and Family Test

Inpatients for 2017/18 total responses received 331 of which 99.4% would recommend our services



## Outpatient Friends and Family Test

Outpatients for 2017/18 total responses received 3033 of which 96.5% would recommend our services.



We also asked patients were asked 'what would have made your visit better'.

Quite often  
here longer  
than expected

Free travel -  
bridge and  
tunnel

Staff super

Very good  
staff

Wifi great

Everything is  
great

All staff are  
wonderful

Please make  
sure unit stays  
local

Caring and  
professional  
staff on  
every level

## 2.5 Implementation of the Duty of candour

The Trust has in place a Being Open and Duty of Candour: communicating patient safety incidents with patients and their carers policy. This policy provides the information and framework to all staff to ensure a culture of openness where communication with the patient, their family or carers and the healthcare team is open, honest and occurs as soon as possible following a patient safety incident. The policy is audited annually and the 2017 audit involved reviewing all incidents that caused harm and all serious incident panels held from 1/12/16-30/11/17. It also involved reviewing all complaints and claims to ensure that the Being Open policy/principles were followed.

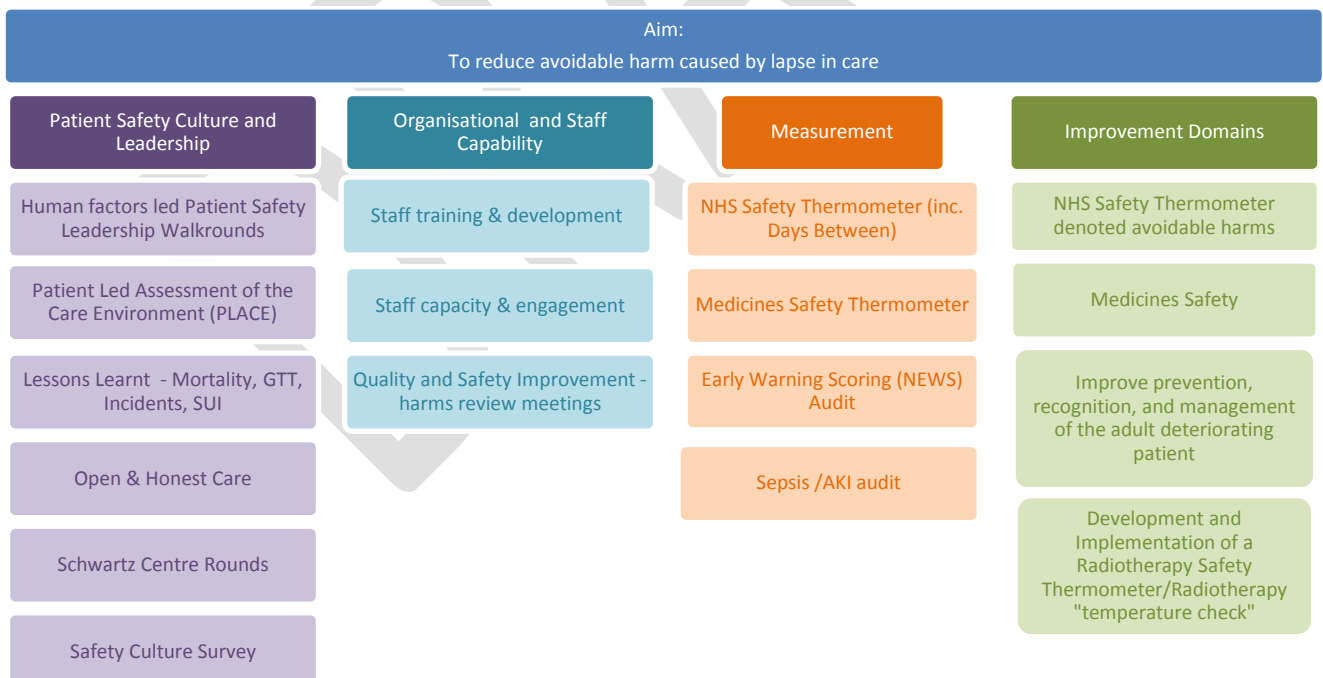
The audit has confirmed that the principles of being open have been undertaken where appropriate and that the required documentation has been completed.

