The ROYAL MARSDEN
NHS Foundation Trust

Integrated Governance Monitoring Report

April to June 2018

Quarter One 2018/19

NHS

Contents

1. Introduction

1.1. Welcome to The Royal Marsden NHS Foundation Trust's Integrated Governance Monitoring Report.

1.2. The Integrated Governance Monitoring Report is a quarterly review of the governance of care, research and infrastructure provided at The Royal Marsden. Together with the monthly quality account, the six-monthly safer staffing report, the Board scorecard and the annual quality account (part of the Trust's annual report) it is part of The Royal Marsden's monitoring of safety and assurance of quality of service.

1.3. The Integrated Governance Monitoring Report is published on the Royal Marsden's website, www.royalmarsden.nhs.uk.

1.4. The Royal Marsden's Community Services Division delivered community services in Sutton and Merton until the end of March 2016. From April 2016 the Community Services Division has provided services in Sutton as The Royal Marsden Community Services (which includes Sutton Community Health Services and Sutton Children's Health Services). This is referred to as *Community Services* in this report.

1.5. The Care Quality Commission's fundamental standards are intended to help providers of health and social care to comply with the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They are:

- Person-centred care
- Dignity and respect
- Consent
- Safety
- Safeguarding from abuse
- Food and drink
- Premises and equipment
- Complaints
- Good governance
- Staffing
- Fit and proper staff
- Duty of candour
- Display of ratings.

The fundamental standards are described in more detail on page 127.

1.6. The Care Quality Commission inspects and assesses organisations against the fundamental standards using five key questions:

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

1.7. Unless otherwise specified text, tables and charts refer to Quarter One 2018/19 (April to June 2018).

2. Executive summary

2.1. Is care safe?

By safe, we mean that people are protected from abuse and avoidable harm.

2.1.1. Incident, complaints and claims investigations

Fifteen new incident investigations were declared this quarter (23 the previous quarter). Eight incident investigations were completed in the quarter and remedial actions were identified (11 the previous quarter). (*Incident, complaints and claims investigations and serious incident reporting*, page 99.)

2.1.2. Infection prevention and control

There have been no cases of MRSA bacteraemia this year. The last case was in July 2016.

There were 28 cases of *Clostridium difficile* toxin (CDT) in the quarter of which one was classed as a 'lapse of care' (against an annual trajectory of no more than 30). Fifty-two cases in the full year 2017/18 were reportable to the Healthcare-associated infection Data Capture System (46 cases in the year 2016/17).

Eleven patients had suspected carbapenemase-producing Enterobacteriaceae (CPE) in the quarter of which 10 were confirmed. (*Infection prevention and control*, page 42.)

2.1.3. Fire

There were two incidents relating to one actual fire in the quarter. The fire was subject to an incident investigation panel in May (see Investigation 2 on page 101 for description). (There were no actual fires in the previous quarter.)

Four fire incidents were attributable to the Trust. Seven fire incidents had been reported in the previous quarter. (*Fire*, page 49.)

2.1.4. Radiotherapy

A new certificate has been received by the Trust following the assessment of quality standard ISO9001:2015 by the BSI in March. The new certificate will be valid until 2021.

There were 39 radiotherapy risk incidents, all risk-rated *low* and *very low* (48 the previous quarter). There were no complaints this quarter; there were 19 letters or cards of praise.

There were 1,373 appointments in the quarter (1,387 in the previous quarter). There were 5,416 appointments in the full year 2017/18. (*Radiotherapy*, page 78.)

2.1.5. Chemotherapy

The delayed final part of the last BSI inspection took place in the quarter. All aspects of the service complied fully with the requirements of ISO9001:2015 and the transition to the latest standard is complete. New certificates have been issued and the next inspection was planned for October 2018.

Of the 125 incidents reported, one was risk rated *moderate*, the others *low* and *very low* (there were 137 in the previous quarter). Of the 125 incidents 111 referred to medication issues (130 in the previous quarter). There were no complaints in the quarter and there were 89 letters of praise and thanks. (*Chemotherapy*, page 80.)

2.2. Is care effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

2.2.1. Commissioning for quality and innovation (CQUIN) goals

Quality improvement and innovation goals are agreed between The Royal Marsden, NHS England and Sutton Clinical Commissioning Group (Sutton CCG) through the Commissioning for Quality and Innovation (CQUIN) payment framework.

CQUIN schedules for 2018/19 have now been agreed with Commissioners with the exception of the Medicines Optimisation CQUIN schedule for which negotiation is ongoing. Achievement against the **2017/18** CQUIN schedules is as documented below:

- **Acute NHS England**: NHS England has confirmed 100% achievement for Quarter One and Quarter Two. Confirmation for Quarter Three and Quarter Four is awaited.
- **Acute CCG**: Sutton CCG has confirmed 100% achievement for Quarter One, Quarter Two, Quarter Three and Quarter Four milestones.
- **Community Services**: Sutton CCG has confirmed 100% achievement for Quarter One, Quarter Two, Quarter Three and Quarter Four milestones.

(*Commissioning for quality and innovation (CQUIN)*, page 14.)

2.2.2. National Institute for Health and Care Excellence (NICE)

NICE published 26 items of guidance which were presented to the Integrated Governance and Risk Management Committee in Quarter One. After the guidance was reviewed, six items were deemed relevant and four items were under review at the time of reporting. Eight quality standards were presented to the committee. The items have been reviewed: two were deemed relevant to The Royal Marsden and three were under review. (*National Institute for Health and Care Excellence (NICE)*, page 72.)

2.2.3. Medical devices

There were 57 incidents relating to medical devices this quarter (44 in the previous quarter). All the incidents were graded *low* and *very low*.

The Medical Device Committee approved 19 proposals to evaluate or use new equipment and approved five products for purchase. (*Medical devices*, page 46.)

2.2.4. Deaths following anti-cancer-therapy

Seventy-six patients who received systemic anti-cancer therapy in the quarter died within 30 days, out of a total of 4,348 (1.7%). There were 66 out of 4,337 (1.5%) in the previous quarter. (*Deaths following anti-cancer-therapy*, page 70.)

2.2.5. Deaths following surgery and anaesthesia

Five patients who received surgery or anaesthesia in the quarter died within 30 days, out of a total of 1,448 (0.9%). There were 14 out of 1,429 (1.0%) in the previous quarter. (*Deaths following surgery and anaesthesia*, page 71.)

2.2.6. Deaths following stem cell transplantation

There were 62 stem cell transplants. One death related to transplant out of 56 adult patients and there were no deaths among the eight paediatric patients. In the previous quarter there had been two adult deaths related to transplant (out of 58), and no deaths among the seven paediatric patients. (*Deaths following stem cell transplantation*, page 72.)

2.2.7. Medicines optimisation

Waiting times for outpatient prescriptions: 77% completed within 30 minutes.

Waiting times for prescriptions dispensed for discharge: over 93% of the prescriptions were completed within 60 minutes and 74% were completed within 30 minutes. (*Medicines optimisation*, page 49.)

2.3. Are staff caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

2.3.1. Letters of praise

In Quarter One the Head of Clinical Legal Services, Complaints and Patient Information received 219 letters of praise (180 in the previous quarter). (*Letters of praise*, page 98.)

2.3.2. Safeguarding of adults at risk

Thirteen reported safeguarding concerns were raised at the Trust's Chelsea and Sutton sites (there were five in the previous quarter). Twenty-four reported safeguarding concerns were raised in Community Services (22 in the previous quarter).

Seven urgent applications were made under the Deprivation of Liberty safeguards (6 in the previous quarter). (*Safeguarding of adults at risk*, page 33.)

2.3.3. Friends and Family Test

In Quarter One the Friends and Family Test showed that

- 95% of Royal Marsden inpatients who responded would recommend the Trust. (Of NHS inpatients in England 96% of respondents would recommend their provider.)
- 95% of Royal Marsden outpatients who responded would recommend the Trust. (Of NHS outpatients in England 94% of respondents would recommend their provider.)

  97% of Royal Marsden community clients who responded would recommend the Trust. (Of NHS community clients in England 96% of respondents would recommend their provider.) (*Friends and Family Test*, page 18.)

2.4. Are staff responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

2.4.1. Concerns and complaints

The Trust uses people's concerns and complaints to improve the quality of its care.

The Trust received 25 new complaints relating to NHS patients and one new complaint relating to private patients in Quarter One. All were acknowledged in three days or less.

Twenty-nine complaints relating to NHS patients and four relating to private patients were completed in Quarter One. Four complaints relating to NHS patients and three relating to private patients did not receive a response by the agreed deadline. (*Concerns and complaints*, page 89.)

2.4.2. Freedom of information

The Trust received 132 freedom of information requests during Quarter One (145 in Quarter Four). Of the 132 requests 130 were answered within 20 working days (98%). (*Freedom of information*, page 75.)

2.4.3. Adult Psychological Support Service

In Quarter Four 2017/18 and Quarter One 2018/19, 431 NHS patients were referred to the service and offered a triage appointment. The increase in the number of referrals seen in the previous two quarters has continued. The Psychiatric Liaison Service assessed and provided support to 135 inpatients in Quarters Four and One. (*Adult Psychological Support Service*, page 27.)

2.4.4. Clinic waiting times

There has been an increase in activity of from 41,725 to 44,421 between Quarter One 2017/18 and Quarter One 2018/19 – an increase of 2,696 (6.5%).Over the same period the number of patients seen within 30 minutes or less of their appointment time has increased from 34,856 to 39,067, an increase of 4,208 (12.1%). (*Clinic waiting times*, page 87.)

2.4.5. Consultant clinics cancelled less than 15 days before planned date

In the quarter 0.40% of NHS clinics (20 out of 4,976) and 2.17% of private care clinics (46 out of 2,117) were cancelled less than 15 days before the planned date. (*Consultant clinics cancelled less than 15 days before planned date*, page 88.)

2.5. Are staff well led?

By well led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

2.5.1. Reports to NHS Improvement and accounts

Clear leadership assures the sustainability of the Trust's financial position. NHS Improvement, the regulator of NHS trusts and foundation trusts, has given the Trust a Use of Resources rating of 1, which means the Trust is considered low risk in financial terms and is one of those providers with maximum autonomy. (*Reports to NHS Improvement and accounts*, page 112.)

2.5.2. Human resources

The vacancy rate has increased to 9.9% (against the target of 5%), but shows improvement over the vacancy rate for the same quarter 2017/18 (11.3%).

The turnover rate is 13.4% and remains above the 12% target.

The sickness rate for the Trust reduced from 3.6 to 2.9 in line with seasonal trends. (*Human resources*, page 55.)

2.5.3. Research governance

Eight projects were awarded Trust sponsorship. There were 15 suspected unexpected serious adverse drug reactions (SUSARs), none of which required further action. (*Research governance*, page 84.)

2.6. Conclusion

The Integrated Governance Monitoring Report demonstrates that The Royal Marsden promotes a culture in which safety concerns raised by staff and patients are encouraged and used to improve the service. Staff are open and fully committed to reporting incidents and near misses. The Trust's safety policies result in consistent progress towards a zero-harm culture.

3. Performance indicators and Commissioning for Quality and Innovation (CQUIN)

3.1. Performance indicators

National Cancer Plan targets

Indicator	Target*	2018/19 (projected)†	2018/19 year to date	2017/18	2018/19 cumulative month
2 weeks					
% of patients seen within 2 weeks of urgent GP referral	93.0%	84.1%	84.1%	96.0%	June
% of patients seen within 2 weeks for breast symptoms	93.0%	85.7%	85.7%	94.4%	June
31 days					
First treatment – % treated within 31 days of decision to treat	96.0%	97.2%	97.2%	97.6%	June
Subsequent drugs – % treated within 31 days of decision to treat	98.0%	98.5%	98.5%	98.8%	June
Subsequent surgery – % treated within 31 days of decision to treat	94.0%	96.7%	96.7%	95.8%	June
Subsequent radiotherapy – % treated within 31 days of decision to treat	94.0%	96.3%	96.3%	95.4%	June
62 days					
All cancers – % treated within 62 days of urgent GP referral	85.0%	78.1%	78.1%	74.7%	June
All cancers – % treated within 62 days of urgent GP referral (post reallocation‡)	85.0%	85.1%	85.1%	85.6%	June
Referral from screening – % treated within 62 days of urgent GP referral	90.0%	84.6%	84.6%	85.2%	June
Referral from screening – % treated within 62 days of urgent GP referral (post reallocation‡)	90.0%	84.9%	84.9%	89.2%	June
Consultant upgrade – % treated within 62 days of urgent GP referral	N/A	77.1%	77.1%	69.6%	June

Patients may be referred by their GPs to their local hospital and from there referred onwards to The Royal Marsden for any subsequent treatment. This additional step in the referral route from the GP is outside the control of The Royal Marsden and is reflected in these figures.

Activity data

Indicator	Target*	2018/19 (projected)†	2018/19 year to date	2017/18	2018/19 cumulative month
Number of NHS elective inpatient full consultant episodes	-	5,317	1,308	5,076	June
Number of NHS daycase full consultant episodes	-	11,382	2,800	11,681	June
Total NHS elective full consultant episodes	**-**	**16,699**	**4,108**	**16,757**	**June**
Number of NHS non-elective inpatient full consultant episodes	-	1,911	470	2,037	June
Number of NHS outpatient attendances	-	195,921	48,197	187,956	June

National access targets

Indicator	Target*	2018/19 (projected)†	2018/19 year to date	2017/18	2018/19 cumulative month
Cancelled operations					
Number of last minute cancelled operations for non-clinical reasons not admitted within 28 days**	0	0	0	0	June
Referral to treatment (RTT)					
RTT % incomplete pathways within 18 weeks	92.0%	98.4%	98.4%	96.8%	June
RTT number of patients on incomplete pathways waiting longer than 52 weeks	2	8	2	10	June

Other national indicators – data quality

Indicator	Target*	2018/19 (projected)†	2018/19 year to date	2017/18	2018/19 cumulative month
% of valid NHS Number submitted to Secondary Uses Service (SUS), as defined in Contract Technical Guidance	99.0%	99.9%	99.9%	99.9%	June

Other national indicators – infection prevention and control

Indicator	Target*	2018/19 (projected)†	2018/19 year to date	2017/18	2018/19 cumulative month
Number of diagnoses of *Clostridium difficile*††	-	41	10	57	June
Number of diagnoses of *Clostridium difficile* (lapses of care 2018/19 identified to date‡‡)	<= 30	0	0	6	June
Number of diagnoses of meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia	0	0	0	0	June

Other national indicators

Indicator	Target*	2018/19 (projected)†	2018/19 year to date	2017/18	2018/19 cumulative month
Number of occurrences of patients in breach of sleeping accommodation guidelines	0	0	0	0	June
Venous thromboembolism (VTE) risk assessment	95.0%	95.2%	95.2%	96.4%	June

* Target is based on Care Quality Commission targets where published.

† 2018/19 figures show the year-to-date position seasonally projected to year-end.

‡ In line with the southwest London reallocation policy, The Royal Marsden reallocates breaches to referring Trusts when referrals are received very late in the 62-day pathway. This is reflected in the 62 day reallocated position and is reported to NHS Improvement.

** Cancellations by the hospital for non-clinical reasons on the day of surgery, on the day the patient is due to arrive, or after arrival for surgery.

†† Figures calculated according to the Department of Health methodology revised December 2008.

‡‡ Lapses of care are determined in conjunction with Commissioners. The determination of what warrants a lapse in care can be several months after the diagnosis.

3.2. Commissioning for Quality and Innovation (CQUIN)

3.2.1. A proportion of the Trust's income in 2018/19 is conditional on achieving quality improvement and innovation goals agreed between NHS England and Sutton Clinical Commissioning Group (CCG) through the Commissioning for Quality and Innovation (CQUIN) payment framework.

3.2.2. CQUIN goals for 2018/19 have been agreed with commissioners in the following subject areas for cancer specialist services and for community services:

3.2.3. Cancer specialist services

NHS England Acute CQUIN Schemes

- Nationally standardised dose banding for adult intravenous systemic anti-cancer treatment
- Hospital Medicines Optimisation
- Enhanced supportive care access for advanced cancer patients
- Sustainability and transformation plan

CCG CQUIN Schemes

- NHS staff health and wellbeing
- Reducing the impact of serious infections (antimicrobial resistance and sepsis)
- Preventing ill health by risky behaviours – alcohol and tobacco
- Sustainability and transformation plan

3.2.4. Community Services

- NHS staff health and wellbeing
- Children's special educational needs and disabilities (SEND)
- Oral medications administration

3.2.5. Acute NHS England CQUIN milestones 2018/19

The table below shows the Trust's submitted position against the milestones for Quarter One of the 2018/19 CQUIN programme.

Scheme	Milestone	Quarter 1
Dose banding	Collection and completion of baseline data. Agree and approve principles and adjustments. Agree targets for remaining quarters.	Achieved

Scheme	Milestone	Quarter 1
Hospital medicines optimisation	90% of new patients receiving best value generic/biologic product on 2017/18 Quarter 1, Quarter 2, Quarter 3 and Quarter 4 list and 2018/19 Quarter 1 list. 80% of existing patients receiving best value generic/biologic product on 2017/18 Quarter 1/Quarter 2 list and 60% of existing patients receiving best value generic/biologic product on 2017/18 Quarter 3/Quarter 4 list. Submission of current antifungal guidelines as baseline. Submit systemic anti-cancer therapy (SACT) and intravenous immunoglobulin (IVIg) dataset. Submit Pharmex baseline (a Department of Health and Social Care database in which medicinal product transaction usage and spend level details from trusts are collected and stored).	Achieved
Enhanced supportive care	Evidence of clinical lead in place. Baseline data collection and agree targets for remaining quarters.	Achieved
Sustainability and transformation plan	Provide outline of RM Partners programme of work for the year. Start planning and development of a colorectal risk stratified pathway within Medical Oncology	Achieved

3.2.6. Acute CCG CQUIN milestones 2018/19

The table below shows the Trust's submitted position against the milestones for Quarter One of the 2018/19 CQUIN programme.

Scheme	Milestone	Quarter 1
NHS staff health and wellbeing	Submission of comprehensive health and wellbeing action plan detailing initiatives and evaluation criteria for 2018/19. Compliance against healthy eating initiatives and submission of plan for improved compliance within Friends outlets.	Achieved
Reducing the impact of serious infections (antimicrobial resistance and sepsis)	Plan for National Early Warning Scores 2 (NEWS2) roll out across Clinical Assessment Unit and inpatient wards. Development of audit criteria, finalisation of requisite IT changes and scoping of changes to ICCA (critical care information system).	Achieved
Preventing ill health by risky behaviours – alcohol and tobacco	Complete information systems audit. Develop training plan for relevant health professionals. Collect baseline data against all indicators and set trajectory for improvement.	Achieved
Sustainability and transformation plan	Provide outline of RM Partners programme of work for the year. Start planning and development of a colorectal risk stratified pathway within Medical Oncology.	Achieved

3.2.7. Community Services CCG CQUIN milestones 2018/19

The table below shows the Trust's submitted position against the milestones for Quarter One of the 2018/19 CQUIN programme.

Scheme	Milestone	Quarter 1
NHS staff health and wellbeing	Submission of comprehensive health and wellbeing action plan detailing initiatives and evaluation criteria for 2018/19.	Achieved
Children with special educational needs and disabilities	Identify and agree appropriate CQUIN scheme with CCG for 2018/19. Scope CQUIN milestones for remaining quarters.	Achieved
Oral medications administration	Scope plan for CQUIN (Quarter 1 and Quarter 2 milestones combined).	Achieved

3.2.8. Commissioner confirmation of achievement 2018/19

The Trust submitted its CQUIN reports on 31 July 2018 and awaits confirmation of achievement.

4. Service users' needs and preferences

4.1. National inpatient survey 2017

4.1.1. The Royal Marsden was one of 148 acute and specialist trusts taking part in the 2017 national inpatient survey. The survey has been run 14 times. Questionnaires were sent to 1,250 inpatients consecutively discharged from the Trust in July 2017. The response rate was 48%.

4.1.2. Of 69 questions asking people who had been inpatients at The Royal Marsden 57 results were better than most other trusts. For 12 questions the Trust scored about the same as other trusts. For no question did the Trust score worse than most other trusts

4.1.3. Improvements are planned in response to the findings of the survey. Actions will include increased help for patients to eat meals, helping patients to find someone to discuss concerns with and improved information for patients when they are discharged.

4.2. Patient and Carer Advisory Group

4.2.1. The Patient and Carer Advisory Group consists of current and former Royal Marsden patients and carers. The group elects one of its members as chairman and is given administrative support by a member of staff. The group works with the Trust on a variety of projects where the views of patients and carers can help make the hospital a better place for patients.

4.2.2. The group discussed with the Equality and Diversity Specialist Lead the importance for patient experience and care that staff are treated in a way that ensures equality and respects diversity. There is a positive correlation between the contentment of staff and the quality of care that patients receive

4.2.3. Members reviewed the draft revised *Non-emergency patient transport policy* with staff. Members agreed an extended transport booking notice period of 48 hours to allow time to plan journeys and for an appeal if necessary. They also recognised the impact that a pattern of short-notice cancellations or aborted journeys will have and agreed that the high number of on-the-day bookings should be significantly reduced to reduce delay for high-need patients properly booked for transport. The group also offered to review the supporting patient literature.

4.2.4. PCAG's draft response to the Trust's Annual Quality Account, 2017/18 was discussed by members and modified to highlight the 'effective care target' for readmission numbers.

4.2.5. Members continued to represent the group on Trust committees and project groups including the Integrated Governance and Risk Management Committee, Quality Account and Patient Experience Committee and the Clinical Audit Committee.

4.3. Customer Service Excellence

4.3.1. The Customer Service Excellence standard was developed to offer services a practical tool for driving customer-focused change within their organisations to ensure services are efficient, effective, excellent, equitable and empowering for their users. The citizen is always and everywhere at the heart of service provision.

4.3.2. The standard tests those areas that research has indicated are a priority for customers, with particular focus on delivery, timeliness, information, professionalism and staff attitude.

4.3.3. The Trust is assessed against a third of the standard each year. The most recent assessment was held in March 2018 when the assessor visited the Chelsea site. The Trust was found to be compliant in all elements of the standard assessed, with one exception, which remained as partially compliant due to the number of audited telephone calls being answered within three rings by staff not meeting the Trust's stringent standard.

4.4. Friends and Family Test

4.4.1. The Friends and Family Test asks all patients the question

How likely are you to recommend our ward to friends and family if they needed similar care or treatment?

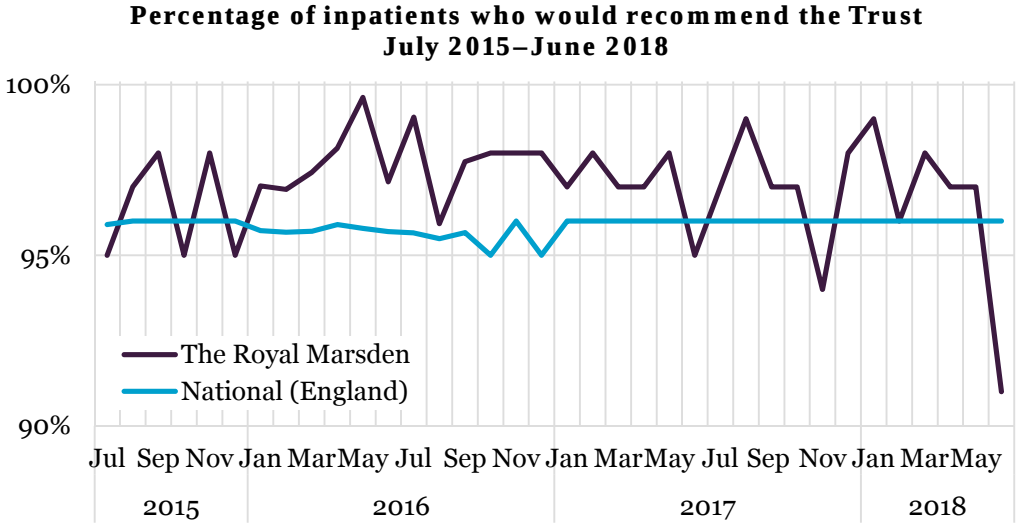
4.4.2. The test is for providers of NHS funded acute services for inpatients including independent sector organisations and for outpatients, community services, dental, ambulance, accident and emergency, maternity, mental health and general practices.

4.4.3. At The Royal Marsden patients being discharged from wards or leaving outpatient areas are given a questionnaire that can be completed anonymously and left in a box on the ward or outpatient area.

4.4.4. In Quarter One the Friends and Family Test showed that

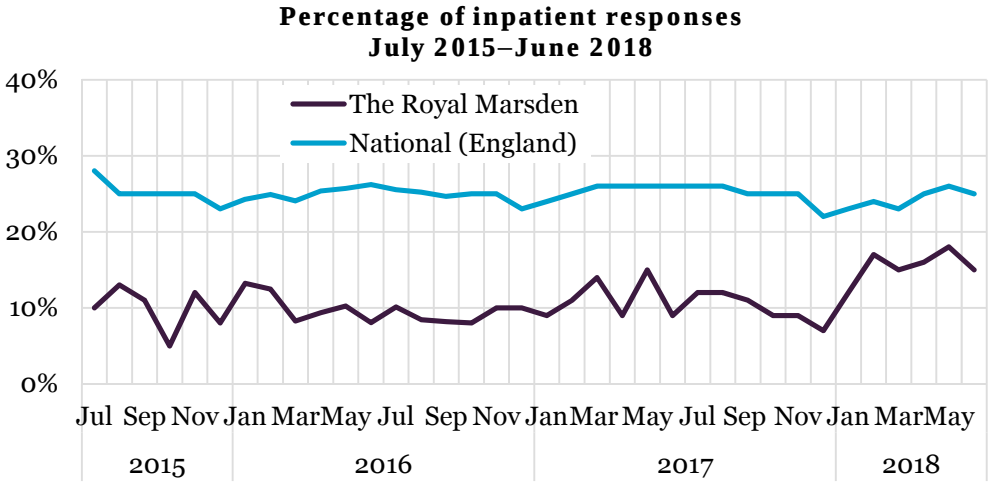
- 95% of Royal Marsden inpatients who responded would recommend the Trust. (Of NHS inpatients in England 96% of respondents would recommend their provider.)
- 95% of Royal Marsden outpatients who responded would recommend the Trust. (Of NHS outpatients in England 94% of respondents would recommend their provider.)
- 97% of Royal Marsden community clients who responded would recommend the Trust. (Of NHS community clients in England 96% of respondents would recommend their provider.)

4.4.5. The results in the chart below show how the Trust compares against national scores for NHS **inpatients**.



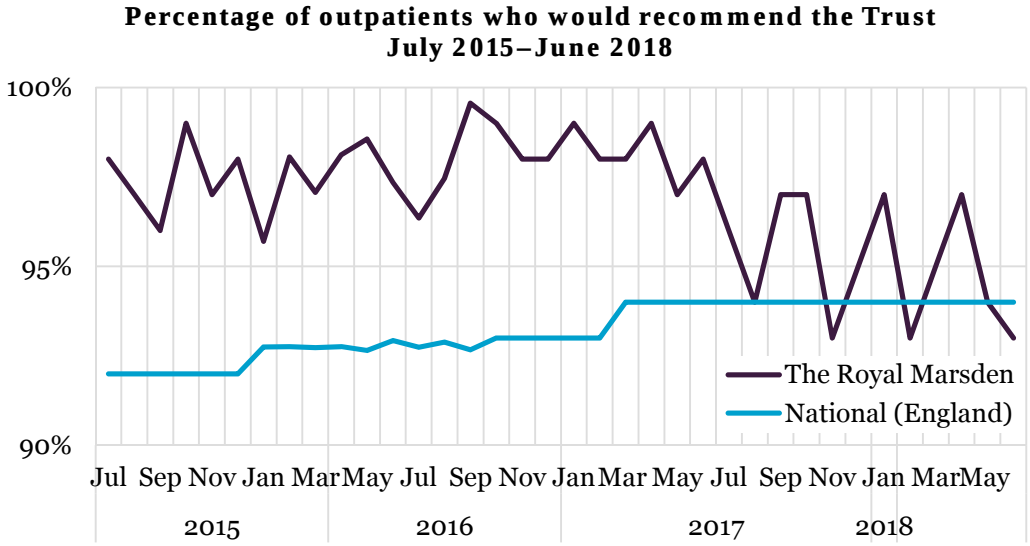
National data from www.england.nhs.uk.

4.4.6. In Quarter One 1,051 inpatients completed the survey. The chart below shows the **inpatient response** rate of the Trust against the national response rate.



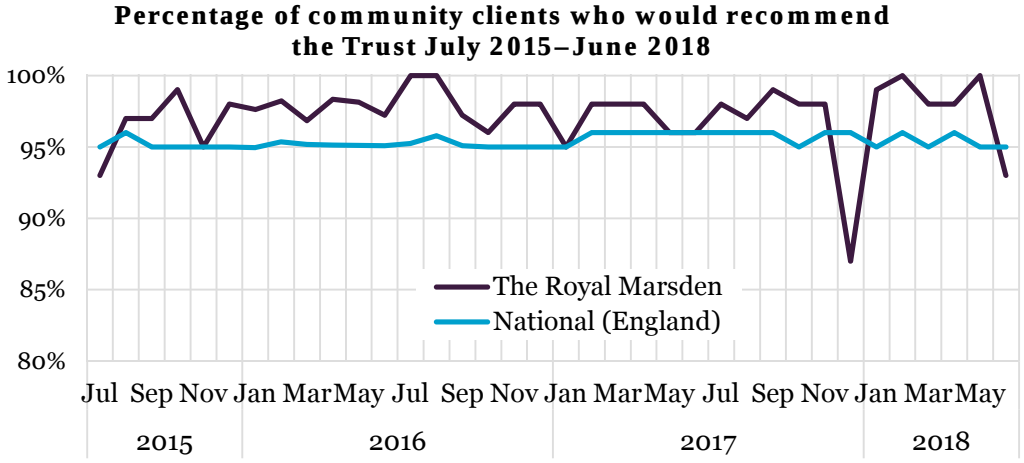
National data from www.england.nhs.uk.

4.4.7. NHS England has also published the national data for outpatients. The results in the chart below show how the Trust compares against national scores for NHS **outpatients**.



National data from www.england.nhs.uk.

4.4.8. NHS England has now published the national data for community services. The results in the chart below show how the Trust compares against these national scores for **NHS community services**.



National data from www.england.nhs.uk.

4.4.9. Patients are encouraged to give their views, constructive suggestions, and feedback on their experiences. These comments are a valuable source of patient feedback and are analysed to help the Trust improve the experience of patients and their families, friends and carers.

4.4.10. The results are examined and reviewed by the Trust's Patient Experience and Quality Account Group which is jointly chaired by the Deputy Chief Nurse and a Trust governor. The group has a membership of Trust governors, Healthwatch representatives, Patient and Carer Advisory Group representatives, and representatives from the Trust's clinical staff.

4.4.11. The feedback can be attributed to an individual ward or department. Ward Sisters and Matrons review the data at minimum monthly, and it is also reviewed at the Clinical Business Units Monthly Performance Review meetings, attended by the Divisional Director, Clinical Lead and Divisional Nurse Director. Actions are taken each month to address any issues. The following are examples of areas that patients suggest require improvement.

4.4.12. Patient's comments on areas where improvement could be made

Inpatients

As usual all ready to go and just waiting for your tablets!!! There was confusion over an appointment changed by RMH … which involved a missing letter (and probably the fact that I'm 80) which resulted in me turning up a week to early and end endoscopy unit call back service didn't work very well.

My only issue was trying to obtain a yearly pass for the car park. Took 3 days to do which worked out more expensive than expected. We were told it was because it was a weekend with reduced staff.

Outpatients

Re admin – 2 letters have arrived late, first one resulted in missed appointment.

If I knew before hand it the scan was going to be 20mins I would have brought some music like in radiotherapy.

Daycase

One problem! I use a wheelchair and enter at the Dover St. entrance. There is a wheelchair-friendly route from here to the MDU [Medical Day Unit] except one heavy white door by the lift. Could this be an automatic door?

It is so busy (Wednesdays). Please for those needing to catch trains after 6pm can we have early appointment and treatment times? Can we ask for this at reception too? Thank you for your hard work. Perhaps have patient support people circulating while we are waiting in waiting area.

Community services

My only criticism is that due to my child being out of mainstream schooling, he was not able to fully experience the service as he should have – however, our therapist did all that she could and we are very grateful. It's a shame that it is also coming to an end now that he is 8 years old.

Hard to book an appointment due to limited spaces.

4.4.13. Some positive comments from patients

Comments from those on inpatient wards

The staff have been absolutely superb, staff … went above and beyond to make me feel relaxed and looked after. The food was tasty and the room was excellent as well. Thank you for a most excellent stay. Kind regards.

