

The ROYAL MARSDEN
NHS Foundation Trust

Integrated Governance Monitoring Report

July to September 2017

Quarter Two 2017/18



NHS

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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 provided services in Sutton as Sutton Community Health Services.
- 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 121.
- 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 Two 2017/18 (July to September 2017).

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

Thirteen new incident investigations were declared this quarter. Ten incident investigations were completed in the quarter and remedial actions were identified. (*Incident, complaints and claims investigations and serious incident reporting*, page 98.)

2.1.2. Infection prevention and control

There were no cases of meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia in the year to date. There was one case in the year 2016/17.

There were 25 cases of *Clostridium difficile* toxin (CDT) in the quarter of which 16 were reportable to the Healthcare associated infection Data Capture System (HCA DCS). (46 cases were reportable to the Mandatory Enhanced Surveillance Scheme in the year 2016/17).

Thirteen patients had confirmed or suspected carbapenemase-producing enterobacteriaceae (CPE) in the quarter. (*Infection prevention and control*, page 41.)

2.1.3. Fire

There were no actual fires in the quarter.

Six fire incidents were attributable to the Trust. Nine fire incidents had been reported in the previous quarter. (*Fire*, page 52.)

2.1.4. Radiotherapy

In September BSI reviewed the Trust's progress in moving to the latest standard, ISO9001:2015. The review concluded that the Trust satisfies the requirements of the new standard and has recommended recertification of the Radiotherapy Service.

There were 41 radiotherapy risk incidents, all risk-rated *low* and *very low* (33 the previous quarter). There were no complaints and 22 letters or cards of praise.

There were 1,350 appointments in the quarter (1,315 in the previous quarter). (*Radiotherapy*, page 77.)

2.1.5. Chemotherapy

One hundred and thirty-three incidents were reported, all risk-rated *low* and *very low* (98 in the previous quarter). All 133 incidents referred to medication issues (91 in the previous quarter). There were two complaints in the quarter and 25 letters of praise and thanks. (*Chemotherapy*, page 79.)

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 (CCG) through the Commissioning for Quality and Innovation (CQUIN) payment framework.

NHS England and Sutton CCG have confirmed full payment for achieving the 2017/18 Quarter One milestones and Sutton CCG has confirmed full payment for achieving its acute Quarter Two milestones. Confirmation is awaited that The Royal Marsden has achieved the other Quarter Two milestones for this year's goals. (*Commissioning for quality and innovation (CQUIN)*, page 14.)

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

NICE published 25 items of guidance which were presented to the Integrated Governance and Risk Management Committee in Quarter Two. After the guidance was reviewed, five items were deemed relevant and six items were still under review at the time of reporting. Twelve quality standards were presented to the committee. Of the four deemed relevant, the Trust is fully compliant with one and partially compliant with three. (*National Institute for Health and Care Excellence (NICE)*, page 71.)

2.2.3. Sepsis

Twenty patients were admitted to the Critical Care Unit with sepsis in the quarter. The data shows that compliance is maintained with the *Sepsis Six* bundle. (*Sepsis*, page 43.)

2.2.4. Medical devices

There were 58 incidents relating to medical devices this quarter (there were 61 in the previous quarter). All the incidents were graded *low* (21) and *very low* (37).

The Clinical Product Review Committee approved 11 proposals to evaluate new equipment and approved three products for purchase. (*Medical devices*, page 45.)

2.2.5. Deaths following anti-cancer-therapy

The number of deaths of patients who received systemic anti-cancer therapy in the quarter and died within 30 days was analysed. There were 77 deaths out of 4,163 patients (1.8%) compared with 63 out of 4,063 (1.6%) in the previous quarter.

2.2.6. Deaths following surgery and anaesthesia

The number of deaths of patients who received surgery or anaesthesia in the quarter and died within 30 days was analysed. There were eight deaths out of 1,409 patients (0.6%) compared with four out of 1,369 (0.3%) in the previous quarter.

2.2.7. Deaths following stem cell transplantation

The number of deaths of patients who received a stem cell transplant in Quarter One and died within 100 days was analysed. (Patients who had stem cell transplants in the previous quarter, Quarter One, are considered so that a full 100 days is available to be analysed.)

There was one death, unrelated to the transplant, out of 56 adult patients, and there were no deaths out of the eight paediatric patients. There had been three adult deaths (two transplant related) out of 40, and no deaths among the five paediatric patients, in the previous quarter.

2.2.8. Medicines optimisation

Ninety per cent of all Trust chemotherapy prescriptions are being prescribed on the electronic chemotherapy prescribing system (eChemo). This figure continues to increase as trials are extended.

Waiting times for prescriptions dispensed for discharge: over 97% of prescriptions are completed within 60 minutes. Over two thirds are completed within 30 minutes. (*Medicines optimisation*, page 45.)

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 Two the Head of Clinical Legal Services, Complaints and Patient Information received 462 letters of praise (97 in the previous quarter). (*Letters of praise*, page 97.)

2.3.2. Safeguarding of adults at risk

Nine safeguarding concerns were raised at the Trust's Chelsea and Sutton sites (there were four in Quarter One). Eighteen safeguarding concerns were raised in Community Services (25 in Quarter One).

Eleven urgent applications were made under the Deprivation of Liberty Safeguards. (*Safeguarding of adults at risk*, page 33.)

2.3.3. Friends and family test

In Quarter Two the Friends and Family Test showed that

- 98% of Royal Marsden inpatients who responded would recommend the Trust. (Of NHS inpatients in England 96% of respondents would recommend their provider.)
- 96% of Royal Marsden outpatients who responded would recommend the Trust. (Of NHS outpatients in England 94% of respondents would recommend their provider.)
- 98% 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 17.)

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 28 new complaints relating to NHS patients and six new complaints relating to private patients in Quarter Two. All the complaints relating to private patients and 26 of the complaints relating to NHS patients were acknowledged in three days or less.

Thirty-five complaints relating to NHS patients and four relating to private patients were completed in Quarter Two. Six complaints relating to NHS patients and three relating to private patients did not receive a response by the agreed deadline. (*Concerns and complaints*, page 87.)

2.4.2. Freedom of information

The Trust received 131 requests during Quarter Two (118 in Quarter One). Of the 131 requests 130 were answered within 20 working days (99.2%). (*Freedom of information*, page 75.)

2.4.3. Paediatric and Teenage Psychological Support Service

The service received 78 new referrals and provided 391 therapeutic sessions in the quarter. (*Paediatric and Teenage Psychological Support Service*, page 29.)

2.4.4. Clinic waiting times

There has been an increase in patients seen outpatient clinics from 41,352 to 42,487 between Quarter Two 2016/17 and Quarter Two 2017/18. Over the same period the percentage of patients seen within 30 minutes or less of their appointment time has improved by 1.1 percentage points and those seen after one hour of their appointment time decreased by 0.9 percentage points. This reflects a similar positive trend to last quarter. (*Clinic waiting times*, page 84.)

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

In Quarter Two 0.54% of NHS clinics (27 out of 4,693) and 2.11% of private care clinics (43 out of 1,580) were cancelled less than 15 days before the planned date. The percentage of cancellations for both NHS and private care clinics has decreased since last quarter. (*Consultant clinics cancelled less than 15 days before planned date*, page 86.)

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 foundation trusts, has given the Trust a Use of Resources Rating of 1, which means that 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 109.*)

2.5.2. Human resources

The vacancy rate has reduced to 10.5% (against the target of 5%). A programme of recruitment and marketing activity started earlier in the year and is beginning to show results. The vacancy rate for hospital nursing has reduced to 9.7%. The community nursing vacancy rate is 22.9%.

The turnover rate is 15.5% and remains above the 12% target.

The sickness rate for the Trust has fallen from 2.7% to 2.6%, and is below the target of 3%.

Appraisal rate compliance has fallen to 81.7%, below the target of 90%. (*Human resources, page 57.*)

2.5.3. Information governance

The Royal Marsden's final submission of the Information Governance Toolkit for the year 2016/17 was 88% (March 2017). Its October performance update will be 66% which is consistent with last year's submission and shows that the Trust is on track to achieve 88% for the final 2017/18 submission in March 2018. (*Information governance, page 74.*)

2.5.4. Research governance

Eleven projects were awarded Trust sponsorship. There were nine suspected unexpected serious adverse drug reactions (SUSARs), none of which required further action. (*Research governance, page 81.*)

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*	2017/18 (projected)†	2017/18 year to date	2016/17	2017/18 cumulative month
2 weeks					
% of patients seen within 2 weeks of urgent GP referral	93.0%	97.2%	97.2%	97.5%	Sep
% of patients seen within 2 weeks for breast symptoms	93.0%	94.4%	94.4%	95.5%	Sep
31 days					
First treatment – % treated within 31 days of decision to treat	96.0%	98.1%	98.1%	98.2%	Sep
Subsequent drugs – % treated within 31 days of decision to treat	98.0%	99.0%	99.0%	99.4%	Sep
Subsequent surgery – % treated within 31 days of decision to treat	94.0%	96.3%	96.4%	94.8%	Sep
Subsequent radiotherapy – % treated within 31 days of decision to treat	94.0%	95.3%	95.3%	97.6%	Sep
62 days					
All cancers – % treated within 62 days of urgent GP referral	85.0%	75.8%	75.9%	77.1%	Sep
All cancers – % treated within 62 days of urgent GP referral (post reallocation‡)	85.0%	86.3%	86.3%	84.9%	Sep
Referral from screening – % treated within 62 days of urgent GP referral	90.0%	90.6%	91.3%	90.0%	Sep
Referral from screening – % treated within 62 days of urgent GP referral (post reallocation‡)	90.0%	90.4%	90.4%	88.1%	Sep
Consultant upgrade – % treated within 62 days of urgent GP referral	N/A	61.2%	61.2%	76.8%	Sep

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*	2017/18 (projected)†	2017/18 year to date	2016/17	2017/18 cumulative month
Number of NHS elective inpatient full consultant episodes	-	5,065	2,523	5,403	Sep
Number of NHS daycase full consultant episodes	-	11,174	5,566	11,295	Sep
Total NHS elective full consultant episodes	-	16,239	8,089	16,698	Sep
Number of NHS non-elective inpatient full consultant episodes	-	2,060	1,026	1,820	Sep
Number of NHS outpatient attendances	-	186,159	92,727	183,034	Sep

National access targets

Indicator	Target*	2017/18 (projected)†	2017/18 year to date	2016/17	2017/18 cumulative month
Cancelled operations					
Number of last minute cancelled operations for non-clinical reasons not admitted within 28 days**	0	0	0	0	Sep
Referral to treatment (RTT)					
RTT % incomplete pathways within 18 weeks	92.0%	96.7%	96.7%	94.6%	Sep
RTT number of patients on incomplete pathways waiting longer than 52 weeks	2	16	8	25	Sep

Other national indicators – data quality

Indicator	Target*	2017/18 (projected)†	2017/18 year to date	2016/17	2017/18 cumulative month
% of valid NHS Number submitted to Secondary Uses Service (SUS), as defined in Contract Technical Guidance	99.0%	99.8%	99.8%	99.9%	Sep

Other national indicators – infection prevention and control

Indicator	Target*	2017/18 (projected)†	2017/18 year to date	2016/17	2017/18 cumulative month
Number of diagnoses of <i>Clostridium difficile</i> ††	-	58	29	46	Sep
Number of diagnoses of <i>Clostridium difficile</i> (lapses of care 2017/18 identified to date‡‡)	<= 31	5	2		Aug
Number of diagnoses of meticillin-resistant <i>Staphylococcus aureus</i> (MRSA) bacteraemia	0	0	0	1	Sep

Other national indicators

Indicator	Target*	2017/18 (projected)†	2017/18 year to date	2016/17	2017/18 cumulative month
Number of occurrences of patients in breach of sleeping accommodation guidelines	0	0	0	0	Sep
Venous thromboembolism (VTE) risk assessment	95.0%	96.2%	96.2%	96.9%	Sep

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

† 2017/18 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. Lapses of care will be reported from Quarter Two 2017/18.

