



2018/19

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

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

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. We constantly strive to continuously improve the quality of service we provide to our patients.

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 2018/19 we were inspected by the Care Quality Commission. The Trust achieved an overall rating of good and outstanding in care.

The Trust Board continues to ensure that Quality and Safety is a key priority and this is reflected in the new governance arrangements and structures introduced in 2018/19. 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 in shaping the Quality Strategy. The Governors are 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:

- A key part of our Trust strategy and Transforming Cancer Care initiative continues to be realised in the building of a new cancer centre in Liverpool due to open 2020. We are committed to working in partnership with our patients and the Royal Liverpool and Broadgreen University Hospital Trust.(RLBUHT)
- The continued integration of our Haemato-oncology service based at RLBUHT, acquired July 2017.
- The opening of a Clinical Decisions Unit in 2018 to provide streamlined quality care for our patients
- I am particularly pleased to be able to report again that we have achieved against our clostridium difficile and MRSA targets. Whilst we had 12 cases of clostridium difficile (C.diff), only 2 cases were attributable against a maximum of 4 cases, post infection reviews identified no lapses in care at time of reporting.
- By 31st March 2019, it has been 7 years and 275 days since our last case of MRSA bacteraemia attributable to the Trust.
- We achieved consistently high scores in the Patient Care Quality Commission surveys and National Cancer Patient Experience Survey (published September 18). The average rating given by the Trust respondents when asked to rate their care on a scale of zero (very poor) to 10 (very good) was **8.9**.
- In the 2018 NHS Staff Survey we saw an improvement in scores relating to the key theme, Quality of care, and

scored above the national sector score. 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' 89% replied yes. 87% agreed that they are satisfied with the quality of care that they give to patients and 91% responded 'Yes' to feeling that their role makes a difference to patients.

- Our annual PLACE (Patient Led Assessment of the Care Environment) was undertaken in May 2018. The actions from this assessment have been regularly reviewed throughout the year to ensure we continue to improve our patient experience.
- We continue to support our healthcare staff in the completion of the Care Certificate. As agreed at Trust level, this includes all band 4 staff and below, existing and newly qualified). As at March 2019, of the 160 staff required to complete, 72 staff have achieved the care certification with 21 in progress

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

In summary, The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) has a solid track record in the delivery of high quality services and outstanding care for our patients. We will continue to deliver against the objectives we have set and will continue to improve quality in the challenging times ahead.

I would like to thank the staff of The Clatterbridge Cancer Centre for their exceptional commitment and professionalism, which ensures that we

can continue to work as a leading cancer centre.

xxxxxxx

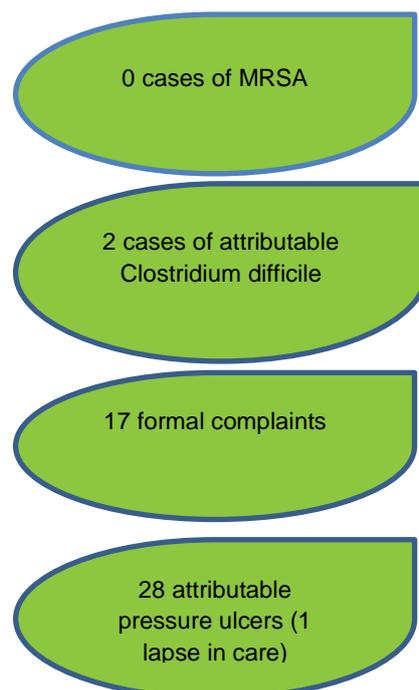
Dr Liz Bishop
Chief Executive

Date: xxx

During the last year in our cancer centre:



During the last year we had:



Introduction

The Quality Report provides an overview of performance in key priorities set for improving the quality of care provided to 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 improving the quality of the service it provides. This is primarily achieved through the delivery of the Quality Strategy. This strategy is being refreshed in 2019, 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- an improvement tool for measuring, monitoring & analysing patient harms & 'harm free' care in 4 key areas: Pressure Ulcers, Falls, Urinary infection (in patients with a catheter), Treatment for Venous Thromboembolism

- Medicines Thermometer- a measurement tool for improvement that focuses on: medication reconciliation, allergy status, medication omission, and identifying harm from high risk medicines.
- 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

<https://www.clatterbridgecc.nhs.uk/about-centre/our-expertise/our-standards>

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

Due to the size of the population served, the Trust has endeavoured to engage with all Healthwatch and Overview and Scrutiny Committees (OSC) in developing the Quality Report and key priorities.

In May and November 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 and progress on the delivery against its 2017/18 key priorities. An engagement event is planned in June 2019 to further discuss 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:

May 18
Healthwatch
9
November 18
Healthwatch
6

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

2.1 18/19 Report: Priorities for Improvement

Priority 1: Safety

Patient Safety: *Always safe, always effective*

Patient safety:

Developing enhanced management and care of the deteriorating patient

Why have we chosen this priority?

In December 2018 the Trust launched a digital pathway to record and escalate a patient's clinical condition and the need for escalation of care. The NEWS2 track and trigger tool is a national tool used to identify the deteriorating patient and support clinical staff in appropriate action. The trust also launched a digital sepsis pathway at the same time. This has helped to highlight and identify patients with potential sepsis and ensure they receive the right treatment according to national guidelines. Education was provided at the time of the launch to patient facing staff in use of the digital tools and an on-going E-Learning module is in place for NEWS2 training. Further enhanced training is proposed for key clinical staff around sepsis and a train the trainer system for sepsis management will be implemented for the deteriorating patient and resus team (DaRT) Nurse Practitioners.

This is linked to the Advancing Quality Alliance (AQUA) programme and audit tool for the management of sepsis. The Clinical Director and Integrated Care Directorate (ICD) Matron are leading on this piece of work with the clinical teams. A deteriorating patient steering group has been set up to support the clinical objectives around the care and management of the deteriorating patient and will also support any future developments. This group will feed into the Mortality and Morbidity Group and Integrated Governance Committee.

As a Cancer Trust, it is essential that the care of patient with potential sepsis is managed efficiently and effectively:-

- To prevent patient harm
- Ensure standardised quality pathways across all clinical services
- Prevent avoidable deaths
- Standardise clinical tool to identify the deteriorating patient

How will we monitor and measure progress of this priority

Monitoring and measuring of progress will be through the Quality Committee of the Board who will have oversight of delivery of:

- Monthly audit of management of the septic patient in line with sepsis 6 guidance
- Daily NEWS2 and Sepsis pathway compliance
- Review of all deaths linked to sepsis in mortality & morbidity meeting
- Education for key staff in sepsis awareness
- Development of the deteriorating patient and resus team
- Interface work with the RLBUHT to agree clinical pathway with critical care and outreach services for 2020.

Priority 2: Experience:

Patient Experience: *Striving for excellent patient satisfaction*

Patient Experience:

Delivering a Nursing and Allied Healthcare Professionals model of Shared Governance

Why have we chosen this priority?

The national critical shortage of registered nurses and AHP's is a worrying theme in healthcare. In response to this situation, more organisations are turning to a shared governance model. This model enables shared decision making based on the

principles of partnership, equity and ownership and empowers all members of the healthcare workforce to have a voice in decision making which directly influences safe patient care and experience.

At the CCC a shared governance framework is being developed to ensure Allied Healthcare Professionals (AHPs) and nursing staff are empowered as leaders to be involved with, and to assist, in shaping organisational clinical decision making. This is evident as part of "business as usual" as well as within the Transforming Cancer Care Agenda. Strong clinical leadership is vital to ensure the Nursing/AHP voice is heard from floor to Board. Nursing has a strong leadership and governance model within the trust and is represented at board level by Director of Nursing & Quality (DoN&Q). Matrons and Ward Leaders work closely with the DoN&Q and Deputy Director of Nursing regarding decision making aligned to the Quality Agenda as well as the Matrons being part of the "triumvirate" within directorate senior leadership teams. Nursing leadership development is a priority area for the Trust as well as pushing the boundaries in developing clinical practice. CCC has a professional nurses forum and this is attended by a number of registered nurses across the organisation and is where National, Regional and local updates are shared and discussed. A similar forum for the non-registered nursing workforce is also being explored.

The senior AHP leaders within the Trust are working with colleagues and the national AHP leaders (providing external advice and support), to develop the first Trust AHP strategy and a more robust AHP reporting structure within the organisation. This will inform, shape and define the structure and development of AHP leadership, AHP clinical practice and AHP clinical developments within the organisation. Through an improved reporting structure and the promotion of innovations, AHP work will be able to more closely align, support and influence the organisational clinical decision making. An

AHP forum will be developed for all AHPs across the Trust and this will feed into the already formed AHP senior leader team for effective monitoring and promotion of their objectives.

How will we monitor and measure progress of this priority

Progress will be monitored through the Quality Committee of the Board against the Trust Objectives for 2019/20:

- Introduction of a refreshed Nursing Forum, led by Matrons, that supports the professional development of all registered nurses and is where National, Regional and local updates are shared and discussed.
- Introduction of a refreshed AHP Forum, led by senior AHPs, that supports the professional development of all AHP groups and is where national, regional and local updates are shared and discussed.
- Q4 implementation of a shared multi-professional forum, decided by consensus, with agreed collaboration to promote mutual core objectives, development and learning.
- Delivery of the Patient & Public Involvement & Engagement Strategy 19-21 milestones to enhance patient care, improve services and patient experience.

Priority 3: Effective:

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

Patient Outcomes/effectiveness:

Delivering outstanding Patient Experience through achievement of the Patient & Public Involvement & Engagement Strategy 19-21

Why have we chosen this priority?

The vision of The Clatterbridge Cancer Centre NHS FT is to provide the best cancer care to the people we serve. This Patient and Public Involvement and Engagement Strategy 2019-2021 aims to support this vision, by ensuring patient and public experience and feedback is used to enhance the care and services we provide

and to ensure, in line with our values, that we always improve our care by listening to our patients and those whose lives we touch. The seven key pledges of the strategy will ensure our patients continue to receive the safest care possible, and in an environment where all complaints raised are listened to, and used, for improving the quality of care by the Trust, as a truly learning organisation.

Patient and public feedback, involvement and engagement is essential in helping us to shape our future model of care and in supporting us on our exciting cancer care transformation journey, allowing us to continue to deliver outstanding care for our patients

How will we monitor and measure progress of this priority

Monitoring and measuring of progress will be through the Quality Committee of the Board who will have oversight of delivery against the key milestones of the 7 pledges of the strategy

How we did last year: Progress made since publication of the 2017/18 report:

In our Quality Report last year (2017/18) we identified the following priorities:

Priority 1: Safety:

Implement a Human Factors (HF) Programme

Why did we choose this priority?

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 –some key implementation examples:

- Human Factors (HF) awareness and training delivered to key staff groups and integrated into leadership training for staff
- Use of fishbone model for investigations/Serious Untoward Incidents
- Re design of incident investigation with focus on HF
- Introduction of Serious Incident Learning Reviews
- Promotion safety culture and use of SBAR tool (Situation, Background, Assessment, Recommendation)
- HF approach embedded into Quality and Safety agenda: Quality & Safety Data Packs
- Shared Learning Briefing and Newsletter launched
- Mortality Review Meetings -forum for HF
- Executive/ Non-Executive and Governor support HF focused leadership walk-rounds
- Re modelling of Policies/Standard Operating Procedures

Progress has been monitored through the Board Quality Committee. Progress is measured against evidence to include staff training, incident review process and evidence of learning.

Priority 2: Experience:

Implement Reminiscence Therapy (RITA) for dementia patients supported by volunteers.

Why did we choose 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 harm 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."

How we did last year

RITA is now established and freely available on the inpatient wards. The device has not only been used for those patients with dementia, the AHP teams have utilised the device to supplement their care using software/games to enhance hand eye coordination. One patient was able to spend some time using the karaoke function which was a favourite of his. The device also has an interpretation function which has been invaluable to improve communication and assisting with patient assessments.

Reminiscence therapy is now a work stream within the Dementia Strategy and will build on the work already implemented such as 'John's Campaign' (visiting rights for family carers of patients with dementia in hospitals in the UK)

Progress of the programme is monitored through the Board Quality Committee. Progress is measured against evidence to include patient and carer feedback, reduction in falls/incidents and complaints.