Nurses were extremely attentive monitoring my medication, fluid intake and observations. Everything was well explained to me and I felt in very good hands. All staff coming in and out were very polite and caring and provided all excellent service.

Comments from those attending as outpatients

I felt I was getting the best care and all my questions were answered. Everyone was very helpful. I was given choices.

The lady on ground floor was helpful. Receptionists were welcoming and friendly which helped as my mum was terrified of attending Royal Marsden on her first visit. The patience shown by all to mum in her wheelchair and tendency to keep repeating things. Thank you, I attended years ago with my dad so was a little upset to have to go.

Comments from those attending Daycase

All the staff are good, kind and understanding – they will always be there with you listening and giving good advice that you feel good and satisfied they treated you so well and I am so happy and glad for that. Thank you so much.

The staff are excellent and show a professional and compassionate approach in all they do. Cannot be faulted. Thank you.

Comments from those attending in community services

Positive experience, lovely welcome at reception, friendly helpful staff. Efficient and professional. (Health visiting)

Instantly put at ease. Each step of assessment clearly explained with results and readings also explained. Inhaler technique demonstrated and able to pick device that I found easy to use. Clear well written information leaflets provided, time given to ask questions, knowledgeable assessor. (Respiratory service)

4.5. Patient Information Service

4.5.1. Activity for the quarter:

Type	New title/ new edition	Revision	Total
Booklets	4	3	**7**
Factsheets	1	6	**7**
Leaflets	1	26	**27**
Total	**6**	**35**	**41**

4.5.2. Leaflets reviewed and updated this quarter include *Welfare rights service* and *Having a thyroid scan.*

4.5.3. Booklets reviewed and updated this quarter include *The symptom control and palliative care service* and *Support at home.*

4.5.4. New booklets produced this quarter include *Teenage and young adults; going home after discharge* and *Bronchiectasis.*

4.6. Ethnic data capture

The table lists the ethnic origin of patients newly registered in the quarter.

Ethnic origin	NHS	Private care and overseas	Total
Asian Bangladeshi	18	1	19
Asian Indian	86	31	117
Asian Pakistani	34	11	45
Asian (other)	91	18	109
Black African	75	14	89
Black Caribbean	99	6	105
Black (other)	6	1	7
Chinese	54	10	64
Mixed White and Asian	9	3	12
Mixed White and Black African	7	0	7
Mixed White and Black Caribbean	9	2	11
Mixed (other)	27	5	32
White British	2,152	418	2,570
White Irish	58	19	77
White (other)	360	84	444
Other	153	183	336
Not disclosed	69	22	91
Total	**3,307**	**828**	**4,135**
Ethnic origin information completed*	3,238	806	4,044
Ethnic origin information completed (%)*	97.9%	97.3%	97.8%

*All values except *Not disclosed*

5. Personalised care, treatment and consent

5.1. Operating theatres and endoscopy

5.1.1. The Endoscopy Team uses feedback from the monthly Friends and Family Test as service improvement indicators. The monthly rating has been consistently above 90% with positive feedback from patients on comfort and the level of reassurance they have received during their treatment.

5.1.2. The Royal Marsden is recruiting internationally and locally to fill the vacancies in the operating theatres and endoscopy. It is difficult to recruit qualified experienced Operating Department Practitioners/Anaesthetic Nurses in London. In this quarter there have been positive results in recruitment to fill our vacancies to support the Anaesthetic and Theatre except Endoscopy services which is challenging due to specialist skills in this area.

5.1.3. The Royal Marsden is improving its overseas nursing recruitment programme. The Operating Theatres education team works closely with Trust education leads and recruitment leads to develop a robust programme in helping newly recruited overseas nurses to undertake the Objective Structured Clinical Examination (OSCE), which assesses the ability to competently apply professional skills and knowledge in practice. Local recruitment drives will be recruiting qualified skilled theatre practitioners throughout 2018. Three overseas nurses started their careers in the unit in March. After successfully completed their OSCE in May the nurses were awarded professional registration with the Nursing and Midwifery Council (NMC) in June. This has demonstrated the continuing effort from the Trust's Training and Development Team in preparing the overseas nurses with comprehensive clinical support during their initial posting on the ward. The experience which overseas nurses gained from the ward and support from the practice education team have been invaluable to their success. One overseas nurse is currently in post as supernumerary working across areas in Theatre L and Endoscopy preparing for the OSCE.

5.1.4. Endoscopy Services has commenced EDC Gold (an enhanced version of NHS Supply Chain's electronic data capture (e-DC) platform, e-DC Gold) as an inventory management solution to capture high cost consumables. The system meets the improvement target in capturing high cost items for both NHS and private patients.

5.1.5. The Theatres team is contributing to the review of the perioperative patient care chapter of the Royal Marsden Manual of Clinical Nursing Procedures. This manual has been the standard in delivery of excellent care to the students as well as a reference guide for the delivery of standard evidence-based practice.

5.1.6. The Theatres team is participating in the transformation project in reviewing perioperative care pathway as well as in improving the clinical documentation with standardisation of patient care information reducing paper reports.

5.1.7. The monthly monitoring of Local Safety Standards for Invasive Procedures (LocSIPPs) compliance is the focus in delivery of quality safe care to patients. The compliance on debriefing continues to improve with strong empowerment to the clinical team to make sure debriefing is taking place at the end of a list with documentation for record of compliance in accordance with quality assurance standard. A six-monthly LocSIPPs compliance report is filed for the Trust's Integrated Governance and Risk Management Committee.

5.1.8. The Theatres and Endoscopy Units delivers good care within the current capacity with smart planning of theatres scheduling working in partnership with multidisciplinary colleagues in delivering world-class service to The Royal Marsden's NHS and private patients. The Robotics Service has expanded with two robotic theatres a day providing comprehensive advanced techniques in oncology services to patients. Extra activities on Saturdays have started with robotic procedures as main users of the service.

5.1.9. In June 2018 Theatre L has hosted visits from non-executive Board members and their visit to the robotic theatre was well received.

5.1.10. Theatre L also had contributed in the BBC's NHS 70 Years programme. The robotic team in robotic Theatre Suite 6 demonstrated a procedure using equipment in the programme.

5.1.11. Refurbishment of the Sutton Theatres' anaesthetic and recovery rooms with lockable cabinets as part of the modernisation of infrastructure was completed in June. This provides an improved system of safe management of medicine in accordance with the Trust's *Medicines management policy*.

5.2. Symptom control and palliative care

5.2.1. Policies and procedures relating to end of life care and symptom control

The integrated palliative care outcome scale (IPOS), a patient outcome measure, continues to be used for patients referred to the Symptom Control and Palliative Care Team. The data collected is analysed on a quarterly basis to allow the team to monitor interventions, guide service delivery and to explore whether, in the future, it might also act as a trigger for referral.

Initial data has revealed an unmet need relating to psychological distress. This has informed the development of a health and wellbeing event scheduled for later this year.

5.2.2. Hospital support

The Symptom Control and Palliative Care Team is now 18 months into a pilot scheme for Lung Unit outpatients to support early advanced care planning and timely referral to specialist palliative care using defined triggers. The project expanded to the Upper GI unit in January and is supported by RM Partners, a cancer alliance across north west and south west London (part of the national cancer vanguard).

The project's aims are

- to improve integration between oncology and palliative care,
- to increase early referral to palliative care, and
- to increase the use of urgent care planning in patients with lung cancer who attend the outpatient department.

These aims will be achieved by the introduction of a new triggers tool together with validated symptom assessment.

Quarter One data shows that the Triggers service is running well with the target of 50% review rate exceeded. The service is identifying a population of patients with palliative care needs and RM Partners funded the short-term expansion. The plan moving forward is to gather formal patient and staff feedback about Triggers service following submission of an updated Service Evaluation proposal for Trust approval.

In addition, an application to host a Darzi Fellowship Project in 2018/19 to support the Triggers project was successful in March 2018. Recruitment to this post is currently being explored with an interview date scheduled for July 2018.

5.2.3. Education and mandatory training

The service delivers mandatory training on end of life care to medical and nursing staff. Annual updates to other clinical and non-clinical areas have been delivered and continue to be scheduled. Staff are taught topics such as recognising dying patients and use of drugs in end of life care.

Every four months the Symptom Control and Palliative Care Team provides junior doctors with formal teaching on subjects related to end of life care and symptom control as part of their weekly teaching programme.

Annual external and biannual internal palliative care update days are held covering topics related to end of life care. The next Palliative Care Update Day is scheduled for November 2018.

A Service Evaluation has recently received Trust approval to review the data relating to the monthly Schwartz Rounds over the past 3 years.

5.2.4. Strategic developments

The Symptom Control and Palliative Care Team is progressing well with the national Commissioning for Quality and Innovation (CQUIN) for Enhanced Supportive Care and the Trust has met the quarterly CQUIN targets to date. The team has attended four meetings of Enhanced Supportive Care leads to share best practice, with the last day attended in Jan 2017, and has visited The Christie NHS Foundation Trust to view an outpatient clinic in action.

Quarter One data has shown that the time between referral to specialist palliative care and death has increased significantly for both gynaecological and renal cancers.

The team has representation on the London End of Life Care Clinical Leadership Group.

5.2.5. Supportive Care Home Team

The Supportive Care Home Team delivers end of life care education, training and clinical support to all residential homes and nursing homes in Sutton.

The pilot scheme providing end of life care education, training and clinical support in 11 learning disability homes continues to progress well and the team have presented at a number of local and national meetings on the work taken forward.

The team was a finalist in the Health Service Journal (HSJ) Patient Safety Awards 2018 in the learning disabilities area, nominated for improving end of life care for people with a learning disability in care homes.

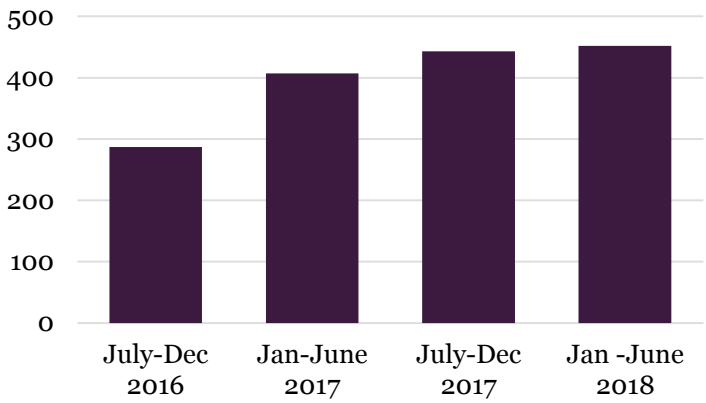
5.3. Adult Psychological Support Service

The Trust provides a confidential psychological support service for patients treated at the hospital. The service offers support particularly in helping individuals and those close to them to adjust to the emotional impact of a cancer diagnosis. This section reports on activity in the period January to June 2018 (Quarters Four 2017/18 and Quarter 1 2018 /19).

5.3.1. Adult Psychological Support Team activity

During the period 452 referrals for NHS patients were made to the service for general psychological therapy. Of these 431 met eligibility criteria and were offered a triage appointment. The increase in the number of referrals seen in the previous two quarters has continued.

The chart shows the number of referrals for general psychiatric support for each of the last four six-month periods.



The Triage system of the service has continued to facilitate earlier contact with patients. In Quarters Four and One, we were able to offer people a telephone triage appointment between, on average, two to four weeks. On average, we were able to offer those patients who required a further face-to-face assessment an appointment within one month (data for patients referred in May and June are not currently available at the time of writing this report).

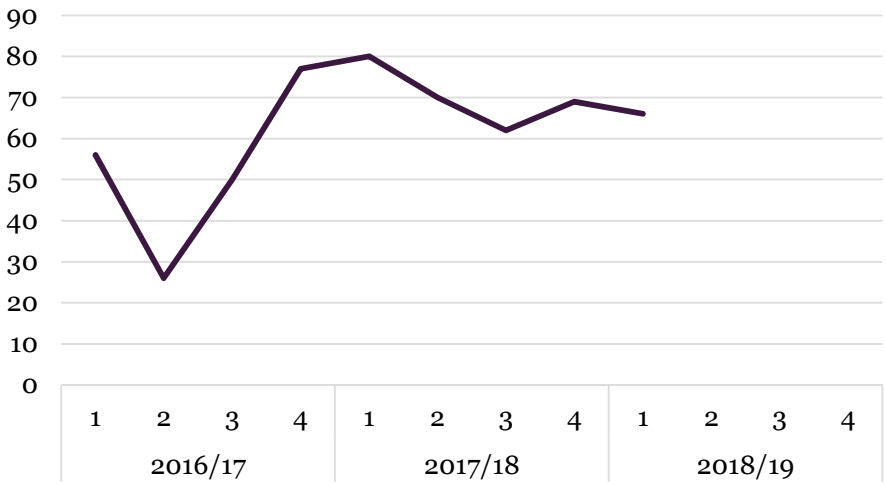
Over the six-month period, the average wait time between referral and first available face-to-face appointment has been approximately seven weeks. There is a correlation between the number of referrals and the number of weeks it takes to offer appointments. Service responsiveness has also been impacted by staff sickness and resignations.

Learning to be Mindful: A Skills Base Course for Patients was run again on the Sutton site of the hospital with nine patients enrolling on the programme. This six-session course focused on helping the participants to develop the skill of paying attention and being present in each moment. A service evaluation of this course is planned before it is run on the Chelsea site of the hospital.

5.3.2. Psychiatric Liaison Service

The Psychiatric Liaison Team – two Psychiatric Liaison Nurses, a Consultant Liaison Psychiatrist and Speciality Doctor – provide mental health assessment to inpatients with challenging psychological needs and arrange on-going support either through advice to the clinical team, direct care to the patient, or through onward referral to other services such as Psychological Support Service or community mental health teams. During the period, they assessed and provided support to 135 inpatients – 87 in Chelsea and 48 in Sutton.

As the graph below shows the number of referrals for each quarter, over the last year the number of referrals is continuing at an average of 70 a quarter in comparison to 2016/17 when the average was 52.



National standards indicate that referrals in core hours (Monday to Friday, 9 to 5) are responded to within 24 hours. There was 90% compliance for Quarter Four and 89% compliance for Quarter One. During this period there have been no detentions under the Mental Health Act.

5.3.3. Family support

Psychological support is available for cancer patients who are parents with children under 18 years old. During the last six month, support has been provided to families in inpatient and outpatient settings.

	Total
Inpatients	11
Outpatients	29
Total	**40**

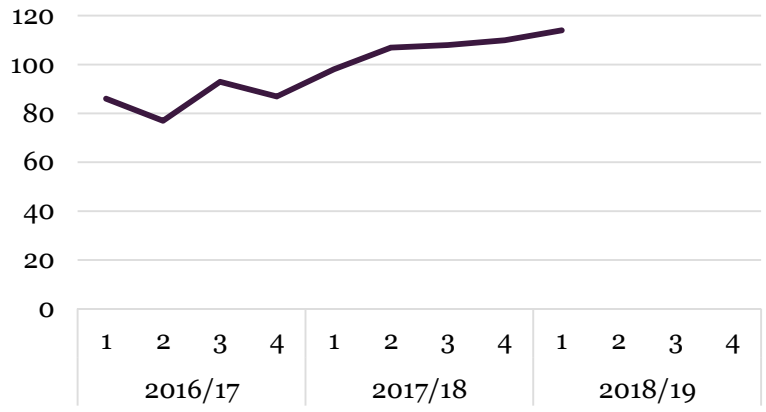
They have also been extending their service to work with young adults (18 to 24 years old) and their families.

5.3.4. Chaplaincy services

The chaplaincy team is available to offer spiritual care and pastoral care for patients, their families and staff of all faiths and of none seven days a week. The table shows the breadth of faith or denominations of the patients visited by the chaplaincy team.

	Quarter 4			Quarter 1			Period total
	Chelsea	Sutton	Total	Chelsea	Sutton	Total	
Church of England	122	101	**223**	118	109	**227**	**450**
Roman Catholic	83	76	**159**	88	89	**177**	**336**
Christian (other)	44	72	**116**	67	61	**128**	**244**
Muslim	88	22	**110**	91	23	**114**	**224**
Hindu	8	4	**12**	7	2	**9**	**21**
Buddhist	2	0	**2**	2	3	**5**	**7**
Jewish	3	1	**4**	2	2	**4**	**8**
Religion not known	27	17	**44**	18	17	**35**	**79**
Not religious	26	32	**58**	26	49	**75**	**133**
Sikh	3	1	**4**	4	0	**4**	**8**
Agnostic	2	1	**3**	0	0	**0**	**3**
Atheist	2	0	**2**	1	0	**1**	**3**
Jehovah's Witness	0	0	**0**	1	0	**1**	**1**
Humanist	0	0	**0**	1	0	**1**	**1**
Native American religion	0	0	**0**	1	0	**1**	**1**
Total	**410**	**327**	**737**	**427**	**355**	**782**	**1,519**

Over the last two years there has been a steady increase in the number of Muslim patients as the graph below shows. The Chaplaincy Team has therefore increased the number of hours provided by recruiting a second imam for a day a week. The chart shows the number of Muslim patients seen each quarter.



There is a weekly service in the chapels on each site of the hospital open to all. The chapels are open day and night for prayer or quiet reflection. There are also separate prayer rooms on each site for Muslim patients.

During the last six months, the chaplaincy team made 2908 visits to 1,519 patients. Of these 1,508 visits were made on the Chelsea site and 1400 visits were made on the Sutton site.

5.3.5. Staff Support Team

All members of the team are qualified and accredited counsellors with considerable experience of workplace psychological support. They offer counselling, supervision and the facilitation of clinical support and reflective practice groups to staff across both hospital sites and the community.

	One-to-one counselling	One-to-one supervision	Debriefing	Supervision groups
Quarter 4	534	80	1	39
Quarter 1	542	72	1	60
Total	**1076**	**152**	**2**	**99**

During the period the team received an average of 13 new referrals a month, this is a decrease from the previous six months when it was an average of 21. The reasons for attending counselling are:

- work-related issues
- personal issues impacting on work
- health issues
- bullying in work.

Mindfulness sessions have continued on both sites with good attendance

6. Eating and drinking

6.1. Nutrition and catering patient surveys

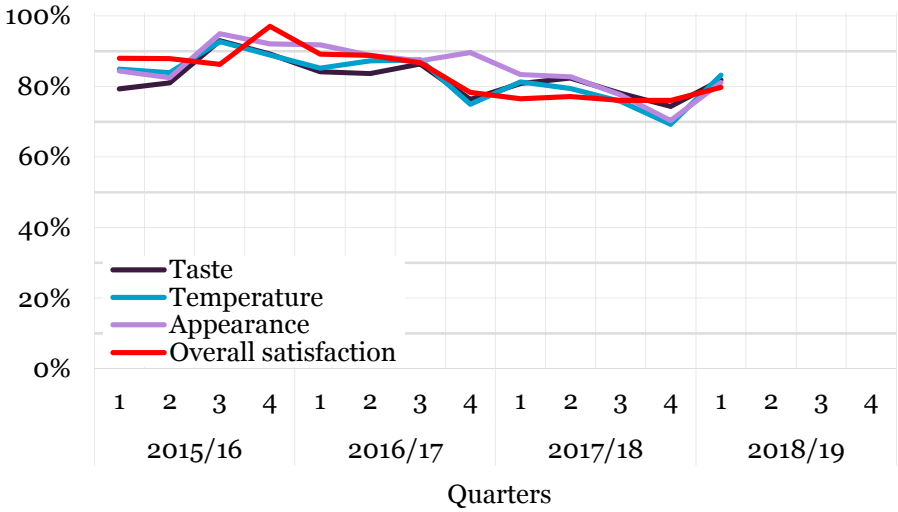
Patient surveys are undertaken at the Chelsea and Sutton sites. The patients' comments are regularly reviewed and particular points are actioned.

6.1.1. Patient survey results – Chelsea

Patients were asked to rate their answers to the following questions as *excellent*, *good*, *acceptable*, *poor* or *very poor*:

- How would you rate the taste of your meal? (95 responses this quarter)
- How would you rate the temperature of the food? (95 responses this quarter)
- How would you rate the appearance of the meals? (90 responses this quarter)
- How would you rate your overall satisfaction with the catering service? (79 responses this quarter).

The chart shows the percentage of respondents who replied *excellent* or *good* to the four questions:

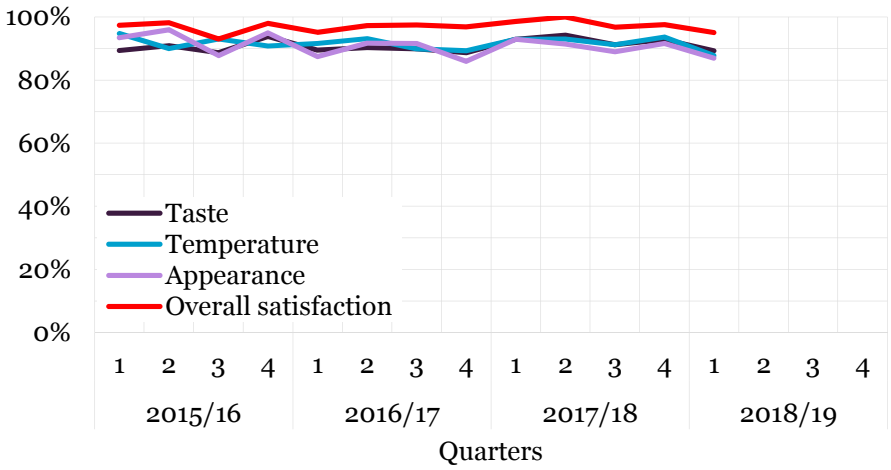


6.1.2. Patient survey results – Sutton

Patients were asked to rate their answers to the following questions as *excellent*, *good*, *acceptable*, *poor* or *very poor*:

- How would you rate the taste of your meal? (122 responses this quarter)
- How would you rate the temperature of the food? (123 responses this quarter)
- How would you rate the appearance of the meals? (123 responses this quarter)
- How would you rate your overall satisfaction with the catering service? (122 responses this quarter).

The chart shows the percentage of respondents who replied *excellent* or *good* to the four questions:



6.1.3. Recognition of nutrition practitioners and teams

Three staff members of the catering team will shortly begin an apprenticeship.

The Royal Marsden has been successful in continuous compliance with Commissioning for Quality and Innovation (CQUIN) targets.

7. Safeguarding and safety

7.1. Safeguarding adults activity

Safeguarding adults at risk from abuse is everyone's responsibility. Safeguarding requires commitment from within the organisation and partnerships to ensure that there are safeguards against harm, abuse, neglect and poor practice. During Quarter One 37 formal safeguarding adults concerns were raised across the Trust. There were two concern raised about alleged abuse within the Trust and the remainder were in relation to concerns of abuse or neglect those patients reported experiencing outside of the Trust. This is an overall increase from Quarter Four when 27 safeguarding adults concerns were raised.

Number of concerns raised Chelsea and Sutton	Quarter 4 2017/18	Quarter 1 2018/19
Number of referrals to local authority	5	13

In Quarter One there were 13 safeguarding concerns raised from the Trust's Chelsea and Sutton sites, however there were an additional 6 cases where safeguarding concerns were identified but the patient declined for a formal safeguarding concern to be made. This is an increase from Quarter Four, where five safeguarding adults concerns were raised. During this quarter, safeguarding adults surgeries commenced within acute services with an aim to provide an opportunity for staff to discuss complex safeguarding cases and advice and support from the safeguarding adults team.

Number of concerns raised Community Services	Quarter 4 2017/18	Quarter 1 2018/19
Number of referrals to local authority	22	24

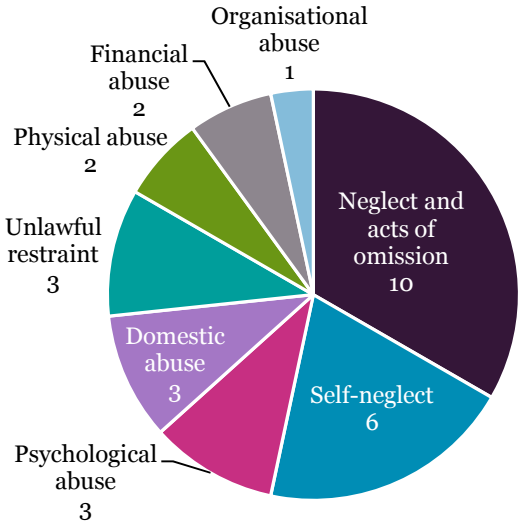
In Quarter One there were 24 safeguarding concerns raised by Community Services, an increase on Quarter Four where 22 concerns were raised. Community teams continue to raise the highest number of safeguarding concerns within the Trust, having raised 24 of the 37 referrals this quarter. Safeguarding adults surgeries continued during this quarter within community services.

7.1.1. Categories of abuse

A safeguarding concern may identify more than one category of abuse for a single referral.

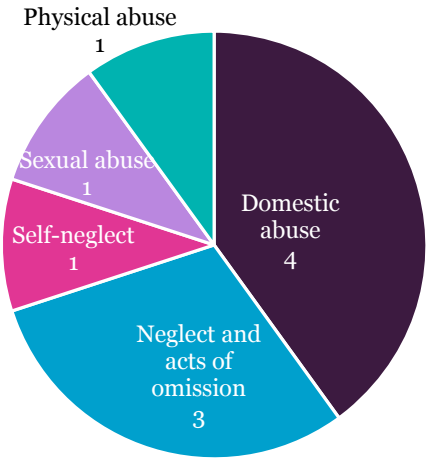
Community Services

In Community Services, neglect and acts of omission continues to be the highest reported category of abuse.



Hospital-based sites (Chelsea and Sutton)

In the hospital-based sites domestic violence is the highest reported category of abuse within Quarter One, which is consistent with previous quarters.



7.1.2. Mental Capacity Act and Deprivation of Liberty Safeguards

In Quarter One, Mental Capacity Act and Deprivation of Liberty Safeguards training has continued to be delivered as a part of the hospital nurses' mandatory training for 2018 and the Community Services induction programme. It is also included within Level 2 safeguarding adults training. Three-hour sessions have also been planned for identified staff in Quarter Two for Community Services.

Deprivation of Liberty Safeguards (DoLS) applications are made when the team caring for the patient (over 18 years of age) consider the patient lacks the capacity to consent to care and treatment and meet the acid test (i.e. is not free to leave and is subject to constant supervision). During Quarter One seven urgent applications were made for DoLS and two standard authorisation requests from Cedar Lodge (Community Services). This is the same as Quarter Four 2017/18 when nine requests were also made.

	Quarter 4 2017/18	Quarter 1 2018/19
Urgent DoLS applications	6	7
Standard authorisation requests	3	2
Total	**9**	**9**

7.1.3. Prevent

All NHS staff that are in contact with patients and the public are required to have basic Prevent awareness training. The aim of *Prevent* (as a part of CONTEST – the Governments counter terrorism strategy) is to help identify vulnerable persons who are at risk of engaging in or supporting terrorism or terrorist activity. The Trust has a *Prevent* policy and procedure and engages with local safeguarding adults boards and Prevent networks as well as having links with the local Channel panel, which discusses and monitors referrals. There have been no referrals made to Channel during this period by the Trust. Awareness training is provided in two levels: basic awareness and the Workshop to Raise Awareness of *Prevent* (WRAP) and the compliance target of 85% has been maintained.

Prevent training Quarter 1	Number of staff completed	Number of staff compliant	Percentage compliance
Basic awareness	1448	3596	89.2%
Workshop to raise awareness of Prevent (WRAP)	37	352	89.1%

7.1.4. Dementia and learning disabilities

The Trust's Dementia Champions and Learning Disabilities Buddies networks continue to aim to meet quarterly and work to support the improvements of patient pathways and environments for patients with dementia and learning disabilities. The Trust has continued to raise awareness around learning disabilities through the hospital based nursing mandatory training sessions and through the support of the Learning Disability Buddy network.

The Trust has made significant environmental improvements to make the Trust more dementia-friendly during this period, and this was recognised during the Trust's annual Patient-Led Assessments of the Care Environment (PLACE) assessment.

The Trust has also continued to raise awareness through training staff for dementia through Tier 1 and 2 training as well as through bespoke dementia friends sessions. Sessions are one-off for staff and offered as a part of induction (Tier 1) for clinical staff or professional development (Tier 2).

Dementia training	Number of staff completed to date
Tier 1	1060
Tier 2	35

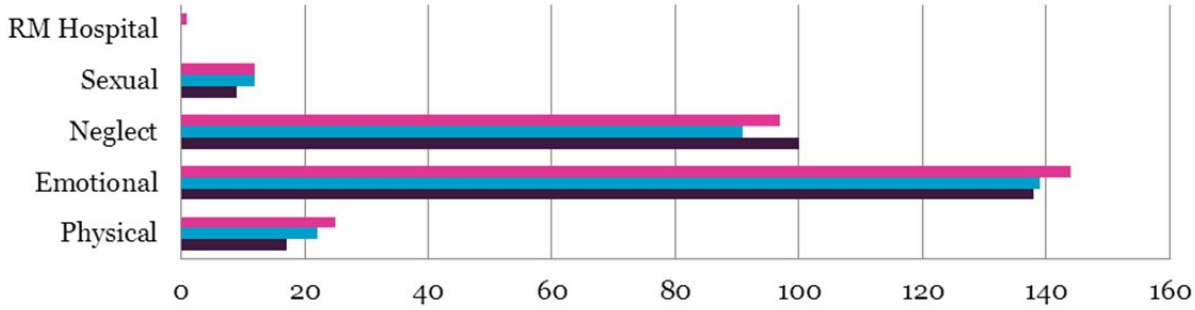
7.1.5. New investments and key achievements

- Safeguarding adults surgeries rolled out across the Trust.
- Developed a new Trust managing allegations against staff policy.
- Completed hospital mental capacity act staff survey as a part of the annual audit plan.
- Developed a new Trust Chaperone policy.
- Revised patient-declined care and equipment documentation to ensure more robust and broader reaching for staff.
- Continued to engage and be an active member of the Sutton Safeguarding Adults Board and relevant subgroups.
- Made improvements to environments to create a dementia friendly hospital environment.
- On-going Review of Savile Action plan.

7.2. Protection and identification of vulnerable children and young adults

A child protection plan is implemented when a multi-agency partnership conference decides that child/children are likely to suffer significant harm. The purpose of this formal plan is to ensure the child is safe from harm and prevent him or her from suffering further harm; promote the child's health and development; and support the family and wider family members to safeguard and promote the welfare of their child, provided it is in the best interests of the child. The plan will record the category of abuse or neglect the child has suffered or is likely to suffer. There are four categories of abuse - physical, neglect, sexual abuse or emotional, the latter being the category of abuse most identified for children subject to a plan in the London Borough of Sutton.

Child Protection Plans (Community Services)

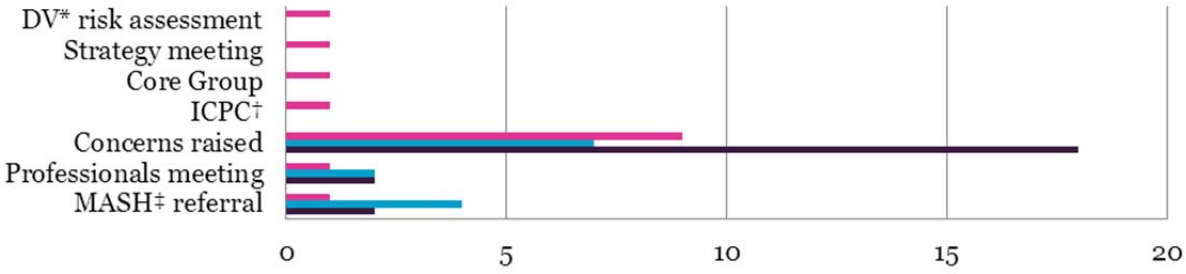


	Physical	Emotional	Neglect	Sexual	RM Hospital
Jun-18	25	144	97	12	1
May-18	22	139	91	12	0
Apr-18	17	138	100	9	0

7.2.1. Hospital

There is currently one child inpatient that is subject to a Child Protection plan. The Specialist Safeguarding Nurse has attended the Initial Child Protection case conference (ICPC) and subsequent Core Group meetings. The number of concerns being raised has stabilised but activity shows a significant increase in statutory safeguarding responses to protect children.

Hospital activity (Children's Unit)



	MASH‡ referral	Professionals meeting	Concerns raised	ICPC†	Core Group	Strategy meeting	DV* risk assessment
Jun-18	1	1	9	1	1	1	1
May-18	4	2	7	0	0	0	0
Apr-18	2	2	18	0	0	0	0

* DV: domestic violence
† ICPC: Initial Child Protection Case Conference
‡ MASH: Multi-Agency Safeguarding Hub.

