Report Cover Sheet

Report to:	Board of Directors
Date of the Meeting:	25 September 2019
Agenda Item:	P1/170/19
Title:	CCC Clinical Quality Strategy 2019-2021
Report prepared by:	Kate Greaves, Associate Director of Clinical Education
Executive Lead:	Sheila Lloyd, Director of Nursing & Quality
Status of the Report:	Public	Private
	X	

Paper previously considered by:	Quality Committee July 2019 and September 2019
Date & Decision:	17.07.19 - Draft strategy presented –for minor amends. 11.09.19 - Approved

Purpose of the Paper/Key Points for Discussion:	This Clinical Quality Strategy 2019-21 supports our Trust strategic priorities, vision and values, and builds on our overarching transformation of cancer care programme, helping all staff to understand the key quality aims and their role in delivering high quality care for our patients and service users over the next 3 years.

Action Required:	Discuss	
	Approve	✓
	For Information/Noting	

Next steps required	For approval by Board of Directors

The paper links to the following strategic priorities (please tick)

Deliver **outstanding care locally**	✓	Collaborative system **leadership** to **deliver better** patient **care**	✓
Retain and **develop outstanding staff**	✓	Be **enterprising**	✓
Invest in **research & innovation** to deliver **excellent** patient **care** in the future	✓	Maintain **excellent** quality, operational and financial **performance**	✓

The paper relates to the following Board Assurance Framework (BAF) Risks

BAF Risk	Please Tick
1. If we do not optimise quality outcomes we will not be able to provide outstanding care	✓
2. If we do not prioritise the costs of the delivering the Transforming Cancer Care Programme we will not be able to maintain our long-term financial strength and make appropriate strategic investments.	
3. If we do not have the right infrastructure (estate, communication & engagement, information and technology) we will be unable to deliver care close to home.	✓
4. If we do not have the right innovative workforce solutions including education and development, we will not have the right skills, in the right place, at the right time to deliver the outstanding care.	✓
5. If we do not have an organisational culture that promotes positive staff engagement and excellent health and well-being we will not be able to retain and attract the right workforce.	✓
6. If we fail to implement and optimise digital technology we will not deliver optimal patient outcomes and operational effectiveness.	✓
7. If we fail to position the organisation as a credible research partner we will limit patient access to clinical trials and affect our reputation as a specialist centre delivering excellent patient care in the future.	✓
8. If we do not retain system-side leadership, for example, SRO for Cancer Alliance and influence the National Cancer Policy, we will not have the right influence on the strategic direction to deliver outstanding cancer services for the population of Cheshire & Merseyside.	✓
9. If we do not support and invest in entrepreneurial ideas and adapt to changes in national priorities and market conditions we will stifle innovative cancer services for the future.	✓
10. If we do not continually support, lead and prioritise improved quality, operational and financial performance, we will not provide safe, efficient and effective cancer services.	✓

Equality & Diversity Impact Assessment		
Are there concerns that the policy/service could have an adverse impact on:	YES	NO
Age		✓
Disability		✓
Gender		✓
Race		✓
Sexual Orientation		✓
Gender Reassignment		✓
Religion/Belief		✓
Pregnancy and Maternity		✓

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

2019-2021

Clinical Quality Strategy

Contents

1. EXECUTIVE SUMMARY

Our Clinical Quality Strategy has been developed to focus on continuously improving the quality of the services we deliver at The Clatterbridge Cancer Centre NHS FT, and is aligned to the CQC key lines of enquiry:

Are we:

Safe

- Effective

Caring

- Responsive

Well Led

This Clinical Quality Strategy supports our strategic priorities, vision and values, and builds on our overarching transformation of cancer care programme, helping all staff to understand the key quality aims and their role in delivering high quality care for our patients and service users over the next 3 years.

Our Quality Goals Are:

Reduce avoidable harm

Achieve the best clinical outcomes

Provide the best patient experience

We will build on our performance and efficiency to create a culture of continuous quality improvement. Our goal is to excel as a learning organisation in which every member understands their role in delivering clinical quality and works towards that goal every day. Also to share this learning as a system leader in the provision of high quality cancer care

We will place considerable emphasis on understanding the systems, practices and behaviours that underpin clinical quality, working towards excellence in our clinical systems and engaging all of our employees in improvement and learning.

Throughout the lifetime of the Strategy we will annually review and amend our quality indicators, and build on our existing governance and safety infrastructure to drive continuous improvement. Part of keeping this strategy live will include holding stakeholder events for both staff and our external stakeholders on delivery of our annual quality priorities. We are committed to continuously engaging commissioners, service users and staff to both hold us to account against delivery of our priority areas and help us identify new areas for each year of the strategy.

The annual detailed implementation plans for the strategy will be based on Trust wide programmes of work alongside improvement activity identified through the annual planning process and performance reviews.

2. Introduction:

Quality –our priority: **Quality First**

Quality: NHS England provides a single common definition of quality which encompasses three equally important parts, stipulating that high quality care is only achieved when all three dimensions are present. These three dimensions are identified as:

- care that is clinically effective– not just in the eyes of clinicians but in the eyes of patients themselves;
- care that is safe;
- care that provides as positive an experience for patients as possible.

Additionally England's health and social care services regulator, The Care Quality Commission, sets out 5 key lines of enquiry which are used to assess services and ensure delivery of high quality care:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

Safety: Developing a safety culture is essential for successful delivery of clinical quality. This is achieved through effective teamwork and leadership, where there is shared responsibility for ensuring delivery of safe care and where all staff are empowered to discuss errors openly and honestly and the organisation listens and learns. An effective safety culture is a common characteristic of high functioning organisations, who build risk management and incident reporting into culture, changing and influencing behaviours and directly positively impacting on continuous improvement and patient outcomes. The Institute for Healthcare Improvement impresses the need for safety to be everyone's priority, driven by senior leaders and involving patients in safety initiatives. The Trust remains committed to quality and safety leadership walk rounds, safety huddles, shared learning briefings and the further development and management of the risk register in capturing, managing, and escalating incident and risk. The Clinical Quality Strategy supports the growth and strengthening of the Trust's Safety Culture.

Our Trust:

The Clatterbridge Cancer Centre NHS FT is one of the country's largest specialist NHS Trusts. We provide non -surgical cancer care and treatment to a population of 2.4 million across Cheshire and Merseyside and to the Isle of Man.

The Trust employs more than 1,300 staff who deliver clinical services across 3 main sites, currently with local chemotherapy clinics held in 7 different locations and outpatient services in 8 additional locations throughout Cheshire and Merseyside and the Isle of Man. With services including radiotherapy and chemotherapy, immunotherapy, proton therapy, stereotactic radiosurgery, diagnostic imaging, triage and assessment for urgent care, haemato-oncology, inpatient and outpatient care, the Trust provides acute oncology support in District General Hospitals and supportive cancer care to include end of life care, as well as chemotherapy at home and at work for our patient population.

The quality of service that we provide is our overriding priority and the common purpose that brings all of our staff together, no matter what roles they do and where they work, and this is rightly central to both our
mission and vision as an organisation. In common with the rest of the NHS, we face a significant challenge: delivering the highest quality of services for our patients whilst ensuring future financial sustainability. This means doing more for less, doing it better and doing it smarter. The Trust has embarked on an ambitious transformation of cancer care programme with a new flagship hospital in Liverpool due to open in 2020, integrating acute oncology services and research centres of excellence in a £162 million investment. Our new clinical model will continue to provide enhanced high quality of care for our patients, access to research and a centralisation of haemato-oncology services across the region, supported by digital integration. High quality of care is at the heart of what we aim to achieve for the patients in our care

We are also writing this strategy at a time when our Board is continuing to consider and reflect on the findings of the latest CQC inspection results. The review has affirmed the Trust continues to provide high quality care for our patients, whilst highlighting the need for enhanced oversight, audit and assessment of the services provided. This has resulted in an immediate review of governance arrangements and processes of escalation of risk, and new processes now in place, requiring embedding to ensure continued delivery of high quality clinical care for our patients. This strategy makes an important contribution to the Trust's ongoing commitment to high quality care, as a learning and responsive organisation.

This strategy has been developed with the Board, in discussion with governors, staff and key stakeholders, to include members of our Cancer Alliance Network and takes account of patient feedback.

3. Purpose

The purpose of the quality strategy is to articulate our ambitions for quality in a way that is meaningful and serves as a statement of intent that patients, carers, staff, commissioners and other stakeholders can use to hold the Trust Board to account for the delivery of high quality services.
By implementing this strategy, we want to enhance our reputation for providing the best possible treatment and treatment outcomes, delivered with excellence in care and compassion.