Priority 3: Effective:

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

Why did we choose 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

Outcomes dashboards and KPI's aligned with Site Reference Groups (SRG's) completed include head and neck, upper GI, Lung, Breast, Skin and Palliative care. Additional dashboards are Gynaecology, Colorectal, Urology, CNS and Acute Oncology/ unknown primary. Work is now ongoing to produce these dashboards from the Trust Data Warehouse to further support the new clinical model introduced in 2018/19 and the Trusts mortality and outcomes programme

Progress has been monitored through the Board Quality Committee and measured against dashboard development, improved outcomes and performance against key performance indicators.

Other key Quality focus Priorities

Safeguarding

In addition to the three priorities identified above the Trust committed in 17/18 to the strengthening and improving of its safeguarding policies and processes. Underpinned by a robust safeguarding improvement action plan delivered in August 2018, the Trust has strengthened its safeguarding team and employed a Head of Safeguarding and Named Nurse for safeguarding. The team continues to support the Trust and its patients by driving this agenda forward and provide expert knowledge and training to all staff

Falls

The Trust has 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 are now in place across the trust in bathrooms/en-suites as a prompt for patients.

Ramblegard falls monitors are now well established on both Conway and Mersey wards.

During 18/19 we have continued to address falls prevention, launching a number of initiatives to help reduce the risk of patients falling. All patients admitted to the trust will now have a lying and a standing blood pressure reading performed, any deficit in this reading is report immediately to the medical team.

Ward pharmacists now perform a medication review on all inpatients with added emphasis on those medications that may increase a patient's risk of falling.

To ensure that patients are supervised appropriately when they are mobilising, the physiotherapy team label all inpatient mobility aids using a RAG rated system. Green for those patients who have been assessed as being able to mobilise independently, amber for those patients who require the assistance of one member of staff and red labels for those patients who need two members of staff to mobilise.

At the start of the year the trust invested in new beds for the Wirral based inpatients, the beds have the ability to be lowered nearer to the floor and also house night lights underneath that can enhance patients orientation if they are mobilising during the night.

All inpatient falls are discussed at the harms collaborative meeting in order that we can learn lessons for the future. One issue highlighted during a review was the bathroom/en-suite lights being energy saving bulbs. This means that there is a short delay in them being bright enough for some patients to see clearly, especially during the night. The Quality Improvement

Manager liaised with Prop care who have now applied for and have been awarded a grant to upgrade the current lights to LED, work will begin soon on this.

The trust has also joined the newly formed Cheshire and Merseyside Falls Prevention steering group, collaborating with regional trusts on a number of work streams to reduce the number fall regionally.

In Patient Falls: How we did

Year	Number Inpatient falls	Inpatient falls per 1000 admissions
2018/19	122	15.2
2017/18	110*	15.1
2016/17	92	24.7

** 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 and assessed, acknowledging increasing levels of Trust patient acuity.

Mortality

The Trust's Council of Governors have selected the mortality indicator: 30 days post radical chemotherapy, expanded to include the Haemato-oncology service in 19/20, to deliver a comprehensive Trust-wide mortality review. As a specialist Trust The Clatterbridge Cancer Centre NHS FT is not eligible to utilise SHMI or HSMR as a mortality review tool.

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. The Trust is committed to improving mortality review and review of serious incidents as a driver for improved quality and patient safety

The Trust Mortality Review Meetings have resulted in a number of changes to clinical

care such as changes to clinical practice, documentation and education and training.

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

Oversight of Trust mortality data summary is included in the annual Trust's Quality Accounts

2.2 Statements of Assurance from the Board

During 2018/19 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 2018/19.

Information on participation in clinical audits and national confidential enquiries

During 2018/19, 18 national clinical audits and 2 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 18 (100%) of national clinical audits and 2 (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 participated in, and for which data collection was completed during 2018/19, 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 Oesophago-Gastric Cancer Audit
- National Head and Neck audit (HANA)
- Female Genital Mutilation
- NCEPOD – Cancer in Children, Teens and Young Adults
- NCEPOD – Pulmonary Embolism
- RCR National Prostate Cancer Audit - Radiotherapy Data
- National Study of Late Effects after Hodgkin Lymphoma
- National Audit of Care at the End of Life (NACEL)
- Acute Kidney Injury
- RCR National audit of the use of radiotherapy in the treatment of vulval cancer
- RCP National Mesothelioma Audit
- Deferred SACT at outpatient clinics
- HCC Sorafinib Outcomes
- 100 day mortality post allogeneic stem cell transplantation
- BSBMT long-term outcomes audit with UK benchmarking, 2004-2016, 9th report published 2018
- NHSE dashboard: outcomes audit with UK benchmarking
- Cancer Outcomes and Services Dataset (COSD)
- National Audit of Breast Cancer in Older patients
- National Lung Cancer Audit

Table 1a: Audits: cases submitted

National Clinical Audit and NCEPOD eligible studies	Cases submitted
National Bowel Cancer Audit	Deadline is June 2019, currently 189/946 (20%) treatment records submitted by CCC (as data has not been uploaded by the referring hospitals to enable CCC treatment data to be submitted)
National Oesophago-Gastric Cancer Audit	Deadline is 24 th May 2019, 197/284 (69%) treatment records submitted by CCC (as data has not been uploaded by the referring secondary hospitals to enable CCC treatment data to be submitted. This is being reviewed and managed by the Clinical Audit and Registries Management Service)
National Head and Neck audit (HANA)	9 files uploaded containing 408 patient records (100%) and 436 treatment records (100%)
Acute Kidney Injury	Data provided within agreed deadline
RCR National audit of the use of radiotherapy in the treatment of vulval cancer	5/5 records completed (100%)
Female Genital Mutilation	Zero return for 2018-19
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 (100%)
NCEPOD – Pulmonary Embolism	3/3 Clinical Questionnaires completed (100%) 3/3 case note extracts returned to NCEPOD (100%)
RCP National Mesothelioma Audit	12/12 (100%) files uploaded successfully
Deferred SACT at outpatient clinics	Local audit expanded to collate data with other Trusts Nationally (for the British Oncology Pharmacy Association)
HCC Sorafenib Outcomes	66 patients identified. SpR undertaking casenote review (Joint project with University College London)
100 day mortality post allogeneic stem cell transplantation	Total Number of Allogeneic Transplants Oct17-Sept 18 = 34 Total Number who died within 100 Days of Transplant = 2 patient
NHSE dashboard: outcomes audit with UK benchmarking	Total Number of autologous Transplants Oct 17 – Sept 18 = 68 Total Number of patients alive 1 year after transplant = 63
RCR National Prostate Cancer Audit - Radiotherapy Data	807 patients records were submitted
BSBMT long-term outcomes audit with UK benchmarking, 2004-2016, 9th	1839 patients records were submitted

report published 2018	
National Study of Late Effects after Hodgkins Lymphoma	213/237 records completed (90%) remaining 24 records was unmatchable patient or casenotes could not be found (Patients dating back as early as diagnosis in 1954)
National Audit of Care at the end of life (NACEL)	5/5 HO records completed (100%) plus 5/5 data reliability records completed. 23/23 CCC Wirral records completed (100%) plus 5/5 data reliability records completed
Cancer Outcomes and Services Dataset (COSD)	12/12 (100%) files uploaded successfully
National Audit of Breast Cancer in Older patients	12/12 (100%) files uploaded successfully
National Lung Cancer Audit	12/12 (100%) files uploaded successfully

The reports of four national clinical audits were reviewed by the provider in 2018/19 and The Clatterbridge Cancer Centre NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Table 1b: 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 2019-20 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
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 2019-20 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
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 2019-20 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
NCEPOD – Cancer in Children, Teens and Young Adults	14/15 recommendations are compliant with 1 action plan in place to develop a bespoke dashboard encompassing side effects and outcomes of SACT. This dashboard enables Specialist the SRG to discuss performance and set improvement goals with findings reported at Board level.

*SRG – Site Reference Group

Table 1c: Local Audits/Quality Improvement Projects

The reports of 43 local clinical audits were reviewed by the provider in 2018/19 (compared to 33 in 2017-18), of which 28 provided assurance (compared to 17 in 2017-18) and 15 made improvements through action plans to improve the quality of healthcare provided (compared to 16 in 2017-18).

Title	Actions to improve quality of care/Assurance Provided	Outcome	Presented
1516-37 Jaw tracking to reduce dose to organs at risk for early stage non-small cell lung treated using Volumetric Arc Therapy (VMAT)	In response to these results, CCC have been using jaw tracking clinically for some time – initially used for SABR lung on the Edge machines but has been used for all sites treated with VMAT since January 17.	Significant improvement made in care	SABR Consortium Annual Conference
1617-25 Quality Improvement Project on Junior Doctor's Meditech Training	Introduction of a video showing a clinician demonstrating the use of Meditech for the clinical tasks i-iii (above) with the aim of avoiding the need for a clinician to attend every trainee IT induction. The format of IT training was amended to more closely map the practical needs of the trainees. It was also agreed that this new training should be tested initially as a joint presentation by a clinician and an IT technician.	Significant improvement made in care	National Acute Oncology Conference Acute Oncology Flow Conference
1617-33 Pilot evaluation of pre-appointment phone Follow-up upper GI	Objective of the project was "To reduce face to face consultations in outpatient". Conclusion of report states "Patients with upper GI tumours avoided an unnecessary visit to outpatient clinic when reporting progressive symptoms & concerns during the pre-appointment telephone consultation, Patients with stable symptoms avoided unnecessary visits to the outpatient clinic. Patient experience questionnaires show overall satisfaction with the pre-appointment physician associate led telephone consultation". Action plan drawn up for two issues specifically expansion of the project and clinic disposal – both of which have been addressed	Significant improvement made in care	General Audit Presentation Event
1617-44 Intra Fraction Motion Bio Optimised RT Prostate	Objective of Audit was "To assess the intrafraction motion of the prostate and whether real time motion management is essential". Lead reports "The study is complete and showed our standard imaging is optimum and the future of soft tissue CBCT pre and post would be the gold standard particularly for those patients with consistently large post image displacements"	Provided Assurance	Poster for Liverpool University School of Science
1516-14 Neutropenic sepsis in Ewings and Rhabdomyosarcoma	Objective of the audit was "The aim of this study was to assess the incidence of neutropenic sepsis in patients who had received aggressive chemotherapy regimens for sarcomas, and assess the point in the chemotherapeutic cycle that patients develop neutropenic sepsis."	Improved knowledge	

Title	Actions to improve quality of care/Assurance Provided	Outcome	Presented
	<p>This concluded that although “Based on several published studies, the use of G-CSF for primary prophylaxis with chemotherapy regimens can reduce the risk of neutropenic sepsis, however this study concludes it can still occur in up to 50% of patients. Neutropenic sepsis is most likely to occur on day 10 of the cycle of chemotherapy for sarcoma patients and if it is going to occur, is more likely after cycles one or two. Further research in a larger population is needed to confirm these observations.”</p>		
1516-06 Efficacy and safety of Ipilimumab in metastatic ocular melanoma	<ul style="list-style-type: none"> • Ipilimumab, as a single agent for the treatment of metastatic ocular melanoma, has shown overall disappointing results with best response being SD and 1-year OS of 40%. • The treatment has significant immunological toxicity, with occasional fatal outcome. Overall immunological toxicity is seen in 60%, being grade 3 or 4 in 26% cases. • Recommended to explore if new regimens of combined immunotherapies have better outcome and different toxicity profile 	Improved knowledge	Skin SRG
1617-45 Rate of uterine perforation before and after the introduction of ultra sound guided brachytherapy for cervical cancer	<p>This procedure is recommended for proper placement of intracavitary applicator as it reduces the rate of uterine perforation and suboptimal placement of uterine applicator. It is fairly accurate, easily available and cost effective.</p>	Provided Assurance	The International Gynaecological Cancer Society (IGCS), Japan
1718-43 Post-Operative Cavity Irradiation for brain metastases	<ul style="list-style-type: none"> • Post-operative fSRS 30Gy in five fractions for surgically resected brain metastases was well tolerated and achieved good local control • Intracranial Relapse Free Survival. Median time to relapse 4.21 months • Median target volume: 18.5 cc [2.31-45.47] • Mean equivalent sphere diameter: 3.1 cm [1.6-4.4] • No reports of radionecrosis or severe (>grade 2) toxicity 	Provided Assurance	BNOS Conference
1718-01 Efficacy of Abiraterone with low-dose Dexamethasone in castration-resistant prostate cancer	<ul style="list-style-type: none"> • Steroid switch is effective in controlling PSA in 63% of cases • The known baseline factors are not predictive of response to steroid switch • Effect of steroid switch is not possible to predict • Given this data, it is difficult to approve to continue low-dose dexamethasone on PSA rise after steroid switch • Recommendation from this audit to consider steroid switch on PSA rise on the treatment with abiraterone/prednisone. 	Significant improvement made in care	Urology SRG8