7.2.2. Multi-Agency Safeguarding Hub (MASH)

The Multi-Agency Safeguarding Hub (MASH) seeks to enable the sharing of information so risks to children can be identified at an early stage and is the 'front door' for all referrals with concerns for a child's welfare. It is a link between universal services such as schools , general practices, Community Services, and statutory services such as police and social care. The number of MASH referrals to the Health Navigator remains stable between Quarters Four and One. The number of referrals by staff in to the MASH increased by 22% in Quarter One.

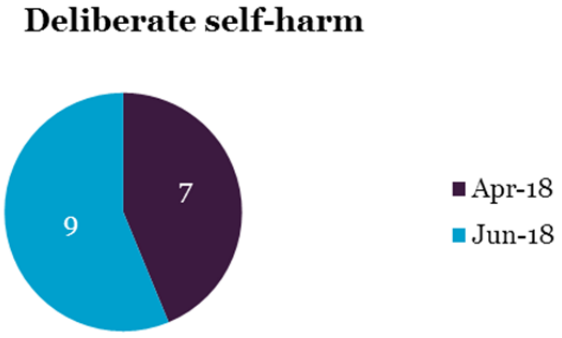
7.2.3. Strategy meetings

Strategy meetings are multi-agency meetings used to share available information to agree what action is required to safeguard and promote the welfare of a child. The safeguarding team attends all strategy meetings on behalf of the Trust. The number of Strategy invites has decreased by 40% in Quarter One. The Named Nurse has raised this as a concern to the Quality and Assurance service in the London Borough of Sutton. The borough's restructure into a locality model of delivery may account for some of this decrease. Community Services is waiting for feedback from the borough in relation to this.

7.2.4. Deliberate self-harm

The London Borough of Sutton has a fortnightly partnership review meeting to scrutinise the assessment and care pathway of all young people identified as at risk of self-harm/suicide. There has been minimal fluctuation between Quarter Four and Quarter One data. The Local Safeguarding Children Board reviewed its protocol for the management of self-harm in November 2017 (available on their website). An audit relating to deliberate self-harm is scheduled into the 2018/19 Safeguarding Annual Audit plan.

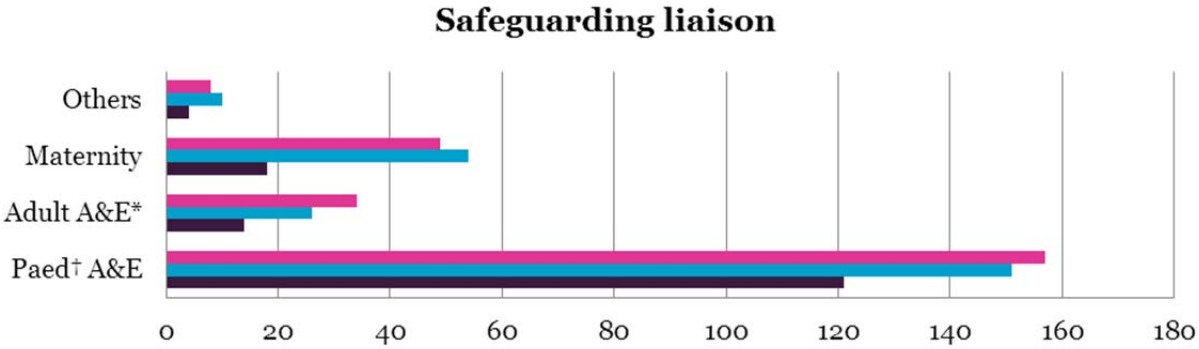
A new Specialist Practitioner Lead was appointed for managing cases of deliberate self-harm (as part of a wider brief) in Quarter Four. No meetings were held in May whilst structures were reviewed but were reinstated by June.



7.2.5. Community liaison

The Specialist Nurse Community Liaison role is part of the Community Services Safeguarding Team Service and is responsible for ensuring that all attendances at hospital accident and emergency departments of a safeguarding nature are notified to Community Services and shared with staff as appropriate. All information sharing between Epsom and St Helier University Hospitals NHS Trust and The Royal Marsden Community Services is managed by an electronic transfer of information by secure email.

Quarter One has seen a 22% increase in children and young people attending accident and emergency departments. Attendance for adults has seen a 40% increase in attendance.



	Paed† A&E	Adult A&E*	Maternity	Others
Jun-18	157	34	49	8
May-18	151	26	54	10
Apr-18	121	14	18	4

* A&E: accident and emergency department
† Paed: paediatric.

7.3. Pressure ulcers

7.3.1. Pressure ulcers are graded according to the European Pressure Ulcer Advisory Panel (EPUAP) classification:

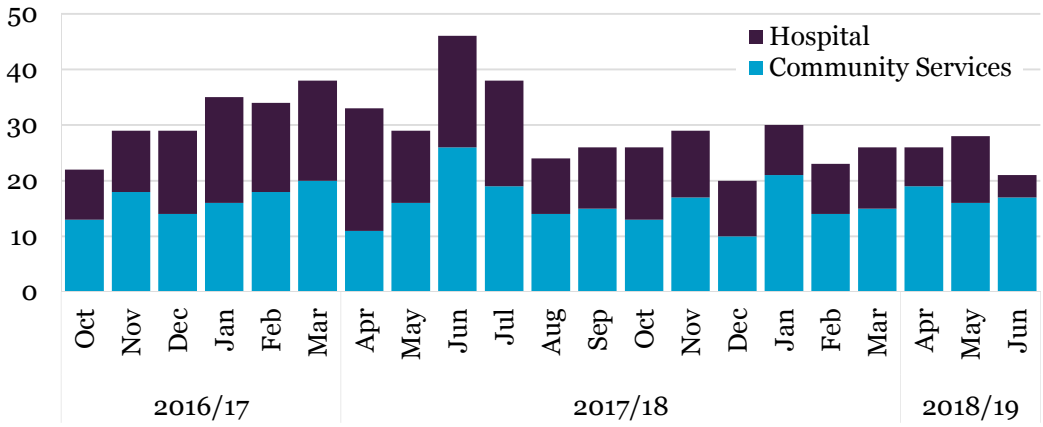
Category	Description
1	Non blanching redness of intact skin
2	Partial thickness skin loss or blister
3	Full thickness skin loss
4	Full thickness tissue loss
Unstageable	Depth unknown
Suspected deep tissue injury	Depth unknown

7.3.2. In Quarter One, one hospital patient and no community services patients developed a category 4 pressure ulcer that was attributable to the Trust.

- More than one pressure ulcer incident may be reported for a patient in the same month; as such, the highest category pressure ulcer is recorded in the relevant month.
- If a new pressure ulcer incident is reported for the same patient in a different month, the data is included in each month.

	April	May	June
Number of patients with pressure ulcers attributable to the Trust	26	28	21
Number of patients with pressure ulcers attributable to the **hospital**	7	12	4
Number of patients with pressure ulcers attributable to **Community Services**	19	16	17
Number of patients with attributable pressure ulcers Category 1	4	8	9
Number of patients with attributable pressure ulcers Category 2	21	17	10
Number of patients with attributable pressure ulcers Category 3	1	1	1
Number of patients with attributable pressure ulcers Category 4	0	1	0
Number of patients with attributable pressure ulcers Unstageable	0	1	0
Number of patients with attributable Suspected deep tissue injury	0	0	1

7.3.3. The chart shows the number of patients who developed pressure ulcers that are attributable to the Trust by month in all categories.



8. Premises and equipment

8.1. Infection Prevention and Control

8.1.1. Mandatory Surveillance

Indicator	Quarter 1 *DCS reportable	Quarter 1 attributable	YTD†	YTD attributable	Target	Variance from target	Forecast
MRSA‡ bacteraemia	0	0	0	0	**0**	0	
S. aureus bacteraemia	3	3	3	N/A	N/A	N/A	
E. coli bacteraemia	18	12	18	12			
Klebsiella sp bacteraemia	5	4	5	4			
Pseudomonas aeruginosa bacteraemia	6	5	1	5			

	Quarter 1	Quarter 1 DCS attributable post 48 hours	YTD post 48 hours	CDT lapse in care YTD: total against target	Target	Variance from target	Forecast
C. difficile toxin	28	10	10	1	30	-29	

* DCS: Healthcare Associated Infection (HCAI) Data Capture System (DCS) formerly known as MESS

† YTD: year to date

‡ MRSA: meticillin-resistant *Staphylococcus aureus*

** N/A: not applicable

8.1.2. Healthcare-associated infections

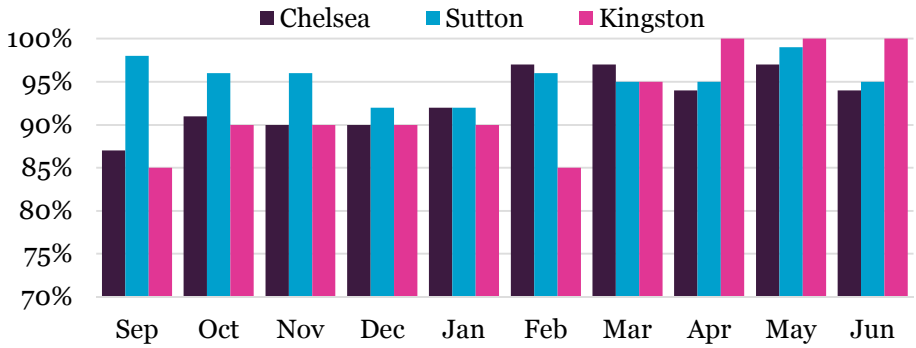
The table shows the actual number of each infection, and in brackets, the number attributable against target more than 48 hours after admission.

	Chelsea	Sutton
MRSA bacteraemia	0	0
MSSA bacteraemia	3	0
E.coli bacteraemia	7(5)	11(7)
Klebsiella sp bacteraemia	5(4)	0 (0)
Pseudomonas aeruginosa bacteraemia	4 (3)	1(1)
Clostridium difficile TOXIN detected (post 48 hour attributable)	14(7)	14(3)

8.1.3. Hand hygiene

The overall hand hygiene compliance score for the Trust in Quarter one is 96%. The Chelsea site compliance score is 94%, Sutton is 95% and Kingston 100%.

The chart shows hand hygiene compliance by month at the three sites from September 2017 to June 2018.



8.1.4. Mandatory surveillance

All trusts are required to submit data on specified infections to the Healthcare Associated Infection (HCAI) Data Capture System (DCS) formerly known as the Mandatory Enhanced Surveillance System (MESS). The required data includes all cases of *Clostridium difficile* toxin, and bacteraemia caused by MRSA, MSSA, *E. coli*, *Klebsiella* species and *Pseudomonas aeruginosa*.

8.1.5. Meticillin-resistant *Staphylococcus aureus* (MRSA)

There have been no cases of MRSA bacteraemia this year to date. The last case was a contaminant in 2016.

The process for review of MRSA bacteraemia has changed and the Trust will no longer be required to do a full post-infection review (PIR) if a case should occur. The PIR process is reserved for a few selected trusts that have had higher figures.

8.1.6. *Clostridium difficile* infection

All stool samples found to be *C. difficile* toxin (CDT) positive are reported to the HCAI DCS. Those cases which occur within 48 hours of admission are deemed to be community attributed. This is a change from the previous year which was cases within 72 hours. Cases which may have been preventable are deemed 'lapses in care' and recorded against *C. difficile* toxin objective target of 31. There was one lapse in Quarter One.

The CDT trajectory will be no more than 30 lapses in care for 2018/19. If this is exceeded, fine of £10,000 per case is levied.

8.1.7. Carbapenemase-producing *Enterobacteriaceae* (CPE)

There were 11 new suspected patients with a probable CPE in Quarter One. Thus far 10 cases are confirmed. Six of the patients are from overseas and 7 are private patients. There was a mix of resistance types (3x OXA-48, 3 x VIM and 4x NDM).

A new *Enhanced contact precautions* sign has been circulated for use with patients isolated for CPE.

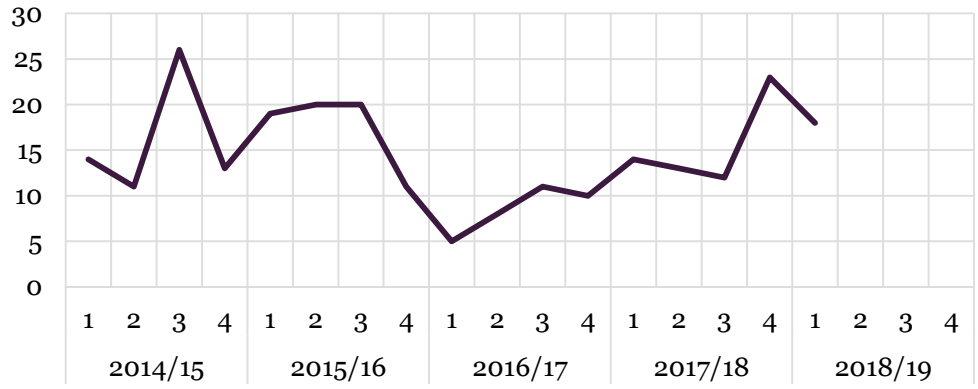
8.1.8. *E.coli* bacteraemia

There is a new requirement for reporting of *E. coli*, *Klebsiella* species and *Pseudomonas aeruginosa* bacteraemia onto the HCAI DCS. These are gram-negative bacteria and numbers of cases have been rising across the UK for some years. These infections are often associated with urinary tract infection, urinary catheterization, dehydration (especially in the elderly), biliary sepsis and gut translocation (in patients receiving chemotherapy). These organisms are also increasingly prone to show antimicrobial resistance making them problematic to treat. The Department of Health and Social Care through NHS Improvement has issued an ambition to see a 50% reduction in these gram-negative blood stream infections by March 2021, starting with a 10% reduction of *E. coli* bacteraemia in this financial year. Nationally the reduction has been around 1%.

In Quarter One there were 18 cases of *E.coli* bacteraemia.

All cases are subject to clinical review to determine likely cause. A major audit project is underway with the Christie and Clatterbridge hospitals to evaluate the risk factors for *E.coli* in oncology patients.

The chart shows *E.coli* infections for each financial year from 2014/15.



The Royal Marsden and The Christie NHS Foundation Trust have jointly appointed a Darzi fellow to investigate reducing *E. coli* blood stream infection in oncology patients and to develop a care bundle to help improve care around patient hydration, care of lines and personal hygiene.

8.1.9. Flu

The 2018/19 flu campaign is being prepared and starts in late September.

8.2. Sepsis

8.2.1. The Royal Marsden joined the *Sign up to Safety* campaign in November 2014. Along with a reduction in medication incidents and pressure ulcers, the aim of the campaign is to reduce the number of avoidable deaths from sepsis. The Consultant in Critical Care and Anaesthesia is the medical lead for sepsis and the Matron for Critical Care and Outreach is the nursing lead.

8.2.2. The leads are working on gap analysis to implement over 150 recommendations following National Institute for Health and Care Excellence (NICE) guideline 51 *Sepsis: recognition, diagnosis and early management* (published July 2016). An adult sepsis policy is due to be introduced incorporating NICE guidance, UK Sepsis Trust recommendations, NEWS 2 charts (national early warning score (NEWS) – an early predictor of deterioration) and an updated sepsis screening tool. Additionally, a senior nurse is due to be appointed to coordinate Trust efforts on sepsis and acute kidney injury.

8.2.3. The Sepsis Implementation Team meets regularly to promote awareness and early identification, escalation and management of sepsis and neutropenic sepsis.

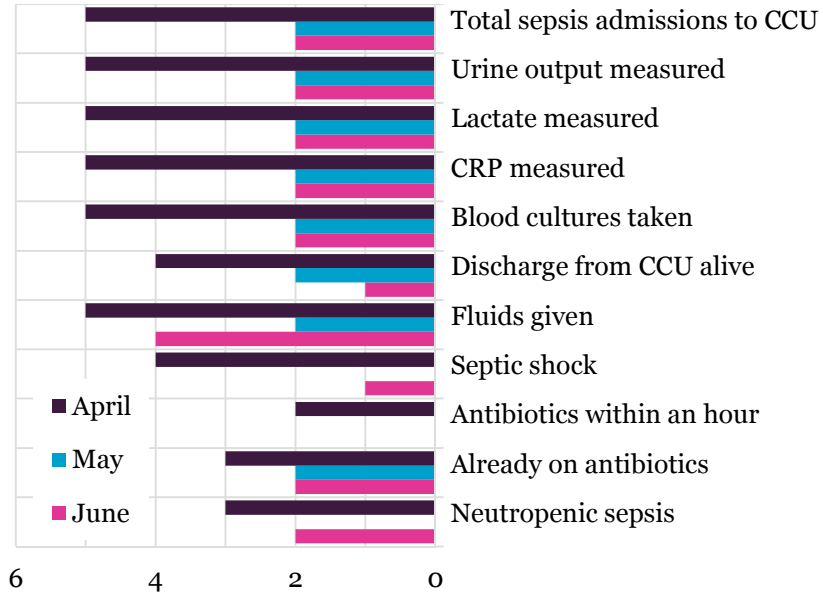
8.2.4. Data collection

The audit of all patients admitted to Critical Care Unit (CCU) with sepsis continued. Quarter One data shows compliance with the *Sepsis Six* bundle being maintained at a high level.

Nine patients were admitted to CCU in the quarter with sepsis. One of these patients died. Five of the nine had neutropenic sepsis and three were treated for septic shock. The neutropenic sepsis audit was completed by the Acute Oncology Service (AOS) team. All nine CCU patients (neutropenic and non-neutropenic) had a C-reactive protein (CRP), lactate and urine output measured. All of the patients were already receiving antibiotics, or received antibiotics within the first hour of presenting with sepsis. This result is in accordance with previous months.

In addition to auditing CCU admissions, sepsis admissions to the Clinical Assessment Units are being monitored, with a view to rollout throughout all inpatient wards.

8.2.5. Sepsis admissions to CCU – April to June 2018



8.2.6. Implementation of action plan

- Gap analysis of NICE guideline 51 for adults and paediatrics is in progress to ensure that the Trust is compliant with recommendations.
- All patients with a NEWS score of 4 or above with a suspected infection should be referred to CCU Outreach (24/7), a clinical site practitioner or an on-call junior doctor for immediate review. If sepsis is suspected it must be escalated to a senior clinician for immediate review. As the NEWS 2 score is being rolled out, thresholds are being published for sepsis suspicion and escalation. This includes flagging of a NEWS score of 5 or greater, or 3 in a single parameter.
- All patients referred to CCU Outreach teams continue to be assessed for signs of sepsis and the assessments are audited.
- All patients with neutropenic sepsis need a Multinational Association of Supportive Care in Cancer (MASCC) risk score to be recorded, and nurses need to complete a neutropenic sepsis audit which is sent to the Quality Assurance Team.
- CCU Outreach teams and the community practice education team continue to educate medical and nursing staff on implementation of the *Sepsis Six* bundle. Roadshows are conducted regularly at each Trust site. The NEWS 2 charts are due to be rolled out in the Trust in the coming quarter (Q2 2018/9).
- Appointment of a senior nurse to spearhead the prevention, assessment and management of sepsis and acute kidney injury.

8.3. Medical devices

8.3.1. Medical device incidents

Fundamental standard *All medical devices must be readily available and suitable for its intended use.*

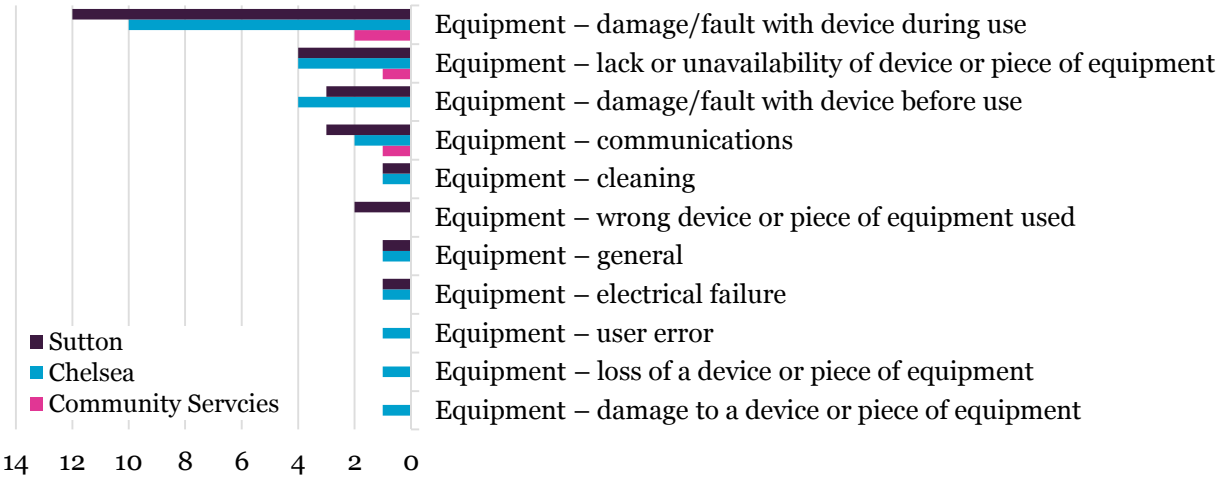
There were 57 patient safety incidents relating to medical devices this quarter (there were 44 in the previous quarter).

The main devices incidents included:

- 13 involving various non-specified equipment
- 6 involving intravenous equipment
- 5 involving endoscopes
- 4 involving feeding tubes
- 3 involving pump/syringe drivers

No incidents were graded *moderate* or above. Twenty-four were graded *low* and 33 *very low*.

8.3.2. Medical device incident category by site



8.3.3. Medical device incidents by category

There were 24 incidents in total relating to 'Equipment – damage/fault with device during use' and 7 'Equipment – damage/fault with device before use':

- 5 involving various non-specified
- 4 involving IV equipment eg. needle, syringe, extension set (all different devices and sites – none related)

8.3.4. Medical device incidents by type

Type of medical device	Total*
Various non-specified equipment	13
Intravenous equipment including needle, syringe, extension set	6
Endoscopes	5
Feeding tubes	4
Pump/syringe driver	3
Anaesthetic and breathing masks	2
Anaesthetic machine/equipment	2
Dressings	2
Facilities miscellaneous	2
Infusion pumps, syringe drivers	2
Magnetic resonance equipment and accessories	2
Radiotherapy equipment eg. simulator, MRI	2
Ultrasound equipment	2
Administration and giving sets	1
Computed tomography (CT)	1
Diathermy equipment and accessories	1
Dialysis	1
Feeding systems enteral	1
Patient monitoring equipment	1
Pathology equipment	1
Thermometers	1
Walking sticks/frames	1
X-ray equipment	1
Total	**57**

* An incident may involve one or more medical devices and a medical device may be included in one or more incidents. Consequently, the number of incidents may not match the number of devices.

8.3.5. Evaluation of new medical devices

The Medical Device Committee met three times in this quarter and approved nineteen proposals to evaluate or use new devices. Five devices were approved for purchase.

Form A (low risk)	5
Form B (proposal to evaluate)	10
Form D (risk assessment - device not evaluated)	4
Approved for purchase	5
Total	**24**

8.4. Medicines optimisation

8.4.1. Medicines safety

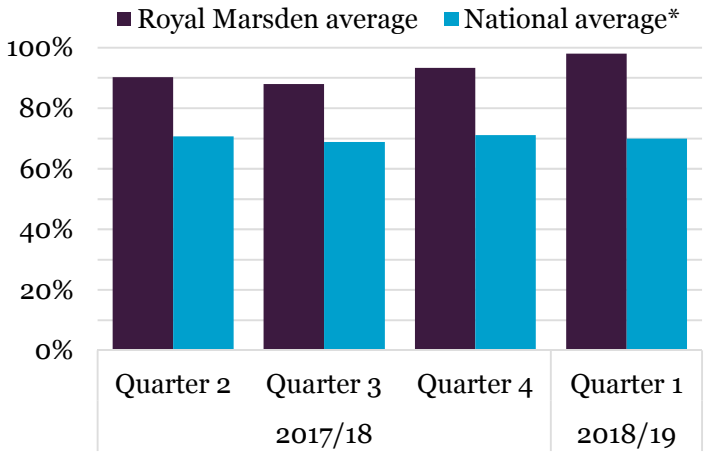
The Trust's commitment to improve the safer use of medicines as part of the *Sign up to Safety* campaign continues to be at the forefront of medicines governance.

8.4.2. Medication reconciliation

Results of the medication safety thermometer for the first quarter has shown a consistently high percentage of patients having their medicines reconciled within 24 hours of admission.

Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking with the goal of providing correct medications to the patient at all transition points of care.

The chart shows the percentage of medications reconciled within 24 hours of admission for the last three quarters in 2017/18 through to the first quarter in 2018/19.

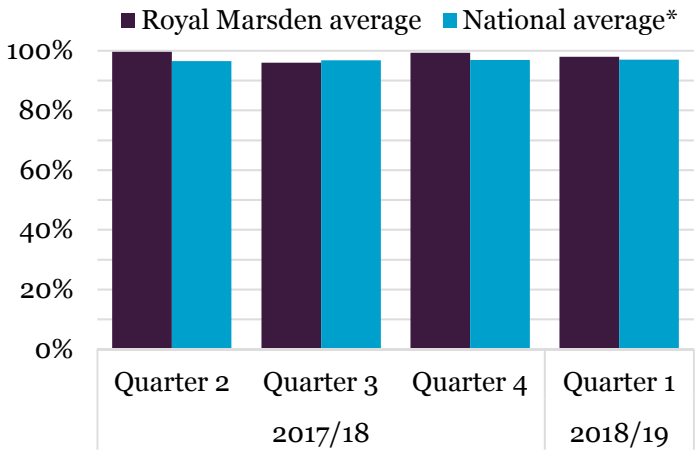


* National averages are calculated from the NHS Medication Safety Thermometer national dashboard.

8.4.3. Allergy documentation

Allergy documentation continues to show high compliance for the fourth quarter on the inpatient drug chart. The Trust target is 100% compliance.

The chart shows the percentage of allergy status documented for the last three quarters in 2017/18 to the first quarter in 2018/19.



* National averages are calculated from the NHS Medication Safety Thermometer national dashboard.

8.4.4. Omission of critical medicines

In the first quarter 2018/19, there were two omissions in April, two omissions in May and seventeen omissions in June. All omissions were for valid clinical reasons.

8.4.5. Electronic prescribing

The focus has been on pre-prescribing and strategies on increasing rates of electronic prescribing across all units.

The system has also provided critical information to aid quality improvements with the aim of improving patient experience. The table below highlights pre-prescribing and pre-screening (pharmacy checking) rates for chemotherapy prescriptions. These processes are an important factor in ensuring that patients' treatments are prepared and ready for their administration appointments.

The table shows the eChemo system prescribing metrics.

	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	Quarter 1 2018/19
eChemo prescriptions prescribed more than 5 days in advance	74%	71%	71%	70%
Available eChemo prescriptions screened more than 4 days in advance	93%	91%	92%	85%

8.4.6. Medication supply partnership

The ongoing governance framework of monthly key performance indicator meetings and quality improvement meetings between Boots UK and Royal Marsden staff has enabled the teams to continue to review prescription pathways to improve the patient experience and expectations around this.

Outpatient waiting time data in the table below shows that 77% of prescriptions were completed within 30 minutes. The average waiting times between April and June were 27 minutes (Sutton) and 18 minutes (Chelsea).

Outpatients	April		May		June	
Minutes	Sutton	Chelsea	Sutton	Chelsea	Sutton	Chelsea
0 to 30	68%	90%	63%	83 %	72%	87%
31 to 60	25%	10%	29%	17%	23%	12%
61 or more	7%	0%	8%	0%	5%	1%

Waiting times for prescriptions dispensed for discharge are shown in the table below. It shows that over 93% of discharges were completed within 60 minutes with 74% completed within 30 minutes. Average waiting times from April to June were 26 minutes (Sutton) and 17 minutes (Chelsea).

Discharges	April		May		June	
Minutes	Sutton	Chelsea	Sutton	Chelsea	Sutton	Chelsea
0 to 30	64%	90%	62%	82%	68%	78%
31 to 60	28%	10%	30%	16%	26%	19%
61 or more	8%	0%	8%	2%	6%	3%

8.5. Waste management

8.5.1. Total Waste Management contract

The Royal Marsden's Waste Management Team continues to monitor and audit its contractor's service for compliance with waste legislation and to provide support with any necessary changes for continuous improvement.

8.5.2. Offensive waste

The offensive waste stream 'tiger stripe' (yellow and black) is now fully operational at both sites, meaning the Trust is in compliance with HTM 07-01 and the Environment Agency's requirements to remove offensive waste from clinical waste.

To facilitate switching from offensive to infectious waste on occasion, magnetic flip labels (one side tiger, one side infectious) have been distributed throughout.

8.5.3. Recycling hubs

Eighty bins will shortly be introduced to communal areas and offices to increase recycling at both sites. This will see the removal of 'at desk' bins, reduce plastic bag use and see recycling increase across the Trust.

8.5.4. Staff training

The Waste Management team will be offering training to all departments from late July. This will be a rolling programme to capture all staff with the aim being to improve correct segregation to comply with our waste and environmental responsibilities. Future plans include the development of waste management intranet pages. These will form an information and knowledge hub that all staff can access and refer to for information on waste management.

8.6. Fire

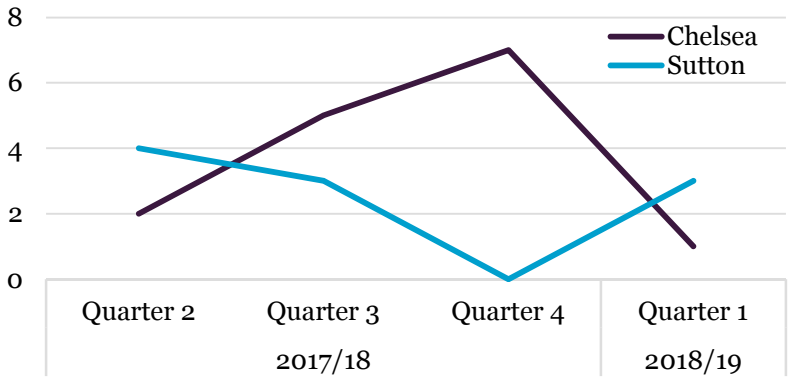
8.6.1. Number of fires

There were two incidents relating to one actual fire in the quarter. The fire was subject to an incident investigation panel in May (see Investigation 2 on page 101 for description). (There were no actual fires in the previous quarter).

8.6.2. Fire-related incidents

The below graph and table shows the number of attributable fire related incidents throughout the Trust over the past four quarters. There has been a 42.9% decrease (from seven down to four) in fire related incidents throughout the Trust since Quarter Four 2017/18.

8.6.3. Fire-related incidents by site



8.6.4. Fire-related incidents by subcategory

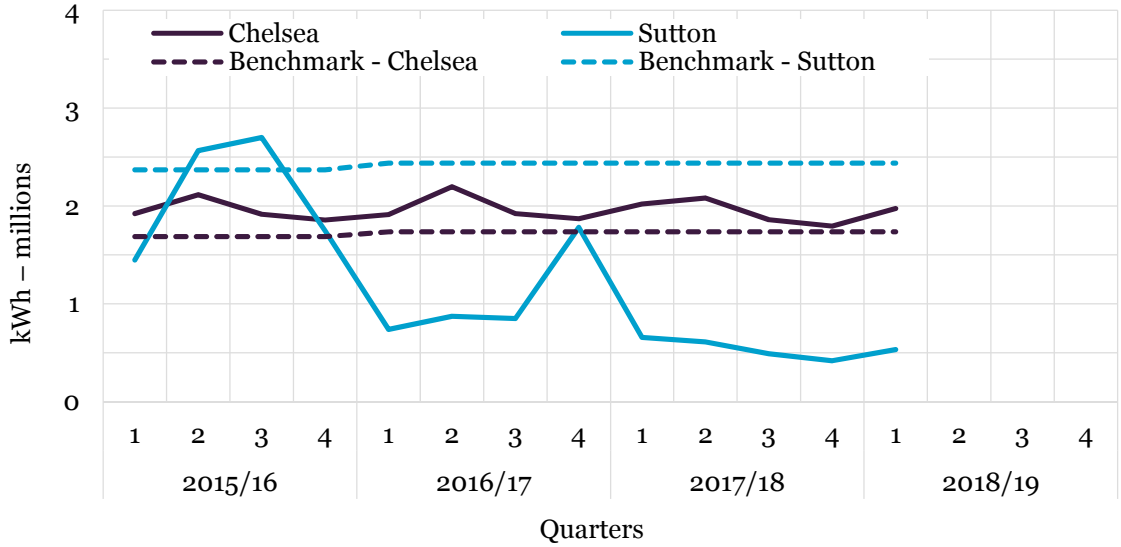
	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	Quarter 1 2018/19	Total
Actual fire	0	0	0	2	**2**
Call point activated – accidentally operated	1	2	1	0	**4**
Detector activated – dust, smoke, building works	0	4	1	0	**5**
Detector activated – electrical equipment	1	0	2	0	**3**
Detector activated – kitchens	2	0	1	0	**3**
Detector activated – overheating of area	0	0	1	0	**1**
Fire safety deficiency	2	1	0	0	**3**
General fire issue	0	1	1	2	**4**
Total	**6**	**8**	**7**	**4**	**25**

8.7. Energy use

8.7.1. Electricity consumption – Chelsea and Sutton

Electricity consumption in Quarter one at Chelsea reduced by 2.3% on the same quarter last year and increased by 10% on previous quarter (Quarter Four 2017/18). The main contributor to the increased electricity is extra load of air conditioning systems due to hotter seasonal weather and heat wave conditions.