3.2. Commissioning for Quality and Innovation (CQUIN)

3.2.1. A proportion of the Trust’s income in 2017/18 was 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 2017/18 were 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

- Clinical Utilisation Review (CUR)
- Enhanced supportive care access for advanced cancer patients
- Nationally standardised dose banding for adult intravenous systemic anti-cancer treatment
- Hospital Medicines Optimisation
- Stereotactic Radiotherapy (SRS/T) Services dataset
- Sustainability and Transformation Plan

CCG CQUIN Schemes

- NHS staff health and wellbeing
- Reducing the impact of serious infections (antimicrobial resistance and sepsis)
- E-Referral Service
- Sustainability and Transformation Plan
- Risk reserve

3.2.4. Community Services

- NHS staff health and wellbeing
- Improving the assessment of wounds
- Personalised care and support planning

3.2.5. Acute NHS England CQUIN milestones 2017/18

The table below shows the Trust’s submitted position against the Quarter One and Quarter Two milestones in year 2017/18.

Scheme	Milestone	Quarter 1	Quarter 2
Clinical Utilisation Review (CUR)	Quarterly CQUIN report.	Achieved	Achieved
Enhanced supportive care	Performance against 2017/18 trajectory.	Achieved	Achieved
Dose banding	Performance against 2017/18 trajectory in Quarter 2.	Achieved	Achieved

Scheme	Milestone	Quarter 1	Quarter 2
Hospital Medicines Optimisation	90% of new patients best value generic/ biologic product on Quarter 1 and Quarter 2 list and 20% of existing patients receiving best value generic/biologic product on Quarter 1 list. Progress against transition plan for increasing use of cost effective dispensing routes for outpatient medicine. Fully and accurately populated submission of outcome intravenous immunoglobulin (IVIg) databases in line with agreed timetable.	Achieved	Achieved
Sustainability and Transformation Plan	Scoping of CQUIN scheme milestones.	No milestone in Quarter 1	Achieved
Stereotactic Radiotherapy (SRS/T) dataset	Submission of agreed SRS/T dataset.	Achieved	Achieved

3.2.6. Acute CCG CQUIN milestones 2017/18

The table below shows the Trust's position against the Quarter One and Quarter two milestones in year 2017/18.

Scheme	Milestone	Quarter 1	Quarter 2
NHS staff health and wellbeing	Staff survey: full update on actions against action plan and present findings of local surveys	Achieved	Achieved
Reducing the impact of serious infections (antimicrobial resistance and sepsis)	Timely identification of sepsis in Clinical Assessment Unit: submit Quarter 2 2017/18 audit baseline and set trajectory for 2017/18. Timely treatment of sepsis in Clinical Assessment Unit: submit Quarter 2 2017/18 audit baseline and set trajectory for 2017/18. Antibiotic Review: submit Quarter 2 2017/18 audit baseline and set trajectory for 2017/18	Achieved	Achieved
e-Referrals	Meet target of 80% two-week rule clinic slots to be published via e-Referrals systems. Evidence slot polling ranges for directly bookable services match or exceed waits for paper referrals and detail Appointment Slot Issues (ASI) by service in line with the agreed trajectory set for 2017/18.	Achieved	Achieved
Sustainability and Transformation Plan	Scoping of CQUIN scheme milestones.	No milestone in Quarter 1	Achieved
Risk reserve	No milestone.	No milestone in Quarter 1	No milestone in Quarter 2

3.2.7. Community Services CCG CQUIN milestones 2016/17

The table shows the Trust's position against the Quarter One and Quarter Two milestones in year 2017/18.

Scheme	Milestone	Quarter 1	Quarter 2
NHS staff health and wellbeing	Staff survey: full update on actions against action plan and present findings of local surveys.	Achieved	Achieved
Improving the assessment of wounds	Commence training of staff in care bundle assessment tools. Refine data collection tool to ensure quarterly reporting. Complete local baseline audit collection venous leg ulcer and pressure ulcer care bundles. Refine key performance indicator definitions, improvement plan and trajectory	No milestone in Quarter 1	Achieved
Personalised care and support planning	Submission of plan to ensure 75+ Patient Health Check assessment is embedded into patient assessment with the identified community clinical team including developing clear pathways and method of recording that the health check assessment has taken place. Identify the number of eligible patients and quantify the number of patients that have multiple long-term conditions, and who will be prioritised for personalised care and support planning. Set improvement trajectory. Capacity planning and determine mechanism to feedback outcome from 75+ Patient Health Check assessment to GPs.	No milestone in Quarter 1	Achieved

3.2.8. Commissioner confirmation of achievement 2017/18

Acute NHS England

NHS England has confirmed 100% achievement for Quarter One milestones. Confirmation for Quarter Two is awaited.

Acute CCG

Sutton CCG has confirmed 100% achievement for Quarter One milestones, and 100% achievement for Quarter Two milestones.

Community services

Sutton CCG has confirmed 100% achievement for Quarter One milestones. Confirmation for Quarter Two is awaited.

4. Service users' needs and preferences

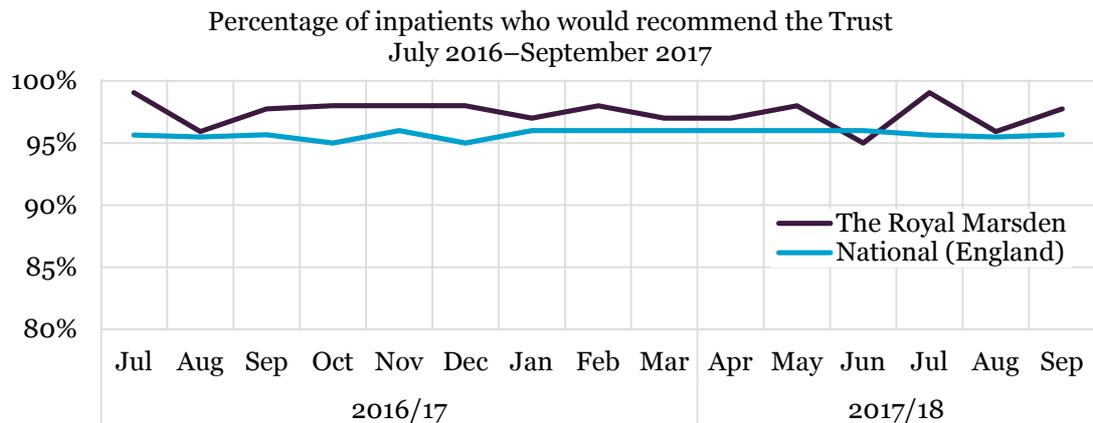
4.1. Patient and Carer Advisory Group

- 4.1.1. 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.
- 4.1.2. The group invited representatives of the private care directorate within the Royal Marsden to describe how the service runs and interacts with NHS services in the Trust.
- 4.1.3. Members who are also members of the Arts Forum in the Trust described the impact of the forum on improving the hospital environment. The Arts Forum arranges painting and photographic exhibitions, music recitals, art competitions, hanging of pictures and poetry readings.
- 4.1.4. Members continued to represent the group on Trust committees and project groups including the Consent Steering Group, Patient Experience and Quality Account Group and the Customer Service Excellence Steering Group and the soft facilities tender process.

4.2. Friends and Family Test

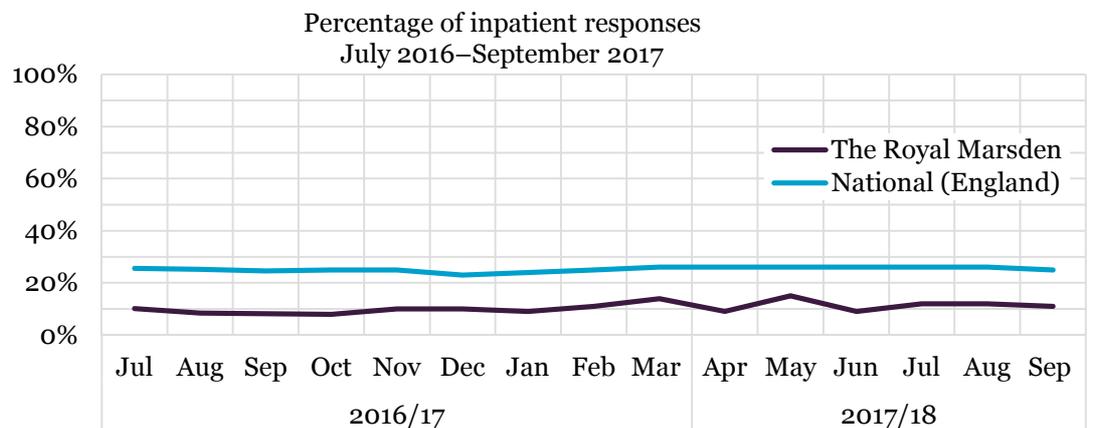
- 4.2.1. The Friends and Family Test asks all patients the question
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?
- 4.2.2. The test is for providers of NHS funded acute services for inpatients including independent sector organisations and for outpatients, community services, dental, ambulance, accident and emergency, maternity, mental health and general practices.
- 4.2.3. 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.
- 4.2.4. In Quarter Two the Friends and Family Test showed that
- 98% of Royal Marsden inpatients who responded would recommend the Trust. (Of NHS inpatients in England 96% of respondents would recommend their provider.)
 - 96% of Royal Marsden outpatients who responded would recommend the Trust. (Of NHS outpatients in England 94% of respondents would recommend their provider.)
 - 98% of Royal Marsden community clients who responded would recommend the Trust. (Of NHS community clients in England 96% of respondents would recommend their provider.)

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



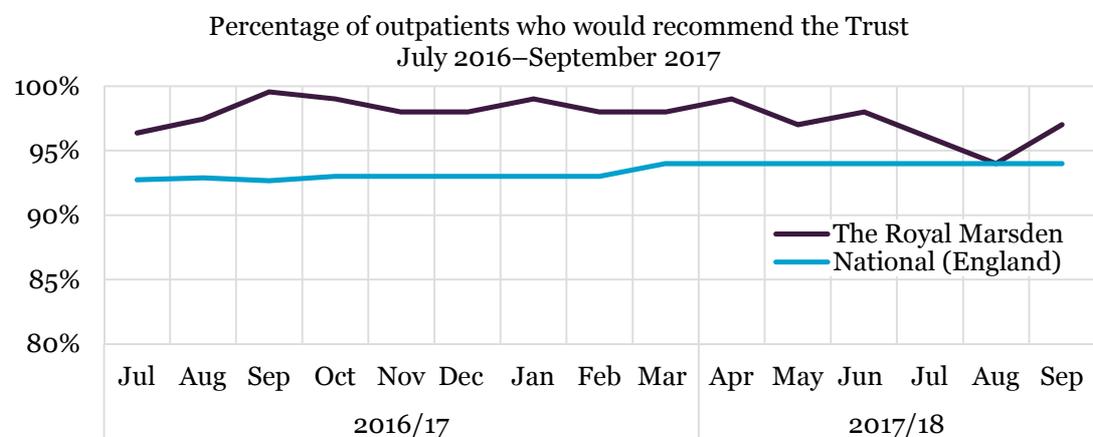
National data from www.england.nhs.uk.

4.2.6. In Quarter Two 1,414 inpatients completed the test. The chart below shows the **inpatient response** rate of the Trust against the national response rate.



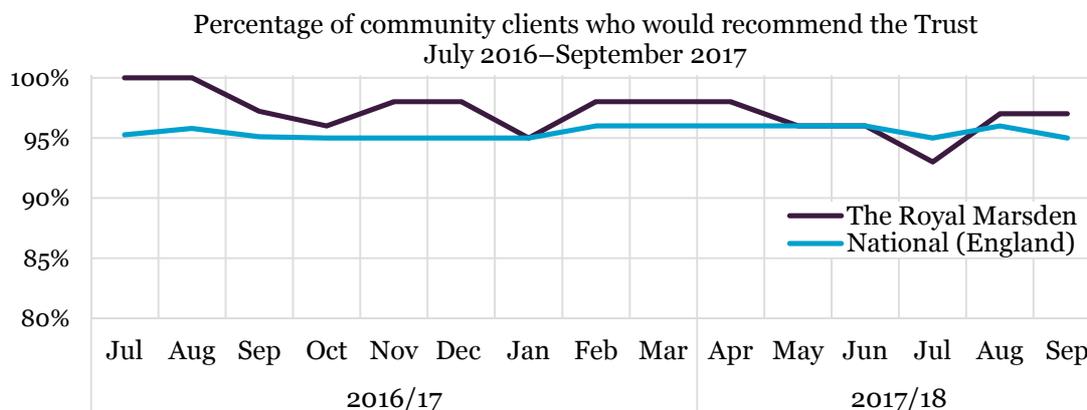
National data from www.england.nhs.uk.

4.2.7. 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.