Title	Actions to improve quality of care/Assurance Provided	Outcome	Presented
	<ul style="list-style-type: none"> Recommendation from this audit to continue low-dose dexamethasone is not substantiated by this data. 		
1617-46 Dose intensity and clinical efficacy of Afatinib in EGFR mutant NSCLC: a multicentre retrospective study	<ul style="list-style-type: none"> Results suggest that neither dose intensity nor dose reductions down to 20mg/day are deleterious to clinical outcomes. Indicates that in mutation-driven cancers using clinical markers of efficacy instead of MTD in early phase studies may contribute to optimise the clinical benefit/toxicity balance of targeted agents. Using afatinib in first line with optimal dose reductions remains an attractive option to control patient disease for those presenting with brain metastasis, whilst keeping open the possibility of second line osimertinib. 	Provided Assurance	ESMO
1718-09 Determination of appropriate CBCT imaging doses for H&N daily imaging protocol	<ul style="list-style-type: none"> Results are indicative that the lower dose imaging protocols do produce comparable quality images in comparison to the default manufacturer settings. The roll out of daily imaging for head and neck patients and CNS patients. 	Significant improvement made in care	
1617-05 Patients experience with PICCS in CCC	<ul style="list-style-type: none"> 99% of patients said their PICC was the best way to get their treatment 57% rated the PICC insertion experience as 10 out of 10, 22% 9 out of 10 & 11% 8 out of 10 	Provided Assurance	Study day hosted by PICC team
1819-07 Evaluation of the addition of GCSF Prophylaxis to the FLOT Chemotherapy regimen	<ul style="list-style-type: none"> After the introduction of filgrastim prophylaxis from day 5 of each cycle of the FLOT regimen, the incidence of neutropenia fell from 61.6% to 3.1%. 	Significant improvement made in care	Liverpool University (Poster) Circulated to Upper GI SRG General audit meeting
1819-09 What do multi-disciplinary staff members at The Clatterbridge Cancer Centre know about the MHRA Yellow Card Scheme?	<p>Results showed knowledge of "Yellow Card Scheme" across the Trust was lacking with the exception of Pharmacy department. Therefore the following actions were introduced:</p> <ul style="list-style-type: none"> Screen saver on all site computers reminding staff of "Yellow Card Scheme" Desktop icon on Trust computers and IOS devices which takes you directly to the Yellow Card reporting website Yellow Card Posters in all staff areas increasing awareness of the scheme Teaching sessions at staff meetings 	Improved Knowledge	Liverpool University (Poster) General audit meeting

Title	Actions to improve quality of care/Assurance Provided	Outcome	Presented
1819-09 Advanced Ovarian Cancer update Merseyside /Cheshire	<ul style="list-style-type: none"> • Sustained significant improvement in overall survival for advanced ovarian cancer (compared to 2006-2009 data) • No significant survival difference between 12-13, 13-14 and 15 cohorts • Similar patient demographics • Ongoing analysis of practice and outcomes will hopefully show ongoing improvement as new therapies are introduced to practice 	Provided Assurance	Gynae Audit Presentation Event
1617-42 A report on patients' information survey before consenting for contact X-ray brachytherapy (Papillon).	The result from our patients' survey suggested that the majority of the patients were satisfied with our process of consenting and that they do not wish to have more time to consider about this before their treatment. The majority of our patients do not wish to come back on a different day for their treatment.	Provided Assurance	
1819-06 Assessing the Value of the Neuro CNS team	100% positive feedback for all questions, bar one "Did you feel your questions were answered by the specialist nurse" which was 97%.	Provided Assurance	CNS SRG Meeting
1718-38 Sorafenib for hepatocellular carcinoma	<ul style="list-style-type: none"> • Survival in HCC depends on interplay of disease stage, liver function and patient performance status which need to be considered when making treatment decisions. • The BCLC staging provides a good prognostic stratification of overall survival in patients diagnosed with HCC and a similar trend would be seen in patients treated in a tertiary transplant unit. 	Provided Assurance	2 posters presented at British Association for the Study of the Liver conference (BASL)
0910-36 HDR Cervix 3 insertions	<ul style="list-style-type: none"> • Cervical cancer patients treated at CCC in 2009 to 2010 have a better OS than previously • There are more patients receiving concurrent Cisplatin chemotherapy • Toxicity during treatment has not increased • Long term toxicity has not increased since the brachytherapy dose increased 	Provided Assurance	Gynae SRG audit day
1718-15 Assessment of adequacy of contrast enhancement in CTPA (CT pulmonary angiogram)	<ul style="list-style-type: none"> • Training: To correct the technique of the bolus tracking and optimal position of the ROI • Introduce saline chaser if possible • Omit patient's deep inspiration: either STOP breathing or no instructions of breathing • Reduced the FOV • Use >20G cannulas or PICC lines (>4F, CT-ready) and flow >4 mL/ 	Significant improvement made in care	Presented to Radiological Department
1718-27 1st line use of Palbociclib and AI in ER+ metastatic breast cancer: Toxicities and benefits in the	<ul style="list-style-type: none"> • In the context of a real world population there does not appear to be any major issues in delivering Palbociclib. • There was a clear and sustained reduction in white cell count and neutrophil count on Palbociclib, this is not seen with other haematological parameters. • Initial progression free survival data is consistent 	Provided Assurance	San Antonio Breast Cancer Symposium (SABCS) / Breast SRG Away Day

Title	Actions to improve quality of care/Assurance Provided	Outcome	Presented
real world	with the data within PALOMA-2.		
1718-48 "What are the barriers to facilitating conversations about erectile-dysfunction for men having hormone-radiotherapy for prostate cancer?"	It is recognised that erectile dysfunction is a common complication of hormone-radiotherapy for prostate cancer. Results showed all clinicians were able to engage patients to discuss this subject and refer to specialists when clinically indicated. Results also showed patients were more concerned with treatment options and it's side-effects.	Provided Assurance	Urology SRG
1819-28 Re-Audit Pressure Ulcer Compliance at CCC	Six monthly audit, May 2018 and October 2018 <ul style="list-style-type: none"> Acknowledged previous actions have been complete. Action was to reinforce to all staff the requirement to complete risk assessments within 6 hours 	Significant improvement made in care	Ward Huddle & Directorate Quality and Safety Meeting
1718-45 Real world assessment of the efficacy of neoadjuvant Trastuzumab and Pertuzumab for HER2 positive early breast cancer	<ul style="list-style-type: none"> Real world efficacy of neoadjuvant Trastuzumab/Pertuzumab reflective of trial data Significant number of LN+ patients become LN- following NA treatment and measures to avoid ANC are needed Docetaxel toxicity frequently results in switching to weekly paclitaxel: a safe option that may be associated with a higher pCR Diarrhoea rates reflect the literature 	Provided Assurance	ASCO / Breast SRG Away Day
1617-11 Real world data regarding the efficacy of neoadjuvant Carboplatin-Paclitaxel followed by dose-dense Adriamycin-Cyclophosphamide for triple negative early breast cancer	<ul style="list-style-type: none"> pCR rates with Carbo-Pac-ddAC are consistent with current literature. These results support the use of platinum based chemotherapy in the neoadjuvant management of TNBC. No all patients <50 appear to have been tested for germ line susceptibility 	Provided Assurance	ASCO / Breast SRG Away Day
1718-33 A retrospective audit on treatment outcomes for patients with high grade neuroendocrine colorectal	<ul style="list-style-type: none"> We have demonstrated that response rates to chemotherapy are low at 33.3% to first line and 0% to second line. Therefore, better systemic treatments are needed and as such patients with colorectal-NEC should preferably be treated on clinical trials 	Improved Knowledge	ESMO GI

Title	Actions to improve quality of care/Assurance Provided	Outcome	Presented
carcinoma			
1819-26 Folfirinox	<ul style="list-style-type: none"> As fewer than 10% of patients are not able to have more than 1 cycle of Folfirinox an in-depth review of patient selection may be justified. Deferral rate should be investigated to see if there is a correlation to cycle number Well tolerated treatment considering the number of agents Successes have been found with this treatment allowing patients to have adjuvant surgeries and curing disease but this should be measured carefully with the toxicities that this treatment may cause 	Improved Knowledge	Drugs & Therapeutics Committee
18-19/11 Melanoma brain metastases: management and outcomes	Brain metastases carries a poor prognosis in Metastatic Malignant Melanoma. This cohort illustrates that patients continue to have a varied treatment regime and poor survival. With earlier, asymptomatic detection and robust, multi-professionally agreed treatment algorithms the outcomes for this patient group may be improved.	Improved Knowledge	General Audit Meeting
17-18/47 A Critical Appraisal of the Impact of my Leadership on the Patient Safety Culture at the Clatterbridge Cancer Centre	Overall, the findings demonstrate that diversity within healthcare often infers the requirement for multiple solutions to individual challenges, in this case that of fostering a positive patient safety culture. Indeed, this is how modern healthcare leaders need to respond, particularly when working in multidisciplinary, integrated formats	Provided Assurance	NHS Leadership Academy
17-18/50 Audit of the Palliative Radiotherapy Service	<ul style="list-style-type: none"> In order to improve the prioritisation of patients for treatment, there was a need to increase communication from referring hospitals regarding patient condition, escort & medication 24hr prior to Palliative Radiotherapy Clinic (PRC) Appointment of Consultant Radiographer in Palliative Radiotherapy, Support Clinical Oncologist Lead Introduction of PRC at CCC Aintree to reduce travel time 	Significant improvement made in care	BIR Annual Congress
16-17/29 Monitoring patients during treatment with Trabectedin	<ul style="list-style-type: none"> Work with pharmacy and IT to embed the serological monitoring into Meditech 	Significant improvement made in care	British Sarcoma Group Conference General audit meeting

Title	Actions to improve quality of care/Assurance Provided	Outcome	Presented
18-19/14 GDE Programme Patient Baseline Survey	Majority of patients state they would utilise self-check in kiosks (>85%)	Provided Assurance	GDE Digital Board
17-18/18 RCA Pressure Ulcer Service Evaluation	The RCA is fit for purpose. It is efficient and it enables the identification of root causes. There is the potential for some minor modification and for the incorporation of trust specific items, and for it to be available for completion on-line	Provided Assurance	Edge Hill University CCG
15-16/16 HNA for high risk uveal melanoma patients undergoing regular liver surveillance	89% of patients showed emotional concerns at baseline which declines then peaks again around 4.5 years which is in line with length between follow-up appointments increasing at the 5 year mark.	Provided Assurance	Venice European Nursing General Audit Presentation Event
16-17/14 Secondary Breast Cancer Pledge	Increased access to services including named clinical nurse specialist for advanced breast patients. Enhanced Supportive Care initiative expanded to this cohort of patients	Significant improvement made in care	Breast SRG Away Day
18-19/19 Ovarian Survival Analysis update	Sustained significant improvement in overall survival for advanced ovarian cancer (compared to 2006-2009 data) No significant survival difference between 2012-2013, 2013-2014 and 2015 cohorts Similar patient demographics	Improved Knowledge	Gynae SRG meeting
18-19/01 Outcomes audit of Lung cancer patient from Isle of Man service	There has been an increase in 1yr OS which acts as a surrogate for treatment effect from 38 to 44%. The one year survival is comparable with other centres	Provided Assurance	
16-17/40 Compliance of Docetaxel in treating breast cancer patients in adjuvant setting using FEC-T	The protocols for adjuvant/neoadjuvant management of breast cancer have been amended such that the standard of care for patients 60 years or older with ER positive early breast cancer (and all patients with triple negative breast cancer) have been changed from Docetaxel to Paclitaxel in response to audit findings.	Significant improvement made in care	Breast SRG Away Day

Information on participation in clinical research 2018/19

The number of patients that were recruited during 2018/19 to participate in research approved by a Research Ethics Committee was 846.