Electricity grid consumption in Quarter One at Sutton reduced by 19% on the same quarter last year and increased 27% on Quarter Four in 2017/18. A problem on Energy Centre gas valve is the main contributor to reduced availability of the CHP system and subsequently increase electricity import compare to previous quarter.

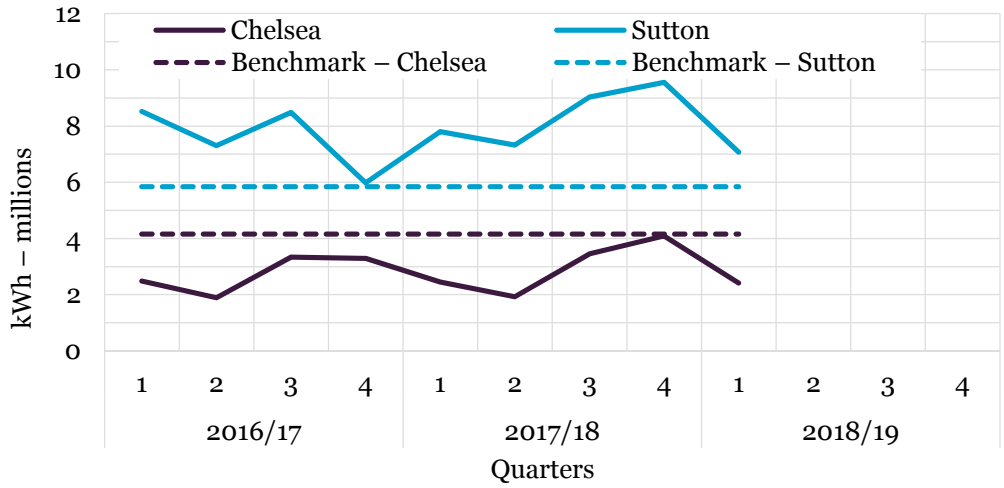


The benchmark used is an average of consumption of five acute trusts in London. The Royal Marsden's electricity consumption at the Chelsea site is slightly above the benchmark line but the consumption at Sutton is below the benchmark line. The Trust is preparing a feasibility study for on-site generation of electricity and a range of energy efficiency measures at the Chelsea site, which will help to reduce the electricity consumption in long term.

8.7.2. Gas consumption – Chelsea and Sutton

Gas consumption in Quarter one at Chelsea reduced 1.3% over the same quarter last year and 41% on Quarter Four in 2017/18. The main reason for reduction is less heating demand due to warmer ambient temperature.

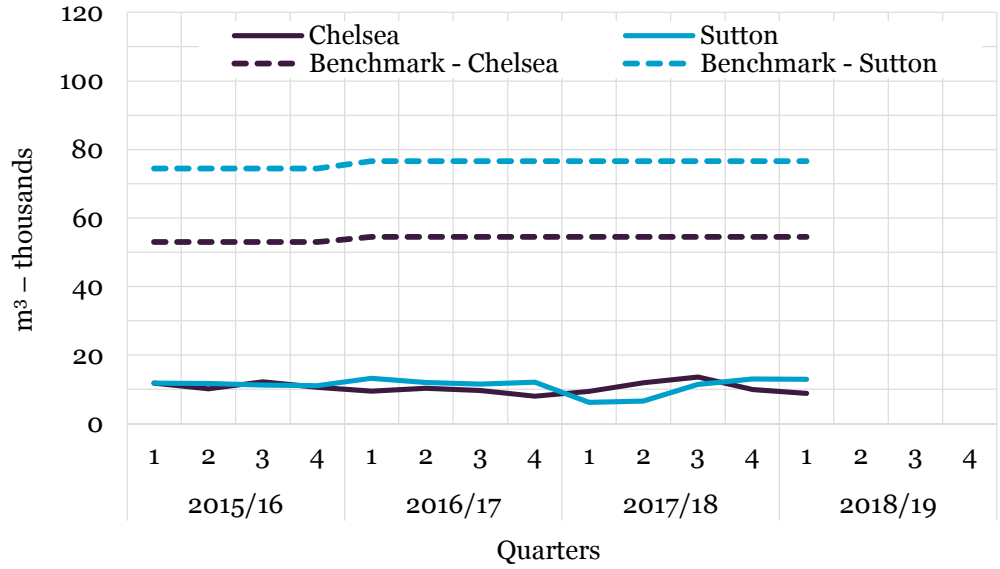
Gas consumption at Sutton was down 19% on the same quarter last year and increased by 27% on Quarter Four in 2017/18. The reduction is due to more efficient running of energy centre and the increase is due to increased CHP hours run.



8.7.3. Water consumption – Chelsea and Sutton

Water consumption in Quarter One at Chelsea was down 6.5% on the same quarter last year and 11.4% on Quarter four 2017-18.

Water consumption in Quarter One at Sutton doubled on the same quarter last year and reduced 1% on Quarter Four in 2017-18. A faulty water meter was replaced in Quarter Three last year and as a result, more realistic water usage is reordered in Quarter One this year compared to incorrect consumption recorded in last year Quarter One.



9. Suitability of staffing

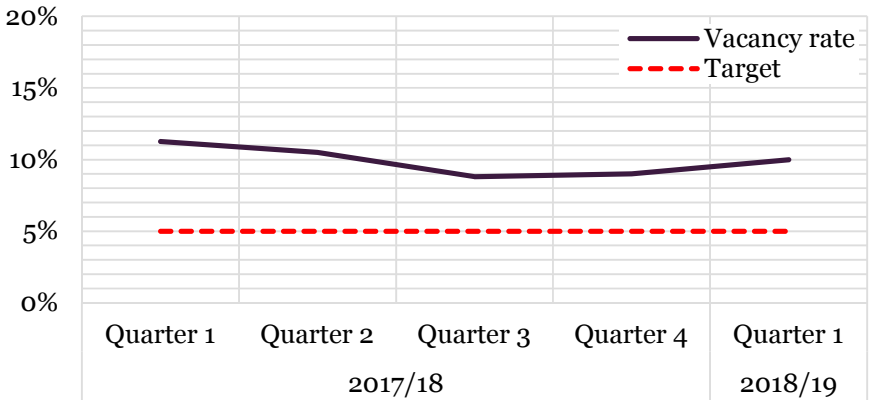
9.1. Human Resources

9.1.1. Performance indicators

	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	Quarter 1 2018/19
Vacancy rate (target 7.0%)					
Trust Total	11.3%	10.5%	8.8%	9.0%	9.9%
Cancer Services	7.2%	7.2%	6.4%	7.7%	9.4%
Clinical Research	13.0%	3.4%	0.6%	-2.3%	-3.9%
Clinical Services	11.3%	12.2%	10.1%	9.8%	11.7%
Community Services	17.8%	16.6%	14.4%	14.7%	16.0%
Private Care	18.0%	17.2%	15.2%	15.4%	13.0%
Corporate	8.0%	7.7%	6.8%	8.6%	9.5%
Voluntary turnover reported from April 18 (target 12.0%)					
Trust Total	15.1%	15.5%	14.9%	15.2%	13.4%
Cancer Services	13.6%	13.9%	12.8%	12.4%	10.5%
Clinical Research	13.0%	13.5%	12.9%	13.0%	10.7%
Clinical Services	13.3%	14.0%	13.9%	14.2%	10.3%
Community Services	21.0%	21.5%	18.7%	18.5%	13.8%
Private Care	20.9%	20.7%	19.0%	20.2%	16.4%
Corporate	14.5%	15.1%	15.9%	16.9%	15.7%
Sickness Absence (target 3.0%)					
Trust Total	2.7%	2.6%	3.2%	3.6%	2.9%
Cancer Services	2.3%	2.7%	2.7%	3.3%	2.2%
Clinical Research	2.3%	2.1%	2.7%	2.6%	2.0%
Clinical Services	2.6%	2.2%	2.9%	3.4%	2.8%
Community Services	2.1%	3.0%	3.3%	4.5%	4.3%
Private Care	4.8%	3.2%	4.6%	5.2%	4.2%
Corporate	3.1%	2.9%	3.9%	4.2%	3.3%
Appraisal rate (target 90.0%)					
Trust Total	85.7%	83.7%	82.6%	84.7%	88.6%
Cancer Services	85.8%	81.8%	77.0%	83.0%	89.4%
Clinical Research	85.0%	80.3%	72.9%	72.9%	85.5%
Clinical Services	85.5%	83.4%	83.5%	83.8%	91.1%
Community Services	85.8%	80.6%	86.3%	83.9%	89.7%
Private Care	81.3%	84.0%	84.0%	88.1%	86.7%
Corporate	86.6%	89.7%	89.7%	87.3%	87.8%
Statutory and mandatory training (target 90.0%)					
Trust Total	89.0%	89.0%	89.2%	83.0%	91.1%
Cancer Services	81.7%	80.9%	80.6%	85.6%	87.1%
Clinical Research	90.3%	89.9%	88.4%	89.2%	89.5%
Clinical Services	90.4%	90.6%	91.6%	91.4%	93.4%
Community Services	93.3%	93.6%	93.6%	88.9%	90.1%
Private Care	90.4%	91.1%	92.2%	87.8%	92.2%
Corporate	93.1%	93.9%	94.1%	86.3%	94.8%
Local induction (target 85.0%)					
Trust Total	84.2%	82.2%	84.0%	86.4%	89.1%
Cancer Services	82.1%	69.4%	76.6%	86.8%	89.8%
Clinical Research	86.9%	86.7%	84.6%	85.3%	90.8%
Clinical Services	88.8%	86.8%	87.2%	87.8%	90.7%
Community Services	81.3%	82.9%	85.7%	89.9%	92.6%
Private Care	75.0%	83.6%	82.9%	87.3%	82.8%
Corporate	82.3%	87.9%	89.3%	91.9%	86.2%

9.1.2. Vacancy

The Trust vacancy rate has increased to 9.9% in Quarter One 2018/19, which is above the trust target, but shows considerable improvement on the vacancy rate this time last year. The Vacancy rate target for the year 2018/19 has been set at 7%, which reflects the challenges for recruitment within London.

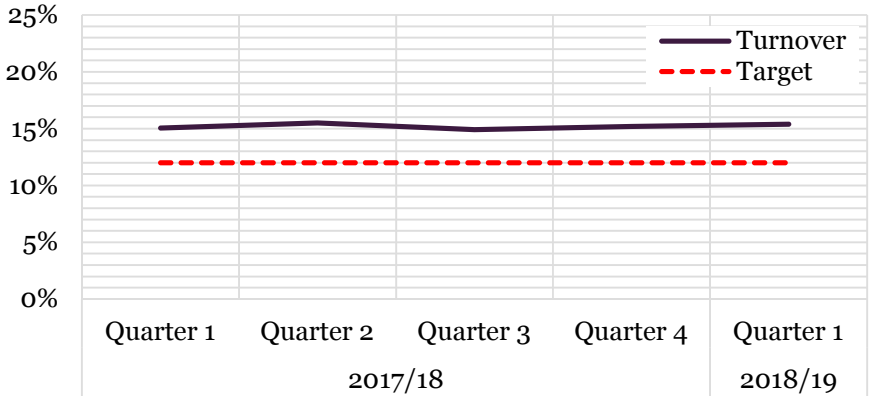


There continues to be a strong focus on nurse recruitment. We met and exceeded our nurse recruitment target of last year, which was to recruit an additional 225 nurses. Our target for 2018/19 is to recruit an additional 250 nurses.

9.1.3. Turnover

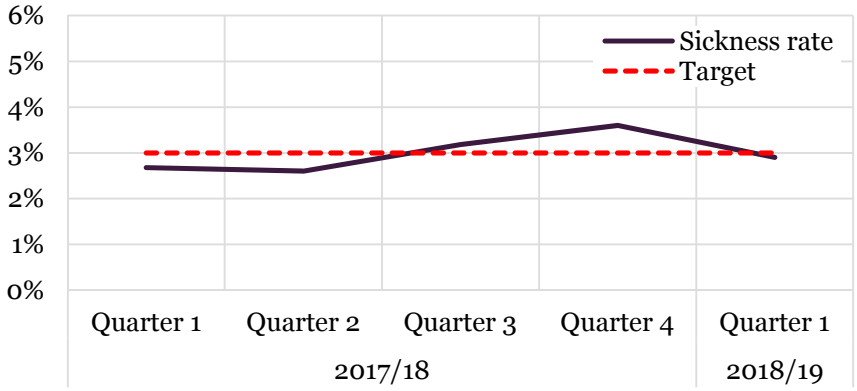
Voluntary turnover rate for the Trust was 13.4% in Quarter One 2018/19. The trust target for 2018/19 is 12%, and half of the Divisions within the trust are already meeting that target. Staff Engagement is an important factor in reducing turnover, and the Trust survey staff each quarter to establish how to improve staff experience both when they join the trust and throughout their service with the trust.

Focus groups are currently taking place to follow on recent feedback, and ideas are being gathering from staff across the Trust, on how the current Recruitment, Induction and Appraisal processes can be improved.



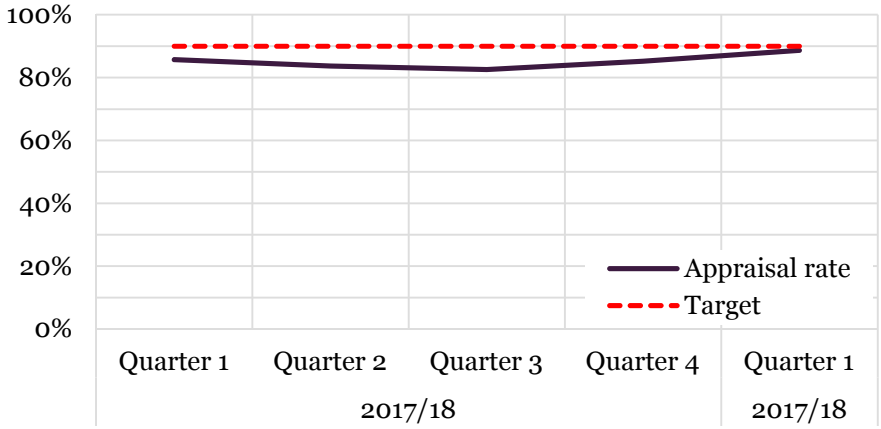
9.1.4. Sickness

The Trust sickness rate this quarter has reduced to 2.9%, below the 3% trust target, and in line with seasonal trends. In the coming quarter the Trust will be preparing for seasonal pressures, by launching its flu vaccination programme. Long-term and short-term sickness absence is reviewed within the Divisions, and the Human Resources and Occupational Health teams provide targeted support to both management and staff members.



9.1.5. Appraisal

Quarter One 2018/19 appraisal compliance is 88.6%, just below the end of financial year target, which is 90%. Quality appraisals are a key factor in motivating staff and supporting professional development, and we closely with managers and staff to support achievement of our target.



9.2. Mandatory training

9.2.1. Statutory and mandatory training forms part of the Trust's risk management strategy to minimise risk to patients, visitors and staff. In addition to the ongoing use of the WIRED mandatory training and appraisal compliance reporting system, progress against these topics are reported to divisions through the monthly scorecard.

9.2.2. The following table shows mandatory training compliance for the core topics for Quarter One. The figures for this quarter's overall compliance rate are shown against the red/amber/green (RAG) rating where

- red is less 60%
- amber is 60% to target
- green is at or above target.

9.2.3. Targets for compliance are set at 90% with the exception of the Workshop to raise awareness of Prevent (WRAP) and Information governance which are set nationally at 85% and 95% respectively.

Mandatory training topics	Update frequency requirement (in years)	Target	Hospital compliance rate	Community Services compliance rate	Overall Trust compliance rate Quarter 4 2017/18	Trend	Overall Trust compliance rate Quarter 1 2018/19
Adult basic life Support	1	90%	86%	86%	**84%**	↑	**86%**
Blood transfusion (generic update)	2	90%	90%	Not applicable	**91%**	↓	**90%**
Conflict resolution for frontline staff	3	80%	80%	84%	**83%**	↓	**81%**
Consent awareness (medical staff)	2	90%	83%	Not applicable	**83%**	↔	**83%**
Equality and diversity	3	90%	93%	94%	**93%**	↑	**94%**
Fire awareness	1 (clinical) 2 (other)	90%	89%	92%	**91%**	↔	**91%**
Infection prevention and control	1 (clinical) 3 (other)	90%	92%	91%	**91%**	↑	**92%**
Information governance	1	95%	95%	97%	**95%**	↓	**94%**
Medicines management (clinical staff)	1	90%	86%	73%	**86%**	↓	**85%**
Manual handling – back care awareness (non-patient handling)	3	90%	92%	95%	**92%**	↑	**93%**
Manual handling (patient handling)	1	90%	86%	83%	**87%**	↓	**86%**
Paediatric basic life support	1	90%	86%	85%	**83%**	↑	**86%**
Risk management awareness	1 (managers) 3 (other)	90%	91%	95%	**92%**	↓	**91%**
Risk training for senior managers	1 (managers)	90%	83%	100%	**79%**	↑	**86%**

Mandatory training topics	Update frequency requirement (in years)	Target	Hospital compliance rate	Community Services compliance rate	Overall Trust compliance rate Quarter 4 2017/18	Trend	Overall Trust compliance rate Quarter 1 2018/19
Safeguarding vulnerable adults (level 1)	3	90%	89%	92%	**90%**	↑	**92%**
Safeguarding vulnerable adults (level 2)	3	90%	91%	93%	**90%**	↑	**92%**
Safeguarding vulnerable adults (level 3)	3	90%	93%	83%	**75%**	↑	**88%**
Safeguarding children (level 1)	3	90%	92%	88%	**91%**	↑	**92%**
Safeguarding children (level 2)	3	90%	91%	96%	**91%**	↑	**92%**
Safeguarding children (level 3)	3	90%	84%	86%	**85%**	↔	**85%**
WRAP (Prevent)	Once only	85%	90%	88%	**86%**	↑	**89%**
Venous thrombo-embolism and pressure ulcers (clinical staff)	1 (clinical)	90%	88%	68%	**86%**	↑	**87%**
Venous thrombo-embolism (medical staff)	Once only	90%	94%	N/A	**94%**	↔	**94%**

9.2.4. Any staff who are on long-term sickness (more than 4 weeks), on maternity/adoption leave, on an external secondment or have been suspended are not included in the WIRED compliance reporting system.

9.2.5. An overall compliance rate of 90% or above has been achieved since January 2018 consistently in all mandatory training topics.

9.2.6. A compliance rate of 90% or above has been achieved in 12 topic areas and a further eleven topics achieved 80% or above with no topics with less than 80% compliance.

9.2.7. This quarter has seen an increase in 13 topics, a slight decrease in six areas and four have remained static.

9.2.8. The Trust achieved the nationally set target for WRAP training of 85% by 31 March 2018. The target and deadline were set by NHS England and a large programme was initiated to meet this requirement. Both WRAP and Safeguarding Vulnerable Adults Level 3 continue to increase in compliance.

9.2.9. Staff who are non-compliant against any of the subject areas have received a notifications routinely during this quarter.

9.2.10. In the areas where a decrease in compliance has been identified, such as in Patient Handling, diagnostics are carried out and improvement plans are put in place. Targeted reminders of non-compliance are being sent by the Learning and Development Team on a regular basis for all topics to improve compliance and sessions are scheduled accordingly. This will continue to be the strategy of the Learning and Development Team over the next quarter.

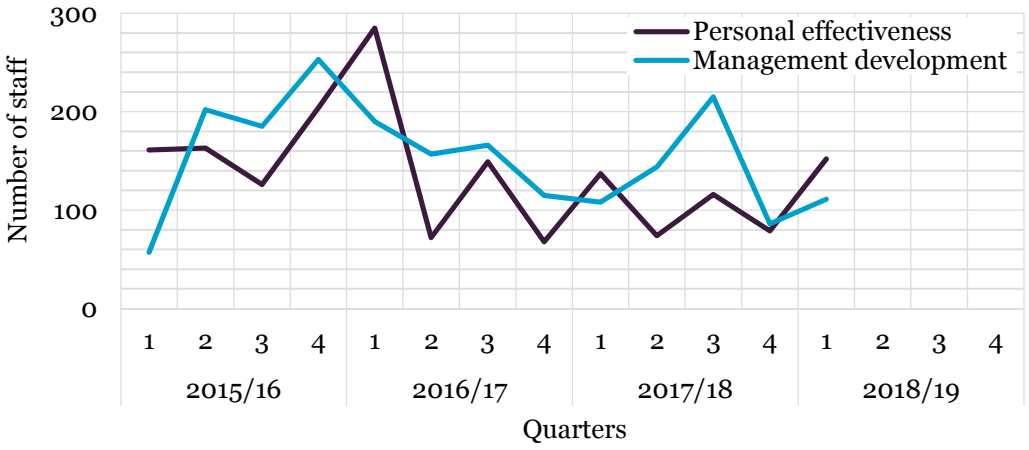
9.3. Induction

9.3.1. For the third consecutive quarter the Trust continues to exceed the target of 85% set for induction. This target was raised in April from 80%. Regular three-monthly targeted follow-up with line managers remains the key strategy for maintaining the local induction compliance rate with monthly reminders to staff to complete the Month One onboarding List and inform the Learning and Development Team. This will continue with monthly reminders targeted at those individuals who are not compliant to further increase compliance.

9.3.2. The Trust continues to exceed the target for attendance at Trust induction. This has decreased slightly to 92% from 93% since the last quarter. Close monitoring, improved communication to delegates, and joint working with the Recruitment Team is ensuring that all new joiners attend Trust induction within two months of their start date. Auditing of new starters against attendance highlights where new joiners have not attended and follow-up continues to be a monthly task carried out by the Learning and Development team.

9.4. Non-clinical training and development

9.4.1. In-house courses in personal effectiveness and management development are open to all staff and managers unless specifically designed for particular groups.



9.4.2. The number of learning activities scheduled continues to be dependent on need. The fluctuation in numbers completing training each quarter is dependent on scheduling patterns and focus on particular topics at different times during the year.

9.4.3. During Quarter One the following workshops were delivered:

- Budget holder skills
- Building your resilience
- Communicating assertively
- Cultural awareness

- Equality and diversity – managing fairly
- Information technology sessions in Microsoft Word, Excel and PowerPoint
- Introduction to medical terminology
- Learning to lead
- Managing poor work performance
- Managing sickness absence
- Meetings and minute taking
- Performance appraisal
- Preparing to conduct human resources investigations
- Presentation skills
- Project management
- Recruitment and selection
- Resilience for leaders
- Time management
- Writing business cases

Feedback from participants suggests that the increasingly innovative learning methods employed has enabled them to gain insight into their own performance and has led to positive behaviour changes back in the workplace.

9.4.4. The fourth cohort of the Paired Learning Programme was launched in quarter one. Twelve learners were selected from a total of 19 applicants from a cross section of the organisational and professional groups. During the programme learners attend monthly workshops and lead on six transformation projects. The programme will complete in October 2018.

9.4.5. The Trust's Career Mentoring scheme was re-launched in June 2018. The scheme was expanded to include staff in bands 1 to 6 from the previous programme which was open to staff in bands 4 to 6. Mentees will be mentored by internal trained mentors over a six-month period. In Quarter One 25 applications were received from staff across the organisation.

9.4.6. The Learning and Development team have worked with teams to identify learning needs at department and individual level and have designed bespoke learning programmes to meet those needs, covering topics such as customer service and leadership.

9.4.7. The Learning and Development team have supported internal trainers and educators by offering a portfolio of training and presentation skills workshops and tailored expert coaching to trainers who wished to improve particular aspects of their practice, for example speaking at a large international conference or dealing with difficult situations.

10. Quality of care provided in a safe and effective way

10.1. Annual quality account

10.1.1. As part of a drive to be open and honest all NHS hospitals and foundation trusts have to publish annual financial accounts and a quality account.

10.1.2. Quality accounts are useful for the Trust Board, which is responsible for the quality of services, and they can use it in their role of assessing and leading the Trust. Frontline staff are encouraged to use quality accounts to compare their performance with other trusts and to help improve their service.

10.1.3. For patients, carers and the public, the quality account should be easy to read and understand, and highlight important areas of safety and effective care provided in a caring and compassionate way. It should also show how the Trust concentrates on any improvements that can be made to care or experience.

10.1.4. The Patient Experience and Quality Account Committee met and reviewed the latest draft of the annual quality account each quarter throughout the year. The committee was asked to review the layout, generate some ideas for photographs, and consider if a change in format was required.

10.1.5. The results of the member's event held in November 2017 were reviewed and the Council of Governors were asked to select what the quality priorities for the next year 2018/19 should be. They chose to keep sepsis as a quality priority for 2018/19.

10.1.6. On 1 March 2018 the draft annual quality account was distributed to external stakeholders for a period of 30 days to allow review and comments with stakeholders invited to submit a statement that will be included in the final version of the annual quality account. The Trust's Integrated Governance and Risk Management Committee, the Nursing, Radiography and Rehabilitation Advisory Committee and Trust Consultative Committee also reviewed the draft annual quality account and agreed quality priorities for 2018/19.

10.1.7. The final draft copy was awarded the Crystal Mark by the Plain English Campaign.

10.1.8. The Trust's annual quality account 2017/18 was published on 29 June 2018 on the Trust's website www.royalmarsden.nhs.uk/about-royal-marsden/quality-and-safety/regulatory-information/quality-account-and-quality-0 and on NHS Choices website www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/about-quality-accounts.aspx.

10.2. Clinical audit

10.2.1. The Clinical Audit Committee coordinates, evaluates and reviews all clinical audits and quality improvement projects in the Trust.

10.2.2. Ten national audits were registered in Quarter One:

- National audit of the use of radiotherapy in the treatment of vulvar cancer
- The head and neck cancer surveillance audit 2018
- Oesophago-gastric anastomosis audit

- Pulmonary embolism (National Confidential Enquiry into Patient Outcome and Death)
- National comparative audit of the use of fresh frozen plasma, cryoprecipitate and other blood components in neonates and children
- Sorafenib for the treatment of advanced hepatocellular cancer
- National Audit of Care at the End of Life (NACEL)
- National Cardiac Arrest Audit (NCAA)
- Evaluating the impact of consensus guidelines for the diagnosis and management of invasive fungal disease (IFD) in children undergoing haematopoietic stem cell transplant
- National audit of outcomes in anaplastic lymphoma kinase (ALK+) patients treated with second generation ALK inhibitors

10.2.3. Twenty-five new clinical audit proposals and three re-audit proposals were approved by the committee in Quarter One.

10.2.4. Five national audit reports were presented in Quarter One:

- National Lung Cancer Audit (NLCA)
  The report can be found here:
  https://www.rcplondon.ac.uk/projects/outputs/nlca-annual-report-2017
- National Clinical Audit Benchmarking (NCAB): Emergency Laparotomy
  The report can be found here:
  https://ncab.hqip.org.uk/results/trust-RPY
- Annual Sentinel Stroke National Audit Programme (SSNAP)
  The report can be found here:
  https://www.strokeaudit.org/Annual-Report/2017/Home.aspx
- The Learning Disabilities Mortality Review (LeDeR) Programme
  The report can be found here:
  http://www.bristol.ac.uk/sps/leder/resources/annual-reports
- National Cardiac Arrest Audit (NCAA)
  Information can be found here:
  https://www.icnarc.org/Our-Audit/Audits/NCAA/Reports

10.2.5. Details of the 35 reports for local audits and quality improvement projects presented and approved by the Clinical Audit Committee in Quarter One are shown in the following table.

10.2.6. Audits conducted at Chelsea and Sutton

Title	Action plan, learning and outcomes
Quarterly infection prevention and control (Quarter 3 2017/18)	Results of the ongoing audit reported to the wards directly with reminders of correct process.
Audit of inpatient and outpatient enteral tube feeding	Results disseminated and shared with the key clinical units for staff awareness and understanding. Further audits in key clinical areas planned. Logistics of undertaking audit within the Department of Nutrition and Dietetics to ensure complete data collection reviewed.

Title	Action plan, learning and outcomes
Prospective audit of radiographer cervical cancer soft-tissue review	Radiographers achieved excellent concordance with Clinical Oncologists in cervical cancer soft-tissue IGRT (Image Guided Radiotherapy). The results of this audit supported the implementation of daily cervical cancer soft-tissue IGRT as standard practice cross-site. Everyday application of this new image review process, by trained radiographers, improves confidence attaining desired clinical target coverage and avoiding normal tissue. Greater advice and guidance on patient hydration recommended.
Annual intravenous (IV) audit	Annual audit results disseminated for staff awareness and understanding. Results highlighted at mandatory training and in IV newsletter. Development of a comprehensive documentation pack with relevant updated core care plans started. Extravasation policy in pack updated. Documentation related to care plans and fluid balance charts updated. To ensure all continuous administration sets are labelled. To ensure all central venous access device (CVAD) dressings are labelled. To improve the documentation of patient group direction (PGD) codes.
Awake fibreoptic intubation (AFOI): Can this ever be a palatable experience?	Poster presented at World Airway Management Meeting. Overall participants felt safe and were comfortable during the AFOI procedure. Majority of patients would not be worried about having a future AFOI.
Thalidomide audit	Best practice confirmed.
Mental Capacity Act hospital audit	Audit report forwarded to Safeguarding teams for review and comments. Continue providing Mental Capacity Act training for hospital staff and managers of services. Reported audit findings at safeguarding surgeries across ward areas. Include learning and themes from audit in The Royal Marsden safeguarding newsletter. Mental Capacity Act awareness hospital staff survey to be completed by March 2019. Ensure safeguarding adults aide memoir (including Mental Capacity Act) is visible to support staff in all clinical areas. Re-audit by March 2019 as a part of the safeguarding adults audit plan.

Title	Action plan, learning and outcomes
Use of clinical photography in breast reconstruction	Breast team reminded to document any refusal. If booking an onco-plastic case include all the additional standards in the definitions for onco-plastic. Standardise points for post-operative photography.
Acute oncology metastatic spinal cord compression (MSCC) audit	Disseminated audit findings to local acute oncology service (AOS) teams and within The Royal Marsden radiotherapy department for staff awareness and understanding. Re-audit by December 2019 to include the proportion of patients receiving single fractions of radiotherapy.
Lung Unit patient experience survey	Develop a secure way to send patient information via email, by collecting email addresses at registration and confirming with patients. Possibly evaluate a wellbeing event at Sutton and incorporate that information to patients. Have information available at clinic appointments i.e. booklets, online websites, diet updates, travel insurance information. Keep being visible in clinic so patients know they can contact us. Present results at the Lung Unit research meeting for staff awareness and understanding.
Reducing the impact of serious infections (antimicrobial resistance and sepsis) (Quarter 4 2017/18)	To develop a situation, background, assessment and recommendation (SBAR) tool to roll out to The Royal Marsden in line with the National Early Warning Score 2 (NEWS2). Continue to request that Clinical Assessment Unit (CAU) staff use the daycase proforma to record observations to allow automatic pull through of observation data. Continue to track performance against a target of 90%. Implementation of a non-neutropenic sepsis patient group direction (PGD) in addition to the existing neutropenic sepsis PGD. Continue with work to embed the documentation into the electronic patient record system to allow for roll out.

10.2.7. Audits conducted at Chelsea

Title	Action plan, learning and outcomes
An audit to investigate the timeliness, completeness and accuracy of electronic discharge summaries: cycle two	Implemented electronic 'to take out' (TTO) medications into the electronic patient record system. Repeat audit following initiation of electronic TTOs.