4. Our Strategic Alignment and drivers

The quality strategy sets out our ambitions for improving quality for the next three years, whilst also recognising that quality is a constantly moving target. Research knowledge is ever-expanding. The state of our local health and social care economy is also likely to change significantly during the lifetime of this strategy, as is cancer care in Cheshire and Merseyside, as we deliver our ambitious transformation goals
and continue to position ourselves and be the recognised system leaders in cancer care across the Cheshire and Merseyside footprint and beyond. We will need to continue to review the strategy on a regular basis, ensuring we are delivering safe, effective, caring responsive and well led cancer services for our patients and using clinical audit and benchmarking to drive improvements. We have listened to our staff and the people who use our services, and used them to shape this strategy. We are committed to continuing to engaging with, and listening to, our staff and patients and using their feedback to shape and improve the services we provide.

Our Strategic Priorities:

This strategy supports achievement of the Trust's strategic priorities, namely:

We will deliver outstanding care as locally as possible

We will retain and develop our outstanding staff

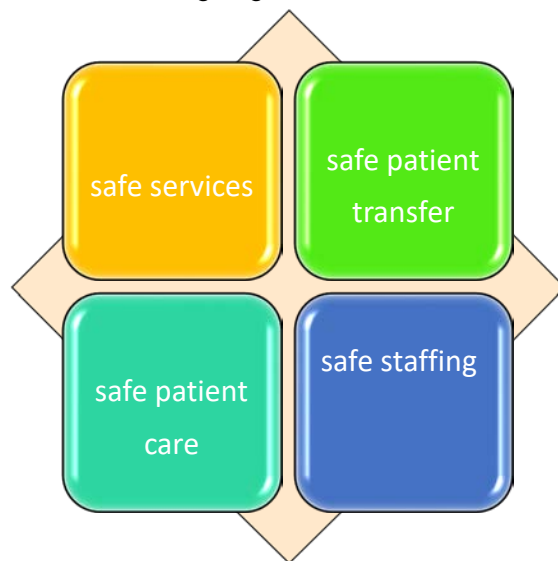| We will invest in research and innovation to deliver excellent patient care in the future |
| --- |

We will be enterprising;

We will maintain excellent quality, operational and financial performance

We will ensure collaborative system leadership to deliver better patient care

Our New Hospital:

As the Trust continues to expand its services across Cheshire and Merseyside, this strategy also supports delivery of the 'pillars' of the Trust's Transforming Care programme and our new clinical model, as we open our new flagship hospital in Liverpool in 2020. This will physically integrate acute oncology services and research centers of excellence, whilst delivering equitable access to high quality care and research for our patients. In securing the transfer of services to Liverpool, and the refocus to the provision of outpatient services at CCC Wirral, This strategy supports the delivery at all Trusts sites of ongoing:

safe services	safe patient transfer
safe patient care	safe staffing

Our desire to deliver the highest quality care is driven by a range of local and national drivers, some of which are described below:
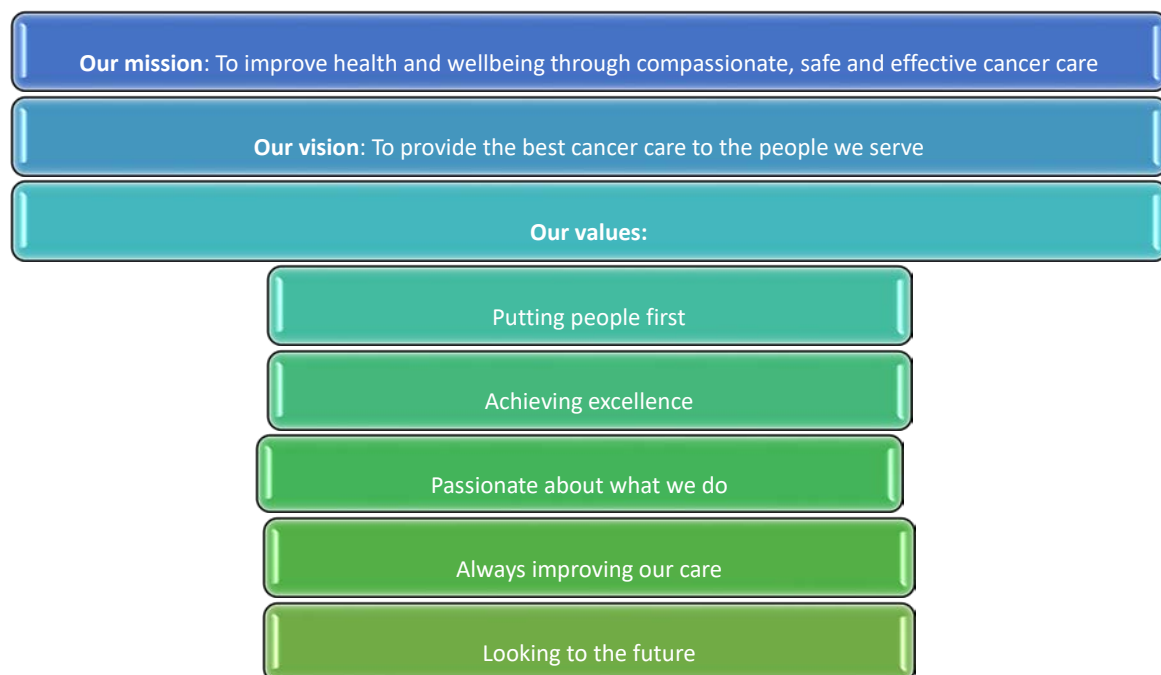
• Meeting regulatory requirement, e.g. Care Quality Commission (CQC) Fundamental Standards;

• 'Sign up to Safety' initiative;

• Quality as a driver of reputation and patient choice;

• Knowing what matters most to patients and the public;

• Implementing the NHS Quality Framework;

• Quality as the check and balance to necessary efficiency savings;

- Implementing recognised best practice, e.g. National Institute for Health and Care Excellence (NICE) standards and guidance;
- The need to learn from our mistakes;
- Meeting quality standards agreed with our commissioners;
- Being open, transparent and candid about quality (Duty of Candour);
- Underpinning the transformation of our hospital
- Responding to patient feedback and concerns;
- Quality as a source of income (Commissioning for Quality and Innovation scheme - CQUINs).

In addition, we will agree a set of quality aims, published via our Quality Accounts, which will determine our key areas of focus annually.

5. Trust Mission, vision and values

This strategy further supports our mission vision and values:

Our mission: To improve health and wellbeing through compassionate, safe and effective cancer care

Our vision: To provide the best cancer care to the people we serve

Our values:

Putting people first

Achieving excellence

Passionate about what we do

Always improving our care

Looking to the future

6. Summary of Key Quality priorities 2019-2021 & Measures of Success/KPIs

Our strategy is structured around the CQC key lines of enquiry core quality themes:

Safe *People are protected from abuse and avoidable harm:*

We will:

1. **Develop and implement Infection Prevention & control E.coli bundle to reduce the number of CCC associated infections**

Measures of Success/KPIs:

- Continue to actively participate in collaborative working to identify the causes of E.coli bacteremia in cancer patients and implement methods to reduce risks to patients

- Each occurrence of gram negative bacteremia will be investigated and discussed in Harm Free Care Group and reported via IPC Committee with lessons learned circulated within the Trust.

- No avoidable gram negative device or wound associated bacteremia

- Overall reduction in CCC associated gram negative bacteremia within Cancer Network and across Cheshire & Merseyside.

- Continue to support clinical staff in methods to improve hydration and launch urine colour charts.

2. **Deliver sustained & effective training in, & escalation & management of, incidents and risk**

Measures of Success/KPIs:

- Risk Management Committee revised to ensure appropriate membership and Terms of Reference

- Risks and incidents will be reviewed within their review timeframes and continue to be monitored by the monthly data packs and board reports.

- Risks will be described and graded appropriately to ensure escalation via department and directorate risk registers and Triple As.