57 Studies opened in 18/19 with a fully diversified portfolio enabling the highest levels of recruitment recorded by CCC

2018/19 Recruitment to Clinical Trials

	Q1	Q2	Q3	Q4	Total
Clatterbridge Cancer Centre	129	145	239	333	846

Research and Innovation

This has been a seminal year for the Research and Innovation Department at CCC. The Trust has recognised research as core business and provided significant investment of £1.8 million over the next three years to support research. This has underpinned the new Research Strategy approved by the Board in July 2018 which holds the mission and values of CCC at its heart and which has taken CCC research to the next level where we will make each patient's experience count.

We have long been recognised as a tertiary cancer centre with strength in the delivery of complex trials of novel agents, however, the new Research Strategy provided ample opportunity to build on this strength and to deliver a wider ranging, diverse, patient focused portfolio of research giving tangible patient benefit and enabling increased patient access to research studies. We appreciate that we are part of a wider health economy and are developing and refreshing relationships with key stakeholders, partners and providing leadership of the cancer agenda across the region that we serve. The Transformation of Cancer Care programme

and expansion into the new CCC Centre of Excellence in the Knowledge Quarter gives us a unique opportunity for research expansion, staff development and system change.

Key Drivers for the Research Strategy

The key drivers for research are:

- Continue to embed research as core business throughout the Trust to become a recognised research active hospital.
- Provide patient centred research and increase recruitment into research studies.
- Ensure our patients have equitable access to research through our hubs and sectors
- Build a dynamic research portfolio based on our strengths in interventional studies and novel agents.
- Diversifying the portfolio to support real world studies, qualitative studies and supporting translational research to identify mechanisms of cancer, biomarkers and understanding toxicities.
- System change across the region to support cancer research.
- Continuing the support of the Liverpool Experimental Cancer Medicine Centre as the NHS partner.
- Increasing the visibility of CCC research.
- Raising the profile of CCC nationally.

Notable Achievements

We have delivered on the goals and milestones of the new Research Strategy at pace.

- Achieved the highest level of recruitment of participants to research attributable to CCC, with 846 patients recruited overall and of those 588 to NIHR portfolio studies to this report date.

- Achieved a number of ‘First UK patient’ recruited to studies where CCC has been a participating site (see table below). We are also in the top 3 sites for recruitment in many interventional studies across our portfolio.
- Diversified the research portfolio by increasing the number of non-interventional, observational and qualitative studies.
- Invested in new posts to support the diversified portfolio.
- Invested in infrastructure support for research facing staff in service department and supported staff Programmed Activities (PA) time for research.
- Supported our research fellows programme.
- Led systems change in bespoke working with partner Trusts, developing Service Level Agreements (SLAs) to speed timelines for opening studies, increasing patient access to cancer trials across the region and partnering in new ways of mutual support and working. We are continuing to work with our University partners particularly the University of Liverpool in driving the cancer research agenda.
- Continue to be an active and committed partner in the establishment of the Liverpool Health Partners Joint Research Service, providing delivery and business intelligence expertise. As nationally recognised leaders in the use of the Edge system, CCC has led the development and implementation of this crucial part of the Joint Research Service (JRS) and will continue to work with the Edge Team and North West Coast Cancer Research Network (NWC CRN) stakeholders in building this novel system for the JRS.
- We have extended our reach in participants from across the UK and Ireland taking part in our studies.
- We continue to support CCC-led research where CCC acts as Sponsor, with studies in Lung, Cervical Cancer, Head and Neck Hepatobiliary, Haemato-oncology and Prostate studies open or in pipeline development.
- The CCC Biobank continues to collect samples to support fundamental research into the mechanisms of cancer, biomarker development and target collections to support our research fellows.
- We have refreshed the Trust research website, making it more user-friendly patient focused and accessible. We are continuing to work on this and upgrade as we move forward.

Therefore we have in this year, re-energised research at CCC. This has resulted in refreshed research facing staff, the highest ever recruitment to NIHR portfolio and non-portfolio studies, increased partnership working, increased patient benefit and care through research.

First UK patient' recruited to studies where CCC has been a participating site

Project Acronym	Project Full title	Principal Investigator	Disease Group
5512 EPIZYME	An Open-Label, Single Center, Two-Part, Phase 1 Study to Characterize the Pharmacokinetics of a Single Intravenous Micro-Dose of Tazemetostat (EPZ-6438) and the Absorption, Distribution, Metabolism and Elimination of a Single Oral [C] Labelled Dose of Tazemetostat in Subjects with Advanced Solid Tumours or With Lymphomas	Palmer, Prof Daniel Pettitt, Prof Andrew	Upper GI Haematological
PRAN-16-52	Phase III, Double-Blind, Placebo-Controlled, Multicenter, Randomized Study Of Pracinostat In Combination With Azacitidine In Patients ≥18 Years With Newly Diagnosed Acute Myeloid Leukemia Unfit For Standard Induction Chemotherapy	Patel, Dr Amit	Haematological
FORT-1	A randomized, open label, multicenter Phase 2/3 study to evaluate the efficacy and safety of rogaratinib (BAY 1163877) compared to chemotherapy in patients with FGFR-positive locally advanced or metastatic urothelial carcinoma who have received prior platinum-containing chemotherapy	Syndikus, Dr Isabel	Bladder
AGIOS AG120-C-005	A Phase 3, Multicenter, Randomized, Double-Blind, Placebo-controlled Study of AG-120 in Previously-treated Subjects with Nonresectable or Metastatic Cholangiocarcinoma with an IDH1 Mutation	Palmer, Prof Daniel	Upper GI
RSV-L	A double blind, placebo-controlled study to assess the antiviral effect, safety and tolerability of inhaled PC786 for the treatment of acute respiratory syncytial virus (RSV) infection in adult hematopoietic stem cell transplant recipients	Patel, Dr Amit	Haematological
CHECKMATE 9DX	A Phase 3, Randomized, Double-blind Study of Adjuvant Nivolumab versus Placebo for Participants with Hepatocellular Carcinoma Who Are at High Risk of Recurrence after Curative Hepatic Resection or Ablation	Faluyi, Dr Olusola	Upper GI
PIVOTALboost	A phase III randomised controlled trial of prostate and pelvis versus prostate alone radiotherapy with or without prostate boost	Syndikus, Dr Isabel	Prostate

CQUINS:

A proportion of The Clatterbridge Cancer Centre NHS Foundation Trust's income (2018/19) 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.

Whilst the Trust did not meet all requirements, we are proud of CQUIN related developments including the expansion of the Enhanced Supportive Care team and the introduction of a network of Cancer Support Workers, both of which have delivered better patient experience. For future CQUINS we have revised processes to ensure achieved.

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 Trust was under enhanced monitoring and required to strengthen its safeguarding service in February 2018. An agreed 6 month action plan was successfully delivered by the Trust in August 2018, and new safeguarding leads appointed. Further detail has been provided in the Safeguarding section of this report.

Information on the quality of data

The Clatterbridge Cancer Centre NHS Foundation Trust submitted records during 2018/19 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: 99.9% 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: 99.8% for admitted patient care and 99.7% 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.

In The Clatterbridge Cancer Centre NHS Foundation Trust Information Governance Assessment for 2018/19 the Trust achieved compliance against all 40 mandatory standards of the new NHS Digital Data Protection and Security Toolkit.

Data Quality Improvement Plans

Good quality information that is accurate, valid, reliable, timely, relevant and complete is vital to enable the Trust and our staff to evidence that high quality, safe and effective care is delivered.

Good quality information also supports the Trust to manage service planning,

performance management and commissioning processes.

The Trust has a Data Quality Policy in place which outlines expected standards around data recording. The Trust has an active data quality group which oversees an annual audit programme that reports into Information Governance Committee for Toolkit requirements including the annual audit of nationally submitted data sets.

During 2019/20 the Trust is replacing the existing Data Quality group with a new Data Management group which will be chaired at Executive level and will meet monthly with a clear focus on data quality. This group will ratify a new Kite Marking policy and will review the existing data quality policy.

The importance of Data Quality is also highlighted in Electronic Patient Record (EPR) System training along with the importance of Good Record Keeping.

The Trust continues to review its Business Intelligence function and has recently recruited to a new post of Head of Business Intelligence to lead a new service within the Trust.

Implementation of the Clinical Standards for Seven Day Hospital Standards

The Trust has made significant progress in the Implementation of the Priority Clinical Standards for Seven Day services. The Consultant of the week rota is now well embedded and has enabled the Trust to meet the 14 hour target of 90% in the last two consecutive months.

We are also consistently compliant in the delivery of the following standards;

Standard 1- Information gathered via our FFT, In Patient surveys and the patient experience group indicate we are compliant with this measure.

Standard 3 - All emergency admissions are assessed for complex and/or on-going needs via the MDT ward round, as per the Transfer and Discharge policy. All ward rounds are led by a consultant.

Standard 4 - Handovers occur at 9am and 4pm daily in a designated location, handover is led by a Consultant and attended by all the junior doctors, consultants on call x2, registrar on call, spinal cord compression coordinator, ward managers, palliative care nurse, critical care outreach nurse, physician associates and a representative from medical staffing. All clinical data is recorded on an Electronic Patient Record system.

Standard 7 - Urgent psychiatric and psychological support is available from the Psychological Medicine team at WUTH for solid tumour in patients on our Wirral site and RLBUHT for our Haemato Oncology patients at the Liverpool site.

Standard 10 - The Trust Integrated Performance report is shared with the Board monthly; this includes performance data relating to quality improvement and patient outcomes. The management and supervision of junior trainees is delivered by an identified education lead for each professional group, this includes Practice Education Facilitators, Medical Education Team, Radiographer Lead and the Head of Physics.

The Trust has made great progress towards achieving compliance against **Standard 9**, there is a Pharmacy service, Physiotherapy service and access to transport services 7 days per week, however, as the Trust delivers services to patients living across a very wide geographical area, the availability of support services, in primary and community health settings are not always available 7 days per week. To improve access to these services CCC has introduced a designated Discharge Coordinator and Patient Flow Team. This Team proactively identify patients that may require additional support within the

community following discharge and coordinate individual care packages for this patient group. The Trust is confident that it

will be fully compliant against standard 9 during 2019.

Learning from Deaths

During 2018/19 89 patients died as an inpatient at The Clatterbridge Cancer Centre NHSFT, 65 patients died at CCC Wirral & 24 patients died at CCC HO Liverpool. This comprised the following number of deaths which occurred in each quarter of that reporting period: 30 in the first quarter; 24 in the second quarter; 18 in the third quarter; 17 in the fourth quarter.

2018-19	No. of Inpatient Deaths
Q1	30
Q2	24
Q3	18
Q4	17
Total	89

As of 8th April 2019, 70 case reviews have completed phase I*, out of which 63 were further investigated at phase II** and 22 were further selected for discussion at phase III*** the Trusts formal Mortality Review Meeting.

* Consultant case record review of own case

** Multi-disciplinary case selection panel

*** Trust – wide formal multi-disciplinary mortality & learning from deaths review meetings)

19 cases require phase I review and will be completed during 2019-20.

26 cases require phase II review and will be completed during Q1 2019-20.

Out of the 22 cases discussed at the formal mortality review meeting, the number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 0 in the first quarter;
- 4 in the second quarter;
- 11 in the third quarter;
- 4 in the fourth quarter.

3 cases awaiting phase III review will be discussed during Q1 2019-20.

63 out 70 cases (90%) had a Structured Judgement Review (SJR) completed, 1 out of 63 was deemed to have had a slight evidence of avoidability (score 5) and 62/63 were scored 6 i.e. definitely not avoidable.