- 4.2.8. 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.

- 4.2.9. 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.
- 4.2.10. 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.
- 4.2.11. The feedback can be attributed to an individual ward or department. Ward Sisters and Matrons review the data at minimum monthly, and it is 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.
- 4.2.12. Patient comments on areas where improvement could be made**

Inpatients

The spirit of the staff is superb, they are enthusiastic about their work and very respectful and helpful to their colleagues, which is quite uplifting for patients. The noise at night is a real nuisance, particularly the chattering by patients as late as 3 am.

Very friendly, helpful, and kind nurses. Could nurses maybe order drugs in advance (day before) I needed painkillers and had to wait 2 hours as did other patients sitting with me.

Excellent facilities. Comfortable beds for parents. Friendly staff. Excellent playroom and staff and activities. Room for improvement: Parents kitchen facilities not cleaned regularly e.g. the milk fridge and dish washer and sink is stained.

Care and attention is superb. Thoroughness is admirable. Excellent Staff are professional. Setting up clinic appointments could be easier. Getting a bed feels like a lottery, but I appreciate the stress of too much demand.

Outpatients

Referred for a clinical trial. First visit here, the nurse who took height and weight prior to seeing doctor didn't introduce herself or give any explanation of what to expect. Left to sit in an uncomfortable clinic room for about 20 minutes not knowing what to expect. Have travelled a long way to be here, didn't feel welcomed. Sent for blood tests, not clear need to take ticket for the queue. Staff would come to the waiting room and press number button and stand there without saying a word, no smile, no welcome, pointed to a chair, no explanation given, no interaction at all, then looked at form and asked me if it was for here. Very poor first impression of the hospital. Phlebotomy staff very poor social skills. It has put me off returning, felt treated like a number!!!

Daycase

The only area where there was a slight 'Talk to the hand' moment was at the Yellow Desk. I asked about how to obtain my pre-treatment medication and was told this was something they could not help with. Full-stop. It would have greatly assisted if I could have been directed specifically on how to solve this issue (which in the event was all sorted out the following day). Perhaps the Yellow Desk people would benefit from not being hidden away behind a partition? Maybe they're a bit lonely and don't feel part of the team!

It was nice to feel that everyone really cared for me and put me at ease, because I was very scared and worried. May be more comfortable seating could be provided around while waiting for the doctors.

School nursing

Engaged well with my daughter. I had to chase up my appointment though, I was not initially informed of it.

Community services

The COPD [Chronic Obstructive Pulmonary Disease] gym was not large enough to accommodate the number of patients attending each session. Therefore the time spent on equipment was at times difficult. However the advice and care was excellent.

4.2.13. Some positive comments from patients

Comments from those on inpatient wards

Everyone recognised me and addressed me with personal greetings. Extremely friendly professional and courteous. Informed about treatment today. Many thanks to nursing team, caring and other professionals.

Staff and quality of care received had been exceptional. This includes catering cleaning/staff. I have been treated with respect. I feel I have been understood. The menu choice and food has been wonderful. The doctors have been knowledgeable - informative and have been amazing.

Comments from those attending as outpatients

Most importantly, treatment at the Marsden has saved my life. I am impressed that staff had today responded to the very hot weather by providing water in the waiting area. I was guided to a cooler room in clinic. I was seen on time for my appointment, despite being scheduled to a later time. Well done.

In four years coming here, never had a bad experience. Thank you for giving me great treatment from all the staff.

There has been a change since last year. I really like the zoning system in the waiting room.

I only have positive comments, excellent care, staff are fabulous, outstanding service.

The nurses and team on the MDU [Medical Day Unit] are always happy, smiling, show empathy, compassion and explain everything in great detail and always make you feel at ease. A big thank you to all.

Comments from those attending in community services

Really good communication with parent. Informed immediately of any problems. Calming and kind to my daughter. Very professional.

My son gets told of what is going to happen e.g. 'it's time for your medication' before the nurses administer any. My son is also positioned correctly and the nurses ensure he is ready for his medication, not rushed. The nurses always let me know in plenty of time when they are running low on any of his medication. This gives me adequate time to organize this and send it to school.

Our health visitor ... was very friendly and has helped us out a lot with the feeding issues we were having and everything else.

Having the six weeks of exercises and discussion made me more aware of my condition, and the book of exercises enables me to continue my exercises at home.

4.3. Patient Information Service

4.3.1. Activity for the quarter:

Type	New title/ new edition	Revision	Total
Booklets	0	3	3
Factsheets	0	17	17
Leaflets	10	6	16
Total	10	26	36

4.3.2. Leaflets reviewed this quarter include *The Royal Marsden Help Centre* and *Private Care; change of status*.

4.3.3. Booklets reviewed and updated this quarter include *The paediatric and teenage psychological support service* and *Radiotherapy; your questions answered*.

4.4. 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	17	2	19
Asian Indian	70	25	95
Asian Pakistani	41	8	49
Asian (other)	96	10	106
Black African	87	7	94
Black Caribbean	87	2	89
Black (other)	12	2	14
Chinese	22	15	37
Mixed White and Asian	12	3	15
Mixed White and Black African	8	0	8
Mixed White and Black Caribbean	7	0	7
Mixed (other)	30	4	34
White British	2,059	289	2,348
White Irish	60	9	69
White (other)	313	65	378
Other	88	138	226
Not disclosed	60	142	202
Total	3,069	721	3,790
Ethnic origin information completed*	3,009	579	3,588
Ethnic origin information completed (%)*	98.0%	80.3%	94.7%

*All values except *Not disclosed*

5. Personalised care, treatment and consent

5.1. Operating theatres and endoscopy

- 5.1.1. The Royal Marsden is continuing its international recruitment drive. The new nurses undertake the Objective Structured Clinical Examination (OSCE), which assesses the ability to competently apply professional skills and knowledge. There is also a drive to recruit qualified skilled theatre practitioners at bands 5 and 6. The Operating Theatres Team will be attending the Royal College of Nursing fair in Newcastle next quarter. A vacancy on the Recovery Team in the Chelsea operating theatres is now filled. Internal recruitment is taking place to provide cover for a vacancy in the Sutton operating theatres.
- 5.1.2. An audit of non-pay consumables is underway to measure expenditure against activity. Costs are being reviewed as part of an initiative to deliver cost-contained high-quality care for patients. A cost improvement project with the Trust's procurement team is taking place to review cost efficiency in managing high-cost high-volume consumables.
- 5.1.3. Workforce establishment and training requirements in the operating theatres are under review in line with the Trust's surgical strategy.
- 5.1.4. The weekly theatres scheduling planning meeting continues its work to improve operating theatres efficiency.
- 5.1.5. The monthly Operating Theatres Endoscopy Quality Safety Meeting is reviewing the new Trust-wide Local Safety Standards for Invasive Procedures (LocSSIPs).
- 5.1.6. The team has a five-minute briefing every morning. A 'message of the week' is put forward to share learning and identify areas for team focus. As a result team communications have improved.
- 5.1.7. An accreditation by the Royal College of Physicians' Joint Advisory Group on gastrointestinal endoscopy (JAG) is underway with online submission of the Annual Report Card.

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, is now being used for patients referred to the Symptom Control and Palliative Care Team. This will allow the team to monitor interventions, guide service delivery and may in future act as a trigger for referral.

5.2.2. Hospital support

The Symptom Control and Palliative Care Team is now six 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 is supported by RM Partners, a cancer alliance across north west and south west London (part of the national cancer vanguard). Its 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 demonstrated that 86% (111 out of 129) of eligible patients were reviewed by the 'Triggers team' within two months of their first Royal Marsden clinic attendance with 68% (79 out of 116) scoring positive on any one of the trigger items. Ninety-seven per cent (75 out of 77) of patients had at least moderate palliative care needs on at least one IPOS item and 81% (62 out of 77) had severe or overwhelming palliative care needs on at least one IPOS item. Ninety-eight per cent (78 out of 79) were offered referral to specialist palliative care which was accepted by 97% (76 out of 78).

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 with the next palliative care update Day scheduled in October.

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. The Trust has met the quarterly CQUIN targets. The team has attended three meetings of Enhanced Supportive Care leads to share best practice and has visited The Christie NHS Foundation Trust to view an outpatient clinic in action.

The team has secured 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.

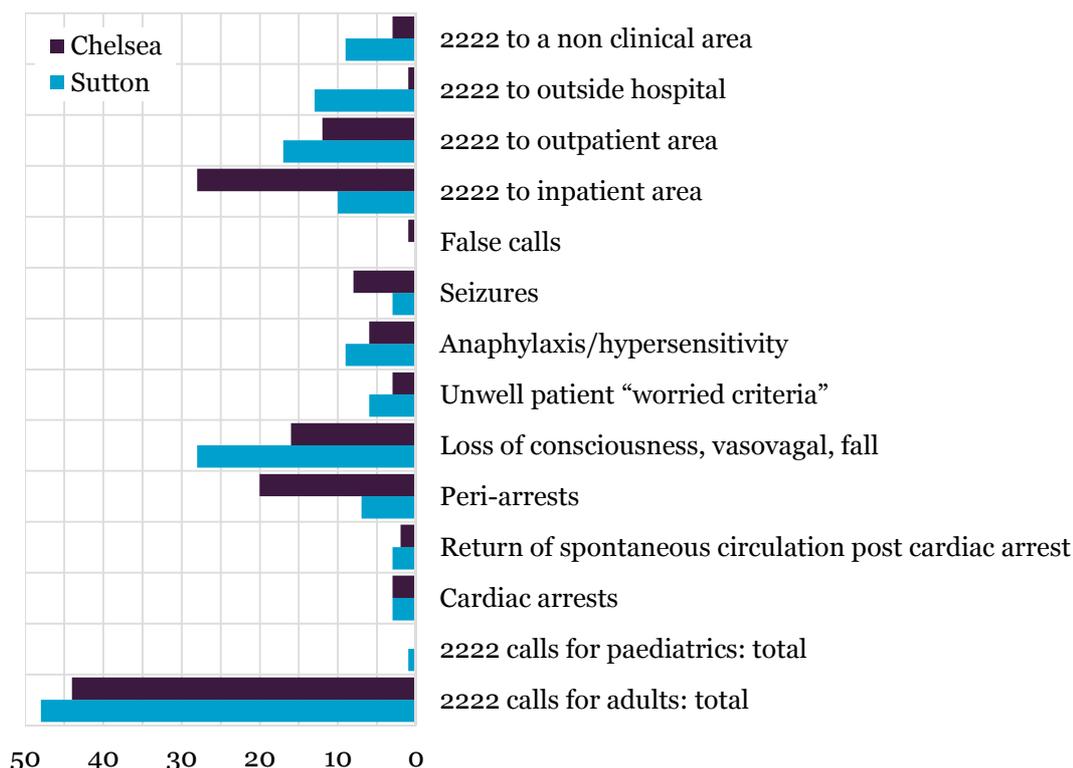
A pilot scheme providing end of life care education, training and clinical support in 11 learning disability homes is progressing well and the team have presented at a number of local and national meetings on the work taken forward.

The team has also been shortlisted for a Health Service Journal Award in the Compassionate Care category. The results will be announced at the awards ceremony in November.

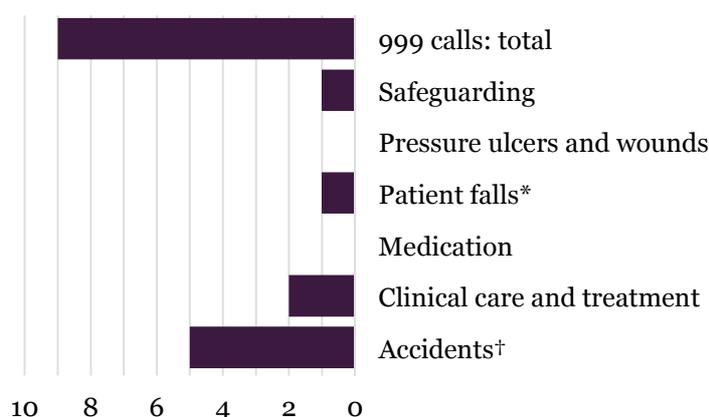
5.3. Resuscitation

This section covers Quarters One and Two 2017/18 (April 2017 to September 2017).

5.3.1. Emergency response calls (2222) – Chelsea and Sutton hospitals



5.3.2. 999 calls – Community Services



* Patient falls including trips and slips.

† Accidents including body fluid exposure and needlestick.