Title	Action plan, learning and outcomes
Pilot of dietetic outcome measures for critical care unit	Results submitted to chair of the British Dietetic Association critical care outcome measures group. Data collection tool amended to make it easier to use. Re-audit in September 2018 using amended tool.
A retrospective review of fludeoxyglucose (FDG) doses and the time of injection to the time of FDG positron emission tomography / computed tomography (PET/ CT) scan against European Association of Nuclear Medicine Guidelines	Technologists advised to improve record keeping. Technologists advised to improve patient preparation and compliance to minimise patient movement during scan. New PET/CT scanner to be installed. Results discussed during Nuclear Medicine Department (Chelsea) team meeting for staff awareness and understanding.
Documentation of multi-disciplinary team (MDT) outcomes in sarcoma patients	Training of junior doctors regarding the electronic patient record (EPR) proforma improved. Update of existing EPR proforma to include easily accessible tick boxes to reflect information discussed. Consensus amongst consultants to ensure stage and grade documented for the patient discussed.
Audit of response to gemcitabine-docetaxel rechallenge in patients with metastatic soft tissue sarcoma (STS)	Sarcoma Unit guidelines updated.
The cost of centralising sarcoma services on the patient – a single centre experience	This snapshot quality improvement project (QIP) has demonstrated the time commitment and the cost this incurs to patients and their families when attending our sarcoma centre. We hope to use this data to improve the quality of the information we provide to new patients referred to our service, in relation to travel, time and cost, and to generate discussion on how to improve the patient experience. We aim to work with key referral centres to provide specific information regarding travelling for specialist appointment and services available prior to the patient's first appointment.

10.2.8. Audits conducted at Sutton

Title	Action plan, learning and outcomes
To investigate the impact of shared decision making on staff engagement by the implementation of staff involvement initiatives	Daily huddles to continue. Undertake lab tours, so that teams have a better understanding and appreciation of what goes on. Work with teams to develop job roles/plans (to include research) and aligning them between the teams. Work with teams in recruitment and retention of staff and look at optimal ratio of senior to junior staff. Work with teams to undertake team-building activities. Develop senior staff with the skills to supervise/ manage staff.

10.2.9. Audits conducted in Community Health

Title	Action plan, learning and outcomes
Safe transcribing of medicines/ medicines management – April 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit will be carried out for Quarter 3 2018/19.
High priority areas for pressure ulcer bundle – April 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit will be carried out for Quarter 3 2018/19.
Audit of the effectiveness of the observation tool used in health visiting and school nursing to identify competence in delivery of the healthy child programme	Revise the *Observation of Practice* document to ensure ease of use and clearer guidelines. Spreadsheet to be placed on data store for team leaders/practice educator with all staff names and dates of observations of practice to ensure timely compliance with annual requirement. Observation of practice to be discussed at annual staff appraisals with team leaders to ensure compliance with annual requirement. Staff required to sign the document after discussion and completion to ensure acceptance to any action plan and agreement (or non-agreement) with observer's comments. Findings shared with team leaders and practice educators for staff awareness and understanding.
5 harms community documentation audit (adults services) – April 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit has been carried out for Quarter 1 2018/19.
Commissioning for Quality and Innovation (CQUIN) leg ulcer bundle	Best practice confirmed.
CQUIN pressure ulcer bundle	Best practice confirmed.
Safe transcribing of medicines/ medicines management – May 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit will be carried out for Quarter 3 2018/19.

High priority areas for pressure ulcer bundle – May 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit will be carried out for Quarter 3 2018/19.
Record keeping audit (children's health visiting service)	Results reported to staff for awareness and understanding. The best practice recommendation in relation to record keeping reiterated. Children and safeguarding management to review the way forward using an alert with the view of considering time limited alerts. To use clinical judgement to update and remove an alert that is not current when accessing records. Alerts reviewed each time records accessed. Each service might need to consider creating a service specific list of abbreviations. Practitioners reminded that it is essential to record consent for each episode of care. To develop service specific record keeping operating procedures for health visiting service and record at the first contact with the health visiting service that valid consent to deliver and receive the healthy child programme offer has been obtained. Any child subject to statutory arrangement should have father's details recorded and other adults living in the households. Clear guidelines must be given regarding recording father's details. The Community Services electronic patient record system team to consider updating their system to allow the capture of date of birth under 'client contacts' or create a separate screen to capture this important information. Update service specific operating procedures regarding demographics for administrative team to record father's details accurately. Practitioners to use demographic cards showing demographics and family details. To run a monthly data quality report to identify any practitioners who are regularly failing to return demographic cards. Practitioners reminded that validation of records in an essential requirement of record keeping and each record must be validated no longer than 48 hours after the episode of care. All progress notes relating to core contacts must refer to health visiting templates. Progress notes must be completed with a clear and concise plan for any future contact. Practitioners must synchronise records at every opportunity.

5 harms community documentation audit (adult services) – May 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit has been carried out for Quarter 1 2018/19.
End of life care community documentation audit (adult services) – May 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton.
Safe transcribing of medicines/ medicines management – June 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit will be carried out for Quarter 3 2018/19.
High priority areas for pressure ulcer bundle – June 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit will be carried out for Quarter 232018/19.
5 harms community documentation audit (adult services) – June 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit has been carried out for Quarter 1 2018/19.
End of life care community documentation audit (adults services) – June 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton.
Changes in clinical outcome; analysis of pulmonary rehabilitation service	Best practice confirmed.
To assess the proportion of adults seen in the tier 3 diabetes consultant clinics who are at moderate or high risk of developing a diabetic foot problem and to assess the percentage of these adults who have been either referred to the foot protection team or are already under the care of the foot protection team	Best practice confirmed.

10.3. Deaths following anti-cancer therapy

10.3.1. Purpose of monitoring

Since participating in the National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD) study the Trust has systematically continued to collect data on deaths following systemic anti-cancer therapy (SACT).

10.3.2. Aim

To track trends in the number of deaths within 30 days of receiving SACT at the Trust and deaths reported to the Trust from Quarter Two 2008/09 to Quarter One 2018/19.

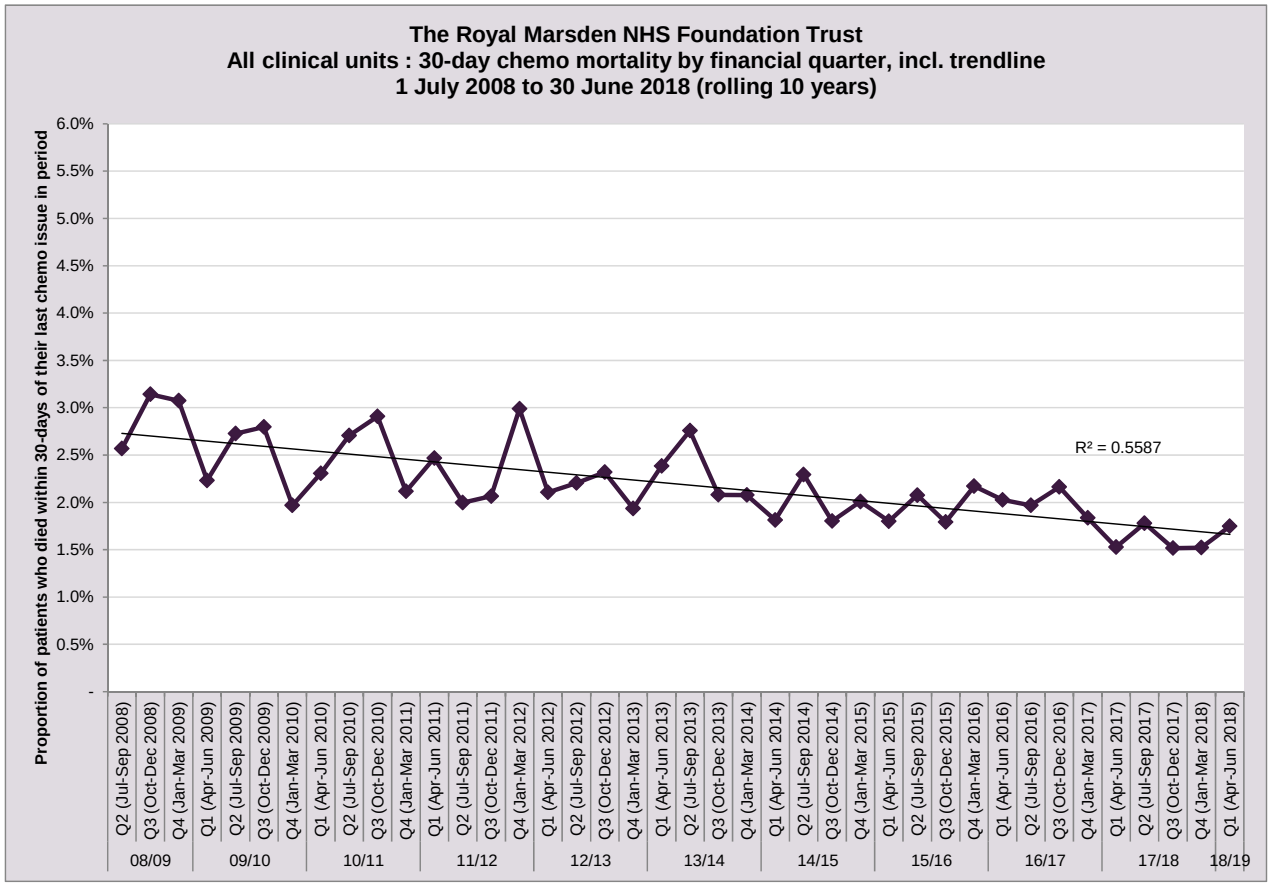
The denominator is the number of patients who were issued SACT in a given quarter. The numerator is the number of patients who, having been issued SACT in a given quarter, died within 30 days of their last SACT.

The last matching using data from the Office for National Statistics (ONS) was carried out on 2 August 2018.

10.3.3. Key points from 30-day deaths trend analysis

- Quarterly graphic representation of trends for 30-day deaths.
- The overall trend has remained stable.
- In Quarter One there were 76 deaths out of 4,348 patients (1.7%). (In Quarter Four there were 66 deaths out of 4,337 patients (1.5%).)

10.3.4. Deaths within 30 days of surgery or anaesthesia (all surgery and procedures in operating theatres)



R^2 is a statistical measure that shows how closely the trend line fits the data. The value is between 0 and 1 – the higher the value the closer the fit.

10.4. Deaths following surgery and anaesthesia

10.4.1. Purpose

To monitor death rates in the 30 days following surgery and anaesthesia (all procedures in operating theatres).

10.4.2. Aim

To track trends over time in deaths at The Royal Marsden and deaths reported to The Royal Marsden.

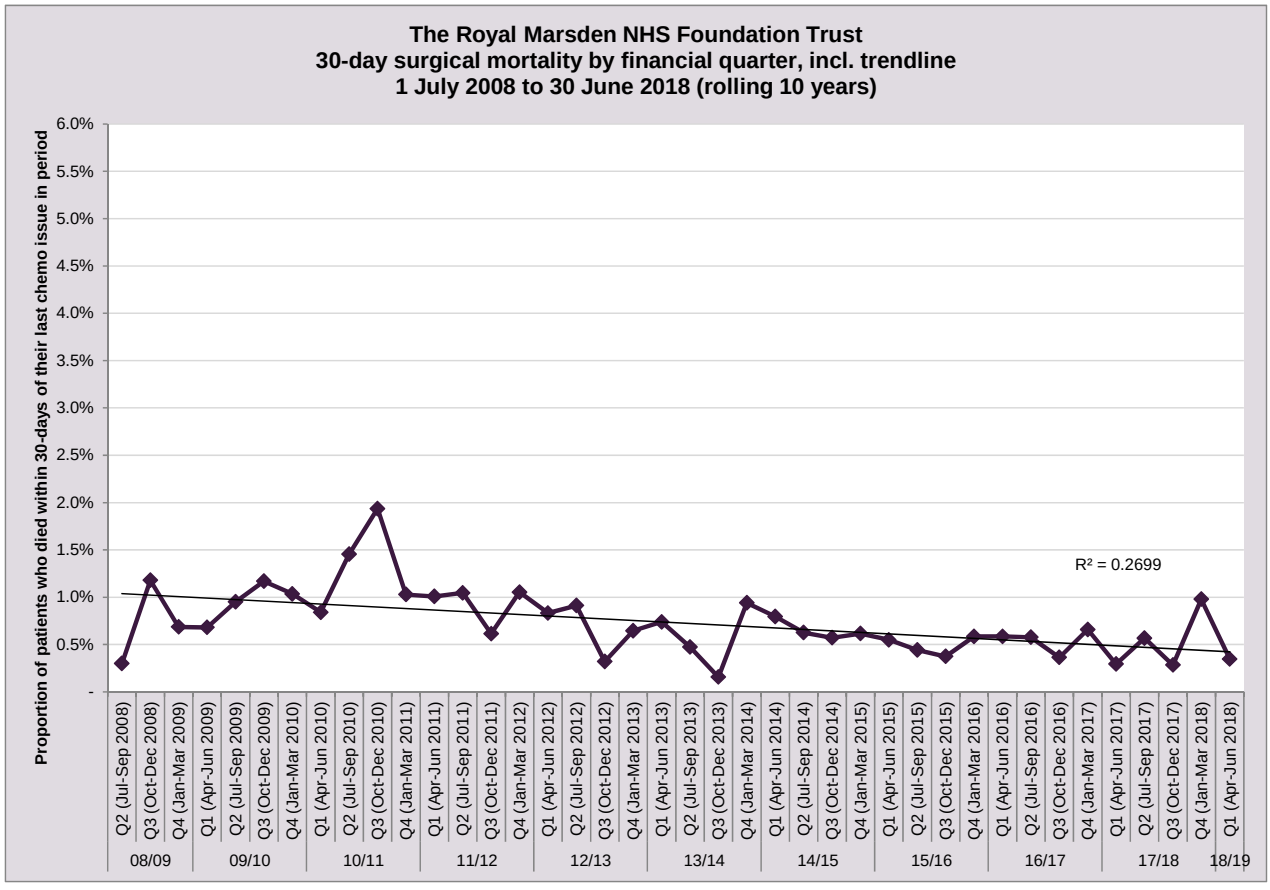
The denominator is the number of patients who had a procedure performed in theatres in a given quarter. The numerator is the number of these patients who, having undergone a theatre procedure in a given quarter, died within 30 days of their last procedure.

The last matching using data from the Office for National Statistics (ONS) was carried out on 2 August 2018.

10.4.3. Key points from 30-day deaths trend analysis

- Data are presented quarterly from Quarter Two 2008/9 to Quarter One 2018/19.
- The overall 30 days death rate has been stable.
- There was no observed trend.
- In Quarter One there were five deaths out of 1,448 patients (0.3%). (In Quarter Four there were 14 deaths out of 1,429 patients (1.0%).)

10.4.4. Deaths within 30 days of surgery or anaesthesia (all surgery and procedures in operating theatres)



R^2 is a statistical measure that shows how closely the trend line fits the data. The value is between 0 and 1 – the higher the value the closer the fit.

10.4.5. Actions

All deaths and complications were reviewed at the Surgical Audit Group to identify deficiencies in management and appropriateness of decision to operate. Selection criteria have been refined for high-risk patients and interventions, particularly for those patients in the latter phase of disease.

10.5. Deaths following stem cell transplantation

10.5.1. Purpose

To monitor the death rates for patients undergoing this highly specialised and intensive form of therapy. To identify the primary cause of death, whether it was from disease progression or resulting from the stem cell transplant, and to show the breakdown of patients and types of transplants undertaken.

10.5.2. Aim

To track trends in deaths at The Royal Marsden and deaths reported to The Royal Marsden within the first 100 days of stem cell transplantation (SCT) from quarterly raw data.

10.5.3. The number of transplants recorded in this quarter (April to June 2018) was 63 but to analyse 100-day mortality it is necessary to consider the transplants undertaken in the previous quarter (January to March 2018). This allows all patients to have reached 100 days post-transplant by the time this report is prepared. For example, a patient having a transplant on 31st March 2018 would reach 100 days on 9th July 2018.

10.5.4. The final number of recorded transplants carried out from January to March 2018 was 64 (56 adult and 8 paediatric patients).

10.5.5. The breakdown of transplant types, number of deaths within 100 days of transplant and the cause of death for January to March 2018 is given below.

Adults

Transplant type	Number of transplants	Number of adult deaths at 100 days post-transplant	Overall TRM* percentage	Disease relapse or progression
Autologous†	40	0	**0%**	0%
Allogeneic‡ (all types)	16	1	**6%**	0
– Allogeneic – unrelated donor	10	0	**0%**	**0**
– Allogeneic – related donor	4	0	**0%**	**0**
– Allogeneic – cord blood	2	1	**50%**	**0**

Paediatric Transplant type	Number of transplants	Number of paediatric deaths at 100 days post-transplant	Overall TRM* percentage	Disease relapse or progression
Autologous†	3	0	**0%**	0
Allogeneic‡ (all types)	5	0	**0%**	0
– Allogeneic – unrelated donor	1	0	**0%**	0
– Allogeneic – related donor	3	0	**0%**	0
– Allogeneic – cord blood	1	0	**0%**	0

* TRM: Transplant related mortality
† Autologous transplant: the patient's own cells are returned.
‡ Allogeneic transplant: a donor's cells are used.

10.5.6. The adult patient who died within 100 days following the transplant received an allogeneic, cord blood transplant for T-cell lymphoblastic leukaemia but died at day 86 from infection.

10.5.7. There were no deaths recorded for paediatric patients receiving a stem cell transplant during the January to March period.

10.5.8. Key points from 100-day deaths trend analysis

- The overall 100-day death rate has been stable.
- The trend in 100-day mortality figures is stable. However, because of the relatively small numbers, the results need to be interpreted with care and are not statistically significant.
- The number of deaths in children and adults each quarter is small and in keeping with European literature.

10.5.9. Actions

The 100-day mortality figures are presented and discussed at the Haematopoietic Stem Cell Transplant (HSCT) Committee meeting, the quality committee for the external JACIE accreditation (the Joint Accreditation Committee of the International Society for Cellular Therapy (ISCT) and the European Group for Blood and Marrow Transplantation (EBMT)) and are signed off as agreed by the JACIE Clinical Programme Director.

All cases are reviewed at the monthly Morbidity and Mortality Meeting to ensure that learning points are discussed and that action points are disseminated to the combined medical, nursing, pharmacy and quality teams.

10.6. National Institute for Health and Care Excellence (NICE)

10.6.1. The National Institute for Health and Care Excellence (NICE) provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. Further details about NICE and its work programmes are available at the NICE website www.nice.org.uk.

10.6.2. NICE standards assist the Trust in reviewing current practice against the latest standards and ensuring is safe, effective and responsive to people's needs.

10.6.3. NICE published 26 items of guidance which were presented to the Integrated Governance and Risk Management Committee (IGRM) in Quarter One. After the guidance was reviewed, six items were deemed relevant and four items were still under review at the time of reporting.

Type of guidance	Seen at IGRM	Under review	Reviewed and deemed not relevant	Reviewed and deemed relevant	Fully compliant*	Partially compliant*
Clinical guideline	5	2	2	1	0	1
Diagnostics guidance	1	0	1	0	0	0
Highly Specialised Technologies	0	0	0	0	0	0
Interventional procedures	9	1	8	0	0	0
Medical technologies	1	0	1	0	0	0
NICE guideline	10	1	4	5	2	3
Total	**26**	**4**	**16**	**6**	**2**	**4**

* For items deemed relevant

10.6.4. The IGRM committee also allocates NICE quality standards to clinical leads to review. During Quarter One there were eight quality standards published by NICE.

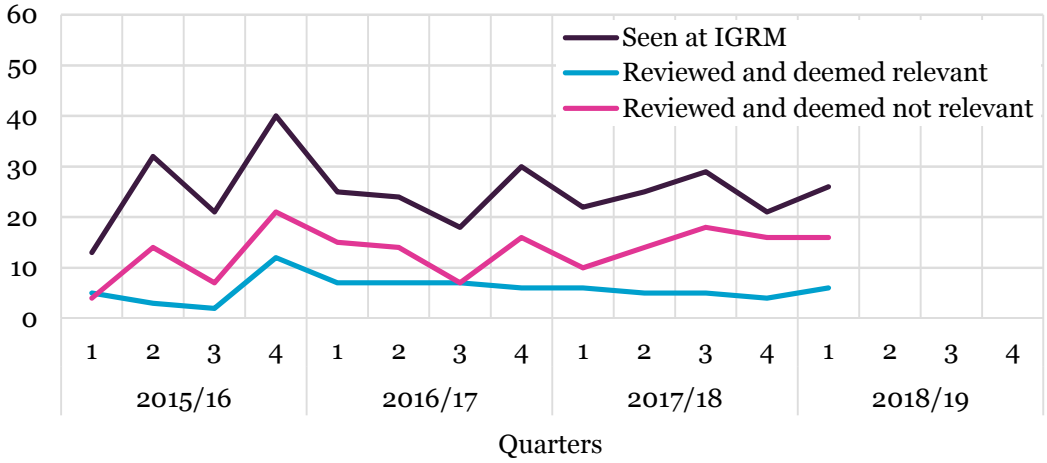
Type of guidance	Seen at IGRM	Under review	Reviewed and deemed not relevant	Reviewed and deemed relevant	Fully compliant*	Partially compliant*
Quality standards	8	3	3	2	1	1

* For items deemed relevant

10.6.5. NICE describes quality standards as a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. The quality standards are derived from high-quality guidance such as that from NICE or sources accredited by NICE. Quality standards are developed independently by NICE in collaboration with healthcare professionals and public health and social care practitioners, their partners and service users. Information on priority areas, people's experience of using services, safety issues, equality and cost impact are also considered during the development process.

10.6.6. NICE quality standards are central to supporting the Government's vision for a health and social care system focussed on delivering the best possible outcomes for people who use services, as detailed in the Health and Social Care Act 2012.

10.6.7. The chart shows the number of items of guidance and quality standards from NICE reviewed since 2015/16 by quarter.



10.7. Information governance

10.7.1. Information Governance Committee

The Trust Information Governance training compliance is currently 94%, which is within acceptable tolerance at this stage of the year. Systems are in place to monitor compliance.

The Information Governance Committee meets regularly to discuss incidents, policy approval, data quality, clinical records management, subject access requests, freedom of information requests, the Information Governance Toolkit, audits and other topics. There were no meetings of the committee in Quarter One due to the focus work related to the General Data Protection Regulation (GDPR).

10.7.2. Data Security and Protection Toolkit

The Information Governance Toolkit has gone through significant change this year. The toolkit has been completely re-designed and renamed *Data Security and Protection Toolkit (DSPT)*. The requirements of the DSPT are designed to encompass the National Data Guardian review's 10 data security standards. The DSPT supports key requirements under the GDPR, identified in the NHS GDPR checklist

The Information Governance Toolkit assessed performance against three levels. Organisations were required to provide evidence of compliance with at least level 2 for all elements of their assessment. The DSPT does not include levels and instead requires compliance with assertions and (mandatory) evidence items.

The assertions and evidence items are designed to be concise and unambiguous. Documentary evidence is only requested where this adds value.

NHS Digital requires NHS organisations to submit annually in order to measure compliance. This year's submission consists of two stages throughout the financial year:

– baseline and performance update (end of October)

– final submission (end of March).

Trusts' scores are available to the general public and to bodies such as

– NHS Digital

– NHS Improvement

– The Care Quality Commission

– The Information Commissioner's Office

The Care Quality Commission's well led inspections will include data security, but details had not been finalised.

10.7.3. General Data Protection Regulation (GDPR) Project

On 25 May 2018, the UK's data protection legislation changed. The introduction of the General Data Protection Regulation (GDPR) is the first major change to data protection law for twenty years. In addition to this, the Data Protection Act 2018 received royal accent on the 23 May. This contains all the sections in GDPR with some amendments negotiated by UK government called derivations.

The Information Commissioners Office is the UK regulator for information rights and data protection law. Following GDPR, the Information Commissioner's Office can issue fines of up to €20,000,000 or 4% for serious breaches of the Data Protection Act and Privacy and Electronic Communications Regulations.

The GDPR Task and Finish Group has agreed an action plan to work towards compliance with the GDPR which consists of the following themes:

- raising awareness/being open and transparent
- information mapping/information asset register
- managing consent
- individual rights
- data security and breaches
- appointment of a Data Protection Officer
- review contractual arrangements with suppliers and partners.

A list of actions is presented under each theme with assigned owners and due dates. Progress in completing the actions is closely monitored by the GDPR Task and Finish Group which meets on a fortnightly basis.

The Trust Secretary has been appointed as the Trust's Data Protection Officer and has reported on progress in this area to the Board sub-committees: the Quality, Assurance and Risk Committee and the Audit and Finance Committee. GDPR compliance has also been added to the Trust Risk Register.

10.7.4. Incident management and enforcement

The Information Commissioner's Office has had the powers to fine organisations since 2010 and The Royal Marsden to date has not incurred any fines.

The Information Commissioner's Office also has the power to issue undertakings, which commit an organisation to a particular course of action in order to improve its compliance and enforcements notices. Enforcement notices are issued to organisations in breach of legislation, requiring them to take specified steps to ensure that they comply with the law. The Royal Marsden has not received any enforcement notices or undertakings to date.

10.8. Freedom of information

The Freedom of Information Act 2000 gives the public a right of access to information held by public authorities about their activities. The Act sets out that public authorities must respond to such requests within 20 working days.

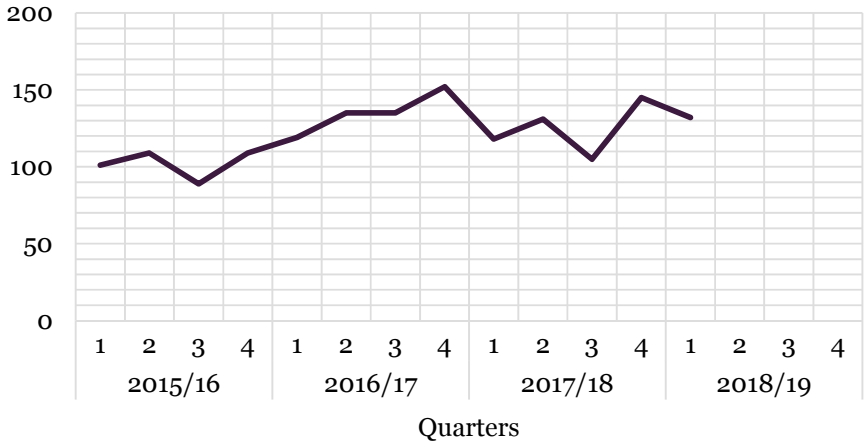
10.8.1. Requests received under the Freedom of Information Act 2000

The Trust received 132 requests during Quarter One, compared to 145 in the final Quarter of the previous year. Of the 132 requests received in Quarter One, 130 were answered within 20 working days (98.4%).

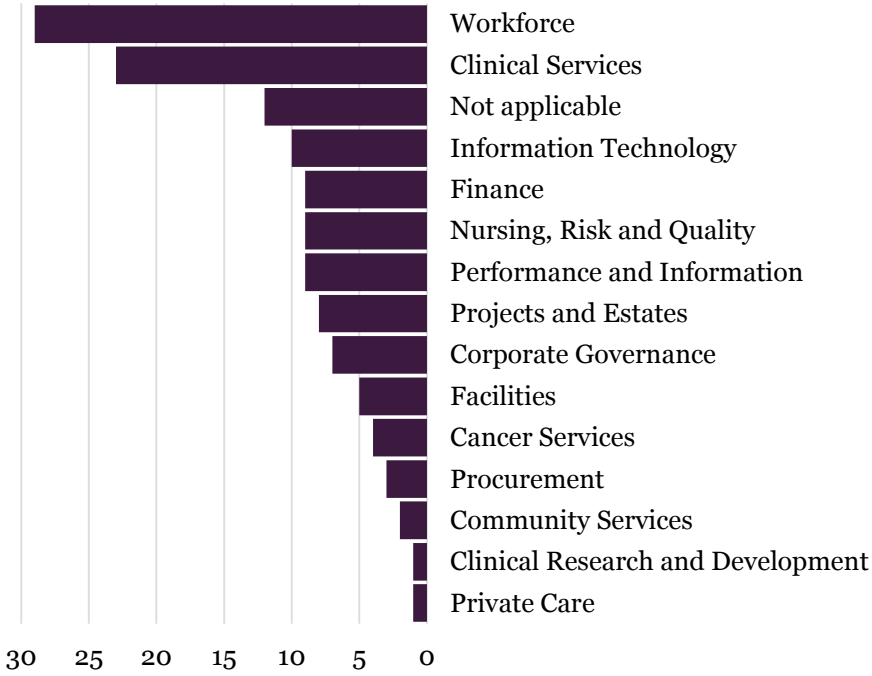
The requests in Quarter One had the following outcomes:

Disclosed	88
Partial	20
Not applicable to The Royal Marsden	15
Information not held or clarification sought	5
Refused – exemption or too expensive to answer	4
Total	**132**

10.8.2. Number of requests received by quarter



10.8.3. Number of requests by directorate and division

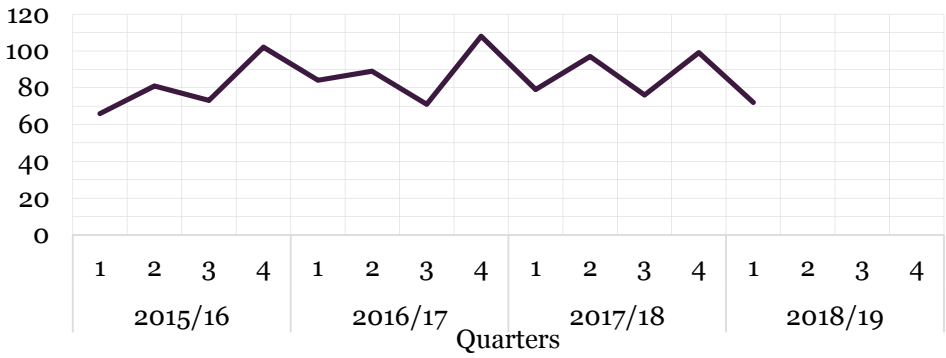


10.9. Access to patient records

10.9.1. The Data Protection Act 1998 requires that patients be given the right of access to and copies of their own medical records.

10.9.2. This quarter the Trust received 72 requests for personal disclosure of medical records for hospital patients. (This excludes notes required by other hospitals and those required for litigation purposes.)

10.9.3. The chart shows the number of requests received for hospital patients each quarter since 2015/16.



10.10. Radiotherapy

10.10.1. The Radiotherapy Service is certified to the ISO9001:2015 quality standard by the British Standards Institute (BSI) and is assessed by an external auditor twice a year.

10.10.2. Following the last assessment by BSI in March, a new certificate has been received and issued around the Trust. This will remain valid until May 2021 pending further six-monthly assessment visits. The next assessment will be over two days and has been planned to take place in September in Sutton and Chelsea.

10.10.3. Four internal audits were planned for the quarter. Three were completed, covering prostate, and gynaecology patient pathways plus one imaging audit. A forth audit at Sutton covering skin pathway remains ongoing as only two patients were undergoing treatment at the date of audit. Nine minor non-conformances are in the process of being closed and will be followed up at the next meeting of the Multiprofessional Team Quality Assurance (Radiotherapy) Committee (MPT QART).

10.10.4. A number of clinical protocols require review and update. Over the quarter these have been issued to appropriate consultants and are now being amended where needed. This will also be monitored at future MPT QART meetings.

10.10.5. This quarter 39 incidents were raised on the Trust's incident reporting system (compared with 48 in the previous quarter). Incidents are coded using the *Towards Safer Radiotherapy* classification system, which allows comparable reporting across the industry. Five were graded as *low* severity and 34 as *very low*, severity. These were reviewed and discussed at the latest MPT QART meeting as part of root cause analysis and agreement reached on any appropriate corrective actions required.

10.10.6. There were no reportable radiation incidents in the quarter.

10.10.7. No complaints relating to Radiotherapy were received but 19 letters or cards of praise for the service were recorded within the quarter.

10.10.8. Since April 2005 all Radiotherapy waiting times for both palliative and radical treatment have been within the 14 day and 28 day target (as set out in the Manual of Cancer Standards).

10.10.9. The table below shows the number of radiotherapy appointments for Quarter One 2018/19.

		2018/19		
Appointments (number)		**Apr**	**May**	**Jun**
Chelsea	Palliative*	41	43	44
	Radical†	153	125	145
	Urgent‡	0	0	3
	Total	**194**	**168**	**192**
Sutton	Palliative	72	74	50
	Radical	212	190	210
	Urgent	5	4	2
	Total	**289**	**268**	**262**
Grand total		**483**	**436**	**454**

* Palliative: treatment intended for alleviation of symptoms
† Radical: treatment intended to cure or eradicate underlying disease
‡ Urgent: treatment given where a beneficial clinical effect can be achieved for a short period of time. The only common example is radiotherapy given within 24 hours for patients with metastatic cord compression.