7 (10%) cases require a SJR which will be completed during Q1 2019-20 to ensure 100% completion of SJR for all inpatient deaths.

Outpatient Deaths

In addition to reviewing all inpatient deaths, The Clatterbridge Cancer Centre NHSFT is also committed to reviewing outpatient deaths for patients within our care who meet the mortality

review criteria; deaths within 30 days of chemotherapy or radiotherapy treatment, and within 90 days of radical radiotherapy treatment. Radiotherapy for spinal cord compression and bone metastases cases do not require review, on the condition that the dose and fractionation given was as per Trust protocol. Therefore the corresponding figures for the **outpatient** deaths during the period are as follows;

During April 2018 – February 2019 **499** 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: 146 in the first quarter; 113 in the second quarter; 152 in the third quarter; 88 in the fourth quarter*.

2018-19	No. of Outpatient Deaths
Q1	146
Q2	113
Q3	152
Q4 (January & February 2019)	88
Total	499

**Death data only available for January & February 2019.*

Of the 499 deaths, 388 cases required a review following the above aforementioned criteria. By 8th April 2019 338 case reviews have completed phase I, out of which 235 were further investigated at phase II and 34 were further selected for discussion at phase III the Trusts formal Mortality Review Meeting out of which 20 were discussed during the period.

2018-19	No. of Outpatient Deaths Reviewed
Phase I	338
Phase II	235
Phase III	34

50 cases require phase I review and will be completed during 2019-20.

153 cases require phase II review and will be completed during Q1 2019-20.

14 cases awaiting phase III review will be discussed during Q1&Q2 2019-20.

Out of the 20 cases discussed at the formal mortality review meeting, the number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 1 in the first quarter;
- 6 in the second quarter;
- 3 in the third quarter;
- 10 in the fourth quarter.

Learning from SUI investigations

Incident	Key learning
<p>Triage call received regarding a patient who was feeling unwell, assessed using UKONS and attended for further assessment. On arrival MET call raised as patient collapsed in car.</p> <p>The Serious Incident learning meeting concluded that the staff acted appropriately and followed due process and were commended for their efforts, especially in the challenging</p>	<ul style="list-style-type: none"> • Communication on the use of the Hotline service to other departments to ensure staff aren't taken away from hotline duties. • Medical Director has highlighted the importance of timely and thorough documentation by medical staff. • An audit of hotline service to be

environment.	<p>completed.</p> <ul style="list-style-type: none"> Review of the UKONS tool has been undertaken and it was agreed that this is the most appropriate tool to assess each individual patient
<p>Patient became unwell after undergoing a radiotherapy planning scan with oral and IV contrast. MET call raised which was quickly escalated to CRASH call but the patient deteriorated rapidly and attempts to resuscitate were unsuccessful. Coroner confirmed the cause of death as anaphylactic shock due to a reaction to the IV contrast medium.</p>	<ul style="list-style-type: none"> To enable faster IV access in case of emergency the post scanning protocol has been amended so that the cannula now remains in situ for 30 minutes after the scan is complete for all Radiation Services patients who have received IV contrast Intraosseous drill purchased for CRASH trolley to be used in cases where intravenous access cannot be obtained Planning staff have received training in in anaphylaxis reactions and administering IM adrenalin Planning staff to be linked with Medical Emergency Team on rotation to enhance decision making for acutely unwell patients

Summary of learning from case record reviews and investigations conducted in relation to deaths (inpatient and outpatient deaths) along with description of actions taken in the reporting period

Case	Background	Action	CCC Lesson learned
1	There was a contraindication between Pazopanib and the patient's current medication, although the contraindication did not affect the patient's outcome. In order to minimise contraindication to Pazopanib, it is necessary to have a current medication list for patients who are on Pazopanib	Addition to current process, pharmacy will ring Pazopanib patients to gain consent to contact GP for current medication list	Acquiring the latest medication list from the patients GP will minimise this risk as consequences can be fatal if there is a contraindication
2	Sub optimal dose of Dexamethasone was prescribed for a patient's condition in the palliative care emergency setting	Ensure there is junior doctor education in palliative care emergencies	Increased and frequent education is essential to ensure junior doctors are confident and capable in dealing with palliative care emergencies
	Dexamethasone prescribing and dosage is not only a local issue, it is also an issue in the wider community	Introduce 3 day Dexamethasone review and update SACT protocol	Ensuring that the SACT protocol contains thorough instructions enables a safe and consistent approach to patient care
		Disseminate Dexamethasone guidelines out to the clinical pharmacist network and acute	Sharing of guidelines enables a safe and consistent approach to

Case	Background	Action	CCC Lesson learned
		<p>oncology team</p> <p>Produce guidance for CNS and air way obstruction in relation to Dexamethasone management for triage</p>	patient care
3	A patient who lived alone was discharged home when it was unclear whether requested community support was in place before discharge	<ul style="list-style-type: none"> • Conway Ward Manager to review/revise discharge process for patients living alone • The patient flow team fully established Jan 2019 • Development of a discharge assessment in Meditech which the patient flow team will lead on. • Implemented daily ward rounds across the 2 wards Feb 2019 • Ward based education regarding safe discharge/documentation • Introduction of 24 hr discharge follow up calls for complex discharges 	The introduction of designated team to provide follow up service to a specific patient group at 24/48hours post discharge will enable us to provide timely intervention if required
4	A fit neoadjuvant patient passed away from surgical complications after receiving pre-op chemotherapy, followed by chemoradiation as standard of care. It was queried whether a conservative "watch and wait" surveillance policy would have sufficed as a complete response after chemoradiation was achieved.	Upper GI SRG to consider an audit of patient survival following Pre-Op ChemoRT in oesophageal cancer	It is good clinical practice to follow established treatment protocol. Protocol should be periodically reviewed / audited to confirm best practice/outcomes.
5	Patient had a very rare catastrophic event. It was felt that Cabozantinib may have led to necrosis in a previously irradiated area	<p>Include potential fatal risk in consent process. SRG agreed that consent form should cover adverse events including death</p> <p>Yellow card completed</p>	<p>It is important to inform patients of rare side effects that could occur in this patient group during the consent process.</p> <p>MHRA monitor the safety of all healthcare products in the UK and ensure they are safe for patients taking the medicines and for clinical staff administering them</p>
6	It was unclear to clinicians when and who should instigate the amber care bundle when clinicians have	Clarity of who initiates amber care bundle	Amber Care Bundle is currently not implemented in the Trust. The group agreed this patient would

Case	Background	Action	CCC Lesson learned
	concerns that patient may have a few months left to live		have benefitted from the amber care bundle. Plan is to form a working group, led by palliative care team and re-launch Amber Care Bundle.
7	Patient's performance status deteriorated between time of consent and start of Pembrolizumab.	Lung SRG to review the Pembrolizumab protocol in light of patients with declining PS prior to treatment commencement after consent	For patient safety it is important that the consultant is informed of a declining performance status before deciding whether to go ahead with treatment as planned
8	Communication issues with patients who present with learning disability. End of life planning presented challenges with patient and carers.	Investigate Learning Disabilities Mortality Review (LeDeR) requirements	Occasionally patients with a learning disability may require additional support to ensure information is understood fully and work with patient family to provide best possible care/support to the patient. Promote safeguarding across the Trust.
9	Inaccurate performance status was recorded by chemotherapy nurses however this did not affect the eligibility for this patient to receive chemotherapy	Performance Status definition training for chemotherapy nurses	Performance status (PS) definition can be subjective. Standardising its definition across the nursing team enables the accurate recording of PS as interpretation can lead to stopping treatment as well as continuation of treatment if appropriate.
10	There was no evidence that the care after death documentation was completed	Investigate if care after death documentation was completed	Secondary checks have been introduced to ensure that all relevant documentation is completed
11	An ultrasound showed a renal mass after radiotherapy and brachytherapy to the pelvic region, it was queried if the renal mass was present before the radiotherapy treatment	Gynae SRG chair reviewed the care with North Wales Colleagues, concluded that there is no identifiable cause of renal failure and we do not feel this was related to the recent pelvic radiotherapy and more likely a consequence of other pre-existing comorbidities. There are no issues with her care whilst attending Clatterbridge	Having a complete patient journey available can be useful in some cases whereby there have been transfers to and from acute hospital Trusts when reviewing mortality cases. Shared learning between Trusts is beneficial to strengthening partnership working
12	Patient became unwell after completing chemoradiation, declined review by a GP or	Confirmed that the Upper GI CNS had completed daily notes in Meditech post triage call until	Excellent service provided by Upper GI CNS in relation to this case

Case	Background	Action	CCC Lesson learned
	attendance at local A&E as per UKONS guidance.	day of death	
13	Appropriateness of transfer was discussed for a patient was in a lot of pain	Transfer policy reviewed	The process of ward transfers has now changed, as patients are moved to tumour group specific wards from CDU and then wouldn't be transferred again between the wards. The discharge and transfer policy has been rewritten to reflect this.
14	Patient's deterioration was likely due to immunotherapy treatment that exacerbated existing comorbidities	Lung SRG to review consent process for Pembrolizumab in light of quarterly 30 day chemotherapy mortality data	It is important for site reference groups to review their consent processes in the context of 30 day mortality for high risk regimes
15	Chemotherapy was given on admission at external hospital. The named surgeon was unaware of admission. An interventional procedure was planned when DNACPR in place but subsequently abandoned. There is no record of involvement with the palliative care team. Urine output was not visibly documented. Management plan not clearly documented.	Contacted external hospital involved in care clinical team to review the care of this case in light of concerns	Shared learning between Trusts is beneficial to strengthening partnership working
16	Lack of communication with patient's family after acute deterioration. The patient's family were not present when patient died and were informed of the patient's death over the telephone.	Amber care bundle tool to be implemented	The use of a structured tool on the wards can help start and guide discussions in end of life care planning
	25% HER2 positive breast patient would develop brain met. If scan HER2 patient at diagnosis of brain met, there is a possibility for resection when they are small, enhancing patient's QOL.	Discuss potential benefits of scanning HER2 + breast cancer patients at diagnosis of metastasis for brain metastases at the next Breast SRG	There is a potential benefit of scanning to investigate whether HER2+ breast cancer patients have brain metastases at diagnosis of other metastases, as early diagnosis can result in survival benefits and increased quality of life in these patients
17	This patient has multiple cancer diagnosis making it unclear as to which pathway should be followed and by	Head & Neck and Skin SRG to develop pathway for St Helens & Knowsley patients	It is very important that patients do not fall into a grey areas within different pathways and instead

Case	Background	Action	CCC Lesson learned
	whom		have a personalised pathway
18	Clinician requested for patient's Apixaban treatment for DVT to be switched to Low Molecular Weight Heparin in preparation for chemotherapy treatment to start. However, the District nurse referral alluded a prophylactic dose of Apixaban of 5000 rather than a therapeutic dose.	Inform external hospital involved in the care and check whether patient was on therapeutic dose prior to treatment of ascites. Risk & Patient safety manager at LWH has been tasked with responding accordingly	Shared learning between Trusts is beneficial to strengthening partnership working
19	Patient had an abdominal x-ray suggesting a possible bowel perforation, however there was no documented surgical review until 4 days later	Request external hospital involved in the care investigate the care of this patient	Shared learning between Trusts is beneficial to strengthening partnership working
20	Patient collapsed at home and taken to a local A&E via ambulance 14 days post cycle 1 chemotherapy, Neuts were 0.1 but no documentation of antibiotic administration until 4 hours post arrival	Request external hospital involved in the care investigate the care of this patient (including time to antibiotic administration)	Shared learning between Trusts is beneficial to strengthening partnership working
21	The choice of radiotherapy protocol given was questioned in a patient with metastatic disease	Any off protocol treatment to be discussed within the peer group and documented in Meditech. Message to be conveyed to Site Reference Group Chairs	Documentation of discussions using structured tool within Meditech will strengthen the mortality review process and provide assurance and evidence of peer review

Freedom to Speak Up (FTSU)

Following the national review across the NHS into Whistleblowing, The Clatterbridge Cancer Centre fully embraced the recommendations to foster a culture of safety and learning in which all staff feel safe to raise a concern. The Trust reviewed the Raising Concerns Whistleblowing Policy and the process for speaking up and in-line with the new national guidance, the reviewed policy has been renamed Freedom to Speak Up (raising concerns in the workplace). The Trust appointed FTSU Executive and Non-Executive Leads, a FTSU Guardian Lead plus five Local Freedom to Speak Up Guardians and launched our Freedom to Speak Up campaign in 2018.