5.3.3. Analysis

Chelsea

The patients involved were medical and surgical. All the calls were for adults.

There were 44 adult emergency response 2222 calls, which included 20 peri-arrest calls for deteriorating patients, 16 for loss of consciousness, vasovagal and falls, three for unwell patients or “worried criteria”, six for anaphylaxis and hypersensitivity and eight for seizures.

Thirty of the calls were for inpatient areas, 14 were in outpatient areas, three were in non-clinical areas, and one was outside the hospital building.

Three calls were actual cardiac arrests: one patient died and two patients had return of spontaneous circulation.

There was one false call for mild dyspnoea.

Sutton

The patients involved were mostly medical.

There were 49 emergency response 2222 calls, of which one was for paediatrics and 48 for adults. These included seven peri-arrest calls for deteriorating patients, 28 for loss of consciousness, vasovagal and falls, six for unwell patients or “worried criteria”, nine for anaphylaxis and hypersensitivity and three for seizures.

Ten of the calls were for inpatient areas, 17 were in outpatient areas, nine were in a non-clinical area, and 13 were outside the hospital building.

Three calls were actual cardiac arrests; three of the patients had return of spontaneous circulation.

There were no false calls.

Community Services

Nine 999 calls were made in the six-month period.

The most frequent reasons for 999 ambulance calls were accidents and clinical care and treatment.

There was one patient fall and one safeguarding incident.

5.3.4. Training

The compliance rates for *Paediatric basic life support* increased to 85% in the previous quarter in response to extra training sessions. The compliance rates for *Adult basic life support* remain static at 82%. The Resuscitation Team is working closely with the Learning and Development Team to analyse the increase in non-compliance and to establish the most appropriate way to maximise attendance. The training rota for 2018 will increase the number of basic life support sessions significantly, and the timing has been changed to make it easier for the members of the multidisciplinary group to attend.

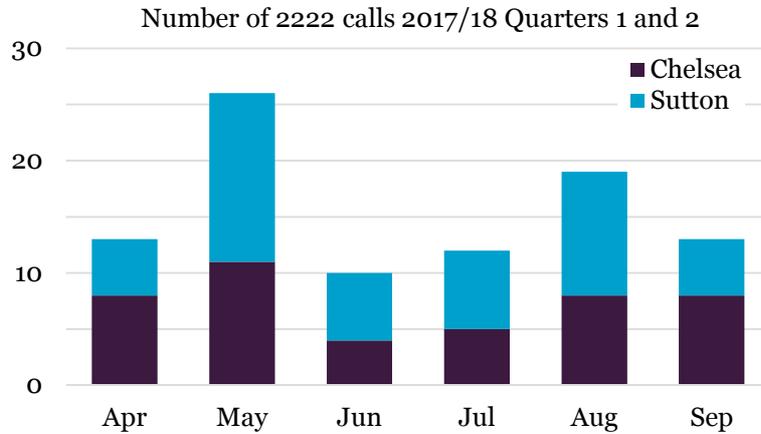
Adult basic life support and *Paediatric basic life support* e-learning is now available for medical staff. The medical staff will continue to have face-to-face learning for the “Do Not Attempt Cardiopulmonary Resuscitation” (DNACPR) update.

The Resuscitation Team has successfully run a 2-day Advanced Life Support Course in Quarter Two.

5.3.5. 2222 calls 2017/18 – Chelsea compared to Sutton

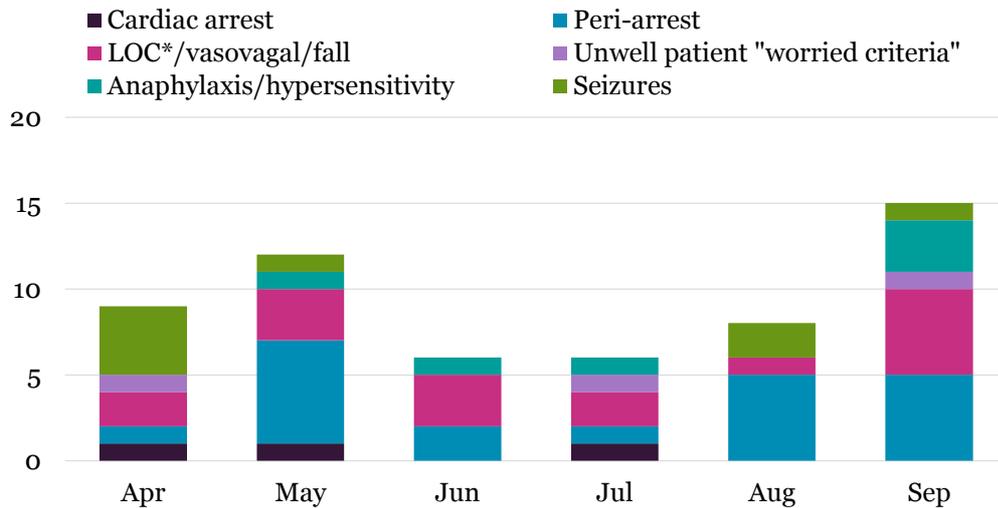
2222 calls, Chelsea: 44

2222 calls, Sutton: 49

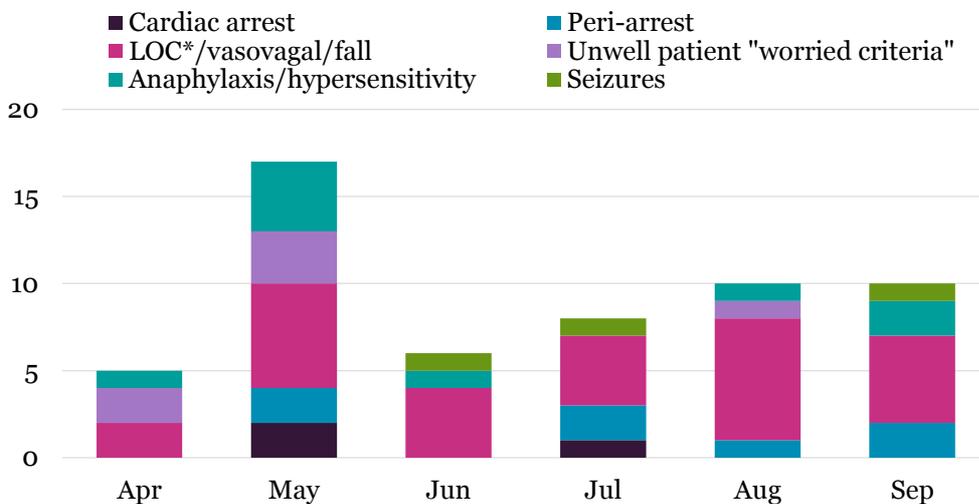


5.3.6. 2222 calls 2017/18 – by type of resuscitation call

Chelsea 2222 calls 2017/18 Quarters 1 and 2

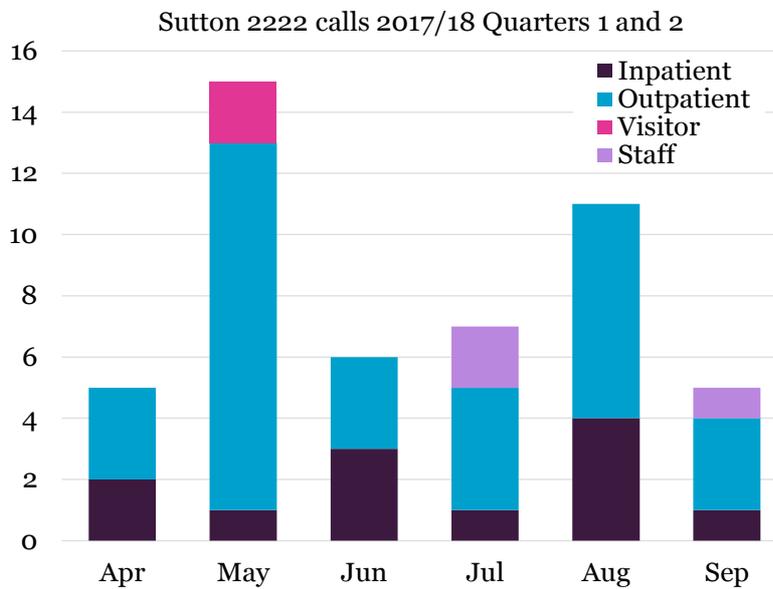
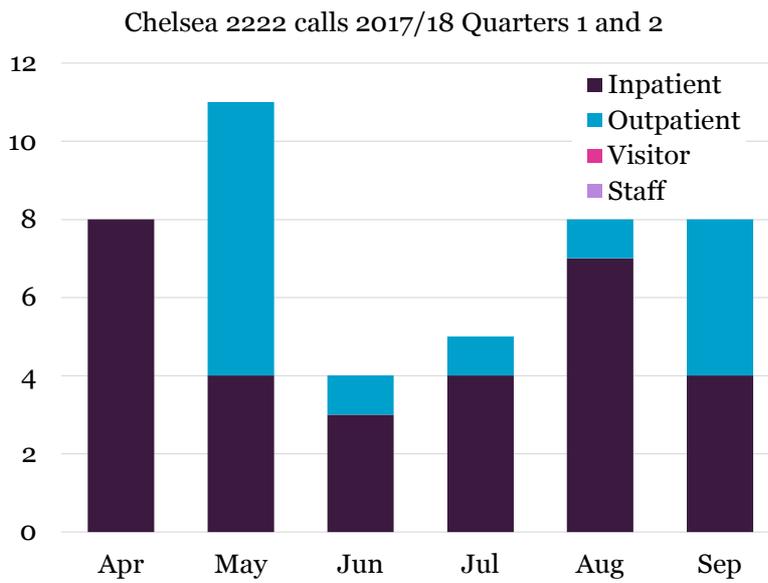


Sutton 2222 calls 2017/18 Quarters 1 and 2

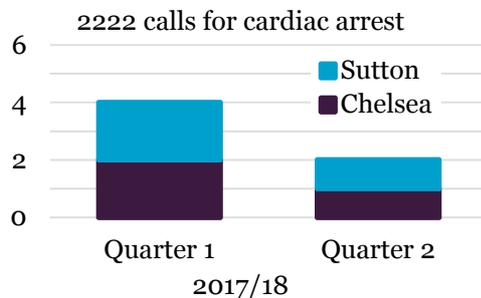


* LOC: loss of consciousness

5.3.7. 2222 calls 2017/18 – by patient group



5.3.8. 2222 calls 2017/18 – cardiac arrest



Chelsea

Total three calls for cardiac arrest:

- Two were inpatients, one was an outpatient.
- Both inpatients had return of spontaneous circulation (ROSC).
- One patient died.

Sutton

Total three calls for cardiac arrest:

- Two were outpatients, one was outside the hospital.
- All three patients had ROSC.

5.4. Adult Psychological Support Services

From this quarter, the Adult Psychological Support Services section will appear every six months, in Quarters One and Three. The Paediatric and Teenage Psychological Support Service section (below) will appear in Quarters Two and Four.

5.5. Paediatric and Teenage Psychological Support Service

- 5.5.1. Patients and their families are supported in coping emotionally with their care, treatment or condition by their clinical team and the Psychological Support Service, which includes the Paediatric and Teenage Psychological Support Service.
- 5.5.2. The service regularly assesses the needs of children, young people, parents and staff to create and plan services and research accordingly.
- 5.5.3. The service received 78 new referrals and provided 391 therapeutic sessions in the quarter.
- 5.5.4. In addition to the individual (one-to-one) supervision the service provides couple and family work, group work, clinical supervision, and staff support groups (for staff in the Paediatric Unit, the Teenage Cancer Trust Unit and the Family Nursing Partnership in Community Services), some of which are run jointly with members of the staff support team.

Quarter 2 2017/18

Clinical supervision groups	11
Staff support groups	10
One-to-one supervision	40
Debriefs/complex case discussion	2

5.5.5. Patient groups

For each of the last six years a confidential, closed group for bereaved parents has been set up, and, as planned, the groups from previous years now meet independently as parent-run support groups. This year the closed group started in April 2016, and its last session took place January 2017. The next closed group is planned to start later in 2018.

The service works as part of a multidisciplinary team and offers groups and one-off therapeutic days such as *Jigsaw*, a pre-school physical, social and communication group which runs weekly.

Regular one-off days include ‘coming off treatment days’ and ‘sibling days’.