All staff receive face to face training on induction on the Duty of Candour. Subsequently Duty of Candour is included in the Risk Management Training for all staff which is an e.learning workbook to be completed every 2 years.

## 2.6 Sign up to Safety Campaign

As reported in our 2016/17 Quality Accounts the Trust is an active participant in the Sign up to Safety Campaign. The full Sign up to Safety improvement plan is available on our website at: <http://www.clatterbridgecc.nhs.uk/about-centre/high-quality-and-safe-care/safe/sign-safety>

The key elements of our plan are:





## 2.7 The Clatterbridge Cancer Centre NHS Staff Survey Results: Workforce Race Equality Standard (WRES)

			2017	Average (median) for acute specialist trusts 2017	2016	Change	Ranking compared with all acute specialist trusts in 2017
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	24%	22%	22%		Below average
		BME	16%	26%	5%		Better than average
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	89%	88%	94%		Better than average
		BME	96%	75%	100%		Better than average

## 2.8 CQC Ratings Grid

The Trust had an inspection from the Care Quality Commission in June 2016. The overall rating for the Trust was 'Outstanding'.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Outstanding	Good	Good	Good
End of life care	Good	Good	Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Outstanding	Good	Requires improvement	Requires improvement
Chemotherapy	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Radiotherapy	Good	Outstanding	Outstanding	Good	Outstanding	Outstanding
Overall	Requires improvement	Good	Outstanding	Good	Outstanding	Outstanding

## How the Trust plans to address areas that require improvement and by when

Action the Trust MUST take to improve in outpatients and diagnostic imaging;

Action	Progress
The Trust must improve the staffing establishment and the professional leadership of the radiology department including the modality lead posts as PET/CT and nuclear medicine were the only specialty with a filled position.	Completed
The Trust must ensure the radiation protection and safety aspects within the Trust are addressed and documentation kept up to date.	Completed
The Trust must improve the quality assurance processes in the diagnostic imaging department, ensuring it is appropriate and timely.	Completed
The Trust must ensure review and update of all policies and procedures surrounding radiation protection in the imaging department to ensure they reflect current practice	Completed

## Part 3: Other information

### 3.1 An overview of the quality of care offered by the Trust

The Board in consultation with stakeholders has determined a number of metrics against which it can measure performance in relation to the quality of care it provides. The Trust has chosen metrics which are relevant to its speciality i.e. non-surgical oncology and which are identified as important to the public. However, this does mean that data is predominantly internally generated and may not be subject to benchmarking at this stage.

#### Safety indicators

	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
Attributable grade 2 or above pressure ulcers / 1,000 bed days'	1.12	0.99	0.87	1.03		
MRSA bacteraemia cases / 10,000 bed days	0	0	0	0	0	0
C Diff cases / 1,000 bed days	0.38	0.28	0.18	0.06	0.12	0.15
'Never Events' that occur within the Trust	0	0	0	0	0	0

Chemotherapy errors (number of errors per 1,000 doses):	1.3	0.57				
Radiotherapy treatment errors (number of errors per 1,000 fractions)	1.07	1.2	1.5	1.4	1.1	0.81
Falls / injuries / 1,000 inpatient admissions	15.07	24.7	29.7	12.6	25.2	22.1
Number of patient safety incidents	2121	2773	2534	1901	1392	1498
Percentage of patient safety incidents that resulted in severe harm* or death.	0.24%	0	0.04%	0	0	0

All indicators:

- Data source: CCC
- The expansion of our services to now include the Haemato-oncology services from the Royal Liverpool & Broadgreen University Hospital Trust in July 2017.

**\*Severe Harm:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care. (National Patient Safety Agency)

According to the NRLS / National Patient Safety Agency organisations that report more incidents usually have a better and a more effective safety culture. You can't learn and improve if you don't know what the problems are.

We will therefore continue to encourage staff to report all incidents and near misses as we see this as indicative of a proactive risk management and patient safety culture.