- Delivery of MIAA Risk Management review action plan

- Datix link staff to be in place to support staff in their Directorates/ Departments

3. **Support a culture of safeguarding awareness, reporting & practice measured against internal & multi-agency action plans**

Measures of Success/KPIs:

- Response to findings identified from safeguarding audits

- Safeguarding incident reporting via Datix

- Number of Safeguarding referrals to local authority

- Number calls, themes and trends identified via CCC safeguarding duty line

- Safeguarding training compliance for Children's, Adult and Prevent Safeguarding Training - eligible cohort of staff

- Training Needs Analysis

- Number of Allegations Against Staff in Positions of Trust

- s11 Audit submissions to local authority

- Completion / Progress against internal and multi-agency action plans

- Policies reviewed annually

- Safeguarding annual report

4. **Support early recognition and escalation of deteriorating patients including VTE and sepsis to achieve work stream milestones**

Measures of Success/KPIs

- DaRT monthly report- MET & Arrest calls- numbers and outcomes

- VTE- monthly compliance

- Sepsis- Monthly audit of door to needle and screening

- Training compliance

- AKI- Monthly audit

- Step up occupancy report

  CDU monthly activity report and patient pathways

5. **Reduce avoidable harm so 95% of all inpatients receive VTE risk assessment and 100% receive prescribed prophylaxis**

   Measures of Success/KPIs

   - 95% of all inpatients to receive a VTE risk assessment (excluding agreed cohort)

   100% of patients receive all VTE prophylaxis prescribed

6. **Ensure timely and efficient Sepsis/News2 patient management**

   Measures of Success/KPIs

   - DaRT monthly report- MET & Arrest calls- numbers and outcomes
   - VTE- monthly compliance
   - Sepsis- Monthly audit of door to needle and screening
   - Training compliance
   - AKI- Monthly audit
   - Step up occupancy report
   - CDU monthly activity report and patient pathways

7. **Strengthen safer staffing through digital monitoring systems**

   Measures of Success/KPIs

   - A strengthened safer staffing report completed every month and presented to Trust Board via the trust committee structure
   - Safer staffing information is triangulated with trust patient incidents/ complaints/PALs enquiries
   - Safe staffing bi-annual review
   - Safe staffing incorporated into workforce planning
   - Global Digital Exemplar programme milestones achieved

8. **Strengthen safety culture through standardisation of safety huddle agenda**

   Measures of Success/KPIs

   - SOP Safety huddle developed and embedded

9. **Invest in research and innovation to deliver excellent patient care in the future**

   Measures of Success/KPIs

   Delivery against milestones and KPIs as outlined in Clinical Research KPIs

We will :

1. **Consistently meet national cancer waiting times standards**

Measures of Success/KPIs

- Two Week Wait standard met
- 31 Day standards: Firsts, Subsequent radiotherapy, Subsequent chemotherapy
- 62 Day standards: Classic, Upgrade, Screening
- 28 Day Faster Diagnosis Standard (in effect from April 2020)

2. **Reduce unplanned admissions and readmissions**

Measures of Success/KPIs

- 80% of patients waiting 30 minutes or fewer in outpatient clinics

3. **Maintain regulatory compliance**

Measures of Success/KPIs

- All CQC Must Dos and Should Dos to be achieved within timescales indicated on agreed action plan
- Implement whole Trust programme of mock inspections and monitor resulting action plans by Quarter 4 19/20
- Imaging department to achieve ISAS accreditation by end of Quarter 3 19/20
- Radiation Services Directorate to achieve 100% compliance with IRMER17 and IRR17 as evidenced by any external inspections and internal audit

Deliver compliance against all mandatory standards of the data security and protection toolkit by Quarter 4 19/20

4. **Improve clinical outcomes and establish SRG KPIs monitored via new digitised SRG dashboards**

Measures of Success/KPIs

- Support ClickHealth to digitalise SRG dashboards

5. **Achieve 90% compliance with NICE guidelines**

Measures of Success/KPIs

- Continue to achieve 90% NICE compliance trust target

6. **Aim to reduce avoidable deaths to zero by disseminating lessons learnt through quarterly newsletter**

Measures of Success/KPIs

- Continue to review patient who suits the set criteria as in SOP
- Disseminate lesson learnt from case review through quarterly lesson learnt newsletter

7. Improve Clinical audit monitoring via clinical audit subcommittee

Measures of Success/KPIs

- Clinical audit progress report through data pack and SRGs
- Clinical audit progress discuss at Clinical Audit Subcommittee as per policy

8. Strengthen clinical data recording monitored via SRG dashboards

Measures of Success/KPIs

- Report new chemotherapy regimen and it's assigned procedure codes to the Drug Reporting Group for Approval
- Present clinical data in SRG dashboard
- Digitised clinical pathways within EPR (12 areas complete)
- Snomed Clinical Coding (phase 2)
- Vital Signs and point of care testing integration to EPR
- Electronic Prescribing and Medicines administration – closed loop within chemotherapy

9. Achieve 95% or better statutory & role essential training and role based competency compliance across the Trust

Measures of Success/KPIs

- 90% or better compliance for mandatory training.
- 90% or better for role essential training.

10. Strengthen management of MCA and DoLS through increase in staff training

Measures of Success/KPIs

- Number staff trained in MCA/DoLs awareness
- Number MCA Assessments
- Number DoLs applications
- Number of urgent DoLs requested
- Number of DoLs authorised by Local Authority

11. Implement stratified follow up of patients to optimise clinical input and appropriate follow up to meet CQUIN requirements

Measures of Success/KPIs

- Redesign OPD activity via new CQUINS as per KPI CQUIN Commissioner milestones

Caring *Staff involve and treat people with compassion, kindness, dignity and respect*

We will:

1. **Continue to achieve top quartile results for patient experience**
   Measures of Success/KPIs:

   - Ensure patient opinion is used to improve continuously improve services through the establishment of twice yearly patient and public listening events

   - All action plans drawn up from patient contacts (PALS and complaints) to be monitored through to conclusion via Quality and Safety Committees

2. **Deliver outcomes identified in dementia strategy to improve dementia care and patient experience**
   Measures of Success/KPIs:

   - The number of patients with a diagnosis of dementia

   - Specific dementia audits

   - Feedback from people living with dementia and their carers/family

   - Evaluation and audit from the environmental changes

   - Uptake of and compliance with mandatory dementia training

   - Reduction in length of stay and readmission for people with dementia

   - Patient led assessment of clinical environment (PLACE) audit

   - Number of complaints received relating to dementia care

   - Care plans routinely include carers wishes/preferences

3. **Deliver Patient and Public Involvement Strategy 2019-21 to improve our methods of engagement**
   Measures of Success/KPIs:

   - All patient experience strategy pledges to be completed within timescales indicated in strategy

4. **Establish a Patient and User Experience Group ensuring we listen and respond to what our service users are telling us**
   Measures of Success/KPIs:

   - Delivery of Patient and Public Involvement & Engagement Strategy 2019 – 2012 containing 8 pledges Evidence user feedback is used to enhance the care and services we provide

   - establishment of e-advisors

   - Continue with Digital user engagement for technology developments for CCC

   Chief Information Officer CIO to lead on citizen engagement across health and social care for STP Digital work stream

5. **Implement the End of Life Strategy to deliver greater choice and support for individuals nearing the end of life**
   Measures of Success/KPIs:

   Delivery of milestones and KPIs as outlined in the Palliative and End of Life Care 5 Year strategy 201802923.

6. **Implement GDE quality digital work streams to include electronic patient information**
   Measures of Success/KPIs:

   - Progress against GDE partner programme deliverables and milestones to include embedding new technologies:.

     - Clinician Virtual Desktop (VDI) and Fast User Switching
     - Telehealth Pilot
     - Patient Education & Experience Pilot
     - Clinical speech recognition (phase 2)
     - Closed loop medicines administration
     - E-consent
     - Bar codes DM&D
     - Self-Check in kiosks (phase 2)
     - Digitising Clinical pathways (16 areas complete)

- Delivery of HIMSS Level 6 and Definition of Done targets

Responsive - *Services are organised so that they meet people's needs*

We will:

1. **Deliver patient care closer to home through new clinical model so 90% of patients travel less than 45 minutes to access treatment**
   Measures of Success/KPIs:

   - Expand the pharmacy homecare strategy, including IO/HO
   - 90% of patients travelling <= 45 minutes for treatment
   - Introduction of telehealth to support remote monitoring

2. **Implement new Directorate complaints handling model monitored via bi-annual audits**
   Measures of Success/KPIs:

   - Demonstrate effective and timely management of complaints through 6 monthly audit of complaints process

3. **Triangulate incidents, complaints and PALs to promote learning and improvements**
   Measures of Success/KPIs:

   - Consistent reporting of learning from incidents, complaints and PALS in each Quality and Safety data pack
   - Demonstrate effectiveness of shared learning through a reduction in avoidable repeated incidents
   - Shared learning newsletter to continue to include learning from incidents, complaints, PALS, claims, Inquests and safety alerts.