5.5.6. Other initiatives, innovations awards and research

The Paediatric and Teenage Psychological Support Service and the Paediatric Neuro-oncology Clinical Nurse Specialist are planning to put on again an information and education day for the schoolteachers of patients. It is planned to run this as an annual event with separate days for primary and secondary schools.

The neurocognitive late effects training will also be extended to train educational psychologists and special educational needs co-ordinators (SENCO) and is currently in planning.

Research initiatives include the development of a short paediatric neuropsychological test battery. This will involve evaluating the developed test battery to determine if it is cost effective, useful and effective to patients, parents and schools. The service is also assessing the neurocognitive report format to make sure that it meets the needs of everyone involved and gives practical and applicable recommendations. This was approved as a service evaluation project and data collection has now stopped and is in the evaluation phase. Specific factsheets about cognitive problems and accompanying strategies will be produced to add to the report. Charity funding has been obtained to ensure continued funding for the project and implementation of regular neurocognitive testing at regular intervals for the next two years..

The research project investigating the development and validation of a paediatric and teenage distress and learning and memory thermometer (part of holistic needs assessment) is now in the analysis stage. Operational guidelines about how to use the holistic needs thermometer will now be completed and put in place over the next year in collaboration with the adult teams.

A trial of offering ‘on the spot’ psychological advice and support in the endocrine and late effects clinic is underway with the current clinical psychology trainees assessing uptake and interest in order to develop a more robust case for extra clinical psychology staffing in this area.

A new initiative offering children and teenagers a multidisciplinary team approach to the chronic persistent pain (CHAMP) service has acquired ‘LIBOR’ funding (from fines levied on the banking industry for manipulating the London Interbank Offered Rate (LIBOR) rate). The funding was acquired through The Royal Marsden Cancer Charity, and starting in September the service is being run every week. Multidisciplinary input including psychology, physiotherapy, massage, and nursing and medical input is being considered on both an individual, patient education day and group approach for a weekly clinic.

Consideration is being given to pilot new stress burnout and resilience tools among the paediatric oncology staff to monitor wellbeing and stress levels

The service is planning to develop a range of colourful family-friendly booklets dealing with common problems in the paediatric oncology population such as

- how to parent effectively
- what behaviours to expect
- impact on siblings
- impact on parents
- night-time problems.

6. Eating and drinking

6.1. Nutrition and catering patient surveys

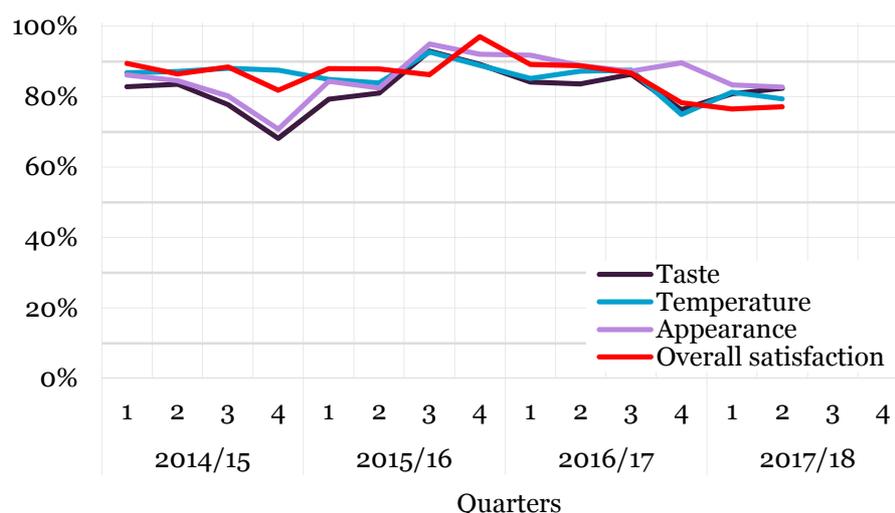
Patient surveys are undertaken at the Chelsea and Sutton sites. The patients' comments are regularly reviewed and particular points are actioned.

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? (91 responses this quarter)
- How would you rate the temperature of the food? (92 responses this quarter)
- How would you rate the appearance of the meals? (87 responses this quarter)
- How would you rate your overall satisfaction with the catering service? (70 responses this quarter).

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

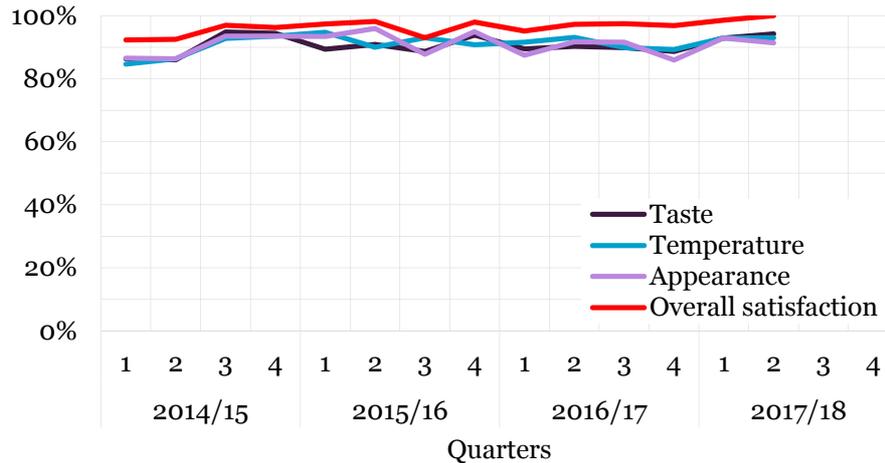


6.1.2. Patient survey results – Sutton

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? (173 responses this quarter)
- How would you rate the temperature of the food? (173 responses this quarter)
- How would you rate the appearance of the meals? (163 responses this quarter)
- How would you rate your overall satisfaction with the catering service? (173 responses this quarter).

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



6.1.3. The Soil Association’s *Food for Life Served Here* award

The Royal Marsden has been recognised for the food it serves to patients, staff and visitors by achieving two *Food for Life Served Here* awards given by the Soil Association. The Trust achieved a silver award for patient catering services and a bronze award for the staff and visitor catering areas.

The Chelsea and Sutton hospital sites serve hundreds of meals to patients, visitors and staff every day. The awards recognise that the Catering Department uses fresh ingredients and is dedicated to serving ethical, sustainable food that meets nutritional guidelines.

The Soil Association said ‘Healthy places must be serving food that is good for the environment and good for us and this is the case at The Royal Marsden’.

7. Safeguarding and safety

7.1. Safeguarding of adults at risk

7.1.1. 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 Two 27 safeguarding adults concerns were raised in the Trust in relation to concerns of abuse or neglect that patients reported experiencing outside of the Trust.

The Trust has also been involved in one Safeguarding Adults Review during this period and presented a case for consideration for a safeguarding adults review. This was decided as not meeting Safeguarding Adults Review criteria but recommended for a learning event.

Number of concerns raised – chelsea and sutton	Quarter 1	Quarter 2	Increase
Number of referrals to local authority	4	9	125%

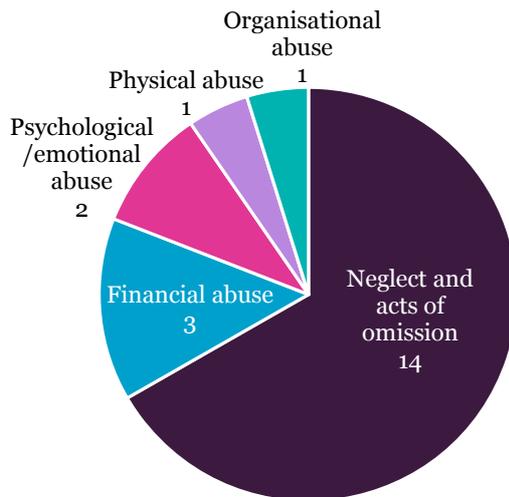
In Quarter Two there were nine safeguarding concerns raised from the Trust's Chelsea and Sutton sites, an increase of 125% since Quarter One.

Number of concerns raised – Community Services	Quarter 1	Quarter 2	Decrease
Number of referrals to local authority	25	18	28%

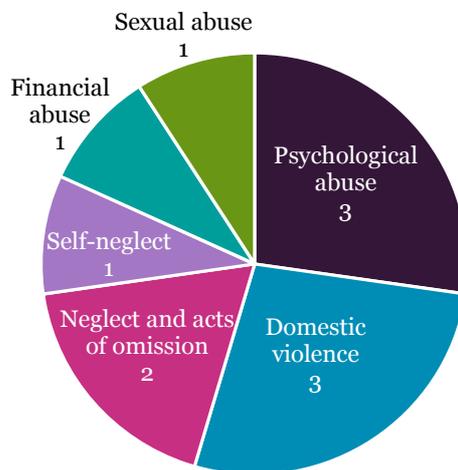
In Quarter Two there were 18 safeguarding concerns raised by Community Services, a decrease of 28% since Quarter One. There is an identified recorded risk that not all concerns raised are being reported on the Trusts reporting system. Community teams however continue to raise the most safeguarding concerns within the Trust, having raised 18 of the 27 referrals this quarter. There was one safeguarding concern raised relating to an attributable pressure ulcer from Community Services.

A safeguarding concern may identify more than one category of abuse for a single referral. In Community Services, neglect and acts of omission continues to be the highest reported category of abuse. Within the hospital-based sites, psychological abuse and domestic violence are the highest reported categories of abuse.

7.1.2. Categories of abuse, Community Services, Quarter Two



7.1.3. Categories of abuse, Chelsea and Sutton, Quarter Two



All multiple pressure ulcers in categories 2, 3 and 4 are screened using the Safeguarding Pressure Ulcer Protocol. There were two this quarter, from Community Services, that were reported to the local authority under the safeguarding adult procedures.

7.1.4. Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) Referrals

A key finding from the Care Quality Commission inspection highlighted that improvements are required in relation to the application of the Mental Capacity Act and Deprivation of Liberty Safeguards in Community Services.

In Quarter Two bespoke Mental Capacity Act and Deprivation of Liberty Safeguards training has been provided to staff in Community Services. Level 2 safeguarding adults training also includes training on the Mental Capacity Act and Deprivation of Liberty safeguards. Community Services compliance was 98% at the end of the quarter.

Deprivation of Liberty safeguards applications are made when the team caring for the patient 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). Eleven urgent applications were made for Deprivation of Liberty Safeguards in Quarter Two. This is a 10% increase from Quarter One, which is attributed to the needs of patients receiving care this quarter and heightened awareness.

	Urgent DoLS applications from Chelsea and Sutton	Increase in urgent DoLS referrals from Quarter 1
Quarter 2	11	10%

7.1.5. 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* (part of CONTEST, the Government’s 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 in place and engages with local safeguarding adult’s 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)*.

Prevent Training	Number of staff completed Quarter 2	Number of compliant staff
Basic awareness	594	3,723
Workshop to raise awareness of <i>Prevent</i> (WRAP)	0	134

Although no WRAP sessions were facilitated during the quarter, the Trust has arranged WRAP sessions for identified staff starting in November, for appropriate staff in line with relevant guidance, to meet the training requirement set by NHS England of 85% by March 2018.

7.1.6. Dementia and Learning Disabilities

The Trust’s Dementia Champions and Learning Disabilities Buddy’s networks 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. During this period, the Patient-led Assessments of the Care Environment (PLACE) results were received which highlighted improvements of signage on the identified dementia wards and also identified areas for improvement for dementia environments, which the Trust is working towards, which includes reviewing the Trust estate infrastructure to ensure it is dementia friendly. The Trust has continued to raise awareness through training staff for dementia through Tier 1 and 2 training as well as through bespoke dementia friend’s 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 within the Trust to date
Tier 1	1,301
Tier 2	80

7.2. Protection and identification of vulnerable children and young adults

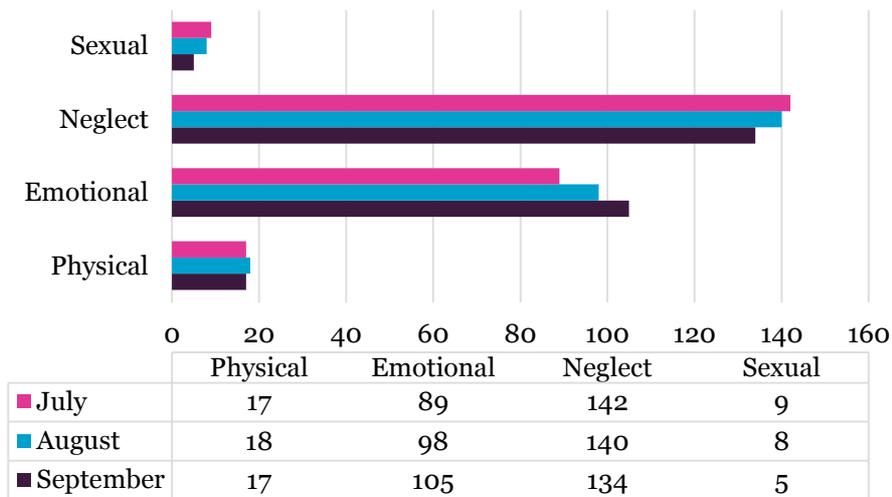
7.2.1. Child protection plans

A child protection plan is implemented when a multi-agency partnership conference decides that a child (or children) is likely to suffer significant harm. The purpose of this formal plan is

- to ensure that the child is safe from harm and to prevent him or her from suffering further harm
- to promote the child's health and development
- to support the family in safeguarding and promoting their child's welfare, as long as it is in the child's best interests.