### Clinical Effectiveness Indicators

	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
30 day mortality rate (radical chemotherapy)	0.67% (Apr 17 – Mar 18)	0.6% (Apr 16- Mar 17)	1.05% (Apr 14- Mar 15)	0.66% (Apr 14- Mar 15)	1.3% (Apr 13- Mar 14)	0.7% (Apr 12- Mar 13)
30 day mortality rate (palliative chemotherapy)	6.1% (Apr 17 – Mar 18)	5.7% (Apr 16- Mar 17)	7.5% (Apr 14- Mar 15)	6.7% (Apr 14- Mar 15)	9.1% (Apr 13- Mar 14)	8.1% (Apr 12- Mar 13)
30 day mortality rate (haemato-oncology)	4.1% (July 17 – Mar 18)					
30 day mortality rate (radical radiotherapy)	3.5% (Apr-Mar 18)	*4.3% (Apr16-Mar17)	0.76% (Apr 14- Mar 15)	0.70% (Apr 14- Mar 15)	0.66% (Apr 13- Mar 14)	0.69% (Apr 12- Mar 13)
30 day mortality rate (palliative radiotherapy)			12.8% (Apr 14- Mar 15)	10.0% (Apr 14- Mar 15)	13.7% (Apr 13- Mar 14)	14.7% (Apr 12- Mar 13)

SHMI:

\*Unfortunately as a Specialist Trust we are not included in the Summary Hospital Mortality Indicator (SHMI) so this data is unavailable.

Mortality rate:

- Data definition: unadjusted mortality rate as a percentage of all cases treated in that category.
- Data source: CCC
- The data provided for 2013/14 varies slightly from that published in last year's Quality Accounts due to additional data being available after the year end.

- \*Radiotherapy intent is not recorded against appointment in Meditech system, a different data source will need to be explored (i.e. Aria system) for mortality reporting in future.

### Patient Experience Indicators

Patients rate as 'always' in the local patient survey programme.

	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
'I was treated with courtesy and respect'	98%	96%	98%	98%	97%	97%
'Was the ward / department clean'	96%	94%	96%	96%	95%	95%
'I never had to wait'	41%	36%	35%	29%	27%	26%
'I was included in discussions about my care'	93%	92%	93%	93%	90%	89%
'Did the staff wash their hands'	90%	95%	95%	95%	93%	93%

Patient survey:

- Data source: data collected from in-house survey
- Survey questions based on annual Care Quality Commission In-patient survey
- Target for compliance agreed by the Trust Board as part of our Quality Strategy

## 3.2 Performance against relevant indicators and thresholds in the Risk Assessment Framework and the Single Oversight Framework

	2017/18	2016/17	2015/16	2014/15	2013/14
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	96.33% (target 92%)	96.2% (target 92%)	98.0% (target 92%)	97.3% (target 92%)	97.6% (target 92%)
All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer	79% post reallocation, against revised NHSE rules (target 85%). The target was achieved in all but 1 month in Q3 and Q4.	89.1% post reallocation (target classic 85%)	90.9% post reallocation (target classic 85%)	88.2% post reallocation (target classic 85%)	87.5% (target classic 79%)
All cancers: 62-day wait for first treatment from: NHS Cancer Screening Service referral	93.3% post reallocation (target 90%).	92.6% post reallocation (target screening 90%)	100% post reallocation (target screening 90%)	100% post reallocation (target screening 90%)	N/A due to de-minimus (Target Screening 90%)
Clostridium difficile – meeting the C. difficile objective: variance from plan	6 attributable (annual target of no more than 5). The target increased when the Trust acquired the Haemato – oncology service	4 attributable (target no more than 1). All cases agreed as no lapse in care.	3 attributable (target no more than 1). 2 cases agreed as no lapse in care.	1 (target no more than 2)	2 (target no more than 2)

	on 1 <sup>st</sup> July 2017). 2 cases remain under review to determine if there was a lapse in care.				
Maximum 6-week wait for diagnostic procedures	100% waiting fewer than 6 weeks				
Venous thromboembolism (VTE) risk assessment	93%				

DRAFT

## **Annex 1**

### **Statement from Commissioners, local Healthwatch organisations and Overview and Scrutiny Committees**

DRAFT



**Healthwatch Watch Warrington's Response to The Clatterbridge Cancer Centre's Draft Quality Account Document 2017 - 2018 (May 2018)**

Healthwatch Warrington welcomes the opportunity to respond to The Clatterbridge Cancer Centre NHS Foundation Trust's (CCC) Draft Quality Account (2017/18). We envision this as an opportunity to consider whether the report reflects people's real experiences of using the services that CCC provides, from a lay perspective. We would also expect to see evidence of a substantive learning culture in place and priorities identified that are clearly measurable and challenging enough to drive quality improvements (reflecting areas of good practice and those requiring improvement).