Freedom to Speak Up Guardians work alongside Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely. Furthermore, the Trust Policy is clear that those who raise concerns are protected from detriment or suffering any form of reprisal and anyone responsible for such detriment will be subject to disciplinary action.

The Trust hopes that all members of staff feel comfortable in raising any concerns openly however, we also appreciate that some staff may wish to raise concerns confidentially. Therefore, unless required to do so by law, the Trust will keep the individuals identity confidential.

The Trust Board is committed to listening to our staff, learning lessons and improving patient care and supporting an open and honest culture where staff feel comfortable and safe to speak up.

The communications to support the campaign are as follows:

- A Trust wide Screen Saver
- E Bulletin – regular updates are included in the Trusts electronic communication bulletin
- An Extranet page is available to all staff which provides
 - Introduction and Trust Values & Behaviours
 - Clarity around who can raise a concern
 - What type of concern can be raised
 - How to raise a concern.
 - Guidelines for anyone to whom a concern has been raised
 - Where to get advice and support.
- Information leaflets have been distributed to all members of staff.
- A dedicated Freedom to Speak Up notice board displays a poster of all the guardians with contact details
- Monthly FTSU meetings have been formalised and are chaired by the FTSU Guardian Lead.
- A confidential email address for staff has been introduced and can only be accessed by the FTSU Guardians.

Oversight of FTSU is ultimately through the Trust Board via quarterly and annual reports.

Raising a Concern

Staff can raise concerns in confidence with any of the people listed below in person, by phone or in writing (including email).

- Directorate, Departmental and Line Manager
- The Workforce and Organisational Development Team (WOD)
- Freedom to Speak Up Local Staff Guardians
- Trade Union Representatives or Professional Organisations (TU)
- Health & Safety Team
- Local Security Management Specialist
- Occupational Health Team
- Safeguarding Team
- Chaplaincy

Staff can visit, telephone or write in confidence to one of the FTSU Guardians or by using the confidential email address.

FTSU Guardians are a point of contact for all staff to raise concerns and act on them by:

- Escalation to the appropriate level (Line Manager, General Manager, Head of Department, Director of Workforce and Organisational Development or The Executive Team including direct access to the Chief Executive if necessary)

- Signposting to the appropriate person or service for further advice and support for example Occupational Health or where issues raised as part of this process clearly relate to employee relations, that they are signposted to Workforce and Organisational Development and Trade Union Representatives.
- Recording and monitoring of concerns raised, providing timely feedback where possible
- Monitoring any trends and themes arising, providing reports as detailed in section.

Investigation:

Once a concern has been escalated to the appropriate Manager, an investigation is conducted by 1 trained investigator and 1 trained Trade Union Investigator who have no regular contact with the individuals involved and who work in a different area.

Outcome following investigation:

The person, who has raised the concern, will be invited to a meeting to discuss the outcome of the investigation and the decision following the investigation report. The Trust will, throughout this process respect the confidentiality of others.

Learning from raising concerns:

The focus of any discussion/investigation will be on improvement. Where it identifies improvements that can be made, the Trust will monitor them via the appropriate governance committee to ensure that any necessary changes are made and furthermore they are embedded within the organisation. Any lessons will be shared with teams across the organisation, or more widely, as appropriate.

There were 5 concerns raised in 2018/19 with no patient safety issues raised. All concerns will be monitored on a regular basis by the FTSU Guardians in conjunction with the Workforce and Organisational Development team and Trade Union representatives, whereby any trends or themes will be monitored and appropriate actions taken as necessary. Update reports will be provided to the Trust Board and appropriate committees on a regular and ongoing basis.

Rota gaps and the plan for improvement to reduce these gaps' re doctors and dentists in training

The Clatterbridge Cancer Centre NHS Foundation Trust does not facilitate Dentists in training, but does provide training to Specialist Registrars and Junior Doctors who are assigned by the Lead Employer St Helen's & Knowsley Teaching Hospital NHS Trust. The funded establishment for the training posts at The Clatterbridge Cancer Centre NHS Foundation Trust are as follows:

Specialist Registrars

Speciality	Number	Type of post	Number of posts funded by Trust
Clinical Oncology	13	Training post	2

Medical Oncology	6	Training post	1
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Junior Doctors

Type of Trainee	Number of Whole time equivalent	Lead Employer
Foundation Year 2 (FY2)	3	Wirral University Teaching Hospital NHS Foundation Trust
Core Medical Trainees (CMT's)	3	St Helen's & Knowsley Teaching Hospital NHS Trust
GP Specialist Trainees (GPST)	3	St Helen's & Knowsley Teaching Hospital NHS Trust

Rotations for FY2 and CMT run for 4 months in Aug-Dec; Dec-Apr; Apr- Aug
 Foundation Year 2 – Rotate to the Trust in August for 4 months and leave in December to continue their training.

Core Medical Trainees – Rotate to the Trust in August for 4 months and leave in December to continue their training.

GP Specialist Trainees – Rotate to the Trust in August for 6 months and leave in February to continue their training (Aug-Feb; Feb-Aug.)

Specialist Registrars – ST3 and above rotate to the Trust every August and remain for the full training programme until they qualify as a Consultant.

For 2018/2019 the Trust was allocated 21 Specialist Registrars (funded establishment was 19 wte), with 5 trainees being out of programme (2 of which were on maternity leave). The Trust also had 2 further trainees on maternity leave. Therefore, the rota that was established was based on a head count of 14 and any identified gaps were covered internally or by the trainees who were out of programme.

The Junior Doctor funded establishment for 2018/2019 was 9 wte. For the first rotation in August, 8.6 wte was allocated by the Lead Employer. As there was a training gap of 0.4 wte, the Trust recruited 2 Clinical Fellows (1.4 wte), with 1 wte being funded by the Trust. As this was over the funded establishment a 1:11 rota was implemented.

The Foundation Year 2's (3) and the Core Medical Trainees (3) left the Trust in December 2018 for their next rotation (6 wte). From December 2018, the Trust had been allocated 3 wte Foundation Year 2 and 2 wte Core Medical Trainees (5 wte). With the recruited Clinical Fellows, there were no identified training gaps. The Trust implemented a 1:11 rota. In November 2018 one of the Clinical Fellows left; in the interim, the shifts were filled internally/agency locum until the vacancy was recruited to in February 2019.

The 3 GP Specialist Trainees (2.6 wte) completed their rotation in February 2019 and the Trust was allocated 2 GP Specialist Trainees (2 wte). From February 2019 until April 2019,

the Trust utilised agency locums and reviewed the rota establishment adjusting this accordingly.

The 3 GP Specialist Trainees (2.6 wte) completed their rotation in February 2019 and the Trust was allocated 2 GP Specialist Trainees (2 wte), therefore, leaving a training gap of 1 wte. This gap was temporary until April 2019, and the Trust utilised agency locums.

Planning for the future, a business case has been submitted to increase the establishment at Foundations Year 2, Core Medical Trainees and GP Specialist Trainees at an additional cost to the Trust in order to ensure compliance with new training requirements to increase clinic experience for trainees. In May 2019, the Trust will be notified by the Lead Employer of the number of Specialist Registrars, Foundation Year 2, Core Medical Trainees and GP Specialist Trainees who have been allocated from August for the year. Any gaps which are identified at Specialist Registrar level will now be advertised as a Senior Clinical Fellow or a Locum Appointed for Service (LAS) and recruited to for a period of 12 months. In tandem with these changes, allied health professional roles are being developed to support the work previously undertaken by the Junior Doctor workforce.

2.3 Reporting Against Core Indicators

See web link to NHS Digital where this data is provided <https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts>

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 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)
2018/19	Data not yet available			
2017/18	83.7	68.6	60.5	85.0
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

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
 - Enhancing our understanding of the ‘patient story’ through patient attendance at Board to talk to our Board members about their experience of our services.

Domain 4: Ensuring that people have a positive experience of care: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (agree or strongly agree).

Period	Trust Performance	National Average (specialist Trusts)	National Range (specialist Trusts) (lowest)	National Range (specialist Trusts) (Highest)
2018	90%	89%	77%	94%
2017	93%	89%	79%	93%
2016	92%	89%	76%	93%
2015	91%	89%	82%	93%

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 and Quality Leadership Walk 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 18/19	92.96%	95.37%	54.86%	100%
Q2 18/19	94.86%	95.37%	68.67%	100%
Q1 18/19	92.39%	95.42%	75.84%	100%
Q4 17/18	80.96%	94.87%	67.04%	100%
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 recognises the % performance figure has been influenced by both changes in reporting and responsibilities for risk assessment completion since 2014/15. The 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 2017 to March 2018	78.6	38.3	0	157.5
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

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 is a specialist cancer Trust and therefore recognises the complexity of performance comparisons to national cases. In acknowledging that the Trust acuity levels have risen, new treatment regimens can be aggressive, and that the Trust now supports haemato-oncology and immunotherapy treatments for patients, the 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 17 – March 18	941	1454	287	3582
April 17 – September 17	903	1448	294	2814
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 17 – March 18	69.9	52.2	17.6	158.3
April 17 – September 17	95.7	56.0	14.8	174.6
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 17 – March 18	2	3	0	15
April 17 – September 17	3	3	0	11
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 17 – March 18	0.15%	0.35%	0.00%	4.34%
April 17 – September 17	0.32%	0.14%	0.00%	0.55%
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
- Improved Organisational shared learning through the introduction of Quality & Safety meetings, a Shared Learning Bulletin and Newsletter

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

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?

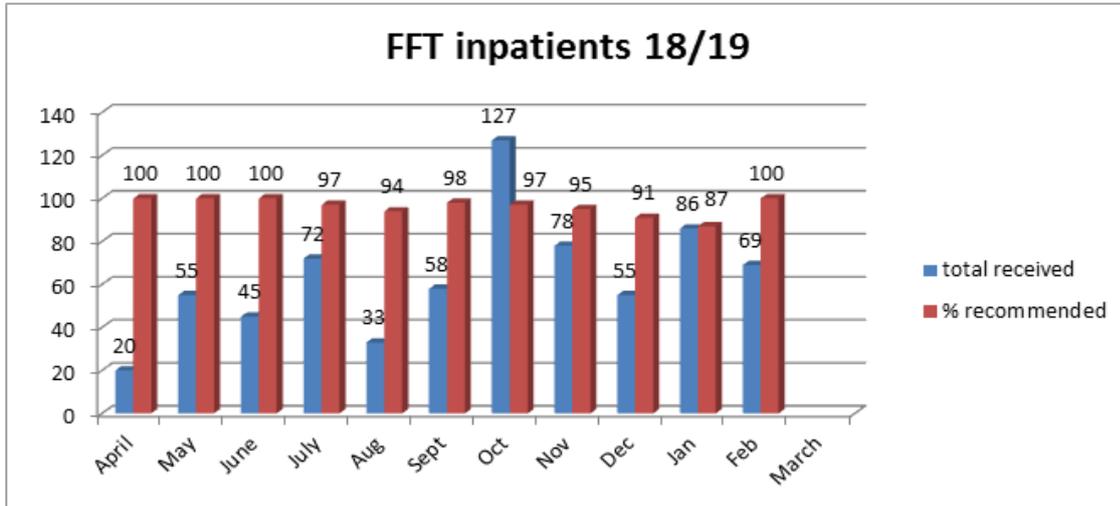
- Extremely likely
- Likely
- Neither likely or unlikely
- Unlikely
- Extremely unlikely
- Don't know

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 in 2018 to facilitate ease of response.