4. **Strengthen care and experience of patients with additional needs**
   Measures of Success/KPIs:

   - Demonstrate processes that ensure we work and engage with people receiving care, their families and carers, as set out in the NHS Constitution.
   - Demonstrate we have made reasonable adjustments to all care pathways
   - Develop mechanisms to identify and flag patients with additional needs from the point of admission through to discharge
   - Ensure staff have the specialist knowledge and skills to meet the unique needs of people with reasonable adjustments
   - Collaborate with CCGs in relation to supporting patients who experience hearing loss
   - Strengthen process for recording of Reasonable adjustments and pictorial pain tool in electronic patient records
   - Demonstrate processes that ensure we engage with people receiving care, their families and carers through the Transforming Cancer care project
   - Delivery of dementia strategy and Learning disability standards

5. **Deliver national learning disability standards**
   Measures of Success/KPIs:

- Demonstrated processes that ensure Trust work and engage with people receiving care, their families and carers, as set out in the NHS Constitution.
- Demonstrated co-design of relevant services with people with learning disabilities, autism or both and their families and carers.
- Demonstrated reasonable adjustments to care pathways
- Have mechanisms to identify and flag patients with learning disabilities, autism or both from the point of admission through to discharge
- Have processes to investigate the death of a person with learning disabilities, autism or both while using their services, and to learn lessons from the findings of these investigations.
- Have measures to promote anti-discriminatory practice in relation to people with learning disabilities, autism or both.
- Staff have the specialist knowledge and skills to meet the unique needs of people with learning disabilities

6. **Improve Friends & Family data capture to achieve 50% response rate by q4 2019/20**
   Measures of Success/KPIs:

   - Achieve 50% response rate for Friends and Family by end of Quarter 4 19/20

7. **Share learning from PALs, complaints, deaths and serious incidents across the patient pathway, working in partnership with the Cancer Alliance**
   Measures of Success/KPIs:

   - Consistent reporting of learning from incidents, complaints and PALS in each Quality and Safety data pack

8. **Expand the volunteer service to support the opening of the new hospital in Liverpool**
   Measures of Success/KPIs:

   - Development of Volunteer Strategy.
   - Planned recruitment and awareness day.

Well-led - *Leadership, management and governance of the organisation assures the delivery of high-qualityPerson-centred care, supports learning and innovation, and promotes an open and fair culture*

We will:

1. **Deliver on Trust's quality focused strategic priorities**
   Measures of Success/KPIs:

   - Directorate monthly Quality & Safety Data pack/Directorate meetings and escalated via Triple A to monthly Q&S sub-committee

2. **Embed new corporate governance and risk committee structure**

Measures of Success/KPIs:

- Continue to refine quality data pack via 6 monthly review with GMs to ensure directorates can perform accurate assessment of performance and risk
- Demonstrate effective and timely recording and management of risks through quarterly audit

3. **Increase national profile and collaborative working as a system leader against regional & national quality priorities/indicators**
   Measures of Success/KPIs:

- Working with the Cheshire and Merseyside Cancer Alliance on a range of initiatives including development of a Cancer Workforce Strategy, redesigning pathways, campaigns to improve cancer awareness and screening uptake, the roll out of genomics and personalised medicine
- Ensuring that clinicians are active members of Alliance Clinical Quality Groups
- Participating in regional and national pilots at every opportunity
- Forming collaborative partnerships with cancer providers across C&M and other HCP programmes such as diagnostics, acute sustainability, elective care and end of life care

4. **Carry out monthly human factors focused quality and safety leadership walk rounds**
   Measures of Success/KPIs:

- Monthly walk arounds with Executive Team, NEDs, Matrons and Patient Safety Leads.

5. **Strengthen Nurse & AHP leadership**
   Measures of Success/KPIs:

- A more robust reporting structure for AHPs which includes the development of a Chief AHP strategic role within the Trust and the First Trust AHP Strategy.

8. Clinical Quality and Associated Services Overview

Quality Team

The Quality Team members, corporate and Directorate, provide support and guidance to all Trust Directorates and departments, across all sites, ensuring continuous improvement of the high quality service provided by the Trust. The Team supports compliance against all regulatory, nationally and regionally mandated metrics, to include compliance with CQC and QST standards, as well as NHSI and NHSE commissioning contracts performance and monitoring standards. Additionally the Team supports delivery of the Trust's Clinical Quality Strategy

The Quality Team supports the development of new services, to include HO integration across Cheshire & Merseyside, ensuring delivery of safe, compassionate and clinically effective patient care and enhanced and equitable patient experience.

The Quality Team additionally supports and embeds new ways of working, ensuring competency and safety in enhanced clinical roles and service expansions, to the benefit our patients. We ensure we embed patient, carers and staff feedback and are a responsive learning organisation. In working with SRGs, the Team supports continuous development of clinical audit data collection and analysis and improves our clinical outcomes for the patients we serve.

The Quality Team will ensure that the Trust is a learning organisation and continues to be recognised as a high performing, regulatory compliant, specialist Trust, providing individualised patient care that is safe, compassionate and clinically effective.

Matrons

The" New Clatterbridge Matron" team is now in place and they have created a "Matron's Charter" which describes their trust wide responsibilities to support the delivery of the CCC Quality & Patient and Public Involvement & Engagement Strategies. Following a number of time out sessions and an away-day which was supported by the senior trust managers and Executive and Non-Executive Trust Directors, The Charter received a glowing endorsement from the Trust Board who agreed with the vision and direction of travel set out in the charter and fully supported the new ways of working that will be needed to ensure they are able to deliver their 7 pledges. This Charter and Matron team will deliver the key fundamental blocks that will provide the trust with a solid foundation on which to deliver, truly world class care to our service users including outstanding patient safety and an exceptional patient, family and staff experience. A formal launch across the trust /communication campaign is also in progress.

The 7 pledges are;
•Maintain high standards of cleanliness and infection prevention and control for patients, Deliver safe patient care, Focus on Staff recruitment & retention, staff education and CPD, Provide good governance and high quality patient experience, Be visible to patients, carers and staff and provide clinical expertise, demonstrating high standards of care, Uphold professional standards and accountability, Deliver on Digital information technology infrastructure.

Radiation Services

The Radiation Services Directorate encompasses the Radiotherapy, Imaging services and the Physics service. Outpatient Radiotherapy services are delivered on 2 sites at present with a third delivery site on the opening of the new hospital which supports the Trust aim to bring services closer to patients. When the new hospital opens Imaging will also offer services to patients on 2 sites.

Chemotherapy Directorate

The Chemotherapy Services Directorate provides systemic anti-cancer therapy (SACT), supportive therapies and outpatient services for patients across Cheshire and Merseyside and the Isle of Man. The Directorate supports the following core services:

Day Case SACT clinics (including phase 1, 2 and 3 clinical trials) on the main site and at 7 DGH's across the Merseyside and Cheshire region, with delivery of >57,000 treatment episodes per annum (as at March 2019). Delivery of treatment closer to home aligned to 5YFV via Clatterbridge

in the Community (treatment at home and work) across the Merseyside and Cheshire Cancer network.

Oncology Outpatient services at 16 sites across the Merseyside and Cheshire region plus Isle of Man, delivering > 130,000 outpatient attendances (as at March 2019). Acute Oncology Services across the main site and 7 acute trusts within the Merseyside and Cheshire region to support SACT toxicity and treatment management.

Cyto-Pharmacy – prescription verification, preparation and dispensing of SACT and supportive therapies. Prescribing support. Trust wide responsibility for medicines management, information and advice. Outpatient pharmacy provision. Specialist R&D team to deliver both NIHR & Commercial trials. Specialist IM&T team to deliver the GDE & medicines related developments.

The Chemotherapy Directorate are committed to the delivery of the Trusts Q&S agenda, monitored via monthly Q&S meetings within the Directorate.

Integrated Care Directorate

The ICD provides supportive and acute services to patients across Cheshire & Merseyside and the Isle of Man. The inpatient and Ambulatory service are currently based on our Wirral site and will be relocated to our new hospital in Liverpool in 2020. The advanced Nursing team and AHP team provide services across the hubs. The directorate supports the following core services.