As a people's champion for health and social care, we continue to recognise the tangible impact that organisational values have in shaping the quality and safety of service delivery, which in turn underpins patient experience and informs the framework of our response. As such, we were pleased to note that the report started by spotlighting the Trust's vision (to provide the best cancer care to the people it serves), which is supported by a strong values base (developed with staff); emphasising passionate service delivery, putting people first, achieving excellence, being future-focused and striving for continuous improvement.

In terms of patient safety, we were happy to read about the Human Factors Programme implementation plans, as this will help to foster a supportive learning culture for staff that is specifically targeted at improving clinical standards for patients, moving forward. We would be interested to hear more about this programme and the specifics of how it will be monitored. The results from audits conducted at the Trust were also largely positive, with good practice being reported in relation to patient safety.

In respect of CCC's progress towards developing a comprehensive falls prevention and management plan, Healthwatch Warrington would strongly recommend a renewed focus on this area; given that a marked rise in falls has been recorded (the extent to which new service acquisition was the cause of this spike in falls was not clarified in the report). Healthwatch Warrington identified falls prevention as a key 2017/18 work stream and would be open to contributing to a renewed initiative.

It was also encouraging to read that CCC is planning to utilise reminiscence therapy to achieve a better care experience for those patients living with dementia. We would be interested to hear more about the number of volunteers that are being recruited to support this initiative, how they will be supported, and some case study examples that illustrate the practical difference that this will make. Similarly, we were pleased to see that CCC had received very high Friends and Family Test (FFT) scores this year, an indicator of largely positive patient experience occurring at the Trust. It would have been useful to know the overall patient response rate to the FFT (i.e. the percentage of those treated who actually responded) to better gauge how representative this feedback sample is.

The report also provided further evidence of a robust learning culture thriving at CCC; with many examples of staff training programmes ( covering topics such as Duty of Candour) being offered to boost capacity and actions completed in respect of the recommendations made by Care Quality Commission following its 2016 2016.

Alongside this, we were impressed to hear about the Trust's commitment to supporting research and innovation; for instance, the establishment of the CCC biobank for cancer research and strategic focus on the development of academic oncology. In particular, we support CCC's plans to build an inclusive research portfolio that aims to capitalise on patient experience data collected by the Trust (strengthening valuable patient input within cutting-edge research).

Healthwatch Warrington appreciates that we received a draft copy of the Quality Account. However, a range of key quantitative data was not included and this has made it difficult to comment on certain aspects of the Trust's performance (for instance, the total number of patients cared for). Some additional qualitative data could have also helped to improve the report.

For example, it would have been good to see how the Trust planned to use patient commentary from the question "what would have made your visit better" in the form of a 'You Said, We Did' table.

Given that the Quality Account is a public document, Healthwatch Warrington also felt that it would be particularly useful to include a 'key terms' glossary as an appendix (for example, to provide more detail around clinical terminology used and topics such as "John's Campaign").

In sum, the successes reported in this year's Quality Account correspond with the anecdotal feedback that Healthwatch Warrington has received in relation to CCC. Patients, carers and family members have told us about the high quality of care received from the Trust, and were particularly impressed with the compassion and commitment shown by members of staff. Over the coming year, we will continue to support CCC's engagement strategy and efforts to improve quality. For example, we have already invited representatives from the Trust to attend our Quality Accounts Involvement Day. This event will be held in May 2018 and serve as an opportunity for CCC to present this year's report to key stakeholders, discuss its future plans and hear the public's voice directly. We look forward to working in partnership with CCC and will continue to facilitate the delivery of high quality care for local people by championing their views.