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, emotional, sexual or neglect, the latter being the category of abuse most identified for children subject to a plan in the London Borough of Sutton.

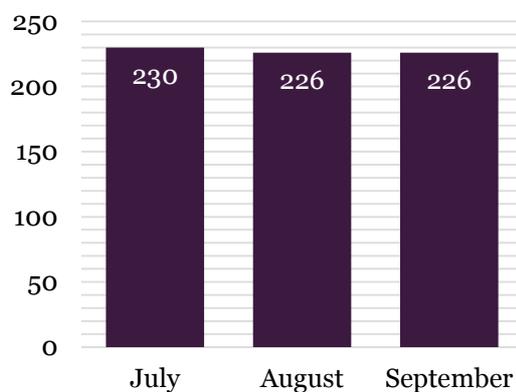
The chart shows the number of child protection plans for each month in Quarter Two.



7.2.2. Looked after children

The number of children looked after by the local authority remains consistent. All of these children/young people are provided with a six monthly or annual health assessment by the specialist nurses for looked after children.

The chart shows the number of looked after children for each month in Quarter Two.

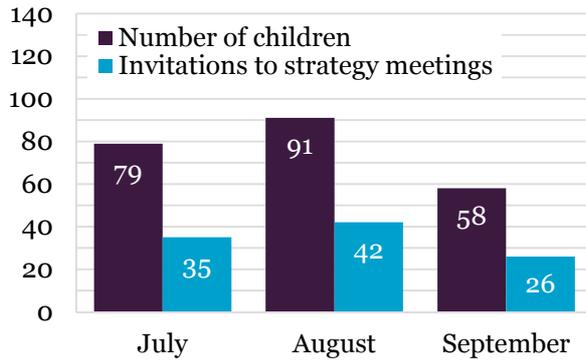


7.2.3. Strategy meetings

Following the inspection of the London Borough of Sutton in November 2016 by the Office for Standards in Education, Children's Services and Skills (Ofsted), there was a recommendation that the borough present evidence of strategy meetings with health partners.

Strategy meetings are multi-agency meetings used to share information to agree the action required to safeguard and promote the welfare of a child. The meetings also agree the conduct and timing of any criminal investigation and/or whether an assessment under Section 47 of the Children Act 1989 should be undertaken. The safeguarding team attends all strategy meetings on behalf of the Trust.

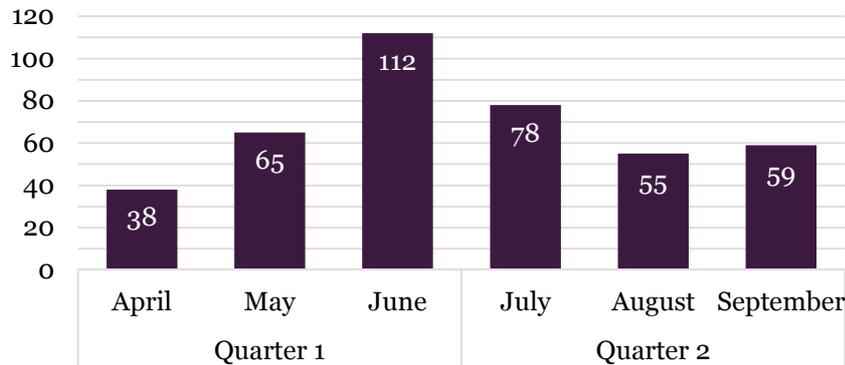
There has been an increase in Quarter Two of the number of strategy meetings being convened which has made additional demands on the service.



7.2.4. Multi-Agency Safeguarding Hub (MASH)

The Multi-Agency Safeguarding Hub (MASH) ensures the sharing of information so risks to children can be identified at an early stage. The MASH is the ‘front door’ for all referrals with concerns for a child’s welfare. It is a link between universal services such as schools and GPs, community services and statutory services such as police and social care. The number of referrals declined in Quarter Two which is attributable to the school holiday period.

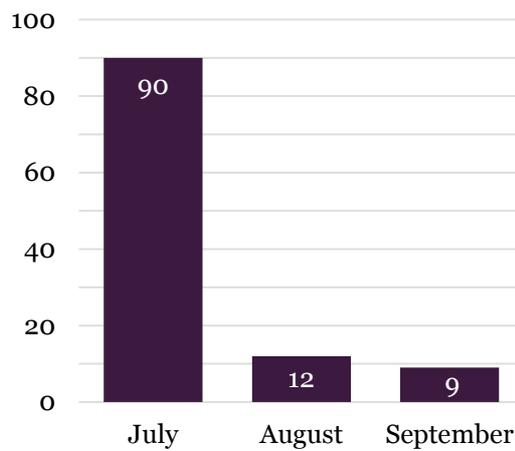
The chart shows the number of referrals to MASH in each month of Quarters One and Two.



7.2.5. Young people at risk of self-harm/suicide

Following the suicides of two young people aged 12 and 15, in July 2017 the London Borough of Sutton instigated a fortnightly partnership review meeting to scrutinise the assessment and care pathway of all young people identified as at risk of self-harm/suicide. The July figures correlate to the end of the school term when the school nursing service provided extensive additional support to schools through the school nurse ‘drop in’ service which enables young people to talk confidentially to staff; this was close to the deaths of the young people. The partnership will be carefully monitoring the figures from September onwards when the school term starts.

The chart shows the number of young people identified as at risk of self-harm/suicide each month in Quarter Two.



7.3. Pressure ulcers

7.3.1. The number of patients that develop pressure ulcers in the Trust is reported in the Quality Account presented each month to the Trust Board and to the Community Services Clinical Quality Review Group.

7.3.2. 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 (fat visible)
4	Full thickness tissue loss (muscle/bone visible)

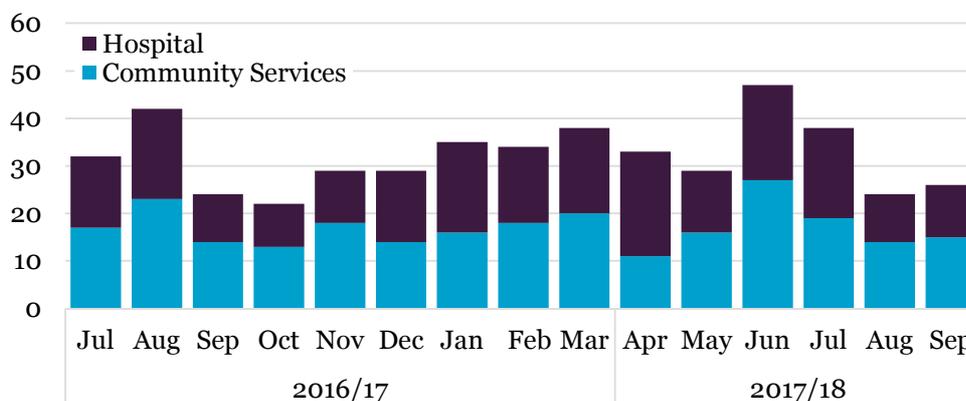
7.3.3. Since June 2015, category 4 pressure ulcers that cause severe harm to the patient and are attributable to the Trust have required reporting under the national serious incident reporting system.

7.3.4. In Quarter Two, no hospital or Community Services patients developed category 4 pressure ulcers that were attributable to the Trust. From 1 April 2016 Community Services data only contains pressure ulcers reported from Sutton Community Health Services.

- More than one pressure ulcer incident may be reported for a patient in the same month, as such the highest category pressure ulcer in 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.

	July	August	September
Number of patients with pressure ulcers attributable to the Trust	38	24	26
Number of patients with pressure ulcers attributable to the hospital	19	10	11
Number of patients with pressure ulcers attributable to Community Services	19	14	15
Number of patients with attributable pressure ulcers Category 1	13	6	4
Number of patients with attributable pressure ulcers Category 2	25	17	21
Number of patients with attributable pressure ulcers Category 3	0	1	1
Number of patients with attributable pressure ulcers Category 4	0	0	0

7.3.5. **Number of patients who developed pressure ulcers that are attributable to the Trust by month – all categories**



8. Premises and equipment

8.1. Infection prevention and control

8.1.1. Mandatory surveillance

Indicator	Quarter 2 DCS* reportable	Quarter 2 DCS attributable	YTD†	YTD attributable	Target	Variance from Target	Forecast
MRSA‡ bacteriaemia	0	0	0	0	0	0	
<i>S. aureus</i> bacteriaemia	0	N/A**	2	N/A	N/A	N/A	
<i>E. coli</i> bacteriaemia	13	9	27	15	42	-27	
VRE bacteriaemia	0	0	1	1	N/A	N/A	
<i>Klebsiella sp</i> bacteriaemia	7		15	4+	29		
<i>Pseudomonas aeruginosa</i> bacteriaemia	4	0	5	0	16		

	Quarter 2	Quarter 2 DCS attributable post 72 hours	YTD post 72 hours	CDT lapse in care YTD: total against target	Target	Variance from target	Forecast
<i>C. difficile</i> toxin	25	16	29	2	31	-29	

* DCS: Healthcare associated infection Data Capture System (HCAI DCS)

† YTD: year to date

‡ MRSA: meticillin-resistant *Staphylococcus aureus*

** N/A: not applicable

8.1.2. Hand hygiene

The overall hand hygiene compliance score for the Trust in Quarter Two is 92%.

The Chelsea site compliance score is 91%, Sutton is 96% and Kingston 90%.

8.1.3. *Clostridium difficile* infection

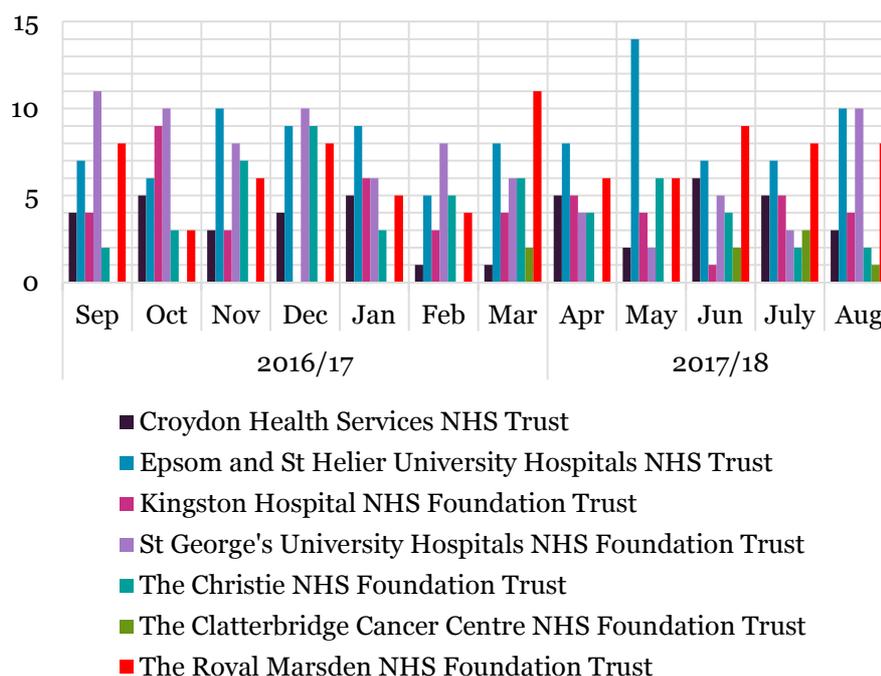
All stool samples found to be *Clostridium difficile* toxin (CDT) positive are reported to Public Health England's Healthcare-associated Infection Data Capture System (HCAI DCS). Those cases which occur within 72 hours of admission are deemed as community attributed. Cases which may have been preventable are deemed 'lapse in care' and recorded against CDT objective target of 31.