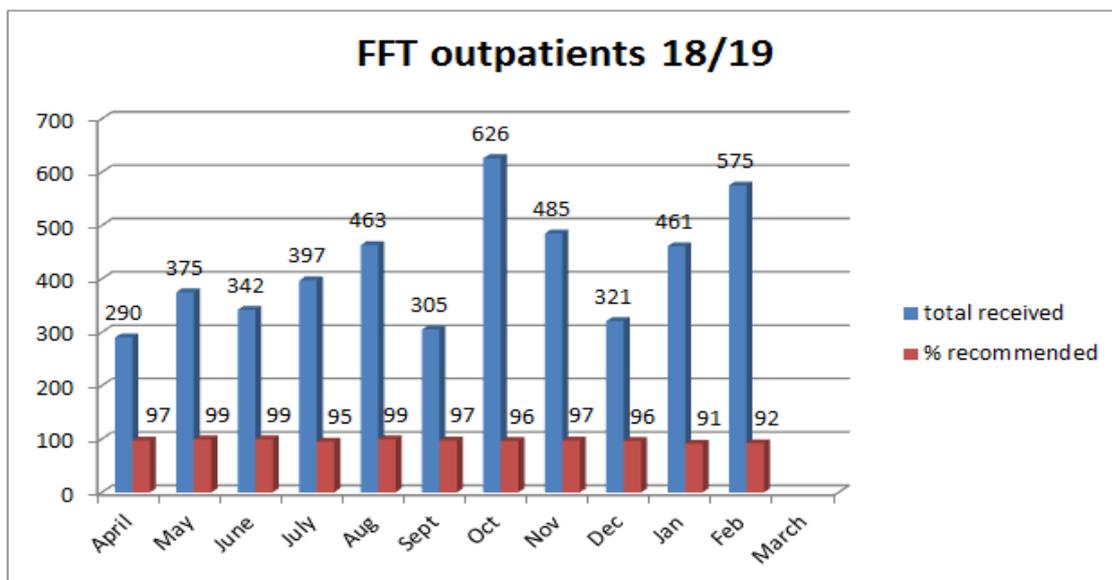
Inpatient Friends and Family Test

Inpatients for 2018/19 total responses received 698 of which 96% would recommend our services



Outpatient Friends and Family Test

Outpatients for 2018/19 total responses received 4640 of which 96% would recommend our services



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

*If there were
no delays in
transport*

*Nothing – made
a bad experience
so much easier to
cope with*

*If parking were free
and if the spaces were
nearer to the hospital*

*Better access
to tea and
coffee*

*Would be better if I
saw the same doctor
every day on the ward*

*Nothing – I
cannot fault
my care*

*If appointments
were on time.
Delays really
need addressing*

*If scan results had
been ready in
time for
appointment*

*Better conditions in
waiting rooms.
Could be brighter
and airier with
more chairs*

Trust response-what are we doing to improve?:

- A Receptionist service is now in place to manage transport requirements and reduce delays
- Patient car parking in Liverpool forms a key part of the Transformation work stream for the new build. Car parking at CCCW is free and accessible for patients
- Medical staff work in teams to reduce reliance on individual doctors and decisions are effectively communicated and discussed through the electronic patient record and at multidisciplinary meetings.
- New vending machines have been purchased and installed. Volunteers provide patients and carers with free tea and coffee outside of mealtimes.
- The new cancer hospital opening in 2020 will provide state of the art facilities for our patients
- We aim to minimise delays where possible and to schedule appointments to avoid unnecessary waits. A patient pager system is in place and we aim to keep patients fully informed at all times of any unavoidable delays

2.5 Implementation of the Duty of candour

The Trust has in place a Guide to Incident Reporting & Being Open/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 2018 audit involved reviewing all incidents that caused moderate harm or above and all serious incidents held from 1/1/18-31/12/18. 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.

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

The Trust is an active participant in the Sign up to Safety Campaign, supporting NHS England’s vision to create the conditions for making care safer. Sign up to Safety comes to an end in March 2019. However as a Trust the work developed either as a direct or indirect consequence of the NHSE Sign Up to Safety campaign continues as “business as usual” within the Trust as shown in below driver diagram.



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

			2018	Average (median) for acute specialist trusts 2018	2017	Change	Ranking compared with all acute specialist trusts in 2018
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	23%	25%	24%	1%	Better than average
		BME	20%	27%	16%	4%	Better than average
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	86%	88%	89%	4%	Below average
		BME	81%	76%	96%	15%	Better than average

2.8 CQC Ratings Grid

The Clatterbridge Cancer Centre NHS Foundation Trust underwent an inspection of a number of core services and a Well Led inspection in Dec 2018/Jan 2019. The overall rating for the Trust was 'Good'. A comprehensive action plan, with weekly performance management meetings, is in place to address the 'must do' and 'should do' issues raised within the inspection report published on 16th April 2019. The ratings grid and must do actions are described below:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Mar 2019	Good ↔ Mar 2019	Outstanding ↔ Mar 2019	Good Mar 2019	Requires improvement ↓ Mar 2019	Good ↔ Mar 2019
End of life care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Outpatients	Good Mar 2019	Not rated	Outstanding Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Diagnostic imaging	Requires improvement Mar 2019	Not rated	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Chemotherapy	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Radiotherapy	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Overall*	Good ↑ Mar 2019	Good ↔ Mar 2019	Outstanding ↔ Mar 2019	Good ↔ Mar 2019	Good ↓ Mar 2019	Good ↓ Mar 2019

How the Trust plans to address 'must do' areas that require improvement

Action	Progress	Monitoring
<p>Fit and Proper Person's Process Regulation 5 – The trust must ensure that people who have director level responsibility for the quality and safety of care and for meeting the fundamental standards are fit and proper to carry out this important role.</p>	<p>The gaps highlighted at the inspection have been rectified and files are complete</p> <p>Full review of the existing Fit and Proper Persons Framework culminating in development of new Policy.</p>	<p>Compliance with policy – internal audit to be undertaken in Quarter 2</p>
<p>Safe Care and Treatment Regulation 12 – The trust must ensure that relevant identification and safety checks are completed prior to initiating exposure to radiation</p>	<p>The work instruction reviewed and updated to indicate explicitly clear roles and responsibilities.</p> <p>Update communicated to all staff.</p> <p>The pause and check process was audited in January 2019 and the report presented to the Quality and Safety committee. The result of this audit was 100%.</p> <p>Trust policy for the identification of the patient reviewed and updated.</p>	<p>A cycle of audits in place next audit due the first week in June 2019.</p>
<p>Good Governance Regulation 17- The Trust must ensure that it has systems and processes in place to enable oversight, audit and assessment of services.</p>	<p>Full review of the governance structure commenced in January 2019.</p> <p>New committee meeting schedule devised.</p> <p>Review of the Terms of Reference for all committees</p> <p>Revised templates for Chair reports and 'Triple A' reports introduced</p>	<p>The governance structure will be audited by internal audit and has been included on the annual work plan for 2019/2020.</p>
<p>Staffing Regulation 18- The Trust must ensure that there is always enough suitably qualified, competent and experienced staff with relevant levels of life support training deployed within the service at all times.</p>	<p>Increased the number of training sessions available</p> <p>Rosters allow staff protected time to attend their allotted session.</p> <p>There has been a significant improvement in compliance levels at end of April All directorates are above the trust's 90% target</p>	<p>Monthly audits are conducted in each clinical area and are reported to directorate quality and safety meetings and escalated through the weekly Improvement Plan Assurance Group.</p>

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

	2018/19	2017/18	2016/17	2015/16	2014/15
Attributable grade 2 or above pressure ulcers/1,000 bed days	0.04	0.92	0.99	0.87	1.03
MRSA bacteraemia cases/10,000 bed days	0	0	0	0	0
C Diff cases / 1,000 bed days	0.09	0.38	0.28	0.18	0.06
'Never Events' that occur within the Trust	0	0	0	0	0
Chemotherapy errors (number of errors per 1,000 doses):	1.31	1.3	0.57		
Radiotherapy treatment errors (number of errors per 1,000 fractions)	1.35	1.07	1.2	1.5	1.4
Falls / injuries / 1,000 inpatient admissions	15.2	15.07	24.7	29.7	12.6
Number of patient safety incidents	2352	2121	2773	2534	1901
Percentage of patient safety incidents that resulted in severe harm* or death.	2*	0.24%	0	0.04%	0

* 2 incidents resulted in death, however not due to harm or lapse in care.

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

	2018/19	2017/18	201617	2015/16	2014/15
30 day mortality rate (radical chemotherapy)	0.7% (Apr 18 – March 19)	0.67% (Apr 17 – Mar 18)	0.6% (Apr 16- Mar 17)	1.05% (Apr 14- Mar 15)	0.66% (Apr 14- Mar 15)
30 day mortality rate (palliative chemotherapy)	7.4% (Apr 18 – March 19)	6.1% (Apr 17 – Mar 18)	5.7% (Apr 16- Mar 17)	7.5% (Apr 14- Mar 15)	6.7% (Apr 14- Mar 15)
30 day mortality rate (haemato-oncology)	5.2% (Apr 18 – March 19)	4.1% (July 17 – Mar 18)			
30 day mortality rate (radical radiotherapy)				0.76% (Apr 14- Mar 15)	0.70% (Apr 14- Mar 15)
30 day mortality rate (palliative radiotherapy)	3.9% (Apr-March 19)	3.5% (Apr-Mar 18)	*4.3% (Apr16-Mar17)	12.8% (Apr 14- Mar 15)	10.0% (Apr 14- Mar 15)

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
- *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.

	2018/19	2017/18	201617	2015/16	2014/15
'I was treated with courtesy and respect'	91%	98%	96%	98%	98%
'Was the ward / department clean'	99%	96%	94%	96%	96%
'I never had to wait'	76%	41%	36%	35%	29%
'I was included in discussions about my care'	95%	93%	92%	93%	93%
'Did the staff wash their hands'	99%	90%	95%	95%	95%

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

	2018/19	2017/18	2016/17	2015/16	2014/15
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	98% (target 92%)	96.33% (target 92%)	96.2% (target 92%)	98.0% (target 92%)	97.3% (target 92%)
All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer	86% post reallocation (target 85%).	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%)
All cancers: 62-day wait for first treatment from: NHS Cancer Screening Service referral	64.5% of screening patients (post allocation) were treated within 62 days against a target of 90%. 9 patients breached in this period; CCC was fully responsible for 1 breach and partly responsible (with another Trust) for 8.	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%)
Clostridium difficile – meeting the C. difficile objective: variance from plan	2 attributable (annual target of no more than 4). 1 case remains under review to determine if there was a lapse in care.	6 attributable (annual target of no more than 5). The target increased when the Trust acquired the Haemato – oncology service on 1 st July 2017). 2 cases remain under review to determine if there was a lapse in care.	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)
Maximum 6-week wait for diagnostic procedures	100% waiting fewer than 6 weeks	100% waiting fewer than 6 weeks			
Venous thromboembolism (VTE) risk assessment	94% (target 95%)	93%			

Abbreviations

AHP	Allied Health Professional
ANP	Advanced Nurse Practitioner
AO	Acute Oncology
AONP	Acute Oncology Nurse Practitioner
AQuA	Advancing Quality Alliance
BSBMT	British Society Of Blood And Marrow Transplantation
C&M	Cheshire and Merseyside
CAS	Central Alerting System
CCC	Clatterbridge Cancer Centre
CCCL	Clatterbridge Cancer Centre Liverpool
CCG	Clinical Commissioning Group
CDS	Cancer data Set
CEO	Chief Executive Officer
CET	Clinical Effectiveness Team
CGST	Clinical Governance and Support Team
CNS	Clinical Nurse Specialist
CoG	Council of Governors
COSD	Cancer Outcomes and Services Dataset
CQC	Care Quality Commission
CQUINS	Commissioning for Quality and Innovation
CSAN	Clinical Specialist Additional Needs
CUP	Cancer of Unknown Primary
DaRT	deteriorating patient and resus team
DDoN	Deputy Director of Nursing
DIPC	Director of Prevention Control
DoN&Q	Director of Nursing & Quality
EPR	Electronic Patient Record
ESC	Enhanced Supportive Care
FFT	Friends and family Test
FT	Foundation Trust
FTSU	Freedom to Speak Up
G-CSF	Granulocyte-colony stimulating factor
GI	Gastro-intestinal
GTT	Global Trigger Tool
HAP	Hepatoma arterial-embolisation prognostic
HCC	hepatocellular carcinoma
HF	Human Factors
HO	Haemato Oncology
HSMR	hospital standardised mortality ratio
HWB	Health & Well Being
IC department	Integrated Care Department
ID	identification
IG	Information Governance
JRS	Joint Research Service
KPI	Key Performance Indicator
L&D	Learning and Development
LD	Learning Disabilities
LWH	Liverpool Women's Hospital