Kind regards



Lydia Thompson  
Chief Executive Officer  
Healthwatch Warrington



## **Statement from Wirral Metropolitan Borough Council**

**15<sup>th</sup> May 2018**

### **Commentary on the draft Quality Account, 2017/18** **Clatterbridge Cancer Centre**

The Adult Care and Health Overview & Scrutiny Committee undertake the health scrutiny function at Wirral Council. The Committee has established a task & finish group of Members to consider the draft Quality Accounts presented by relevant health partners. Members of the Panel met on 9<sup>th</sup> May 2018 to consider the draft Quality Account and would like to thank Clatterbridge Cancer Centre for the opportunity to comment on the Quality Account 2017/18. Panel Members look forward to working in partnership with the Trust during the forthcoming year. Members provide the following comments:

#### **Overview**

Members welcome the Trust's ongoing commitment to continuous improvement, which is evidenced by progress achieved against last year's priorities and the selection of the priorities for improvement for 2017/18. This evidence is supported by other information in the draft Quality Account, including the excellent outcomes on infection control (MRSA and clostridium difficile). Members note that the key strategic objective for the trust is the delivery of the 'Transforming Cancer Care' programme which will result in the building of the new cancer centre in Liverpool. Members also look forward to the continued development of cancer treatment services at the existing Clatterbridge site.

#### **Priorities for Improvement 2018/19**

For all of the three priorities identified for 2018/19, there is little detail available to explain how success will be measured. Without a baseline, monitoring the real impact of performance for these three priorities will be difficult.

#### **Progress made since publication of the 2016/17 report**

##### **Focus on falls**

Although a comprehensive falls prevention action plan has been developed, it is noted that 110 in-patient falls were recorded in 2017/18 compared to 82 in the previous year (2016/17). While it is recognised that the data since July 2017 includes the haemato oncology service which has transferred from Royal Liverpool and Broadgreen University Hospital Trust, the extent to which this factor has affected outcomes is unclear. Further monitoring of the impact of the action plan would be welcomed.

#### **Other comments**

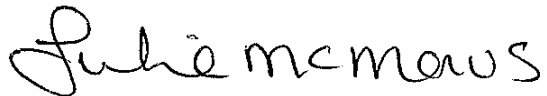
##### **Friends and Family Test**

Members welcome the high scores for the Friends and Family Test with inpatients recording 99.4% for the percentage of patients likely to recommend the ward to a friend or family. Similarly, a high score of 96.5% was achieved for outpatients.

### Patient Experience Indicators

While the general patient experience indicators score highly for 2017/18 with, for example, 98% of respondents agreeing that 'I was always treated with courtesy and respect', the result for 'I never had to wait' is somewhat lower at 41%. Although this indicator is showing a higher result than in previous years, it does perhaps identify an area on which the Trust could focus in the future.

I hope that these comments are useful

A handwritten signature in black ink, reading 'Julie McManus'. The script is cursive and fluid, with the first name 'Julie' written in a larger, more prominent hand than the surname 'McManus'.

Councillor Julie McManus  
Chair, Adult Care and Health Overview & Scrutiny Committee  
Wirral Borough Council

## Annex 2

### Statement of Directors' Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to May 2018
  - Papers relating to Quality reported to the Board over the period April 2017 to May 2018
  - Feedback from the commissioners dated xxth 05 2018
  - Feedback from governors dated April 2017 to June 2018
  - Feedback from Local Healthwatch organisations dated xth 05 2018
  - Feedback from Overview and Scrutiny committee dated 15<sup>th</sup> May 2018
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018
  - The latest National Patient Survey 2017
  - The latest National Staff Survey 2017
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated March 2018
  - CQC Inspection Report dated 01/02/2017
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and



- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Signed

Phil Edgington  
Chair

Date: xx<sup>th</sup> May 2018

Signed

Ann Farrar  
Interim Chief Executive

Date: xx<sup>th</sup> May 2018

## **Annex 3**

### **Independent Auditor's Limited Assurance Report**



**Grant Thornton**

**Independent Practitioner's Limited Assurance Report to the Council of Governors  
of The Clatterbridge Cancer Centre NHS Foundation Trust on the Quality Report**