10.10.10. The table below shows radiotherapy waiting times for the financial year 2017/18 Quarter One 2018/19.

			2018/19		
Average waiting time (days)			**Apr**	**May**	**Jun**
Chelsea	Radical	All*	14.5	15.2	14.4
	Radical	No delay*	20.2	18.3	16.9
	Palliative	All	3.5	4.3	3.4
	Palliative	No delay	3.9	5.1	4.1
Sutton	Radical	All	15.8	15.2	17.8
	Radical	No delay	21.4	19.2	21.9
	Palliative	All	3.8	3.9	3.6
	Palliative	No delay	4.3	4.6	4.0

* **All**: all patients receiving radiotherapy. Within this are two groups:

firstly, those patients who receive radiotherapy as part of a range of other treatments (such as surgery or chemotherapy). The radiotherapy is scheduled to fit in with the whole package of treatments.

secondly **No delay**: those patients for whom radiotherapy is the first definitive treatment and who are only waiting for radiotherapy (i.e. not delayed by other treatments).

10.11. Chemotherapy

10.11.1. The Chemotherapy service is certified to the ISO9001:2015 quality standard and is assessed by an external auditor from the British Standards Institute (BSI) twice a year.

10.11.2. The delayed final part of the last BSI inspection went ahead as rescheduled on 16 April. The inspection concluded that all aspects of the service complied fully with the requirements of ISO9001:2015 and the transition to this latest standard was completed. New certificates have since been issued and circulated around the Trust. No non-conformities were raised and the next inspection was planned for 29 October 2018.

10.11.3. Internal auditing continued during the quarter with three audits covering Bud Flanagan West, the Sir William Rous Unit at Kingston and the Pharmacy Stores at Sutton. Six minor non-conformities were raised that have all since been closed.

10.11.4. Incidents are reported in accordance with Trust policy using the Datix Incident Reporting System, which is used to analyse incident details. In the quarter, 125 incidents relating to the multidisciplinary chemotherapy service were recorded compared to 137 in the previous quarter. Seventy-five were graded *very low,* 49 as *low* and one as *moderate*.

10.11.5. One hundred and eleven of the incidents related to medication issues. In accordance with Trust policy, actions were agreed to ensure lessons are learned following any incident. The incidents will be reviewed at the next Quality Assurance in Chemotherapy Services Committee meeting.

10.11.6. No complaints were received in the quarter and 89 letters of praise and thanks from patients were logged.

10.11.7. Waiting times have been monitored for a number of years and discussed by the Quality Assurance in Chemotherapy Services Committee. Waiting times include a number of steps which take place before administering chemotherapy:-

- taking blood and awaiting results
- consultation with doctor
- chemotherapy preparation by pharmacy.

10.11.8. Total wait time is largely dependent on whether a patient chooses to have all these steps on the same day (one stop) or whether the cycle of chemotherapy is given on a separate day after preparation (two stop).

10.11.9. One stop patients wait longer as chemotherapy cannot be given until all preparation tasks are complete which typically takes 3 to 5 hours. Most patients prefer the one stop option, if geography allows, as this saves two separate visits to the hospital. Patients can be issued with a pager so allowing them to leave the site whilst preparation takes place.

10.11.10. The number of chemotherapy appointments is rising across all sites. The overall target of no more than five per cent of patients waiting more than four hours for treatment was missed at eight per cent as shown in the tables below, although individual units show some fluctuations.

10.11.11. The table below shows the number of chemotherapy appointments with waiting times longer than four hours for the financial year 2017/18.

Appointments	Total appointments	Appointment waits over 4 hours	Percentage waits over 4 hours
Medical Day Unit (Chelsea)	**2,528**	439	17%
Granard House Day Unit	**1,359**	77	6%
Homecare	**28**	0	0%
Private Care Centre	**97**	10	10%
Wiltshaw Ward Consulting Room	**3**	0	0%
Main Outpatients	**82**	0	0%
Ambulatory Inpatients (Bud Flanagan West)	**55**	13	24%
Children's Day Unit	**1,018**	33	3%
Bud Flanagan Ambulatory Care Unit	**662**	111	17%
Kennaway Day Unit	**323**	1	<1%
Medical Day Unit (Sutton)	**2,260**	0	0%
Robert Tiffany Day Unit	**743**	7	1%
West Wing Day Unit	**429**	3	1%
Oak Day Unit	**155**	110	71%
Mobile Chemotherapy Unit	**126**	0	0%
IV Services (Sutton)	**0**	0	-
Teenage Cancer Trust Unit	**0**	0	-
Sir William Rous Unit	**740**	0	0%
Total	**10,608**	**804**	**8%**

10.11.12. The table below shows chemotherapy waiting times (from patient's arrival in clinic to start of treatment) for the financial year 2017/18.

Appointments	No waiting	1min-1hr	>1hr -2hrs	>2hrs -3hrs	>3hrs -4hrs	>4hrs -5hrs	>5hrs -6hrs	>6hrs -8hrs	Over 8hrs
Medical Day Unit (Chelsea)	272	1,199	288	133	197	242	135	59	3
Granard House Day Unit	107	457	353	236	129	53	18	6	0
Homecare	0	28	0	0	0	0	0	0	0
Private Care Centre	4	25	31	21	6	8	0	2	0
Wiltshaw Ward Consulting Room	0	2	0	0	1	0	0	0	0
Main Outpatients	10	59	12	1	0	0	0	0	0
Ambulatory Inpatients (Bud Flanagan West)	3	32	2	2	3	3	5	5	0
Children's Day Unit	196	428	215	108	38	23	5	5	0
Bud Flanagan Ambulatory Care Unit	55	229	129	69	69	59	33	18	1
Kennaway Day Unit	42	234	35	10	1	0	1	0	0
Medical Day Unit (Sutton)	859	1,398	2	0	1	0	0	0	0
Robert Tiffany Day Unit	133	431	118	45	9	6	0	1	0
West Wing Day Unit	16	254	103	41	12	3	0	0	0
Oak Day Unit	1	10	8	12	14	22	41	42	5
Mobile Chemotherapy Unit	26	98	2	0	0	0	0	0	0
IV Services (Sutton)	0	0	0	0	0	0	0	0	0
Teenage Cancer Trust Unit	0	0	0	0	0	0	0	0	0
Sir William Rous Unit	77	591	69	2	1	0	0	0	0
Total	**1,801**	**5,475**	**1,367**	**680**	**481**	**419**	**238**	**138**	**9**

10.12. JACIE accreditation

10.12.1. The Joint Accreditation Committee of the International Society for Cellular Therapy (ISCT) and the European Group for Blood and Marrow Transplantation (EBMT) (known as JACIE) promotes high-quality patient care and laboratory performance in haematopoietic stem cell collection, processing and transplantation centres through voluntary accreditation. The Royal Marsden service was first accredited in June 2009.

10.12.2. The full inspection of the Stem Cell Transplant service last November highlighted many areas of good practice but also some raised some points where improvement was needed. Over the quarter, work has continued to address these improvement actions. At the end of June the majority of more minor issues had largely been addressed but work continues to complete larger scale changes:

- *The introduction of a new information technology (IT) system that is capable of producing ISBT 128 compliant labels and greatly improves IT capabilities across the service. (ISBT 128 is an international information standard for use with medical products of human origin.)*

  This project involves complex procurement, installation and commissioning processes and will take some time to complete. Contract agreement is in late stages and will be followed by submission of a project plan. These items will be submitted to JACIE as evidence that we are "actively implementing" a system for production of compliant labelling. Once complete this project will not only satisfy JACIE requirements but will represent a significant upgrade to current systems.

- *Plans to improve the Stem Cell Laboratory reception and storage space were prepared that would have satisfied JACIE requirements.*

  However, it has since been agreed that further improvements need to be made. A more comprehensive plan has been proposed that would address all the JACIE recommendations and in addition provide a significant improvement to clean room facilities. Due to the more extensive nature of the proposed improvement, this work is estimated that work will be completed in September 2019. Plans have been submitted to the JACIE committee for consideration and approval. Although this represents a delay in addressing the inspection findings, it is hoped that this will be accepted as a more comprehensive and beneficial longer-term solution.

- *A planned upgrade to the Q-Pulse document management IT system has begun with the provision of a new server.*

  The web-based version of Q-Pulse is undergoing further development by the suppliers and is not yet recommended. The current plan is to upgrade to the previous non-web-based version as an interim step and complete a further upgrade when this is fully tested and available.

10.12.3. JACIE has classified the Trust as *pending re-accreditation* until the accreditation committee has had an opportunity to review and approve the work currently in progress. The latest documentary evidence will be submitted by 5 August.

10.12.4. Internal quality audits of processes are carried out regularly covering all areas of the transplantation service. Seven further audits were completed in Quarter One Reports and findings are reviewed at Haematopoietic Stem Cell Transplant (HSCT) and Stem Cell User Group meetings.

10.12.5. The HSCT unit continued to identify, evaluate and report errors, accidents, and suspected reactions, which are reported through the Trust's electronic incident reporting system and discussed at the HSCT Committee and at the Haemato-oncology Risk Management Committee. During the quarter 34 incidents attributable to transplant patients were raised. All these incidents were graded as *very low* (21) or *low* (13). The largest category was medication incidents which accounted for 16 (47%) of the total.

10.12.6. Deviations from standard operating procedures are brought to the HSCT Committee for discussion and sign-off. In Quarter One three planned and three unplanned deviations were recorded. It was agreed by the committee that unplanned deviations will be logged as incidents in future.

10.12.7. No transplant related complaints were received during this quarter.

10.12.8. Imaging Services Accreditation Scheme (ISAS)

10.12.9. All the recommendations made after the inspection of November 2017 have been implemented.

10.12.10. The Imaging and Quality Assurance teams are continuing to gather documentary evidence needed to complete the United Kingdom Accreditation Service (UKAS) web-based assessment tool. Several hundred documents have been uploaded already and work is now well underway to link these documents to the assessments being written for each clause of the standard. This has also provided the opportunity to review and update a number of procedural documents and to archive evidence from previous submissions to ensure the web based document box is current and well organised.

10.12.11. It is intended that this work will be completed by the end of August to meet the September deadline for submission.

10.12.12. The Quality Assurance in Diagnostic Imaging Services (QADIS) Meetings took place as planned on 12 April and 19 June. Progress of the ISAS submission was reviewed together with a number of other quality objectives. An additional meeting has been planned for July to consider the requirements and organisation for internal auditing.

10.12.13. Incidents are reported in accordance with Trust policy using the Trust's incident reporting system. In the quarter 56 incidents relating to imaging services were recorded compared to 59 in the previous quarter. Thirty-one were graded *very low* and 24 as *low*. One case was classed as *moderate* grade and was discussed at the Discrepancy Review Meeting.

10.12.14. Over the quarter no complaints relating to imaging services were received; two letters of praise and thanks were logged.

10.13. Research governance

10.13.1. Research sponsor

Trust sponsorship was awarded to the following eight projects:

Reference number	Title	Single or multiple centre
CCR4888	PRISM - Prostate Radiotherapy Integrated with Simultaneous MRI	Single
CCR4911	EMIT -Exploratory study of molecular characterisation in patients with metastatic Germ Cell Tumours refractory/resistant to platinum treatment	Single
CCR4927	Gustatory function following Radiotherapy to the head and neck: A prospective longitudinal study	Single
CCR4930	TRIGGERS - Assessing the sensitivity and acceptability of the Royal Marsden Palliative Care Referral 'Triggers' Tool and Integrated Palliative Care Service for patients with cancer	Single
CCR4937	Testicular Cancer Post-Treatment Symptoms and Quality of Life Study	Single
CCR4884	PAVEMENT - Phase Ib Study of Palbociclib and Avelumab in Metastatic AR+ triple negative breast cancer	Multiple
CCR4939	MONITOR-UK: Multi-centre Observational study of maintenance Niraparib In Treatment of Ovarian CanceR	Multiple

CCR4825	SOlAR: A translational phase II study of Single agent OLaparib or single agent ATR INHIBITOR AZD6738 in the second or subsequent line treatment of advanced oesophageal, gastro-oesophageal junction and gastric cancer.	Multiple

10.13.2. Suspected unexpected serious adverse drug reactions

The following is a breakdown by study of the 15 suspected unexpected serious adverse drug reactions (SUSARs) that occurred in the quarter, of which so far no further action has been required.

Study code	Total number of SUSARs	Number of SUSARs which required no further action	Number of SUSARS which required further monitoring	Number of SUSARs requiring flagging to a REC*
JB57	1	1	0	0
JB58	1	1	0	0
JL04	4	4	0	0
KB1	1	1	0	0
MA2	1	1	0	0
MG1	1	1	0	0
NT2	3	3	0	0
UB18	1	1	0	0
UB19	1	1	0	0
UB7	1	1	0	0

* REC: Research ethics committee

10.14. Human Tissue Authority – human application licence

10.14.1. Compliance

The Stem Cell Transplant facility is licensed by the Human Tissue Authority (HTA) for the use of stem cells in human application. The last inspection took place in September 2016 resulting in renewal of the licence. The next inspection was due in August 2018 but has been delayed by the HTA until early in 2019.

The department is required to adhere to regulatory requirements covering the procurement, testing, processing, storage, therapeutic use and disposal of stem cells. Compliance with HTA regulations ensures that patient welfare is the focus of the Trust's work and that stem cell harvesting and transplantation are performed safely and effectively following proper consent. Compliance requires an appropriately qualified team of personnel working to high standards to ensure the best possible service provision.

An application has been submitted to the HTA to extend the human application licence to include collection of additional tissue types for planned cellular therapy trials.

A supplier has been awarded the contract to provide a specialist stem cell transplant programme IT system to meet JACIE and HTA requirements. Contracts are being finalised and an implementation plan is being prepared.

10.14.2. Quality improvement – audits

Audits are integral to the stem cell transplant quality management programme.

Audits carried out during the quarter in addition to monthly fire safety audits and quarterly health and safety audits:

– *An audit of additional in-process environmental testing in the clean room*

  Following the detection of contamination in the clean room additional environmental testing was performed. No fungal growth was detected but some minor changes were made to cleaning schedules as two areas of low-level bacterial contamination were noted.

– *Audit of the effectiveness of the Quality Management Programme*

  This is an audit required by regulatory bodies. The quality management programme was found to be effective.

– *Audit of external facilities performing services for the Stem Cell Laboratory*

  Four external suppliers who provide services to the stem cell laboratory were audited to check that contracts are in place and valid, that a purchase order exists if required, that deliveries take place according to the contract and that delivery notes are provided. The results showed that suppliers met requirements.

– *Audit of CD34+ dose infused and time to engraftment 2017*

  Results of this audit showed that engraftment took place within acceptable limits.

– *Audit of CD34 potency and stability in cryopreserved hematopoietic progenitor cell (HPC) products*

  An annual audit is performed to check that stem cells - which are stored for up to ten years - show no loss of viability or potency over this time. The results of the audit were within acceptable limits.

– *Audit of standard operating procedure reading in the Stem Cell Laboratory*

  Although an improvement was seen since the previous audit, some staff are still failing to read and sign new versions of standard operating procedures. This will be re-audited.

10.14.3. Adverse events, reactions and incidents

Under the European Union Tissue and Cells Directive (EUTCD) the HTA maintains a system for tissue establishments to report serious adverse events and reactions. The Stem Cell Transplant Laboratory collates, evaluates and investigates errors, accidents and incidents according to Trust protocols, and in order to comply with HTA regulations. During this quarter three incidents were reported to the HTA.

Two incidents involved the loss of small quantities of patient's stem cells during thawing and infusion on the ward. Neither of these resulted in delayed stem cell engraftment.

The third incident involves the detection of a contaminant in the clean room. Full fumigation of the area was performed. The HTA are monitoring the outcome of further environmental testing.

10.15. Clinic waiting times

10.15.1. Standard

At the outpatient clinic 90% of patients should be seen within 30 minutes of appointment time.

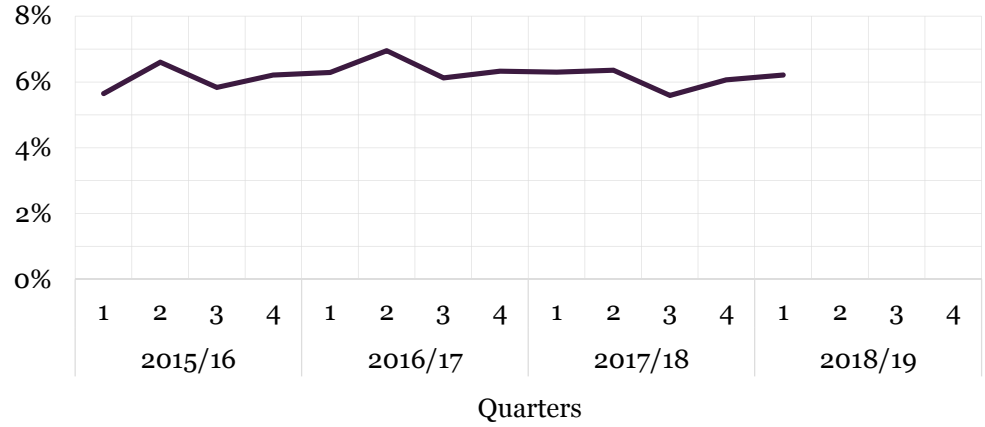
10.15.2. Waiting times

	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	Quarter 1 2018/19
Total (all patients seen in outpatient clinics)	41,725	42,487	42,940	43,756	44,421
Patients seen in 30 minutes or less	34,856 (83.5%)	35,660 (83.9%)	37,491 (87.3%)	37,758 (86.3%)	39,064 (87.9%)
Patients seen after 30 minutes and up to 1 hour	4,693 (11.2%)	4,583 (10.8%)	3,597 (8.4%)	3,785 (8.7%)	3,398 (7.6%)
Patients seen after 1 hour	2,176 (5.2%)	2,244 (5.3%)	1,852 (4.3%)	2,213 (5.1%)	1,959 (4.4%)

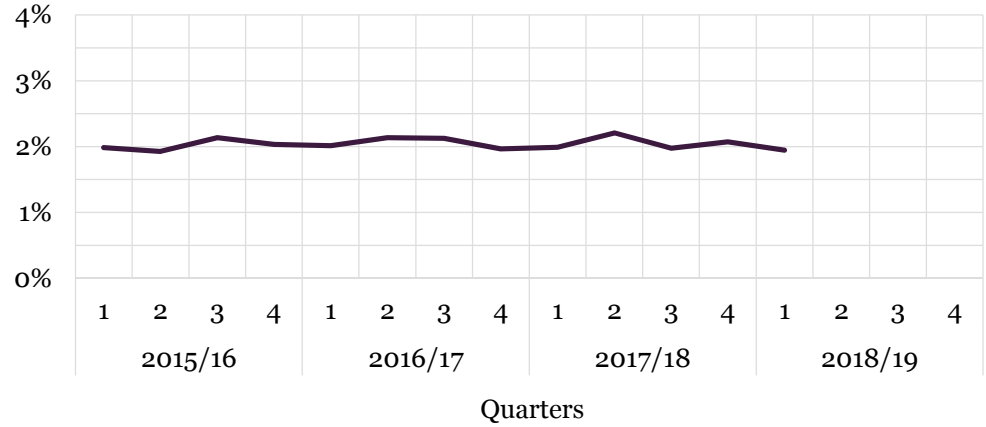
Monitoring sample: NHS patients included in the computerised booking system (excluding Bud Flanagan outpatients and invalid records) including the clinic types: consultant, nurse and professions allied to medicine e.g. physiotherapy.

10.16. Outpatient non-attendances

10.16.1. Non-attendance at first appointment

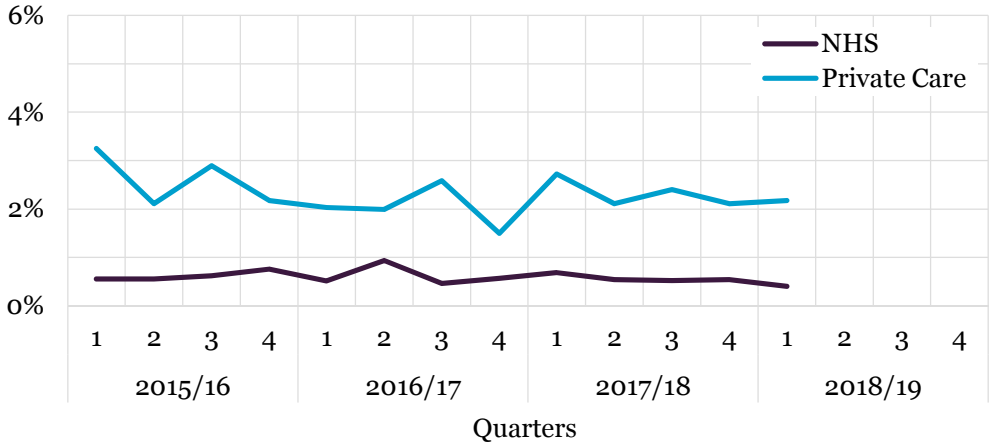


10.16.2. Non-attendance at subsequent appointment



10.17. Consultant clinics cancelled less than 15 days before planned date

10.17.1. In the quarter 0.40% of NHS clinics (20 out of 4,976) and 2.17% of private care clinics (46 out of 2,117) were cancelled less than 15 days before the planned date. The chart shows the percentages of clinics cancelled less than 15 days before planned date for the most recent financial years.



10.17.2. Reasons for cancellation this quarter

Reason	NHS		Private care		Total	
	Clinics cancelled	Appointments affected	Clinics cancelled	Appointments affected	Clinics cancelled	Appointments affected
Doctor on annual leave	12	60	35	127	47	187
Clinic day changed	5	35	3	22	8	57
Doctor attending conference	2	11	4	7	6	18
Doctor attending meeting	0	0	3	12	3	12
Doctor on study leave	1	3	1	2	2	5
Total	**20**	**109**	**46**	**170**	**66**	**279**

11. Concerns, incidents and clinical legal services

11.1. Concerns and complaints

All expressions of dissatisfaction are classed as concerns or complaints according to the issues raised and the level of investigation required.

11.1.1. Concerns

Concerns are expressions of dissatisfaction that can be resolved by Patient, Advice and Liaison Service (PALS) officers or the Complaints Team and do not require a written response.

11.1.2. Number of concerns received this quarter

	Chelsea	Sutton	Community Services	Total
Concerns relating to NHS patients	44	43	3	90
Concerns relating to private care patients	9	0	Not applicable	9
Total	**53**	**43**	**3**	**99**

11.1.3. Complaints

Complaints are expressions of dissatisfaction that require investigation and a written response or a meeting. The following sections give details of the complaints received and completed this quarter.

Each complaint is categorised by its main subject. A letter of complaint may contain more than one subject and relate to more than one service area.

11.1.4. Standard

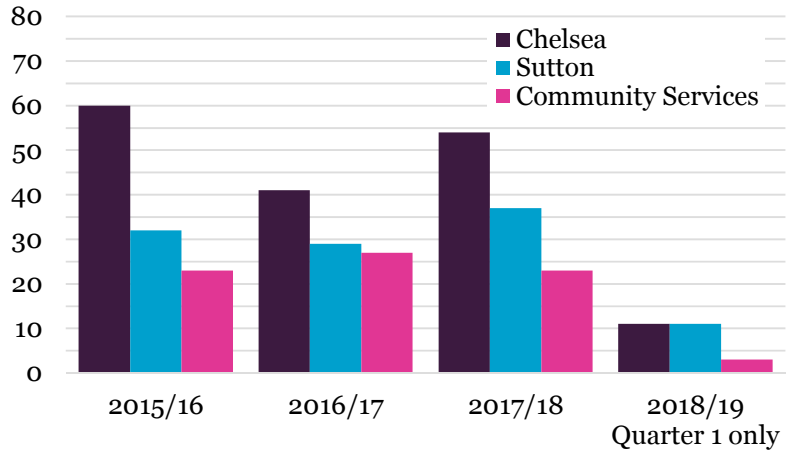
It is a Trust standard that all complainants receive

- a personal acknowledgement within three working days
- a full response with a deadline agreed with the complainant (25 working days is considered best practice for written responses)
- regular/frequent progress reports
- information about their right to further redress if not satisfied.

11.1.5. Number of complaints received this quarter (NHS patients)

	Chelsea	Sutton	Community Services	Total
Complaints received	11	11	3	**25**
Complaints acknowledged within three working days	11 (100%)	11 (100%)	3 (100%)	**25 (100%)**

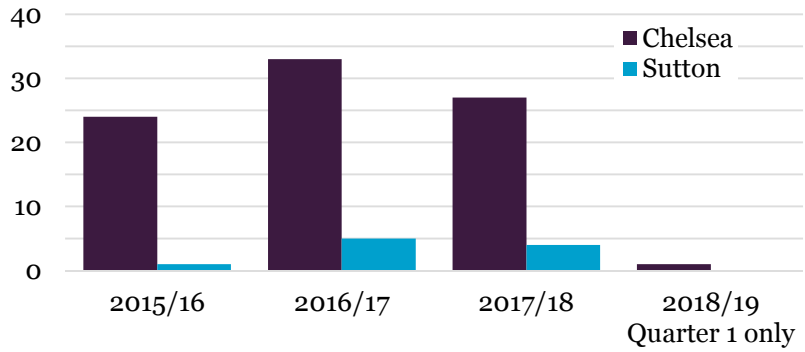
11.1.6. Number of complaints by financial year and site (NHS patients)



11.1.7. Number of complaints received this quarter (private care patients)

	Chelsea	Sutton	Total
Complaints received	1	0	**1**
Complaints acknowledged within three working days	1 (100%)	0	**1 (100%)**

11.1.8. Number of complaints by financial year and site (private care patients)

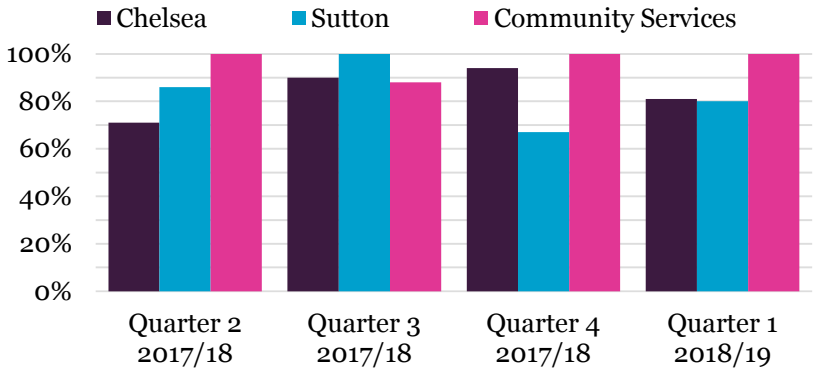


11.1.9. Number of complaints completed this quarter (NHS patients)

	Chelsea	Sutton	Community Services	Total
Complaints completed	16	5	8	**29**
Complainants receiving a response within agreed deadline	13 (81%)	4 (80%)	8 (100%)	**25(86%)**

Complaints performance has been measured on complaints closed within the quarter to provide a definitive performance indicator. The breaches were due to length of investigation; awaiting a statement from a member of staff and awaiting final signature. Some investigations are more complex than others and although the Trust works to a 25 working day timescale for investigations, this is no always possible and will be agreed with the complainant.

11.1.10. Responses within agreed deadline (NHS patients)

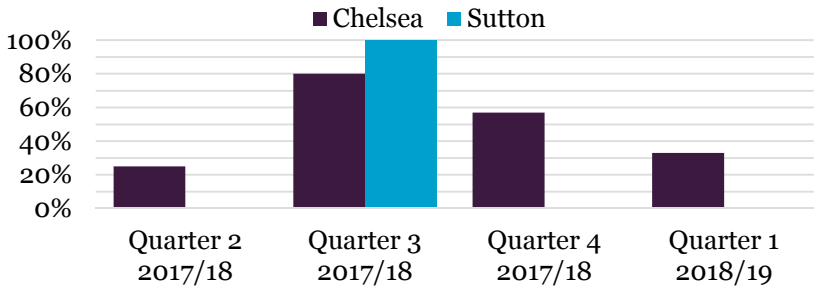


11.1.11. Number of complaints completed this quarter (private care patients)

	Chelsea	Sutton	Total
Complaints completed	3	1	4
Complainants receiving a response within agreed deadline	1 (33%)	0	1 (25%)

Complaints performance has been measured on complaints closed within the quarter to provide a definitive performance indicator. The three breaches were due to length of investigation and awaiting final signature.

11.1.12. Responses within agreed deadline (private care patients)



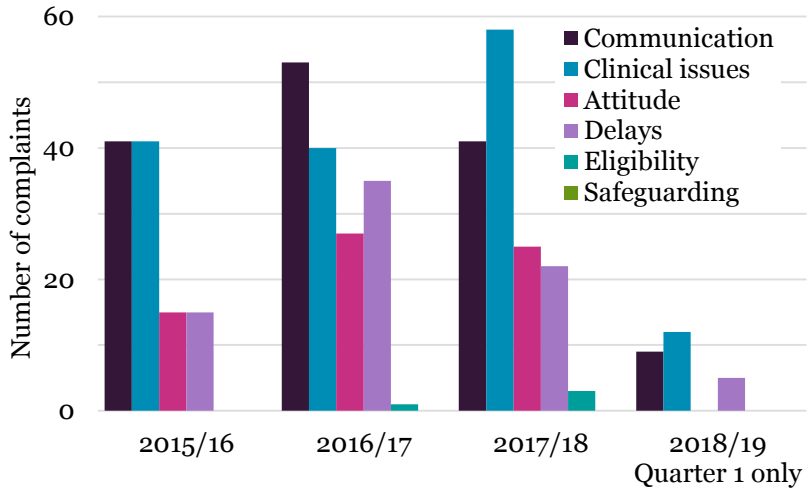
11.1.13. NHS complaints by patients' clinical commissioning groups (CCGs)

Clinical commissioning groups (CCGs) are the clinically led statutory NHS bodies responsible for the planning and commissioning of health care services for their local areas. The table shows the number of complaints received in the quarter ordered by the patient's CCG.

CCG	Number of complaints
NHS Brent	1
NHS Camden	1
NHS Coastal West Sussex	1
NHS Croydon	2
NHS East and North Hertfordshire	1
NHS East Surrey	1
NHS Kingston	1
NHS Southwark	1
NHS Surrey Downs	1
NHS Sutton	13
NHS West Kent	2
Total	**25**

11.1.14. Complaint subjects: main themes by financial year

Communication, clinical issues, attitude and delays are consistently the main four themes of all complaints received within the Trust. Any trends (recurrent themes) in particular service areas that are identified are reported to the appropriate senior manager for service-level review and remedy.



11.1.15. Ethnicity of complainants for complaints received this quarter

The Royal Marsden collects ethnicity data for all complainants to ensure that all users of the Trust are able to access the Complaints Service. Together with other data, it will help the service to understand who is using the complaints process. The increased knowledge will help in continually improving the service.