There were 25 cases of CDT in Quarter Two. Of these 16 were HCAI DCS reportable as post 72 hours.

The trajectory remains at no more than 31 lapses in care for 2017/18.

Two cases have been assessed as lapses for the period April to August.

8.1.4. *Clostridium difficile* infection in comparison with other providers



8.1.5. Carbapenemase-producing Enterobacteriaceae (CPE)

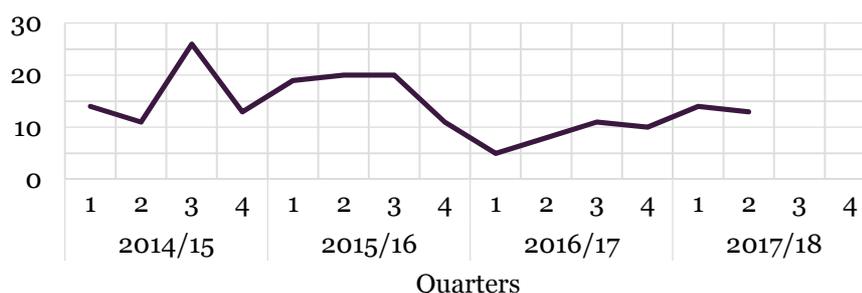
There were 13 patients with confirmed or suspected Carbapenemase-producing Enterobacteriaceae (CPE) in Quarter Two. Most of the patients were from overseas.

8.1.6. *Escherichia coli* bacteraemia

There is a requirement for reporting of *Escherichia coli*, *Klebsiella* sp. and *Pseudomonas aeruginosa* bacteraemia to the HCAI DCS. These are all 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 catheterisation, dehydration (especially in the elderly), biliary sepsis and gut translocation (in patients receiving chemotherapy). These organisms increasingly show antimicrobial resistance making them problematic to treat. The Department of Health 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.

The Infection Prevention and Control Team has previously noted a 27% decline in *E. coli* bacteraemia since 2014 which may be due to use of Ciprofloxacin prophylaxis in neutropenic patients or introduction in late 2015 of the film dressings for vascular access devices. Most cases are still seen in haematology patients and are thought to be caused by translocation of gut flora because of damage to the gut caused by chemotherapy. The Infection Prevention and Control Team will continue to review each case in line with the new guidance.

8.1.7. *E. coli* bacteraemia - reportable



8.1.8. Contract review meetings and audit

The tender for the Fulham Road Collaborative facilities contract has selected the current incumbents as the preferred bidder. This will be treated as a new contract and mobilisation will begin shortly ready for the contract start in January. Staff will be encouraged to engage with process as new service level agreements are set and new equipment and technology introduced to support the contract.

Monthly contract review meetings are held to monitor any concerns and ensure that actions are followed through. Operational audits are carried out weekly to validate cleaning scores submitted by the contractor's supervisors.

8.1.9. Flu

Staff flu vaccination commenced at the end of September with 25% of staff vaccinated in the first three weeks. The Trust is keen to vaccinate as many staff as possible as there are indications from Australasia that the 2017 flu season could be bad one.

Flu vaccinations for staff are available through occupational health or through peer vaccinators positioned throughout the Trust.

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 severe sepsis and septic shock in the Trust by 100% over three years. 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). Furthermore, there is work underway to incorporate potential new definitions of sepsis, new recommendations from the Surviving Sepsis Campaign and combine guidance on generalised and neutropenic sepsis. Additionally, a senior nurse is due to be appointed to coordinate Trust efforts on sepsis and acute kidney injury.

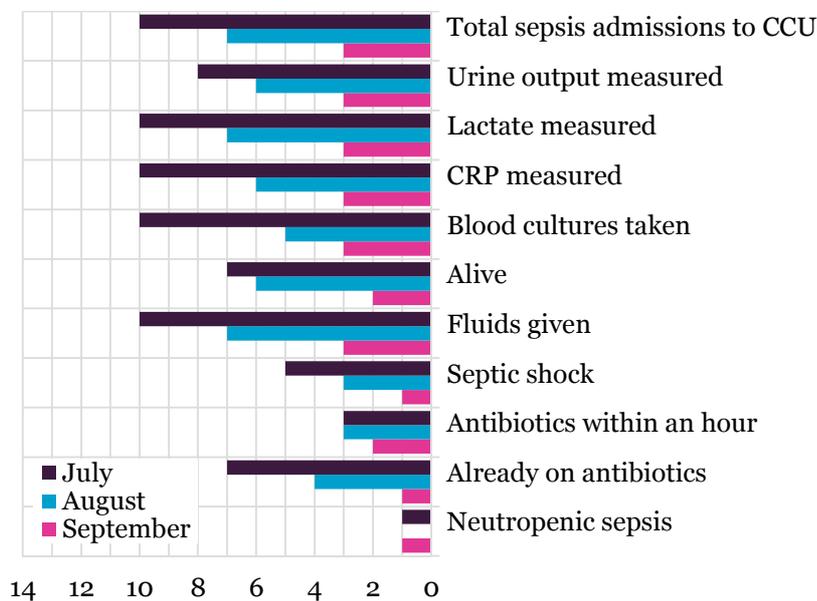
8.2.3. The Sepsis Implementation Team meets regularly to promote awareness and early identification, escalation and management of sepsis and neutropenic sepsis.

8.2.4. Data collection

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

Twenty patients were admitted to CCU with sepsis in the quarter. Of these, five patients died. Only two of the patients had sepsis associated with neutropenia and nine had septic shock. The neutropenic sepsis audit was completed by the Acute Oncology Service (AOS) team. Of the twenty patients (neutropenic and non-neutropenic), all bar one patient had a C-reactive protein (CRP) measured and 90% of patients had blood cultures taken. All had lactate and urine output measured. All the patients were already receiving antibiotics, or received antibiotics within the first hour of presenting with sepsis. Taken together, this demonstrates that the progress achieved with the *Sign Up to Safety* campaign is being maintained.

8.2.5. Sepsis admissions to CCU – July to September 2017



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 national early warning score (NEWS – an early predictor of deterioration) 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.
- 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. Further roadshows are being planned.
- 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.*

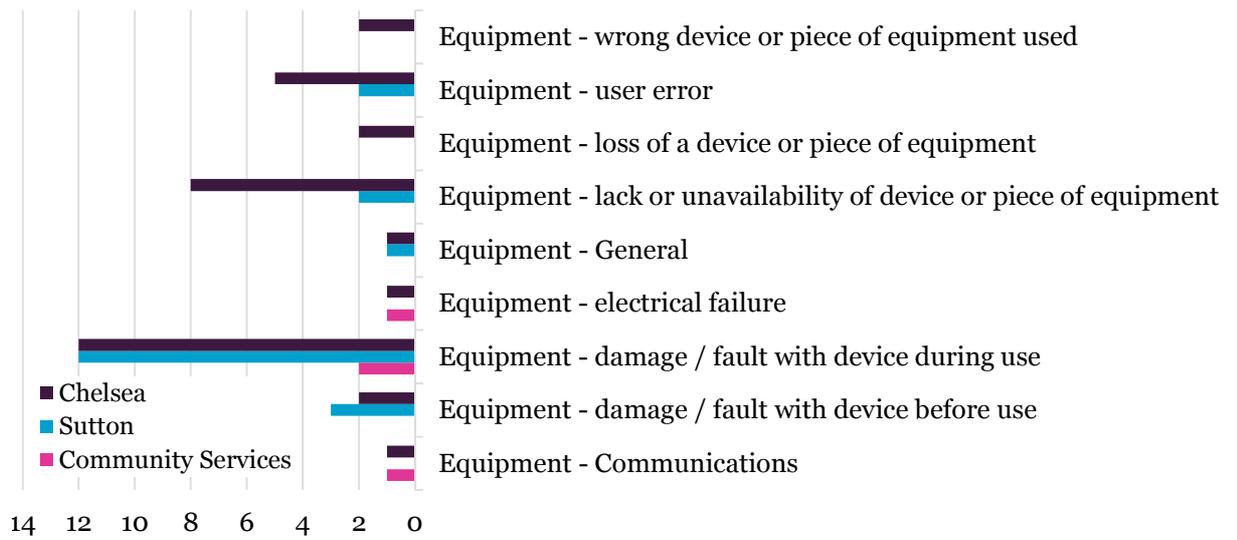
There were 58 incidents relating to medical devices this quarter (there were 61 in the previous quarter).

The main medical device incidents included:

- nine involving various non-specified equipment
- seven involving beds (including mattresses)
- six involving administration and giving sets
- six involving pathology equipment

No incidents were graded *moderate*; 21 were *low* and 37 were *very low*.

8.3.2. Medical device incident category by site



8.3.3. Medical device incidents by type

Type of medical device	Total
Various non-specified equipment	9
Bed (including mattress)	7
Administration and giving sets	6
Pathology equipment	6
Intravenous equipment (such as needle, syringe, extension set)	3
Surgical instruments	3
Anaesthetic machine/equipment	2
Facilities (other)	2
Infusion pumps, syringe drivers	2
Pump/syringe driver	2
Therapy equipment	2
Anaesthetic and breathing masks	1
Computed tomography (CT)	1
Diathermy equipment and accessories	1
Endoscopes	1
Feeding tubes	1
Fridge/freezer	1
Furniture	1
Needles and syringes	1
Physiotherapy equipment	1
Resuscitators	1
Radiotherapy equipment such as simulator, magnetic resonance imaging (MRI)	1
Thermometers	1
Wheelchair	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.

8.3.4. Evaluation of new medical devices

The Clinical Product Review Committee met three times in the quarter. The committee approved eleven proposals to evaluate new equipment. Three products were approved for purchase.

8.3.5. Clinical Product Review Committee medical device proposals

Form A (low risk)	2
Form B (proposal to evaluate)	11
Form D (risk assessment - device not evaluated)	1
Approved for purchase	3
Total	16

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 second 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 two quarters in 2016/17 through to the second quarter of 2017/18.

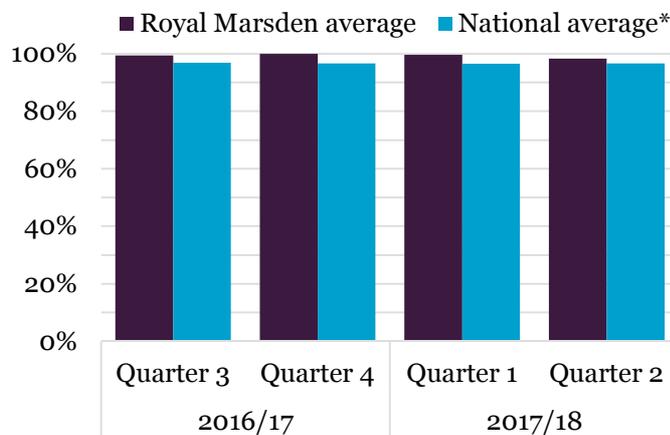


* National averages are calculated from the NHS Medication Safety Thermometer national dashboard.

8.4.3. Allergy documentation

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

The chart shows the percentage of allergy status documented for the last two quarters in 2016/17 through to the second quarter of 2017/18.

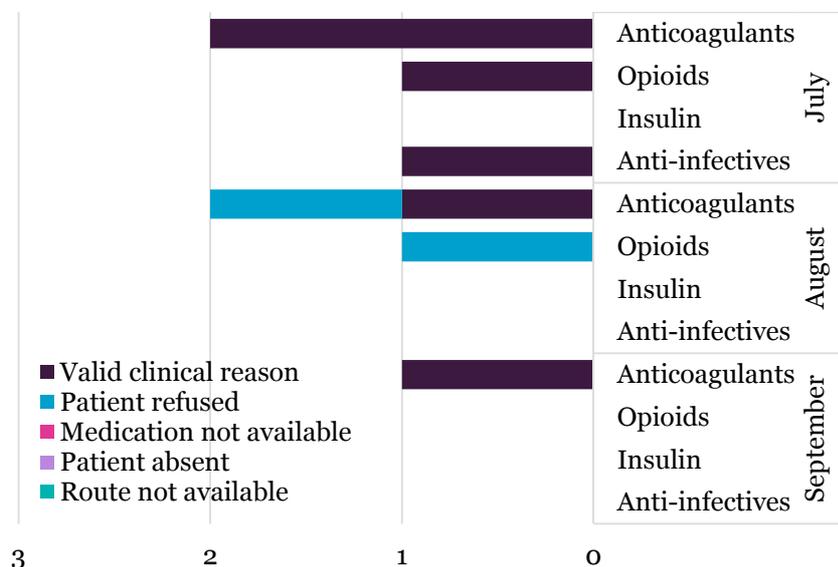


* National averages are calculated from the NHS Medication Safety Thermometer national dashboard.