In patient services

The inpatient services provide care on our 2 inpatient wards this are:-

Conway Ward- Intermediate Cancer Ward and the provision of 2 Step-up beds- acutely unwell patient requiring closer monitoring

Mersey Ward- Common and Rare cancer Ward and the provision of a dedicated TYA 4 bed unit for patients 16-24 years old

Ambulatory Care

- Sulby Day case Ward - for supportive treatments and delivery of SACT
- Clinical Decision Unit (CDU)- A dedicated unit for the assessment and support of patients requiring acute care
- 24/7 Telephone Nurse Led advice hotline for patient on treatment or within 6 weeks of completing treatment
- Acute outreach service- DaRT Nurse Practitioners leading on MET, Arrest calls and resuscitation training for the trust
- Acute Oncology ANPs- Nurse leads in the CDU service and the H@N service
- Patient Flow Team- CUR and supports the safe admission and discharge of inpatients

Cancer Rehabilitation and Support Team (CReST)

Lead Cancer Nurses for Common, Intermediate and Rare Cancers

Advance Nursing Team- CNS & ANP's teams working in cancer specialities

Palliative Care team- Medical and Nursing services

Psychological support service

Teenage & Young Adult (TYA) regional service

Lymphedema Nurse Led service

Clinical Intervention Team- Nurse led service for PICs/PORTs insertion and care

Cancer Support Workers- Focusing on HNA pathway

Allied Health Professionals –Physiotherapy, Occupational therapy, Speech & Language Therapy & Dietetics teams

We are committed to providing services that meet the needs of our patient and their families and all service changes will benefit patients through improvement in the quality of experience and support the network acute oncology agenda. We will continue to develop our workforce to deliver safe, high quality care, and to do so we must develop and up skill our workforce and explore expansion of roles. We will continue to invest in new professional groups that can bridge the gaps such as the Physician & Nursing Associates.

These initiatives will support safe, high quality care, and enrich the roles our teams deliver.

Haemato – Oncology

CCC-Liverpool Haemato – Oncology (HO) service is the main provider of tertiary (H-O) services in Merseyside and Cheshire. The Directorate serves a population of 425 thousand as well as providing a specialist service serving to approximately 2.3 million people living within Merseyside and Cheshire, the Isle of Man and North Wales.

The H-O Directorate receives referrals from primary care, secondary care, internal referrals, and emergency admissions through A&E. The directorate delivers inpatient care and ambulatory and treatment for blood cancers condition such as; acute and chronic leukaemia's, lymphoma, and multiple myeloma. The directorate also delivers the Cheshire and Merseyside Stem Cell Transplant service as well as providing access to a wide range of clinical trials within blood cancer and stem cell transplantation.

As a directorate we recognise that clinical quality and safety improvement is paramount in providing the best patient experience and outcomes and we are committed to the delivery of the Trust's clinical quality priorities. This is through continuous service improvement, providing quality assurance and accreditation of the services, listening and involving patients as well as continuously monitoring of our performance and patient outcomes.

Palliative Care

The Specialist Palliative Care Team at The Clatterbridge Cancer Centre is a multiprofessional team dedicated to the care of patients through their treatment journey from the time they are diagnosed with incurable illness, through their anticancer treatment and beyond. Our work supports the clinical quality priorities by delivering safe and effective care in line with the implementation of our 5 year Palliative and End of Life Care Strategy and measured using the KPIs within it. In addition, our drive in line with the Trust Strategy is to provide care closer to people's homes within our new model of working from 2020, and constantly improve our care through the use of audit, research and quality metrics to ensure our care is always effective, compassionate and patient-centred.

Safeguarding

The Trust Safeguarding Trust declaration represents assurance that The Clatterbridge Cancer Centre NHS Foundation Trust (the Trust) Board has arrangements in place to ensure that children and Adults at Risk of harm, who come into contact with the Trust either directly, or as a family member of one of our patients, are safeguarded from harm.

In the past year the Trust has met all its statutory requirements in relation to safeguarding children, young people and adults and is fully compliant with the CQC fundamental standards relating to safeguarding.

Recruiting and maintaining a safe workforce: Under the Safeguarding Vulnerable Group Act 2006 and the Protection of Freedoms Act 2012 the Trust complies with requirements of the Home Office Disclosure and Barring Service (DBS) in order to ensure that appropriate level of pre-employment checks are carried out during the recruitment process particularly those engaging in Regulated Activity.

The Trust also ensures appropriate referrals are made to DBS if the Trust has dismissed or removed a person from working with children or adults at risk (or would or may have if the person had not left or resigned etc.) because the person has behaved in a way that may have caused harm.

Policies and procedures: The Trust has Safeguarding Children, Adults and Prevent Policy that is reviewed three yearly as well as whenever amendments are required in line with new national or local policy and legislative requirements.

Safeguarding Incidents identified within the Trust are reported on the Trust's incident reporting system.

Training

Safeguarding Children, Adults and Prevent Training is mandatory for all staff that is employed by or work for the Trust. All new staff receives a safeguarding briefing on the Trusts induction

programme which is also mandatory for all staff. The identified mandatory development of staff related to safeguarding training levels is in place.

The level of training undertaken depends on the nature of the staff member's role within the Trust.

Safeguarding staffing: The Executive Director of Nursing & Quality is the Executive lead and is supported by key named safeguarding leads.
The Safeguarding Team is in place to ensure that all staff within the Trust receives the required advice, support, supervision and training in order to safeguard and promote the welfare of children and adults at risk·

The Trust Board receives as a minimum an annual report of safeguarding activities and assurances from the Safeguarding Team via the Integrated Governance Committee and Quality Committee reporting mechanisms.

The Trust has a Safeguarding Committee in place which reports into the Integrated Governance Committee with external safeguarding representation.
Collaborative Working: The Trust is committed to comprehensive partnership working.

AHP Service

The AHP Service aims to provide a range of high quality therapy services which includes; Physiotherapy, Occupational Therapy, Dietetics and Speech and Language Therapy to patients under the care of The Clatterbridge Cancer Centre (CCC)

We will deliver safe and effective care by providing timely interventions to all in patients and out patients receiving their care at CCC to ensure that patient pathways are managed efficiently and that discharges occur effectively.

We will deliver a responsive service that works with the multi-disciplinary team and with community colleagues and external agencies as required ensuring a seamless provision of care to patients.
The individual AHP services will work together to deliver the Trust's quality focused strategic priorities and embed the new corporate governance structure as part of the Integrated Care Directorate governance structure.

Performance & Planning Service

The Performance and Planning function coordinates the Trust's strategic and operational planning cycle, ensures that structures are in place at all levels of the organisation to report performance and escalate risks and concerns up to Trust Board, ensures that 'Ward to Board' data is accurate, timely, benchmarked where possible and available to those who rely on it to make decisions and improve services, and ensures that staff are both held to account and supported to deliver

improvements. This function is integral to the delivery of the Trust's clinical quality priorities as it coordinates the development and implementation of Directorate plans, which are aligned to and therefore will deliver the priorities (including clinical quality) within the Trust Strategy and Operational Plans. It also supports the provision of data (related to both regulatory and internally identified metrics), ensures effective monitoring and reporting and seeks to identify the best performers for CCC to emulate.

Research and Innovation

The Research and Innovation (R&I) Directorate is led by the Director of R&I Operations and the Clinical Director for R&I. The Executive Lead is the Medical Director. The Director of R&I Operations is responsible for the operational oversight of all clinical and academic research taking place at the Trust and the Clinical Director for R&I is responsible for the strategic direction of research for the organisation. The R&I Directorate is made up of the Research Delivery Team, the Research Management and Governance Team and the Research Finances Team.

The Research Delivery Team has the largest group of staff in R&I Directorate with dedicated Research Practitioners and Clinical Trials administrative staff. Their core functions are to:

- Deliver safe and effective care and treatment for patients participating in clinical studies.
- Support the recruitment of patients to clinical studies and provide a high quality patient experience.
- Coordinate patient care whilst on a trial.
- Support Investigators through the process.

The Research Management and Governance Team is a cross cutting service that ensures studies are opened safely and in a timely way. Their core functions are to:

- Ensure robust research governance processes are in place for all areas including study set-up, management and oversight.
- Support academic oncology by acting as Sponsor for CCC-led studies and support the advancement of CCC-led research activity.
- Confirm the assessment of local impact for all studies taking place at site.
- Build strong relationships with pharmaceutical companies enabling our patients to access novel agents and treatments.