Ethnic origin of complainant	Number of complaints
Asian Bangladeshi	0
Asian Indian	0
Asian Pakistani	0
Asian (other)	0
Black African	2
Black Caribbean	1
Black (other)	0
Chinese	0
Mixed White and Asian	0
Mixed White and Black African	0
Mixed White and Black Caribbean	0
Mixed (other)	0
White British	5
White Irish	0
White (other)	0
Other	0
Not disclosed	5
Awaiting confirmation	12
Total	**25**

11.1.16. Complaints completed this quarter – Chelsea

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Breast	Very low	Delays in care	Concerns around delays that resulted in not being eligible for clinical trial	Patient offered pain clinic appointment. No further actions.	Not upheld
Breast	Very low	Diagnosis /treatment	Treatment and attitude of staff during inpatient stay	Staff reminded of the importance of clear communication.	Not upheld
Diagnostic radiology	Low	Diagnosis /treatment	Scan results did not pick up growth	Review of the checking systems in place for the multidisciplinary team navigators to ensure that all external reports are available to the radiologist when reviewing external imaging.	Partly upheld

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Gastro-intestinal	Very low	Delays in care	Patient unable to receive funding for treatment and therefore had private care	Explanation around NHS funded treatment given.	Not upheld
Gastro-intestinal	Low	Diagnosis /treatment	Patient rapidly deteriorated and cancer recurred following surgery	Meeting to address concerns. Explanation and apology given.	Not upheld
Gastro-intestinal	Very low	Communication	Poor attitude of secretary during a telephone call	Discussions surrounding the importance of courtesy towards patients and visitors. Apologies given.	Upheld
Gynaecology	Low	Diagnosis /treatment	Issues regarding reoccurrence of cancer	Patient's case reviewed at the radiology learning from discrepancies meeting and fed back to radiology team. *Related to Investigation 15 on page 100.*	Upheld
Gynaecology	Very low	Diagnosis /treatment	Poor communication from clinical team	Apology that sense of urgency caused concern.	Not upheld
Gynaecology	Very low	Communication	Delays in communication around second opinion	No action required.	Not upheld
Haemato-oncology	Very low	Communication	Comments made by consultant regarding patients diagnosis	Explanation and apologies given.	Not upheld
Head and neck	Low	Diagnosis /treatment	Concerns regarding post-surgery care and following complication	Enhanced education for Critical Care Unit staff regarding pressure sore management and the availability and access of the Tissue Viability Nurse.	Partly upheld
Pharmacy	Low	Medication /radiation	Patient's treatment was delayed by over three hours as Pharmacy did not prescribe the drugs	There will be a post-clinic checklist to ensure that all relevant drug charts are sent to the Pharmacy Service.	Upheld
Pharmacy	Very low	Medication /radiation	Delays in Pharmacy and poor communication between departments	Delays identified and pharmacy pathway is being reviewed. Explanation and apologies given.	Upheld
Private patients	Very low	Communication	Quality of care and treatment provided which has resulted in delay in recovery and additional costs.	Staff reminded of the need for clear communication with patients and families when attending clinics on weekends.	Partly upheld

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Private patients	Very low	Delays in care	Care and treatment received following chemotherapy	Apologies for behaviour of nursing staff.	Upheld
Private patients	Low	Communication	Confusion surrounding treatment plan and genetic testing being carried out without consent.	Clearer communication around out of hours access for visitors.	Partly upheld
Sarcoma	Very low	Diagnosis /treatment	Concerns in relation to delay in diagnosis of cancer reoccurrence and lack of continuity	Confirmation that there were regular follow-ups and scans showed no evidence of cancer recurrence.	Not upheld
Sarcoma	Low	Delays in care	Delays in Medical Day Unit Chelsea	Explanation and apologies given.	Partly upheld
Urology	Low	Diagnosis /treatment	Concerns around misdiagnosis and poor care and treatment provided by medical team	Concerns resolved via meeting and explanation.	Not upheld

11.1.17. Complaints completed this quarter – Sutton

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Breast	Low	Diagnosis /treatment	Concerns around misdiagnosis and delay in accessing an appointment	Explanation and apology given. *Related to Investigation 01 on page 99.*	Upheld
Drug development unit	Low	Medication	Delays in medication being administered caused by particle contamination	Review of process for preparing the chemotherapy treatment.	Upheld
Gastro-intestinal	Low	Delays in care	Query around delays pathway. Unhappy with lack of continuity in doctors and having to repeat information.	Patients' pathway was appropriate. Apology given for having to repeat information.	Partly upheld
Lung	Low	Communication	Communication breakdown between nurse, patient and family. Delay in administration of patient's medication.	Apologies given. No action required.	Partly upheld
Private patients	Very low	Communication	The care and treatment during appointment	Review of nursing documentation practices and audit undertaken by unit.	Partly upheld

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Urology	Very low	Communication	Lack of communication regarding reason why patient was not approved for clinical trial	Current process in place for radiology cover for unforeseen circumstances will be reviewed.	Partly upheld

11.1.18. Complaints completed this quarter – Community Services

Service area	Risk grade	Subject	Concern	Action taken	Outcome
District nursing	Low	Delays in care	Poor management of patient's home visits	Apologies for duplicate visits.	Partly upheld
Neuro intermediate care	Very low	Miscellaneous	Query regarding Parkinson's disease nurse service as there is no nurse in post at present	Service is still trying to recruit to post. Information and explanations given.	Upheld
Older people's assessment and rehabilitation service	Low	Diagnosis /treatment	Lack of coherent and efficient Parkinson's disease medication regime	Team has now implemented a system that all actions must be recorded on the electronic patient record and communicated to the patient.	Partly upheld
Physiotherapy outpatients	Low	Diagnosis /treatment	Unhappy with physiotherapy treatment spanning a year and felt that it was not been beneficial	Departmental escalation policy reiterated to staff. Audit undertaken.	Upheld
Physiotherapy outpatients	Low	Diagnosis /treatment	Delays and minimal input from Physiotherapy	Staff have been reminded to document the reason for cancellations and ensure an appointment is booked at that time.	Partly upheld
Podiatry – community	Low	Delays in care	Poor podiatry services and lack of referral to another service provider	Referral made. Apology and explanations for delays in communication given.	Partly upheld
Podiatry – community	Very low	Communication	Poor continuity of care and appointments scheduling.	Review of local procedure which has resulted in it reverting to previous process.	Upheld

11.1.19. NHS Digital data – benchmarking

NHS Digital collects data on complaints about NHS hospital and community health services in England. The data includes a count of written complaints made by, or on behalf of, patients.

The results for Quarter Four 2017/18 (the latest available) are shown in the table below for selected service providers. On its website NHS Digital describes the data as 'provisional and experimental and … care should be taken when interpreting the results'.

	Total brought forward	Total new	Total resolved	Number upheld	Number partially upheld	Total not upheld	Total carried forward
NHS England	20,058	30,099	26,483	8,909	8,127	9,447	23,674
NHS England London	3,045	5,207	4,898	1,573	1,598	1,727	3,354
The Royal Marsden	**15**	**32**	**24**	**5**	**11**	**8**	**23**
The Christie NHS Foundation Trust	7	15	17	2	10	5	5
University College London Hospitals NHS Foundation Trust	151	229	212	62	105	45	168
Chelsea and Westminster Hospital NHS Foundation Trust	160	186	160	91	33	36	186
St George's University Hospitals NHS Foundation Trust	216	268	212	212	-	-	272

From webpage digital.nhs.uk/data-and-information/publications/statistical/data-on-written-complaints-in-the-nhs/data-on-written-complaints-in-the-nhs-2017-18-quarter-4-experimental *Data on written complaints in the NHS, 2017-18 Quarter 4, Experimental* on the NHS Digital website (published 7 June 2018; retrieved 2 August 2018).

11.1.20. Learning from complaints

Following on from recommendations in the Francis Report, and in line with Trust policy, action required and learning from concerns and complaints is disseminated and discussed at departmental and divisional level to benefit service users and the Trust.

The sharing of learning is being further reviewed to ensure all relevant staff groups are informed and able to reflect on their practice and service. Learning reports are circulated to Trust staff and these are sent monthly.

It is an ongoing process that Viewpoint cards, concerns and complaints, and Friends and Family Tests are discussed with representatives of the Patient and Carer Advisory Group.

Posters are currently being reviewed around the Trust with the view of updating these to demonstrate work that has been undertaken in response to service user feedback.

The main topics of learning are Communication, Delays, Clinical issues and Attitude of staff, reflecting the categories of complaints received.

Communication

Clearer information around out-of-hours access for visitors to be provided.

Delays

Staff have been reminded of the importance of ensuring take home medications are checked and dispensed to avoid delays in discharge.

Clinical issues

Review of the checking systems in place for the multidisciplinary team navigators to ensure that all external reports are available to the radiologist when reviewing.

Attitude of staff

Staff have been reminded of the importance of courtesy towards patients and visitors at all times.

11.1.21. Parliamentary and Health Service Ombudsman referrals

There was no new referral to the Parliamentary and Health Service Ombudsman in Quarter One.

The Trust currently has two complaints under investigation by the Ombudsman.

11.2. Letters of praise

11.2.1. Staff are encouraged to send any letter of praise they receive to the Head of Clinical Legal Services, Complaints, and Patient Information for noting in this report and to help identify any members of staff who should receive personal thanks for their work from the Chief Executive.

11.2.2. In the quarter 219 letters of praise were received by the Head of Clinical Legal Services, Complaints and Patient Information. Some examples of the comments made in letters of praise follow.

11.2.3. Chelsea

General thanks

I came to your hospital on Friday and what a pleasant surprise my son and I had. A nurse came for me, introduced herself, then took me to a room and I was met by a doctor who was very pleasant, helpful and explained to me what he was doing. I can't praise your hospital [enough]. I am not worried about coming back now for my treatment as I know I am in good hands. I think you have a very clean and helpful hospital.

Lung

Just to thank you for the incredible care and treatment you gave to my beloved husband over the past year. Although we are very sad that he is no longer with us we know that had he not had the opportunity to be treated at the RM he might not have survived as long as he did, he was so very proud to be under your care. You gave us a year of making some wonderful memories. We will be eternally grateful for having that time and for everything you did for him.

Wilson Ward

Our huge thanks for all the wonderful care you gave to my brother. We know there were some challenges but you were so patient and kind. We also deeply appreciated your kindness to us. You certainly have lived up to the widely acknowledged high reputation of The Royal Marsden on the ward.

11.2.4. Sutton

Rapid Diagnostic and Assessment Centre

All the staff very helpful and friendly was all done within an hour! Very reassuring and made a worrying time a lot easier.

Smithers Ward

I wish to offer a big thank you to all the staff who gave care, consideration, love and humour. You made life good and she loved you all.

11.2.5. Community Services

Cedar Lodge

Thank you so much for your kindness, generosity and support. You are doing a fantastic job of giving our girls a safe, stimulating environment to develop their skills, enjoy and make new friends.

Community nursing

With your support mum was able to remain at [home], where she felt happy and safe. Mum enjoyed her chats with you all and your friendly smiles.

11.3. Incident, complaints and claims investigations and serious incident reporting

11.3.1. Incident, complaints and claims investigations and serious incidents (SIs) declared new

Following the initial investigation and Root Cause Analysis (RCA) if it is felt that the circumstances surrounding the event are clear and the actions if required are straightforward there will not be a panel meeting. The final report if required is approved at the Integrated Governance and Risk Management Committee (IGRM).

Investigation number	Description	Investigation update/panel date
Investigation 01	Delay in diagnosis (related to complaint on page 95)	Handled under the complaints process – confirmed low harm
Investigation 02	Fire	Panel review 21 May 2018
Investigation 03	Acute deterioration	Confirmed an unavoidable event no further action required
Investigation 04	a) Category 3 pressure ulcer b) Suspected deep tissue injury	Panel review 28 June 2018
Investigation 05	a) Category 4 pressure ulcer (SI) b) Category 3 pressure ulcer	Panel reviews 21 June and 24 July 2018.

Investigation number	Description	Investigation update/panel date
Investigation 06	Delay in diagnosis	RCA underway to confirm if panel is required
Investigation 07	Missing equipment	RCA underway to confirm if panel is required
Investigation 08	Community health visiting	Report to June IGRM
Investigation 09	Medication incident	Panel review 5 July 2018
Investigation 10	General standard of care	RCA underway to confirm if panel is required
Investigation 11	Pressure ulcers for review	Later confirmed by the Tissue Viability Nurse that not for investigation
Investigation 12	Clinical assessment	RCA underway to confirm if panel is required
Investigation 13	Category 3 pressure ulcer	Panel review 24 August 2018
Investigation 14	IT service interruption	Panel review 31 July 2018
Investigation 15	Radiology discrepancy (related complaint on page 94)	Handled under the complaints process

11.3.2. Incident, complaints and claims investigations (including SIs) completed

Incidents grading

Green	None/insignificant harm
Yellow	Low harm
Orange	Moderate harm
Red	Severe harm/death

Incident investigations may be undertaken on low graded incidents that had the potential to cause significant harm.

Investigation number and incident grade	Description	Outcome of investigation	Action taken following investigation include:
Investigation 21 Green	Medication incident	EChemo prescription was not amended and the patient's requirements were not adhered to.	Raise awareness of the requirements of eChemo and remind staff to check the name of the drug with the patient prior to administration.
Investigation 39 Orange	Care and treatment	The preoperative checks did not identify that a preparatory procedure had not been undertaken.	Implementation of the *Surgical admission and Perioperative* booklet.
Investigation 46 Green	Medication incident	Care and service delivery issues were identified in the process	Review the pharmacy multiple checking process and consider the implications Trust-wide

Investigation number and incident grade	Description	Outcome of investigation	Action taken following investigation include:
Investigation 51 Green	Medication incident	The incorrect medication was selected and the dispensing error was not noticed by subsequent checkers.	Review of the pharmacy guide to ensure it provides a clear step by step process and references the standard operating procedure for dispensing preparation and labelling of Investigational Medicinal Products (IMPs)
Investigation 55 Green	Tissue consent	At the time of the incident the Trust did not have a robust system in place for obtaining a generic consent for tissue for research for future use.	Task and finish group chaired by the Chief Operating Officer/Deputy Chief Executive Officer
Investigation 60 (SI)	Radiotherapy	Patient received treatment and was unaware that they were in the early stages of pregnancy	Change the radiotherapy protocol to re-confirm pregnancy question at the patient's first treatment.
Investigation 02 Yellow	Electrical fire	It is thought that the fire was caused by either the overheating of electrical components, or a paper operating manual or spare receipt rolls touching hot electrical components in the cash dispenser.	Feedback to the bank regarding the probable cause of this incident to hopefully prevent reoccurrence in the future.
Investigation 08 Green	Delay in screening	Lack of awareness of the blood spot screening process.	Education and training to be provided for health visitors undertaking the extended role to obtain new-born blood spots in children under 1 year transferring in from abroad to ensure they are fully aware of all of the processes (clinical and administrative).

11.4. Contractual Duty of Candour and Regulation 20 – Care Quality Commission

11.4.1. If an incident occurs that is graded moderate harm or above, a specific process needs to be followed to meet the requirements of the duty of candour.

– The patient or their family/carer must be informed that a suspected or actual patient safety incident has occurred within at most 10 working days of the incident being reported to local systems (Datix).

- The initial notification must be verbal (face to face where possible). The verbal notification must be accompanied by an offer of written notification. The notification must be recorded in the electronic patient record for audit purposes.
- An apology must be provided – a sincere expression of sorrow or regret for the harm caused both verbally and in writing.
- A step-by-step explanation of what happened, in plain English, based on fact must be offered as soon as is practicable. This may constitute an initial view pending an investigation, but patients and families must be kept informed of the process.
- Any incident investigation reports must be shared with the patient/family within 10 working days of being signed off as complete and the incident closed by the relevant authority.
- If the requirements of the contractual Duty of Candour are not met the Commissioners can withhold the cost of an episode of care or implement a fine of £10,000 if the cost is not known.

11.4.2. The *Being Open and Duty of Candour Policy* incorporates the requirement and the Risk Management team supports staff with this process to ensure compliance with the contractual requirement.

11.4.3. The Risk Management Team audits compliance against the requirements of the Duty of Candour six monthly. The audit was undertaken in July 2018 and the comparative scores are below.

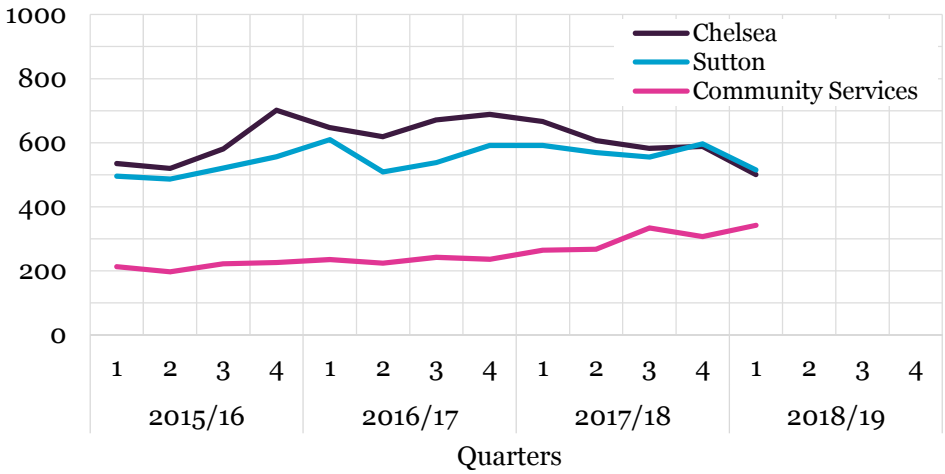
	July to December 2016	**January to June 2017**	**July to December 2017**	**January to June 2018**
Is there evidence that the incident has been discussed/ recorded in the patient record	100%	96%	94%	96%
Is it recorded at the time of the incident*	97%	92%	100%	96%
Has an apology been documented as being given	97%	100%	93%	92%

* Within 10 working days of the incident being reported on the incident reporting system

11.5. Incident statistics

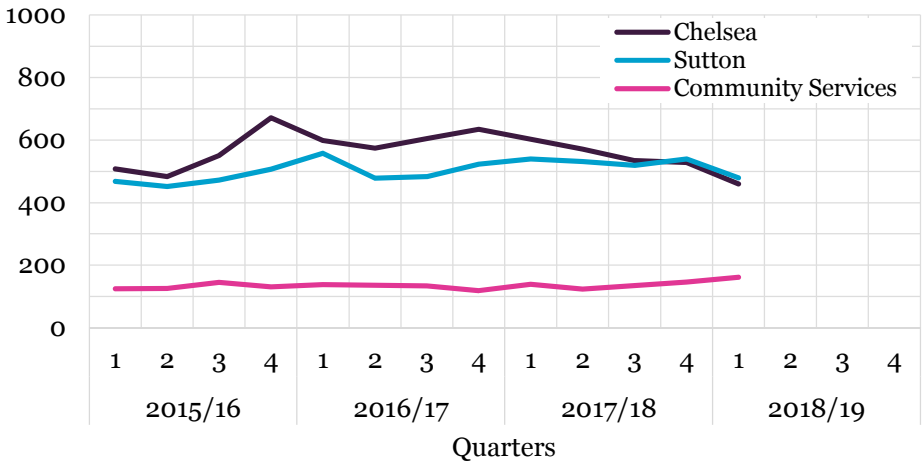
This section displays incident statistics for services which are currently run by The Royal Marsden NHS Foundation Trust. Historical data relating to services now commissioned by other healthcare providers have been excluded.

11.5.1. All reported incidents



11.5.2. All attributable incidents

Only incidents that are attributable to The Royal Marsden are represented in the following sections. Categorisation of attributable patient safety incidents occurred from January 2012.

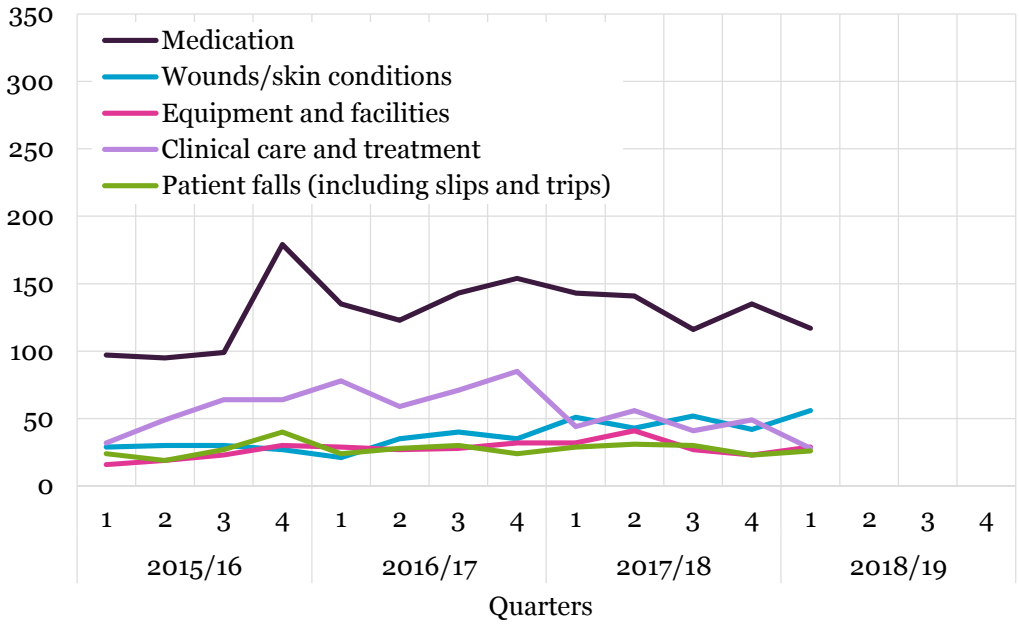


11.5.3. Patient safety incidents – top five categories

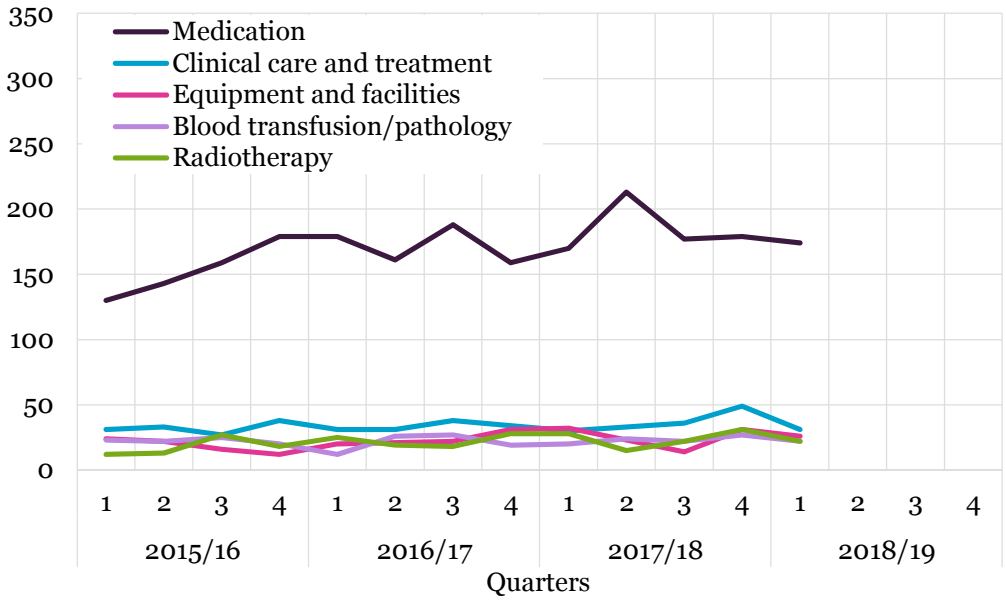
Patient safety incidents are those incidents that could have or did lead to harm for one or more patients.

The charts show the five categories with the largest number of incidents in Quarter One, and the number of incidents for these categories in previous quarters.

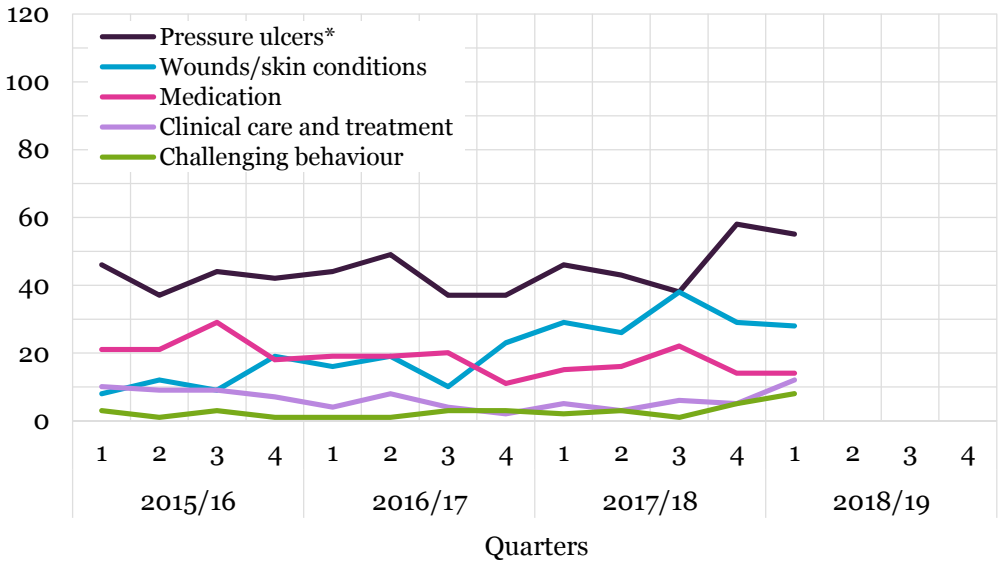
Chelsea



Sutton



Community Services



* One incident may represent more than one pressure ulcer.

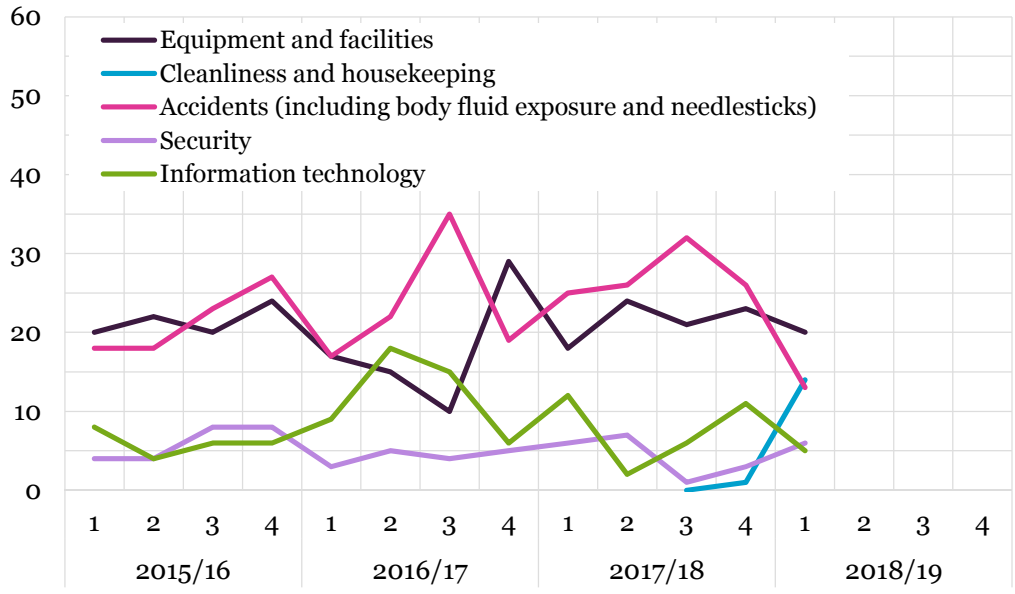
11.5.4. Non-patient safety incidents – top five categories

Non-patient safety incidents are those incidents that do not directly involve a patient.

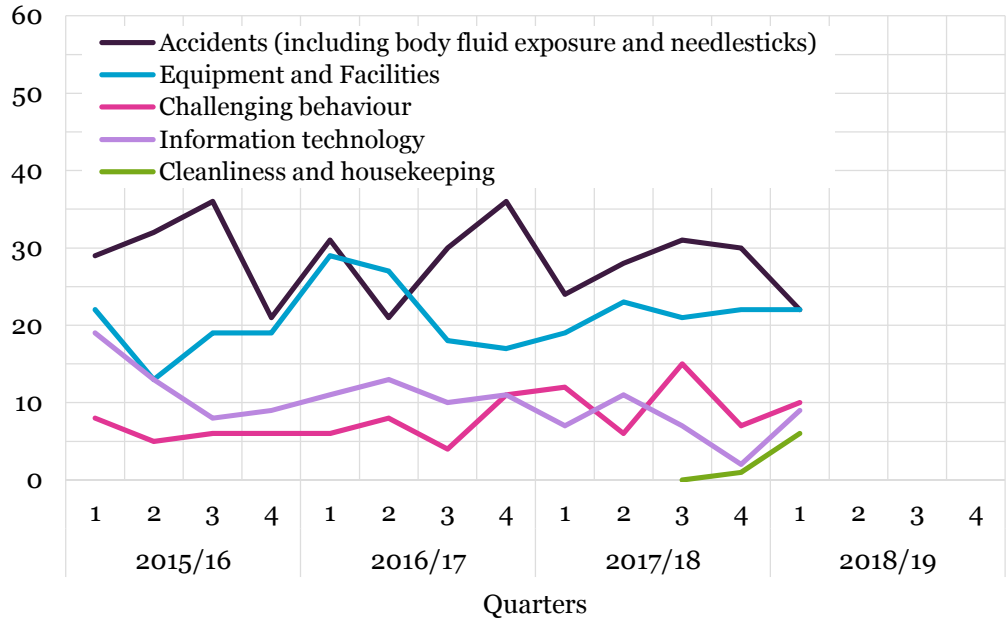
The charts show for the Chelsea and Sutton sites and for Community Services the five categories with the largest number of incidents in Quarter One, and the number of incidents for these categories in previous quarters.

The new category *Cleanliness and housekeeping* was added in Quarter Four 2017/18.

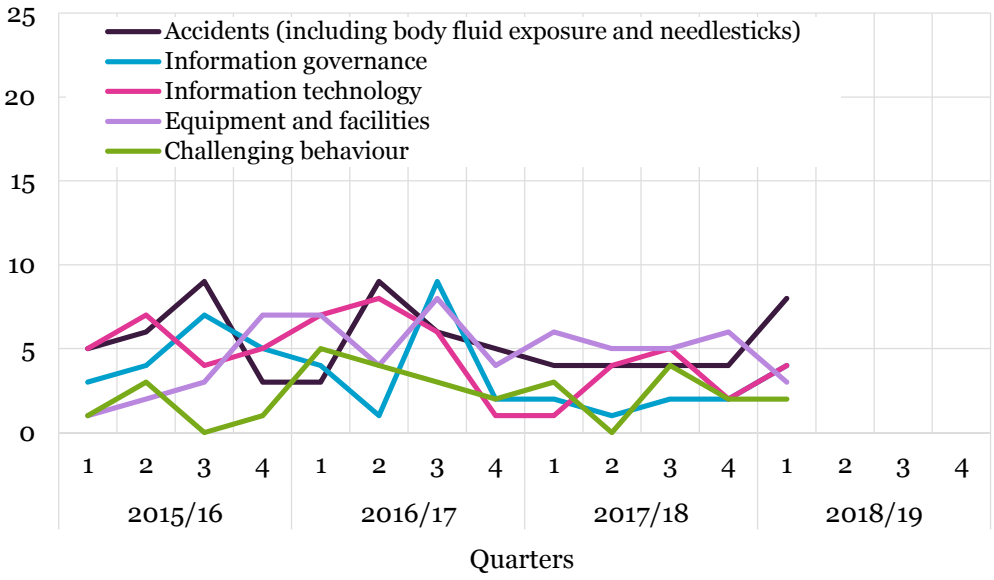
Chelsea



Sutton



Community Services



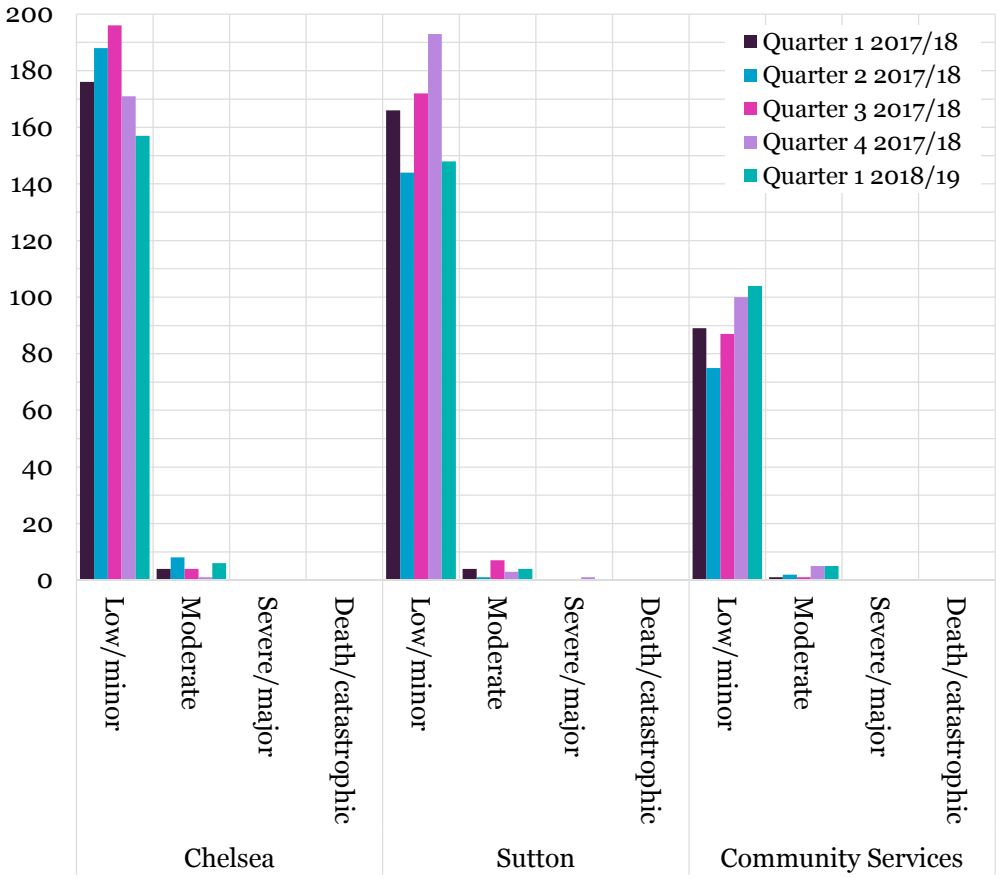
11.5.5. Severity

The following table and chart show for the Chelsea and Sutton sites and for Community Services the number of incidents by severity for the last five quarters.