MDT	Multi-Disciplinary Team
MHRA	The Medicines and Healthcare products Regulatory Agency
MRM	Mortality Review Meeting
MRSA	methicillin-resistant Staphylococcus aureus
NCEPOD	National Confidential Enquiry into Patient Outcome & Death
NCS	National Cancer Survey
NED	Non-Executive Director
NEWS2	National Early Warning Score
NHSE	NHS England
OSC	Overview and Scrutiny Committee
PALs	Patient Advocacy and Liaison Service
pCR	Polymerase chain reaction
PICC	Peripherally Inserted Central Catheter
PLACE	Patient Led Assessment of the Care Environment
PSA	prostate specific antigen
Q&S	Quality & Safety
QA	Quality Assurance
QoL	Quality of Life
R&D	Research & Development
R&I	Research and Innovation
RAG	Red Amber Green
RCA	Root Cause Analysis
RCR	Royal College of Radiologists
RITA	Reminiscence Interactive Therapy Activities
RLBUHT	Royal Liverpool & Broadgreen University Hospital Trust
SABR	Stereotactic body radiation therapy
SACT	Systemic Anti-Cancer Therapy
SBAR	Situation-Background-Assessment-Recommendation
SHMI	Summary Hospital-level Mortality Indicator
SLA	Service Level Agreement
SOP	Standard Operating Procedure
SpPCT	Specialist Palliative Care Team
SpR	Specialist Registrar
SRG	Site Reference Group
SUI	Serious Untoward Incident
SUS	Secondary Uses Service
ToR	Terms of Reference
UKONS	United Kingdom Oncology Nursing Society
VMAT	Volumetric Arc Therapy
VTE	Venous Thromboembolism
WOD	Workforce and Organisational Development
WRES	Workforce Race Equality Standard
WUTH	Wirral University Teaching Hospital
XML	eXtensible Markup Language

Annex 1

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

NHS England



**Quality Account Commentary
for Clatterbridge Cancer Centre NHS Foundation Trust
provided by Healthwatch Wirral CIC
May 2019**

Healthwatch Wirral would like to thank Clatterbridge Cancer Centre for the opportunity to comment on the Quality Account for 2018/19.

Over the last year Clatterbridge Cancer Centre has welcomed Healthwatch Wirral's input on improving patient experience.

Members of the Healthwatch Wirral Working Group met during May 2019 to discuss the Trust's Quality Account and produce the following commentary.

Priorities for Improvement

The account detailed the priorities and outlined the Trust's commitment to them. The three priorities noted were recorded under the following headings: - Patient Safety, Patient Experience and Effective/Patient Outcomes.

Priority 1 - Healthwatch would appreciate a quarterly performance update on the digital pathway for the management of the deteriorating patient introduced in December 2018.

Priority 2 – Introducing a Nursing Allied Healthcare Professional Model of Shared Governance. The Quality Account lacked clarity on how this initiative would directly lead to improved shared decision making.

Priority 3 – Patient Involvement Strategy – Healthwatch would appreciate details of what the key milestones are for the 7 pledges that the Trust will monitor.

Healthwatch look forward to hearing what will be the measures and indicators of success for these priorities along with updates on their progress throughout the year.

Progress made since the publication of the 2017/18 report.

The account set out their outcomes and achievements.

Healthwatch would welcome any information on the impact of the introduction of RITA (Reminiscence Interactive Therapy Activities) and what difference it has made.

Improving the Quality of Mortality Review and Serious Incident Investigation.

Healthwatch Wirral have noted that the Trust continues to evaluate and improve these processes.

CQINS

It was disappointing to see that the Trust did not meet all requirements but it was interesting to see that CQUIN related developments resulted in better patient experience.

Research and Innovation

Healthwatch Wirral welcomed the significant investment over the next 3 years to support research and to ensure that patients have equitable access to research through the Trusts hubs and sectors.

Safeguarding

The Trust should be commended for strengthening and improving its safeguarding policies and procedures including the recruitment of a Head of Safeguarding and Named Nurse.

Falls

Reassuringly, the Trust has a comprehensive falls prevention and management plan and they continue to address falls prevention.

Although Healthwatch Wirral welcomed the number of initiatives that have been launched to reduce the risk of patients falling, there were concerns that the incidence of falls continue to increase.

Friends and Family Test

The Friends and Family test responses recorded that, of those who responded, 96% of inpatients and 96% of outpatients would recommend the service to family and friends. These findings mirror positive public feedback that Healthwatch Wirral received in relation to the Trust.

However, the Trust response rate was lower than desired due to a number of circumstances but it was reassuring that the Trust is addressing this by introducing digital software to facilitate ease of response.

Staff Surveys

It was concerning that 43% of staff reported to have experienced harassment, bullying or abuse from other staff in the last 12 months.

Healthwatch would like to be updated on whether the newly launched Freedom to Speak Up Campaign will make a difference to future statistics.

Reporting Against Core Indicators

Healthwatch noted the Trust's performance and look forward to receiving updates when the most recent data is available.

Overall, the Quality Account was comprehensive.

Healthwatch Wirral welcome the Trust's ongoing commitment to continuous improvement and its vision to provide the best cancer care to their patients.

Karen Prior

**Chief Officer - Healthwatch Wirral
On behalf of Healthwatch Wirral**

Clatterbridge Cancer Centre – Quality Account 2018/19

NHS England Specialised Commissioning Team and Liverpool Clinical Commissioning Group would like to thank The Clatterbridge Cancer Centre for the opportunity to comment on their Quality Account for 2018/19. The account reflects the performance for the organisation during 2018/19.

The Quality Account clearly sets out the outcomes and achievements for 2018/19 and details the priority areas and rationale for the coming year. The priority areas demonstrate patient's engagement and a commitment to improving quality for patients in the coming year.

Clatterbridge's values have been developed by staff and demonstrate a focus on improvement of care and commitment. Commissioners are keen to see the revised governance arrangements, structures and Quality Strategy following the new Board appointments and are looking forward to working with the Trust during the move to their new cancer centre in Liverpool City Centre.

The trust should be commended on meeting their mandated targets and the maintenance of zero tolerance to MRSA as again there have been no cases of MRSA. The trust has not exceeded its Clostridium Difficile (CDiff) threshold, with 2 cases of hospital attributable CDiff reported in the last year against a maximum of 4. Commissioners are keen to see further integration of Haemato-oncology services at the Royal Liverpool site into the organisation. Achievements against last year's priority areas are clearly stated and have resulted in positive changes to practice. Work on the digital sepsis pathway should be noted and it will be good to see the impact this has on patient outcomes and care.

The account shows how future priority areas will be measured, monitored and reported within the Trust. Commissioners will also monitor progress through regular Quality and Performance meetings. It is evident that there is a focus on patient and public involvement which is of particular importance this year in the run up to the new cancer centre opening in 2020.

The Trust have demonstrated a transparent learning culture in serious incident monitoring and have a robust system in place working with Commissioners to review serious incidents and ensure lessons learnt are shared. One of the mechanisms for sharing is via the Trust newsletter. The account also reports learning from deaths and there is evidence of changes in practice as a result of reviewing deaths.

Safeguarding procedures have been improved over the last year with investment in new posts to ensure safeguarding is embedded into practice and that there is Board oversight.

The Quality Account shows commitment to National and Local audits and research. There is a demonstrable focus on improving patient safety and improving quality outcomes and experience. A recent CQC inspection has rated the Trust as 'Good', Commissioners will be working with the Trust to ensure improvements are made in the coming year and monitoring against the action plan.

The Clatterbridge Cancer Centre provides quality assurance throughout the year to commissioners via regular Quality, Performance and Contracting meetings and we look forward to working in partnership in 2019/20 to further improve quality and experience for patients.



ANDREW BIBBY

**Director of Specialised Commissioning Health and Justice North
West**

Liverpool CCG



Jan Ledward

Chief Officer

Date: 20th May 2019

Healthwatch Liverpool



The Clatterbridge Cancer Centre NHS Foundation Trust Quality Account 2018/19

Statement from Wirral Metropolitan Borough Council

The Adult Care and Health Overview & Scrutiny Committee are responsible for the discharge of the health scrutiny function at Wirral Council. The Committee established a task and finish group in May 2019 in order to review the Quality Account of the Clatterbridge Cancer Centre NHS Foundation Trust for 2018/19 and were grateful for the opportunity to comment on the draft report.

Members are satisfied that the Trust has delivered on its targets for the last year within the quality indicators of patient safety, patient experience and clinical effectiveness. In particular, the implementation of reminiscence therapy (RITA) for dementia patients is welcomed as an innovative approach to dealing with inpatient co-morbidity. It is particularly encouraging to see the individualisation of patient care through use of personal life stories, as well as an extensive timetable of weekly activities. Members look forward to receiving updates on this initiative.

Members are particularly pleased with the Trust's sustained record of infection control, with achievements against both clostridium difficile and MRSA targets. In addition, it is noted that the Trust operates a comprehensive mortality programme, with investigation taking place around avoidability and learning from case record reviews fully documented. The focus on implementation of the Duty of Candour further contributes to a culture of openness and transparency around incident reporting.

Early in 2019, Members were disappointed to learn that the Trust's CQC rating had fallen from 'Outstanding' to 'Good' following inspection, and were particularly concerned with the CQC report's comments around the 'well-led' inspection area. Members have been made aware that this is an area of focus for the Trust and steps have already been taken to strengthen the senior management structure, with a number of executive roles recruited to. Members have also been adequately assured that work is ongoing to guarantee robust processes are in place and that governance arrangements are stable. It is expected that these developments will contribute to the permanency of the organisation in the coming year.

The Trust's strong record of participation in audits, research and academic oncology is commended, along with its commitment to digital innovation. The introduction of the outcomes dashboard is welcomed as a key development in order to provide an oversight of performance indicators in different delivery areas. Members also welcome the Trust's encouraging results in the Friends & Family Test – with a score of 96% satisfaction for both inpatients and outpatients.

There is concern amongst Members around the increasing number of falls at the Trust, with an increase of 30 inpatient falls since 2016/17, although it is appreciated that there has been a focus on incident reporting and implementation of a series of initiatives to combat this; such as thorough blood pressure checks on admission and upgraded lighting.

Members welcome the Trust's key priorities for 2019/20; in particular the planned delivery of a shared governance framework for nurses and allied healthcare professionals in response to the national shortage of healthcare staff. This collaborative approach to clinical decision making is noted by Members as an area of good practice and allows for a fully engaged workforce. Members also look forward to the anticipated expansion of services and the opening of the new Cancer Centre facility in Liverpool in 2020.

The Adult Care and Health Overview & Scrutiny Committee look forward to continued partnership working with the Trust during the forthcoming year and note its priorities for 2019/20.

A handwritten signature in black ink that reads "Julie McManus". The signature is written in a cursive, flowing style.

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 2018/19 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 2018 to May 2019
 - Papers relating to Quality reported to the Board over the period April 2018 to May 2019
 - Feedback from the commissioners dated May 2019
 - Feedback from governors dated April 2018 to June 2019
 - Feedback from Local Healthwatch organisations dated May 2019
 - Feedback from Overview and Scrutiny committee dated May 2019
 - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
 - The latest National Patient Survey 2018
 - The latest National Staff Survey 2018
 - The Head of Internal Audit's annual opinion over the Trust's control environment dated xxx 2019
 - CQC Inspection Report dated April 2019
- 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

Xxx

Signed

Kathy Doran
Chair

Date: xxx

Xxx

Signed

Dr Liz Bishop
Chief Executive

Date: xxx

Annex 3

Independent Auditor's Limited Assurance Report



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