The Research Finances Team is another cross cutting service within the Directorate. Their core functions are to:

- Support costing and negotiation for all trials.
- Assess and report on the full resource impact of research trials at Clatterbridge.
- Ensure all invoicing for trials is carried out in a timely way.
- Grant management for all CCC-led studies

Workforce and OD

The Workforce & Organisational Development department provides leadership for all aspects of people management and development, in order to enable quality patient care and support the achievement of our objectives and business plans. The responsibilities of the senior Workforce & OD team encompass a wide range of work areas that collectively support the Trust to deliver high quality patient care.

We are responsible for ensuring all our staff receive a comprehensive induction on commencing employment and that staff have access to on-going professional development to ensure they have the knowledge, skills and behaviours to deliver exceptional care to patients.

Working in partnership with managers and trade union colleagues we ensure the effective and efficient development and implementation of HR policies and processes, the development of the Trust's workforce plan, and the associated implementation plans. Providing professional HR advice and support to managers and staff throughout the clinical divisions and corporate directorates across a range of areas including workforce planning, change projects, employment policies and employee relations issues. In addition, the team work with managers to ensure that actions are taken in response to feedback from staff surveys, and they also deliver training on issues related to people management.

Our Recruitment team handle internal and external recruitment and ensure that all appointments comply with NHS guidelines for employment checks: Occupational Health clearance; Criminal Records Bureau check; satisfactory references; eligibility to work, identification check. All vacancies are advertised on TRAC and NHS Jobs.

The team use a variety of electronic systems to streamline HR processes:

- ESR Manager Self-Service enables managers to access information about their team, and the ability to record appraisals, training and development, and absence and attendance.
- Healthroster is used for managing rosters for shift-based staff, and booking temporary staff. The system enables clear oversight of the allocation of the workforce at ward and departmental level.
- The Clinical Resource Management System (CRMS), provides a streamlined system for doctors in respect of job planning, appraisal and annual leave management.

Whilst payroll services are outsourced the Workforce & OD team provides support to ensure that pay and expenses are processed accurately and promptly.

We also lead the facilitation of the annual staff survey and staff friends and family test aiming to listen and understand the views of staff and act upon areas where they feel improvements are needed. In addition our health and wellbeing strategy directs support and interventions for staff to enable them to make lifestyle and behavioral choices.

Digital Services

The Digital team is led by the Chief Information Officer and team delivers digital transformation services, Information Technology services and an emerging business intelligence function. The Executive lead for Digital services is the Finance Director. Clinical leadership is provided by the Chief Clinical Information Officer and the Medical Director is the Senior Responsible Officer for our Global Digital Exemplar programme

Using Digital technology to improve Quality

Our new technologies will transform the way we deliver care and be a key enabler in improving the quality of our services. As a Global Digital Exemplar (GDE) partner organization, we were funded to build on our digital developments and our involvement in the GDE programme will enable us to move faster with our plans. It will help us to think differently, innovate and learn from the best practice of others to transform the use of technology for our healthcare professionals and patients. Digital is not just about technology, it is about people, and as a Trust we will be engaging with clinicians and patients to jointly identify and design digital tools that will transform the treatment and management of cancer.

Our Programme aims to support:

The Digital Patient – Improving the health and well being of our patients, making it easy to manage their condition, connect with our services and access help and guidance.

The Agile Clinician – Delivering safe and effective care with a reliance on fast and efficient access to the information they need to make the best decision for our patients.

To support this and to improve efficiency and safety we are:

- Redesigning our clinical processes through digitising clinical pathways, working with our staff and our patients to empower clinicians and patients to make personalised, informed and safe decisions

- We are supporting care closer to home through the provision of improved access and information through the provision of technologies including telehealth.

- We are ensuring that new technologies enables clinical information to be captured safely and efficiently through tools such as clinical speech recognition directly into the patient record

- We are implementing closed loop medicines administration for enhanced patient safety and improved efficiency of the entire medication management process.

9. Accountability, Governance, Monitoring & Reporting delivery of our Clinical Quality Strategy

Implementation, monitoring and reporting of progress against the strategy aims and escalation of issues will be reported to the Quality Committee of the Board through monthly updates to the Integrated

- Are we targeting and measuring what matters most to patients?
- Do we know how good we are?
- Do we know where we stand relative to the best?
- Do we know how much variation in practice we have and where that variation exists?
- Do we have the right capabilities, tools and engagement to deliver the changes we need to make?

Governance Committee by associated Trust operational Committees (see Appendix 1).

The Trust Board's responsibilities in respect of quality are:

• To ensure that minimum standards of quality and the safety of our patients are being met by every service within the organisation;

• To ensure that the organisation is striving for continuous quality improvement and excellence in every service, and;

• To ensure that every member of staff is supported and empowered to deliver our vision for quality.

In discharging these responsibilities, the Board has an absolute commitment to the clinical quality vision set out in this strategy. Each month, our Board will receive a range of performance data demonstrating progress towards achieving our goals, enabling the Board to exercise challenge where necessary. In seeking continuous improvement, the Board will constantly be guided by five key questions:

Our Board will also continue its existing practice of receiving a patient story at the start of its meetings – where possible, from the patient in person. The purpose of the story is to remind the Board about the people it serves and to create a context for the vital discussions and decision making that follows.

At the end of each year of the strategy, the Board will review and, if necessary, adjust our 2021 goals. The Board will also agree a set of annual quality aims to keep us moving towards our vision. We will do this in consultation with staff, patients, members, partners and governors. The aims, which will

relate to the themes of our quality strategy, will be published in our annual Quality Account; and every quarter, the

Board will receive a report detailing the progress we have made towards achieving them.

10. Measuring Success

Key indicators/measures and supporting data:

The strategy will be delivered over a three year timeframe and detailed one year implementation plans will be developed following collation of service level initiatives alongside Trust wide programmes of improvement activity. Measurement tools and outcome measures will be identified, developed and agreed by Quarter 1 2019 to enable quantitative monitoring in addition to work-stream updates.

Implementation Plan

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
SAFE					
Infection Prevention & Control- E. Coli bundle	DK	Infection Prevention & Control Committee	• Continue to actively participate in collaborative working to identify the causes of E.coli bacteraemia in cancer patients and implement methods to reduce risks to patients	Q1 through 4 2019 -2020	DoN&Q
			• Each occurrence of gram negative bacteraemia will be investigated and discussed in Harm Free Care Group and reported via IPC Committee with lessons learned circulated within the Trust.	Already in place and will continue to be strengthened 2019-2021	
			• No avoidable gram negative device or wound associated bacteraemia	Q2 2020	
			• Overall reduction in CCC associated gram negative bacteraemia within Cancer Network and across Cheshire & Merseyside.	Q4 2020	
			• Continue to support clinical staff in methods to improve	Q4 2019	

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			hydration and launch urine colour charts.		
Sustained & effective training in, & escalation & management of, incidents and risk	VAD	Risk Management Committee Incidents & Investigations Committee	• Risk Management Committee revised to ensure appropriate membership and Terms of Reference	Q1 19/20	DoN&Q
			• Risks and incidents will be reviewed within their review timeframes and continue to be monitored by the monthly data packs and board reports.	Q2 19/20	
			• Risks will be described and graded appropriately to ensure escalation via department and directorate risk registers and Triple As.	Q2 19/20	
			• Delivery of MIAA Risk Management review action plan	Q2 19/20	
			• Datix link staff to be in place to support staff in their Directorates/ Departments	Q2 19/20	
A culture of safeguarding awareness, reporting and practice	JR	Safeguarding Committee	• Response to findings identified from safeguarding audits	Q1-4 2019	DoN&Q
			• Safeguarding incident reporting via Datix		
			• Number of Safeguarding		

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			referrals to local authority		
			• Number calls, themes and trends identified via CCC safeguarding duty line		
			• Safeguarding training compliance for Children's, Adult and Prevent Safeguarding Training - eligible cohort of staff		
			• Training Needs Analysis	Annual	
			• Number of Allegations Against Staff in Positions of Trust		
			• s11 Audit submissions to local authority	Annual	
			• Completion / Progress against internal and multi-agency action plans		
			• Policies reviewed annually		
			• Safeguarding annual report		
The deteriorating patient work stream milestones	ED/ CB	Deteriorating Patient Committee	• DaRT monthly report- MET & Arrest calls- numbers and outcomes	Q1-4 2019-21	DoN&Q /MD
			• VTE- monthly compliance		
			• Sepsis- Monthly audit of door to needle and screening		
			• Training compliance		
			• AKI- Monthly audit		