The categories are:

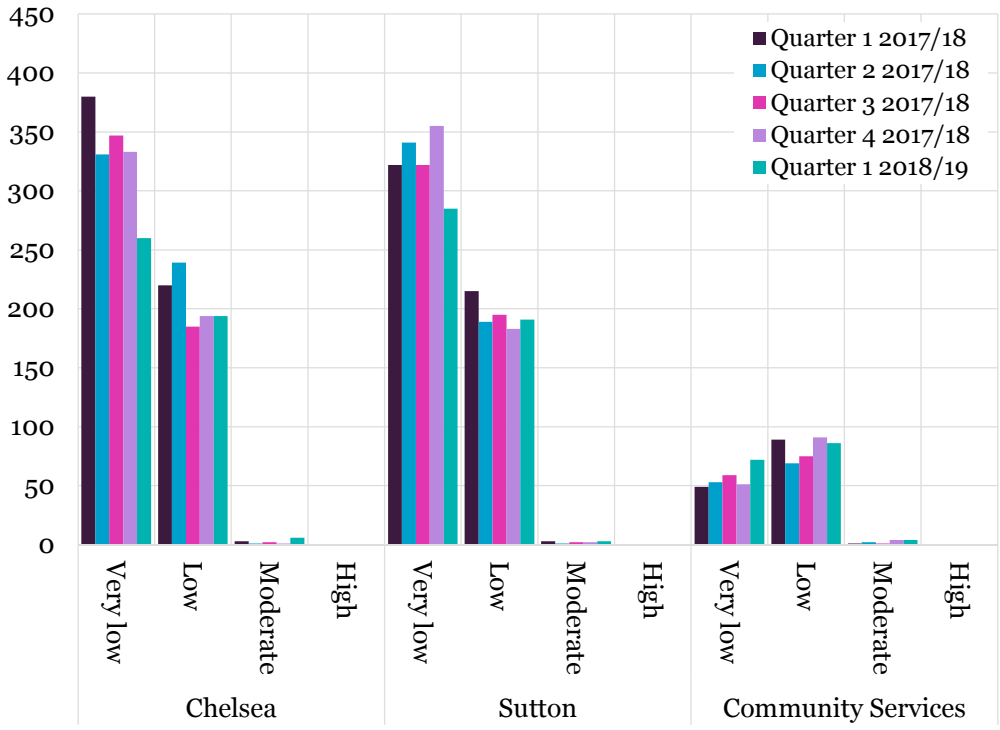
- No harm (listed in the table but not shown in the chart so that detail of the higher severity categories is clearer in the chart)
- Low/minor (minimal harm)
- Moderate (short term harm)
- Severe/major (permanent or long term harm)
- Death/catastrophic (caused by the incident).

		Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	Quarter 1 2018/19
Chelsea	No harm	423	375	334	356	297
	Low/minor	176	188	196	171	157
	Moderate	4	8	4	1	6
	Severe/major	0	0	0	0	0
	Death/catastrophic	0	0	0	0	0
Sutton	No harm	370	386	340	343	327
	Low/minor	166	144	172	193	148
	Moderate	4	1	7	3	4
	Severe/major	0	0	0	1	0
	Death/catastrophic	0	0	0	0	0
Community Services	No harm	49	47	47	41	53
	Low/minor	89	75	87	100	104
	Moderate	1	2	1	5	5
	Severe/major	0	0	0	0	0
	Death/catastrophic	0	0	0	0	0



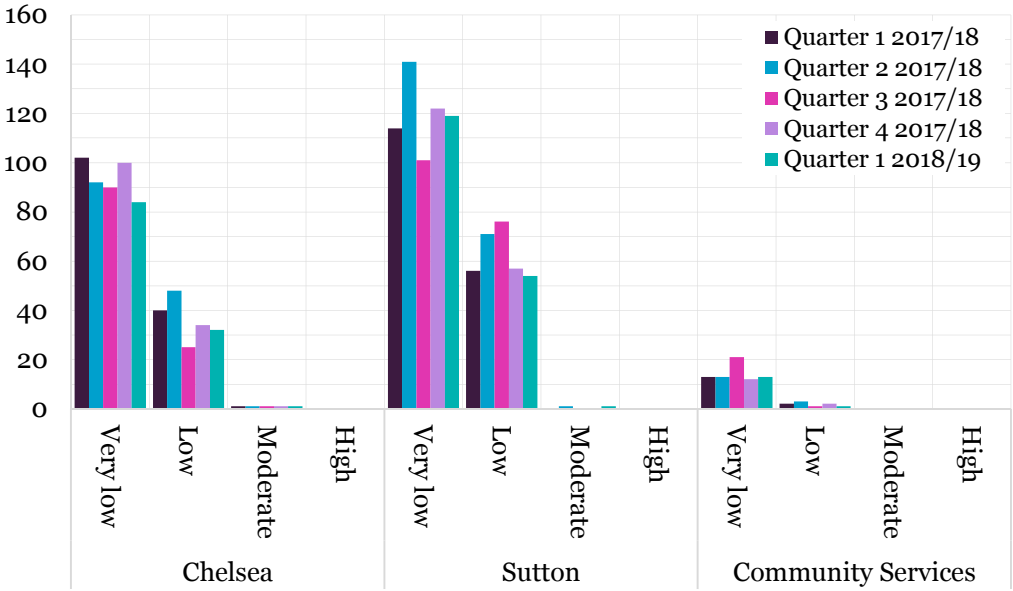
11.5.6. Risk grade

The chart shows for the Chelsea and Sutton sites and for Community Services the number of incidents by risk grade for the last five quarters.



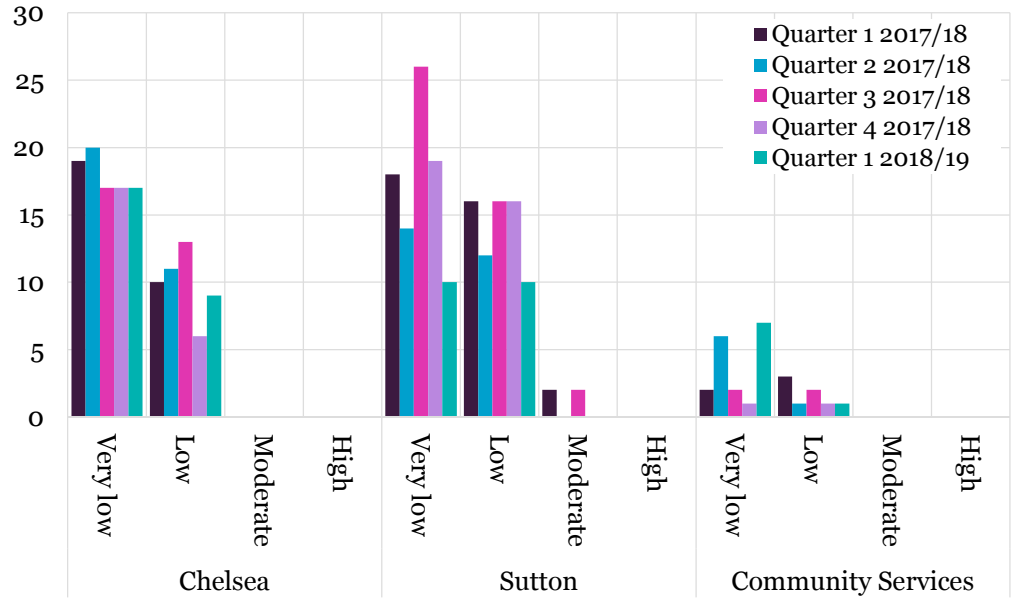
11.5.7. Medication incidents by risk grade

The chart shows for the Chelsea and Sutton sites and for Community Services the number of medication incidents by risk grade for the last five quarters.



11.5.8. Patient fall incidents by risk grade

The chart shows for the Chelsea and Sutton sites and for Community Services the number of patient fall incidents by risk grade for the last five quarters.



11.6. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations incidents

11.6.1. There were three incident involving staff reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

- A staff member sustained a cut to their finger while using a kitchen knife. This required them to have more than seven days off work as a result of the injury. Retraining on knife skills was provided on their return to work.
- A member of staff using the inter site coach suffered a fall. This resulted in them requiring more than seven days off work. Regular physiotherapy sessions have resolved the problems caused by the fall.
- A needlestick injury to a member of staff from a high-risk patient occurred while suturing. The staff member has been reviewed according to policy: correct prophylaxis has been issued and will be followed up appropriately. There has been a change in type of sutures used.

11.7. Risk assessments – the Trust risk register

11.7.1. The Trust risk register contains risks that score a risk rating above 12. The register continues to be reviewed and updated each quarter. All risks that score 9 and above remain on the divisional registers and those whose scores have been reduced through preventative action are downgraded.

11.7.2. The Trust risk register is reviewed quarterly at the Integrated Governance and Risk Management Committee and the Quality, Assurance and Risk Committee.

11.7.3. Departmental risk assessments, incident reports, targets and other areas that identify significant risks are added as new risks at the time that they are identified.

11.7.4. The register is held electronically which means that the registers are more accessible for the nominated leads in the divisions. If high graded risks are reported these are escalated immediately to appropriate members of the executive team.

11.8. Clinical Legal Services

This section covers Quarter Four 2017/18 and Quarter One 2018/19 (January to June 2018).

11.8.1. Claims received during Quarters Four and One

The Trust received five requests for medical records, seven inquest notifications and four claims were made against the Trust.

11.8.2. Open claims during Quarters Four and One

The table below shows the number of claims at each stage.

Stage	Sub-stage	Total	Description of sub-stage
Pre-action			
	Letter before action/claim/ notification of claim	**16**	Pre-action letter detailing allegations likely to be subject to court proceedings
	Letter of Claim	**11**	Response to the allegations as set out in the Letter of Claim
	Letter of response	**4**	Response to the allegations as set out in the letter before action/claim
	Negotiating settlement	**3**	Attempts to reach settlement without recourse to the court
Issued claims			
	Claim form served	**0**	Formal court proceedings sent to the Trust
	Particulars of claim served	**1**	Formal allegations sent to the Trust and court
	Defence served	**0**	Trust provides formal response to allegations denying all or some of the allegations made
	Negotiating Settlement	**1**	Attempts to reach settlement without recourse to the court
	Structured payment	**1**	Claim settled and annual payments made to Claimant
	Discontinued	**0**	Claimant withdrew claim. Legal costs to be confirmed
Total		**37**	

11.8.3. Open live files by category

Of the 37 live claims 31 relate to clinical negligence claims and six are personal injury claims.

11.8.4. Closed claims in Quarters Four and One

Claim withdrawn	**0**	Claimant notifies Trust that they no longer intend to proceed with claim **or** length of time since last contact suggests claim withdrawn.
Claim repudiated	**1**	Claims repudiated by NHS Resolution
Settled pre-action	**0**	Damages were paid (with, or without an admission of liability) before court proceedings
Settled out of court	**2**	Damages were paid (with, or without an admission of liability) after court proceedings have been issued
Judgment for Trust	**0**	Trust wins claim at court
Judgment for claimant	**0**	Claimant wins claim at court
Total	**3**	

The repudiated claim was a clinical negligence claim.

11.8.5. Inquests notifications received in Quarters Four and One

The Trust received notification of seven inquest notifications for Quarters Four and One.

Stage	Chelsea	Sutton	Community Services	Kingston
Request for documents	5	0	0	0
Inquests listed for hearing	2	0	0	0

Witness statements and medical notes were submitted to the coroners to consider the evidence.

11.8.6. Inquests concluded during Quarters Four and One

Eight inquests were closed and concluded in Quarters Four and One. Of the eight inquest notifications, five concluded with industrial disease related deaths i.e. mesothelioma and three inquests concluded with natural causes.

12. Suitability of management

12.1. Reports to NHS Improvement and accounts

12.1.1. NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHS Improvement regulates foundation trusts to ensure they comply with the NHS provider licence. This is a detailed set of requirements covering how foundation trusts must operate.

12.1.2. In Quarter One 2018/19 the Trust submitted the following finance and governance reports as part of the requirements:

- 2018/19 draft financial plan and narrative sent to NHS Improvement on 6 April 2018, final submission sent 30 April 2018 and national resubmission sent 20 June 2018
- Month 12 key data return submitted 17 April 2018
- Month 12 monthly return, trust accounts consolidation and draft annual accounts submitted 24 April 2018
- Final 2017/18 Annual Accounts submitted 29 May 2018
- Month one 2018/19 In-Year Monitoring Workforce and Finance Returns and commentary sent on 16 May 2018
- Month two 2018/19 In-Year Monitoring Workforce and Finance Returns and commentary sent on 15 June 2018
- Weekly agency returns sent to NHS Improvement on compliance with price caps and frameworks

12.1.3. In September 2016, NHS Improvement introduced a new Single Oversight Framework to align the approaches of the entities it consists of. One element of this, the Use of Resources Rating, replaced the previous Financial Sustainability Risk Rating. The Use of Resources Rating aligns providers into four segments: 1 (providers with maximum autonomy), 2 (providers offered targeted support), 3 (providers receiving mandated support) and 4 (providers in special measures).

12.1.4. At the end of Quarter One 2018/19 The Royal Marsden had a Use of Resources Rating of 1. This means that the Trust is considered by NHS Improvement to be low risk in financial terms.

13. Glossary

AHP

Allied health professional.

Alfentanil

An opioid analgesic drug, used for anaesthesia in surgery.

ASD

Autism spectrum disorder.

bacteraemia

The presence of bacteria in the blood.

BacT/Alert

An automated microbial detection system.

brachytherapy

An advanced cancer treatment: radioactive seeds or sources are placed in or near the tumour, giving a high radiation dose to the tumour while reducing the radiation exposure in the surrounding healthy tissues.

BRCA genes

The human genes *BRCA1* and *BRCA2*. They provide instructions for making a protein that acts as a tumour suppressor. Tumour suppressor proteins help prevent cells from growing and dividing too rapidly or in an uncontrolled way. Mutation of these genes is a cancer risk.

care pathway

The route a person takes through healthcare services.

Care Quality Commission (CQC)

The independent regulator of health and adult social care in England.

Its role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and to publish its findings, including performance ratings.

CCG

See *clinical commissioning group (CCG)*.

CDI

See Clostridium difficile *infection (CDI)*.

Cerebra

A charity for children with neurological conditions.

Channel

Part of the *Prevent* strategy. The process is a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism.

chemotherapy

Treatment with anti-cancer drugs to destroy or control cancer cells.

ciprofloxacin

An antibiotic.

clinical commissioning group (CCG)

A clinically-led statutory NHS body responsible for the planning and commissioning of health care services for its local area. CCGs were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013.

***Clostridium difficile* infection (CDI)**

A type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of CDI can range from mild to severe and can include diarrhoea, a high temperature and painful abdominal cramps. CDI can lead to life-threatening complications.

Following academic convention, the name of the bacteria is italicised, and, after the first mention in a section, abbreviated to *C. difficile*.

CNS

Clinical nurse specialist *or* Central nervous system.

commissioning

The process used by health services and local authorities to: identify the need for local services; assess this need against the services and resources available from public, private and voluntary organisations; decide priorities; and set up contracts and service agreements to buy services. As part of the commissioning process, services are regularly evaluated.

Commissioning for Quality and Innovation (CQUIN)

A payment framework that lets commissioners link a proportion of healthcare providers' income to the achievement of local quality improvement goals.

computed tomography (CT)

A medical imaging system that produces cross-sectional X-ray images.

C-reactive protein (CRP)

A substance produced by the liver that increases in the presence of inflammation in the body. An elevated C-reactive protein level is identified by blood tests and is considered a non-specific 'marker' for disease.

CQC

See *Care Quality Commission (CQC)*.

CQUIN

See *Commissioning for Quality and Innovation (CQUIN)*.

CT

See *Computed tomography (CT)*.

Customer Service Excellence standard

The government's customer service standard. It replaced the Charter Mark.

DAHNO

Data for Head and Neck Oncology – software and database used in the national head and neck cancer audit.

Data Security and Protection Toolkit (DSPT)

An online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

This system is subject to ongoing development. Previous versions of the DSPT were known as the Information Governance Toolkit.

Datix

The proprietary software used by The Royal Marsden (and other trusts) to record and report incidents, complaints and patient comments.

DNA

Patient non-attendance – 'did not attend'.

DSPT

See *Data Security and Protection Toolkit (DSPT)*.

eChemo

The electronic chemotherapy prescribing system developed and used by The Royal Marsden. The system allows the electronic transmission of charts to the pharmacy in advance of patient appointments, which helps to save time screening, manufacturing and dispensing chemotherapy. It also speeds up the processing time for last-minute dose changes.

EPR

Electronic patient record.

Escherichia coli

Bacteria that live in the intestines of humans and animals. Although most types are harmless, some cause sickness. Following academic convention, the name of the bacteria is italicised, and, after the first mention in a section, abbreviated to *E. coli*.

ESMO

The European Society for Medical Oncology.

EudraLex

The collection of rules and regulations governing medicinal products in the European Union.

FCE

See *full consultant episode (FCE)*.

Five Senses Observation Study

A study which involves patients and members of staff working together to identify good practice and areas that might need improving, noting perceptions under the categories *see*, *hear*, *smell*, *touch* and *taste*.

full consultant episode (FCE)

The period of time an inpatient spends under the care and responsibility of one consultant team. A patient's entire stay in hospital is an inpatient spell, and usually consists of one FCE, but a transfer of care can result in multiple FCEs under more than one consultant team.

GCP

See *Good Clinical Practice (GCP)*.

Good Clinical Practice (GCP)

An international ethical and scientific quality standard for the design, conduct and record of research involving humans that applies to all clinical investigations that could affect the safety and well-being of human participants (in particular, clinical trials of medicinal products).

haematopoietic stem cell (HSC)

Haematopoietic stem cells are progenitor cells that have the ability to both generate all types of blood cells, including those of the myeloid and lymphoid lineages, and to replace themselves.

In adults, they mainly reside in the bone marrow.

HCA

Healthcare assistant.

HCAI

See *Healthcare-associated infection*.

Healthcare-associated infection (HCAI)

Infection that occurs as a result of contact with the healthcare system.

Healthcare-associated infection Data Capture System (HCAI DCS)

Public Health England's Data Capture System provides an integrated data reporting and analysis system for the mandatory surveillance of *Staphylococcus aureus*, *Escherichia coli* bacteraemia and *Clostridium difficile* infections.

holistic

Characterised by the treatment of the whole person, taking into account mental and social factors, rather than just the symptoms of a disease.

holistic needs assessment

Patients at The Royal Marsden are offered a holistic needs assessment to see if they have any concerns. A holistic needs assessment considers all aspects of a person's needs including their physical, social, psychological and spiritual aspects, all of which are closely interconnected.

See *holistic.*

Hospital2Home

An initiative developed by The Royal Marsden that supports patients' end-of-life choices. The scheme gives patients under palliative care more confidence about choosing to be cared for at home by improving communication between hospital and community services. The scheme is supported by a specialist team funded by The Royal Marsden Cancer Charity.

HPC

Haematopoietic progenitor cell.

HSC

See *haematopoietic stem cell (HSC)*

ICR

See *Institute of Cancer Research (ICR).*

IGRM

See *Integrated Governance and Risk Management Committee (IGRM).*

Imaging Services Accreditation Scheme (ISAS)

A patient-focused assessment and accreditation programme designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments.

Information Governance Toolkit

See *Data Security and Protection Toolkit (DSPT).*

Institute of Cancer Research (ICR)

A public research institute and a constituent college of the University of London specialising in oncology.

In partnership with The Royal Marsden the ICR forms the largest comprehensive cancer centre in Europe.

Integrated Palliative care Outcome Scale (IPOS)

IPOS is a new development that integrates the most important questions from the Palliative care Outcome Scale (POS) tools. It captures the most important concerns in relation to symptoms, information needs, practical concerns, anxiety or low mood, family anxieties and overall feeling of being at peace.

See *Palliative care Outcome Scale (POS).*

integrated governance

The system and processes by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service.

Integrated Governance and Risk Management Committee (IGRM)

An internal committee of The Royal Marsden that meets monthly to oversee patient safety.

Integrated Governance Monitoring Report

This report. A quarterly publication that reviews the governance of care, research and infrastructure at The Royal Marsden. The report is published on the Royal Marsden's website.

IPOS

See *Integrated Palliative care Outcome Scale (IPOS).*

ISAS

see *Imaging Services Accreditation Scheme (ISAS).*

ISBT 128

An international information standard for use with medical products of human origin.

The standard provides the specification for many of the elements of the information environment required in transfusion and transplantation. It defines the lower three levels of the model: standardised terminology, reference tables, and data structures. Minimum requirements are defined for delivery mechanisms and labelling. By complying with ISBT 128 collection and processing facilities can provide electronically readable information that can be read by any other compliant system.

ISBT stands for Information Standard for Blood and Transplant; 128 is the number of characters in the character set used for encoding. The standard is maintained by the ICCBBA (International Council for Commonality in Blood Banking Automation).

JACIE

See *Joint Accreditation Committee of the International Society for Cellular Therapy (ISCT) and the European Group for Blood and Marrow Transplantation (EBMT) (JACIE).*

JAG

The Royal College of Physicians' Joint Advisory Group on gastrointestinal endoscopy.

Joint Accreditation Committee of the International Society for Cellular Therapy (ISCT) and the European Group for Blood and Marrow Transplantation (EBMT) (JACIE)

A non-profit body established in 1998 for the purposes of assessment and accreditation in the field of haematopoietic stem cell (HSC) transplantation.

Its primary aim is to promote high-quality patient care and laboratory performance in HSC collection, processing and transplantation centres through an internationally recognised system of accreditation.

'LIBOR' funding

Funding from fines levied on the banking industry for manipulating the London Interbank Offered Rate (LIBOR) rate. The Treasury announced in 2012 that 'the proceeds from LIBOR fines would be used to support armed forces and emergency services charities and other related good causes that represent those that demonstrate the very best of values'.

linac

Linear accelerator.

LocSSIPs

Local Safety Standards for Invasive Procedures.

magnetic resonance imaging (MRI)

A medical imaging technique used in radiology to image the anatomy and the physiological processes of the body. MRI scanners use magnetic fields and radio waves to form images of the body. The technique is widely used in hospitals for medical diagnosis, staging of disease and follow-up without exposure of the body to ionizing radiation.

medical devices

All products, except medicines, used in healthcare to diagnose, prevent, monitor or treat illness or disability. For example, a device might be a pacemaker, knee replacement, X-ray machine or blood pressure monitor.

meticillin-resistant *Staphylococcus aureus* (MRSA)

A type of bacteria that is resistant to a number of widely used antibiotics, making it more difficult to treat than other bacterial infections.

MR Linac

A radiotherapy machine that combines MRI scanner and linear accelerator technologies to precisely locate tumours, tailor the shape of X-ray beams in real time and accurately deliver doses of radiation of moving tumours.

MRSA

See *meticillin-resistant* Staphylococcus aureus *(MRSA)*.

MRI

See *magnetic resonance imaging (MRI)*.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

Independent charitable organisation that reviews medical and surgical clinical practice and makes recommendations to improve the quality of the delivery of care for the benefit of the public.

National Early Warning Scores (NEWS)

A system that provides an early accurate predictor of deterioration by identifying physiological criteria that alert the ward nursing staff of an adult patient at risk. It is one of a group of physiological track and trigger systems (including Paediatric Early Warning Score for children) which use multiple parameter or aggregate weighted scores which allow a graded response.

National Institute for Health and Care Excellence (NICE)

A non-departmental public body accountable to the Department of Health with responsibility for providing guidance and advice to improve health and social care in England.

NCEPOD

See *National Confidential Enquiry into Patient Outcome and Death (NCEPOD)*.

NEWS

See *National Early Warning Scores (NEWS)*.

NEWS 2

The latest version of the National Early Warning Scores (NEWS) system, updated in December 2017.

See *National Early Warning Scores (NEWS)*.

NHS Improvement

The body that is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. In April 2016 it incorporated Monitor, the NHS Trust Development Authority, Public Safety (including the National Reporting and Learning System (NRLS), and some smaller bodies.

NHS Litigation Authority (NHS LA)

See *NHS Resolution*.

NHS Resolution

A not-for-profit part of the NHS that provides indemnity cover for legal claims against the NHS, assists the NHS with risk management, shares lessons from claims and provides other legal and professional services for its members. NHS Resolution is a 'public alias' for the NHS Litigation Authority, adopted in April 2017.

NHS standard contract

The NHS standard contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care.

NICE

See *National Institute for Health and Care Excellence (NICE)*.

NMC

See *Nursing and Midwifery Council (NMC)*.

Nursing and Midwifery Council (NMC)

The professional regulatory body for nurses and midwives in the UK.

open access follow-up

A type of follow-up where routine, clinical examination-type appointments are replaced by a system where patients can contact the Trust when they have a problem or symptom. In this way patients need only attend when they need to, and do not have to visit hospital when they are feeling well and symptom-free.

Palliative care Outcome Scale (POS)

A group of tools used developed to measure palliative care needs of patients and their families. The POS measures are specifically developed for use among people with advanced diseases such as cancer, respiratory, heart, renal or liver failure, and neurological diseases.

PALS

See *Patient Advice and Liaison Service (PALS)*.

parotidectomy

The surgical removal of one or both of the saliva-producing parotid glands.

Patient Advice and Liaison Service (PALS)

The service that provides information, advice and support to help patients, their families and their carers. Each NHS trust has a Patient Advice and Liaison Service.

Patient and Carer Advisory Group (PCAG)

A group of current and former Royal Marsden patients and carers that works with the Trust on projects where the views of patients and carers help make the hospital a better place for patients.

Patient Group Direction (PGD)

A written instruction for the supply and administration of a specified medicine to a group of patients who may not be individually identified before presentation for treatment in an identified clinical situation.

PCAG

See *Patient and Carer Advisory Group (PCAG)*.

perioperative

Of a process or treatment: occurring or performed before, during or after an operation.

peripherally inserted central catheter (PICC) line

A long, thin, flexible tube called a catheter used to give chemotherapy and other medicines. It is put into one of the large veins of the arm, above the bend of the elbow, then threaded into the vein until the tip is in a large vein just above the heart.

PET

See *Positron emission tomography (PET)*.

PGD

See *Patient Group Direction (PGD)*.

Pharmex

A Department of Health and Social Care database in which medicinal product transaction usage and spend level details from trusts are collected and stored.

PICC line

See *peripherally inserted central catheter (PICC) line*.

pilot study

A small-scale trial run of a particular approach.

POS

See *Palliative care Outcome Scale (POS)*.

positron emission tomography (PET)

A medical imaging technique that uses a very small amount of radioactive drug to show how body tissues are working.

Prevent

One of the four elements of *CONTEST*, the government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism.

Public Health England

An executive agency that delivers services to protect the public's health through a nationwide integrated health protection service, provides information and intelligence to support local public health services, and supports the public in making healthier choices.

QMS

See *Quality management system (QMS)*.

Q-Pulse

Proprietary quality management system software.

quality management system (QMS)

A formalised system that documents processes, procedures and responsibilities for achieving quality policies and objectives. A quality management system helps coordinate and direct an organisation's activities to meet customer and regulatory requirements and improve its effectiveness and efficiency on a continuous basis.

R^2

A statistical measure that shows how closely the trend line fits the data in a chart. The value is between zero and one – the higher the value the closer the fit.

radiotherapy

The use of high energy rays to destroy cancer cells. It may be used to cure some cancers, to reduce the chance of cancer returning, or to control symptoms.

RAG rating

Red/amber/green rating.

RCN

The Royal College of Nursing.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

Regulations that put duties on employers, the self-employed and people in control of work premises to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses).

RIDDOR

See *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).*

RIG

Radiologically-inserted gastroscopy.

RM Partners

The cancer alliance across north west and south west London – part of the national cancer vanguard.

SALT

Speech and language therapy.

Schwartz rounds

A forum for staff working in health organisations, from all backgrounds, to come together to talk about the emotional and social challenges of caring for patients. They are once a month usually at lunchtime (with lunch provided) for an hour. The first 15 minutes is taken up by a patient's story, presented by the team who looked after him/her. The following 45 minutes is for discussion, guided by a facilitator, exploring issues raised by the story.

sepsis

A common and potentially life-threatening condition triggered by an infection.

In sepsis, the body's immune system goes into overdrive, setting off a series of reactions including widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced.

If not treated quickly, sepsis can lead to multiple organ failure and death.

Sepsis Six

Six tasks for treating sepsis – blood cultures, lactate measurement, oxygen, fluids, early antibiotics and urine output monitoring – to be instituted within one hour by non-specialised practitioners at the front line.

Sign up to Safety

A national campaign designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement.

SOP

Standard operating procedure.

sustainability and transformation plans (STPs)

The NHS and local councils in England developed proposals to make improvements to health and care. These proposals, called sustainability and transformation plans (STPs), are place-based and built around the needs of the local population.

Sutton Community Health Services

Provider of NHS community services in the London Borough of Sutton from April 2016. Sutton Community Health Services are provided by The Royal Marsden's Community Services Division.

Triggers tool

The Triggers tool (developed by the London Cancer Alliance) helps clinicians recognise patients who need an early referral to specialist palliative care. It was successfully piloted at The Royal Marsden with funding from The Royal Marsden Cancer Charity. The tool allows oncologists to assess patients' needs at an earlier stage, and to potentially refer them to specialist palliative care and active treatment.

TUPE

Transfer of Undertakings (Protection of Employment) Regulations 1981.

TYA

Teenage and young adult.

United Kingdom Accreditation Service (UKAS)

The UK's National Accreditation Body, responsible for determining, in the public interest, the technical competence and integrity of organisations such as those offering testing, calibration and certification services.

UKAS

See *United Kingdom Accreditation Service (UKAS).*

venous thromboembolism (VTE)

Blood clot typically occurring in the leg but which can occur in any blood vessel.

VTE

See *venous thromboembolism (VTE).*

Waste Issue Report and Enquiry (WIRE)

The on-line, auditable, waste issue reporting system used by the Royal Marsden's waste contractor.

WHO

See *World Health Organization (WHO)*.

WIRE

See *Waste Issue Report and Enquiry (WIRE)*.

WIRED

The mandatory training and appraisal reporting system used at The Royal Marsden.

World Health Organization (WHO)

A specialised agency of the United Nations that is concerned with international public health.

14. Care Quality Commission fundamental standards

From webpage www.cqc.org.uk/content/fundamental-standards on the Care Quality Commission's website (webpage last updated 29 May 2017; retrieved 12 July 2018).

Person-centred care

You must have care or treatment that is tailored to you and meets your needs and preferences.

Dignity and respect

You must be treated with dignity and respect at all times while you're receiving care and treatment.

This includes making sure:

- You have privacy when you need and want it.
- Everybody is treated as equals.
- You're given any support you need to help you remain independent and involved in your local community.

Consent

You (or anybody legally acting on your behalf) must give your consent before any care or treatment is given to you.

Safety

You must not be given unsafe care or treatment or be put at risk of harm that could be avoided.

Providers must assess the risks to your health and safety during any care or treatment and make sure their staff have the qualifications, competence, skills and experience to keep you safe.

Safeguarding from abuse

You must not suffer any form of abuse or improper treatment while receiving care.

This includes:

- Neglect
- Degrading treatment
- Unnecessary or disproportionate restraint
- Inappropriate limits on your freedom.

Food and drink

You must have enough to eat and drink to keep you in good health while you receive care and treatment.

Premises and equipment

The places where you receive care and treatment and the equipment used in it must be clean, suitable and looked after properly.

The equipment used in your care and treatment must also be secure and used properly.

Complaints

You must be able to complain about your care and treatment.

The provider of your care must have a system in place so they can handle and respond to your complaint. They must investigate it thoroughly and take action if problems are identified.

Good governance

The provider of your care must have plans that ensure they can meet these standards.

They must have effective governance and systems to check on the quality and safety of care. These must help the service improve and reduce any risks to your health, safety and welfare.

Staffing

The provider of your care must have enough suitably qualified, competent and experienced staff to make sure they can meet these standards.

Their staff must be given the support, training and supervision they need to help them do their job.

Fit and proper staff

The provider of your care must only employ people who can provide care and treatment appropriate to their role. They must have strong recruitment procedures in place and carry out relevant checks such as on applicants' criminal records and work history.

Duty of candour

The provider of your care must be open and transparent with you about your care and treatment.

Should something go wrong, they must tell you what has happened, provide support and apologise.

Display of ratings

The provider of your care must display their CQC rating in a place where you can see it. They must also include this information on their website and make our latest report on their service available to you.

The Trust would welcome your comments on this report. If you wish to make any comment or require further copies please contact:

The Data Officer
Quality Assurance
The Royal Marsden NHS Foundation Trust
203 Fulham Road
London SW3 6JJ

Email IGMR@rmh.nhs.uk

Life demands excellence

Radiotherapy and Chemotherapy Services
FS38021 & FS38022