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			• Step up occupancy report • CDU monthly activity report and patient pathways		
Reduction in avoidable harm to include VTE	KK /CS	Harms Committee	• 95% of all inpatients to receive a VTE risk assessment (excluding agreed cohort) • 100% of patients receive all VTE prophylaxis prescribed	Q2 19/20 Q4 19/20	DoN&Q
Timely and efficient Sepsis/News2 patient management	ED	Deteriorating Patient Committee	• DaRT monthly report- MET & Arrest calls- numbers and outcomes • VTE- monthly compliance • Sepsis- Monthly audit of door to needle and screening • Training compliance • AKI- Monthly audit • Step up occupancy report CDU monthly activity report and patient pathways		DoN&Q /MD
Strengthened safer staffing through digital monitoring systems	KK	Matrons Meeting/ Digital Board	• A strengthened safer staffing report completed every month and presented to Trust Board via the trust committee structure • Safer staffing information	Q3-4 19/20	DoN&Q /DoF

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			is triangulated with trust patient incidents/ complaints/PALs enquiries • Safe staffing bi-annual review • Safe staffing incorporated into workforce planning Global Digital Exemplar programme milestones achieved A series of milestones are monitored through digital board and NHSx. Milestones include: • Digiitising Clinical pathways- further 12 areas completed • Telehealth (phase 1 implementation) • Clinical Virtual Desktop (phase 1 implementation) • Integration with Regional portal • Extranet development through sharepoint • Vital Signs and point of care testing	anticipated delivery are Q3 and Q4 2019/20	DoF

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			• Patient portal • Phase 2 of clinical speech recognition The next series of milestones (milestone 4 commence in Q1, Q2, and Q3 2019		
Strengthened safety culture through standardisation of safety huddle agenda	GM	Integrated Governance Committee	SOP Safety Huddles.doc	Q1-4 2019/20	DoN&Q
EFFECTIVE					
The national cancer waiting times standards	LBen HG	Trust Operational Group, Monthly Directorate reviews/Performance Committee	Two Week Wait standard 31 Day standards: Firsts, Subsequent radiotherapy, Subsequent chemotherapy 62 Day standards: Classic, Upgrade, Screening 28 Day Faster Diagnosis Standard (in effect from April 2020)	Q1 2019/20 Q2 2020/21	DoOps
Reduced waiting times	JS	Directorate Meetings/monthly clinical directorate reviews Performance Committee	80% of patients waiting 30 minutes or fewer in outpatient clinics	Q3 2019/20	DoOps
Reduction in unplanned admissions	CVB/	Monthly performance reviews/Performance Committee	New KPIs to be agreed	Q4 2019/20	DoOps

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
and readmissions	AA				
Maintained regulatory compliance	RS	Integrated Governance Committee	• All CQC Must Dos and Should Dos to be achieved within timescales indicated on agreed action plan • Implement whole Trust programme of mock inspections and monitor resulting action plans by Quarter 4 19/20 • Imaging department to achieve ISAS accreditation by end of Quarter 3 19/20 • Radiation Services Directorate to achieve 100% compliance with IRMER17 and IRR17 as evidenced by any external inspections and internal audit • Deliver compliance against all mandatory standards of the data security and protection toolkit by Quarter 4 19/20	q4 2019/20 q3 2019/20 q4 2019/20	DoN&Q
Improved clinical outcomes and establish SRG KPIs	HW/ PP	Integrated Governance Committee/Data management Group & Digital Board	• Support ClickHealth to digitalise SRG dashboards	Initial planning by q4 2019/20 further progress	DoN&Q /DoF

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
				through Q1 & 2 2020/21	
Compliance with NICE guidelines	HW	Nice Assurance Committee	• Continue to achieve 90% NICE compliance trust target	q4 2019/20	DoN&Q /MD
We will aim to reduce unexpected deaths	GMs /CDs	Mortality Review Meeting Mortality Surveillance Group	• Continue to review patient who suits the criteria as set out in the SOP • Disseminate lesson learnt from case review through quarterly lesson learnt newsletter	q4 2019/20	MD
We will aim to deliver zero avoidable deaths	GMs /CDs	Mortality Review Meeting Mortality Surveillance Group	• Continue to review patient who suits the set criteria as in SOP • Disseminate lesson learnt from case review through quarterly lesson learnt newsletter	q4 2019/20 Q1-4 2019-21	MD
Improved Clinical audit monitoring	HW	Integrated Governance Committee	• Clinical audit progress report through data pack and SRGs • Clinical audit progress discuss at Clinical Audit Subcommittee as per policy	q4 2019/20	DoN&Q
Strengthened clinical data recording	HW/ PP	Digital Board Data Management Group & Digital Board	• Report new chemotherapy regimen and it's assigned procedure codes to the Drug Reporting Group for Approval	q4 2019/20	DoF/MD

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
	GO/ SB		• Present clinical data in SRG dashboard	Q4 2019/20	DoF/MD
			• Digitised clinical pathways within EPR (12 areas complete)		
			• Snomed Clinical Coding (phase 2)	Q4 2019/20	DoF/MD
			• Vital Signs and point of care testing integration to EPR	Q4 2019/20	DoF/MD
			• Electronic Prescribing and Medicines administration – closed loop within chemotherapy	Q4 2019/20	DoF/MD
Stat & role essential Training and role based competency compliance across the Trust	JG	Workforce and OD Committee	• 90% or better compliance for mandatory training.	Q2 2019/20	DoW&OD
			• 90% or better for role essential training.	Q4 2019/20	
Strengthened management and understanding of MCA and DoLS	JR	Safeguarding Committee	• Number staff trained in MCA/DoLs awareness	Q1-4 2019/20	DoN&Q
			• Number MCA Assessments		
			• Number DoLs applications		
			• Number of urgent DoLs requested		

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			• Number of DoLs authorised by Local Authority		
Implement stratified follow up of patients to optimise clinical input and appropriate follow up	FY	monthly directorate reviews/Performance Committee	• Redesign OPD activity via new CQUINS as per KPI CQUIN Commissioner milestones	Q3 and Q4 2019/20	DoOps
Clinical Research Operational Improvements: Increase patient recruitment	GH	Integrated Governance Committee	• Increase participant recruitment to research: from 526 patients in 2018 to 1000 patients in 2020.	Clinical Research - KPIs Measures of suc	MD
Increase qualitative/observational studies	GH	Integrated Governance Committee	• High quality qualitative and observational studies will move from 11% of the portfolio in 2018 to 20% of the research portfolio in 2020.	As outlined in Clinical Research KPIs (see previous attachment)	MD
Increase Investigator-led studies	GH	Integrated Governance Committee	• Increase the number of studies for which CCC act as Sponsor: By 2021 CCC will act as Sponsor for 10 clinician led studies from 5 in 2018.	As outlined in Clinical Research KPIs (see previous attachment)	MD
Improve access to clinical trials	GH	Integrated Governance Committee	• Better integration with partner Trusts to improve access to	As outlined in Clinical	MD

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			clinical trials. CCC will develop system leadership and assure that the cancer research agenda is embedded.	Research KPIs (see previous attachment)	
CARING					
Continued top quartile results for patient experience	SR/K K/ GMs	Patient Experience Committee	• Ensure patient opinion is used to improve continuously improve services through the establishment of twice yearly patient and public listening events • All action plans drawn up from patient contacts (PALS and complaints) to be monitored through to conclusion via Quality and Safety Committees	Q1-4 2019 - 2021	DoN&Q
Deliver dementia strategy	JR	Safeguarding Committee	• The number of patients with a diagnosis of dementia • Specific dementia audits • Feedback from people living with dementia and their carers/family • Evaluation and audit from the environmental changes • Uptake of and compliance with	Q1-4 2019/20	DoN&Q

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			mandatory dementia training		
			• Reduction in length of stay and readmission for people with dementia		
			• Patient led assessment of clinical environment (PLACE) audit		
			• Number of complaints received relating to dementia care		
			• Care plans routinely include carers wishes/preferences		
Deliver Patient and Public Involvement Strategy 19-21	SL	Patient Experience Committee	• All patient experience strategy pledges to be completed within timescales indicated in strategy	Q1-4 2019 - 2021	DoN&Q
Establish a Patient and User Experience Group	KK	Patient Experience Committee	• Delivery of Patient and Public Involvement & Engagement Strategy 2019 – 2012 containing 8 pledges Evidence user feedback is used to enhance the care and services we provide • establishment of e-advisors • Continue with Digital user	Q2 2019 Q1-Q4 2019/2020 Launched Q2 - ongoing	DoN&Q DoF DoF

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			engagement for technology developments for CCC • Chief Information Officer CIO to lead on citizen engagement across health and social care for STP Digital work stream		
Implementation of the EOL Strategy	DM	Integrated Governance Committee	• KPIs are documented within the Palliative and End of Life Care 5 Year strategy 201802923. The Strategy contains a detailed implementation plan for each year and successful achievement of KPIs is expected to be in line with the delivery of each milestone.	As per delivery milestones within the strategy	DoN&Q
Implementation of GDE quality digital work streams to include electronic patient information	SB	Digital Board Patient Experience Committee	The Digital team continues to make good progress against its GDE partner programme deliverables. The team is now focused on implementing a number of Milestone 4 deliverables which will embed new technologies at the	Q4 2019/20	DoF/MD

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead

			CCC-Wirral site, in preparation for future implementation at the new hospital site in Liverpool in 2020 including:
			
			   o Clinician Virtual Desktop (VDI) and Fast User Switching
			   o Telehealth Pilot
			   o Patient Education & Experience Pilot
			   o Clinical speech recognition (phase 2)
			   o Closed loop medicines administration
			   o E-consent
			   o Bar codes DM&D
			   o Self-Check in kiosks (phase 2)
			   o Digitising Clinical pathways (16 areas complete)
			 The team are progressing towards HIMSS Level 6 and Definition of Done targets and has made demonstrable improvements
			 A significant number of		

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			achievements were delivered in Milestone 3 (q4 2019 and Q1 2019 The programme continues to receive an external assurance rating of Green from NHS X		
Develop research active workforce	GH	Integrated Governance Committee	• Develop a forward facing research active workforce: By 2021 80% of CCC consultants will be research active from 50% in 2018.	Q4 2021	MD
RESPONSIVE					
Our future clinical model to deliver patient care closer to home	FY SB	TCC board, CFF Committee/monthly directorate reviews Performance Committee Digital Board	• Business Planning Objective MD1.1: Expand the pharmacy homecare strategy, including IO/HO Business Plan 2018192021 Chemo a • 90% of patients travelling <= 45 minutes for treatment Introduction of telehealth to support remote monitoring	 Q1 2022 (in CCC strategy) First stage Q4 2019/20	DoOps DoF/MD

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
Implementation of new complaints handling in Directorates model	SL	Patient Experience Committee	• Demonstrate effective and timely management of complaints through 6 monthly audit of complaints process	Q2 2019	DoN&Q
Triangulation of incidents, complaints and PALs to promote learning and improvements	SR	Integrated Governance Committee	• Consistent reporting of learning from incidents, complaints and PALS in each Quality and Safety data pack • Demonstrate effectiveness of shared learning through a reduction in avoidable repeated incidents • Shared learning newsletter to continue to include learning from incidents, complaints, PALS, claims, Inquests and safety alerts.		DoN&Q
Strengthened care and experience of patients with additional needs	DDJ	Patient Experience Committee	• Demonstrate processes that ensure we work and engage with people receiving care, their families and carers, as set out in the NHS Constitution. • Demonstrate we have made reasonable adjustments to all	q1-4 2019-21	DoN&Q

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			care pathways		
			• Develop mechanisms to identify and flag patients with additional needs from the point of admission through to discharge		
			• Ensure staff have the specialist knowledge and skills to meet the unique needs of people with reasonable adjustments		
			• Collaborate with CCGs in relation to supporting patients who experience hearing loss		
			• Strengthen process for recording of Reasonable adjustments and pictorial pain tool in electronic patient records		
			• Demonstrate processes that ensure we engage with people receiving care, their families and carers through the Transforming Cancer care project		
			Delivery of dementia strategy and Learning disability standards		

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
Delivery of the national Learning disability standards	JR	Safeguarding Committee	Trusts must : • Demonstrate processes that ensure they work and engage with people receiving care, their families and carers, as set out in the NHS Constitution. • Demonstrate that they co-design relevant services with people with learning disabilities, autism or both and their families and carers. • demonstrate they have made reasonable adjustments to care pathways • have mechanisms to identify and flag patients with learning disabilities, autism or both from the point of admission through to discharge • Have processes to investigate the death of a person with learning disabilities, autism or both while using their services, and to learn lessons from the findings of these investigations. • Have measures to promote	q1-4 2019-21	DoN&Q

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			anti-discriminatory practice in relation to people with learning disabilities, autism or both. • ensure staff have the specialist knowledge and skills to meet the unique needs of people with learning disabilities		
Improvements in F&F data capture	SR/ DJ	Patient Experience Committee	• Achieve 50% response rate for Friends and Family by end of Quarter 4 19/20	Q4 19/20	DoN&Q
Shared learning from PALs, complaints, deaths and SI's incidents across the patient pathway, working in partnership with the Cancer Alliance	SR	Integrated Governance Committee Patient Experience Committee	• Consistent reporting of learning from incidents, complaints and PALS in each Quality and Safety data pack	Q4 19/20	DoN&Q
An expanded volunteer service to support the opening of the new hospital in Liverpool	SR	Patient Experience Committee	• Development of Volunteer Strategy. • Planned recruitment and awareness day.	Q2 – 2019 Q4 – 2019/20	DoN&Q

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
WELL LED					
Trust's quality focused strategic priorities	FY/J M/LF /ZH	Integrated Governance Committee	• Directorate monthly Quality & Safety Data pack/Directorate meetings and escalated via Triple A to monthly Q&S sub-committee	Q1-4 2019-2021	DoN&Q
Embed new corporate governance and risk committee structure	AW/ VAD	Integrated Governance Committee	• Continue to refine quality data pack via 6 monthly review with GMs to ensure directorates can perform accurate assessment of performance and risk • Demonstrate effective and timely recording and management of risks through quarterly audit	Q1-4 2019-2021	CEO/ DoN&Q
Increased national profile and collaborative working as a system leader against regional & national quality priorities/indicators	MZ	Integrated Governance Committee	• Working with the Cheshire and Merseyside Cancer Alliance on a range of initiatives including development of a Cancer Workforce Strategy, redesigning pathways, campaigns to improve cancer awareness and screening uptake, the roll out of genomics and personalised medicine	Q1-4 2019-2021	DoN&Q

Priority: What do we want to achieve	Lead	Operational/Oversight Committee	Measures of Success/KPIs	Year & Quarter for delivery	Executive Lead
			• Ensuring that clinicians are active members of Alliance Clinical Quality Groups • Participating in regional and national pilots at every opportunity • Forming collaborative partnerships with cancer providers across C&M and other HCP programmes such as diagnostics, acute sustainability, elective care and end of life care		
Human factors focused quality and safety leadership walk rounds	PP	Integrated Governance Committee	Monthly walk arounds with Executive Team, NEDs, Matrons and Patient Safety Leads.	Commencing Q1 - 2019	DoN&Q /MD
Strengthen Nurse & AHP Leadership	PR	Integrated Governance Committee	• A more robust reporting structure for AHPs which includes the development of a Chief AHP strategic role within the Trust and the First Trust AHP Strategy.	Q4 19/20	DoN&Q

Quality Committee

Integrated Governance Committee NEW (Monthly – DON/IMD)
- Mortality Surveillance Group (Medic Chair)
  - Mortality Review
- Safeguarding Committee (Quarterly DON)
- Infection Control Group
  - Water Safety
  - Antimicrobial Stewardship Group
- Clinical Audit Committee & NICE Compliance
- Information Governance (SIRO)
- Directorate Quality
- Patient Experience & Inclusion Group NEW (Deputy DON)
  - Equality and Diversity
  - Patient Experience
  - Volunteers
  - Dementia
  - Health & Wellbeing
- Incidents & Investigations NEW
- Research

Drugs & Therapeutics (Monthly – Clinical Director)
- Medicines Safety Advisory
- Non Medical Prescribing
- Patient Group Directions
- Medical Gas Group

Digital Programme Board (Monthly – MD)
- Clinical Reference Group (Monthly – CCIO)
- Data Management Group
- Medicines optimisation Group

Workforce, Education & OD Committee (Bi-Monthly DofW & OD)
- Education Group
- Equality and Diversity (Bi-monthly)
- Culture and Engagement NEW (Bi-monthly)
- Workforce Productivity
- Strategic Partnership Forum/JLNCC

Risk Management Committee NEW (Monthly – COO)
- Integrated Care Chemotherapy Radiation Services Haemato-Oncology Corporate
- Health and Safety Group
  - Fire Safety Group
  - Security
  - Moving & Handling
  - Radiation Safety Committee
  - Radiation Protection Supervisors Forum
  - Medical Devices
  - Emergency Planning