8.4.4. Omission of critical medicines

The main reasons identified for omission of critical medicines was for valid clinical decision and therefore not an area of concern.

The chart shows occurrences of omission of critical medicine doses for Quarter Two.



8.4.5. Electronic prescribing

By the end of September all clinical units including adult solid tumours, adult haematology and paediatrics are using the electronic chemotherapy prescribing system (eChemo) with 90% of all Trust chemotherapy prescriptions being prescribed on the system. This figure continues to increase as more low-use trials are added.

An audit of prescribing errors before and after implementation of the eChemo system has demonstrated a reduction in error prevalence of approximately 35%.

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 3 2016/17	Quarter 4 2016/17	Quarter 1 2017/18	Quarter 2 2017/18
eChemo prescriptions prescribed more than five days in advance	77%	75%	74%	71%
Available eChemo prescriptions screened more than four days in advance	93%	92%	93%	91%

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 88% of prescriptions are completed within 30 minutes. The average waiting times between July and September were 21 minutes (Sutton) and 14 minutes (Chelsea).

Outpatients Minutes	July		August		September	
	Sutton	Chelsea	Sutton	Chelsea	Sutton	Chelsea
0 to 30	81%	96%	79%	95%	83%	95%
31 to 60	18%	3%	20%	4%	15%	5%
61 or more	1%	1%	1%	1%	2%	0%

Waiting times for prescriptions dispensed for discharge are shown in the table below. It shows that over 97% of discharges were completed within 60 minutes with over two thirds completed within 30 minutes. Average waiting times from July to September were 25 minutes (Sutton) and 18 minutes (Chelsea).

Discharges Minutes	July		August		September	
	Sutton	Chelsea	Sutton	Chelsea	Sutton	Chelsea
0 to 30	72%	87%	67%	87%	78%	88%
31 to 60	25%	12%	27%	12%	19%	12%
61 or more	3%	1%	6%	1%	3%	0%

8.5. Patient Led Assessment of the Care Environment (PLACE)

The Patient Led Assessment of the Care Environment (PLACE) is an annual national assessment which examines various aspects of the patient environment.

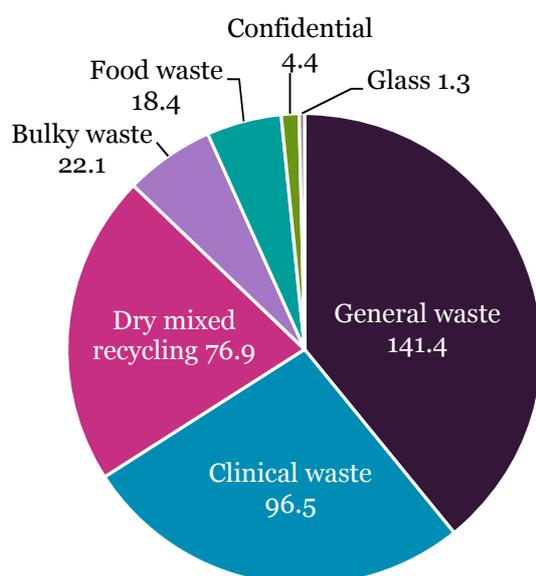
The Trust's hospital environments scored higher than the national average across most domains:

- the domains of *cleanliness, food, privacy/dignity/wellbeing* and *condition/appearance/maintenance* all scored above the national averages for both Chelsea and Sutton sites.
- the Trust scored very highly on *food* (almost a full 10% above the national average in Sutton).
- the Trust scored below the national average on *dementia* (marginally at Chelsea, but by nearly 20% at Sutton).
- the Trust scored above the national average on *disability* for the Chelsea site, but below the national average for the Sutton site (but with a 5% improvement from 2016).

Criteria	National Average Score 2017	Chelsea 2016	Chelsea 2017	Sutton 2016	Sutton 2017
Cleanliness	98.38%	99.57%	99.85%	98.49%	98.75%
Food	89.68%	95.78%	96.49%	96.81%	98.12%
Privacy, dignity and wellbeing	83.68%	89.87%	94.86%	94.40%	91.32%
Condition, appearance and maintenance	94.02%	98.91%	97.80%	92.72%	94.59%
Dementia	76.71%	73.96%	76.20%	62.50%	57.46%
Disability	82.56%	80.68%	88.35%	72.71%	77.63%

8.6. Waste management

The chart below shows the values in tonnes and type of waste generated at the Chelsea and Sutton sites from July to September.



The combined volume of waste disposed of in Quarter Two was 360.89 tonnes. A further breakdown in tonnes is provided below.

Month	Dry mixed recycling	General waste	Glass	Clinical waste	Haz/WEEE*	Confidential	Bulky waste	Food waste	Total weight
July	25.20	45.86	0.40	32.61	0.00	1.46	4.02	5.93	115.48
August	26.40	47.88	0.50	31.35	0.00	1.73	11.54	5.74	125.14
September	25.27	47.62	0.40	32.54	0.00	1.18	6.52	6.74	120.27
Totals	76.87	141.36	1.30	96.50	0.00	4.37	22.08	18.41	360.89

* Haz/WEEE: Hazardous waste and waste electrical and electronic equipment

8.7. Fire

8.7.1. Statutory compliance

All premises that the Trust owns, occupies or manages have fire risk assessments in compliance with the Regulatory Reform (Fire Safety) Order 2005.

The Trust has developed a capital fire infrastructure programme for both hospital sites with the London Fire and Emergency Planning Authority (LFEPA) to eliminate or reduce fire risk to as low as reasonably practicable.

The Trust has not been subject to any enforcement action by LFEPA.

The Trust has no unresolved enforcement actions to implement.

The Trust complies with the Department of Health's Fire Safety Policy contained within health technical memorandum (HTM) 05-01.

The Trust is confident that, in relation to design and layout, where premises are altered or their use is changed, the continued safety and suitability of the premises has been maintained.

Appropriate fire safety measures are incorporated into project design as required by the Department of Health’s Firecode guidance document.

8.7.2. Fire risk assessments

All fire risk assessments are reviewed annually and regular risk register update meetings are held.

8.7.3. Fire preparedness

The Trust maintains fire preparedness. It tests the use and function of the fire detection systems, fire alarms and fire extinguishing equipment; prepares employees for competent performance during a fire emergency; ensures employees are aware of potential fire hazards; and promotes a safe environment for patients, employees, students and all other visitors.

8.7.4. Planned evacuation procedures

The Trust operates a two-stage fire alarm system in support of its planned procedure of progressive horizontal evacuation. Sounding of the continuous alarm indicates that there may be a fire in the local zone. Sounding of the intermittent alarm indicates that there may be a fire in an adjacent zone.

8.7.5. Simulated evacuations

Simulated evacuation exercises are undertaken every year with records of learning outcomes maintained.

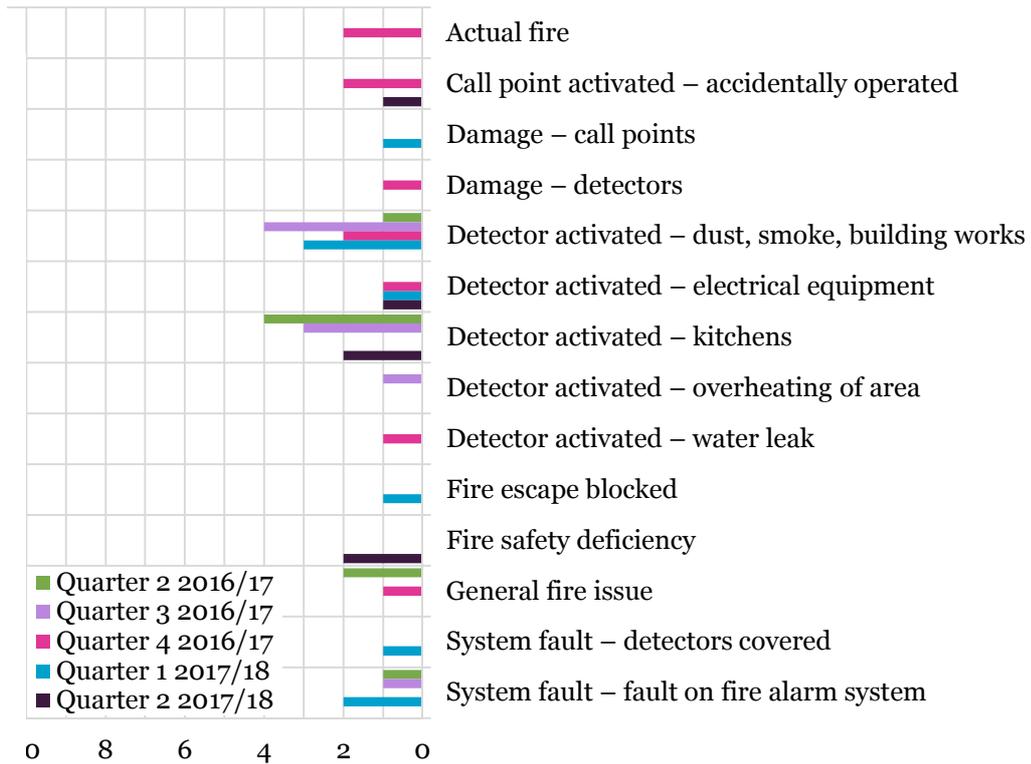
8.7.6. Fire incidents this quarter

There were no actual fires this quarter.

There were six fire incidents attributable to the Trust. (Nine fire incidents were reported in the previous quarter).

Incident category	Number of incidents
Detector activated – kitchens	2
Fire safety deficiency	2
Call point activated – accidentally operated	1
Detector activated – electrical equipment	1
Total	6

8.7.7. Fire incidents in the last five quarters

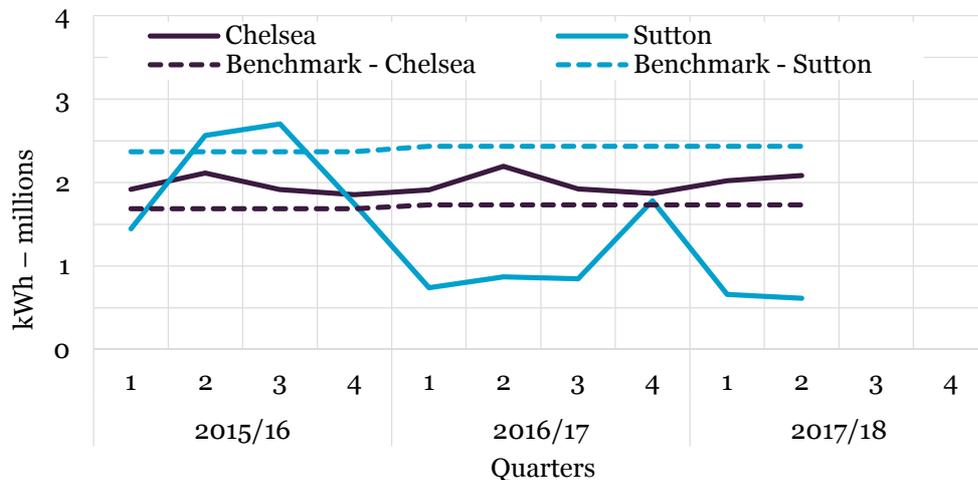


8.8. Energy use

8.8.1. Electricity consumption – Chelsea and Sutton

Electricity consumption in Quarter Two at Chelsea reduced by 5.2 % on the same quarter last year and increased by 3% on Quarter One this year. The main contributor to the increased electricity is extra load of air conditioning cooling systems due to summer heat.

Electricity grid consumption in Quarter Two at Sutton reduced by 30% on the same quarter last year and 7% on Quarter One this year. The generation of electricity from the on-site combined heat and power plant (CHP) has reduced the amount of electricity imported from national grid to the site.

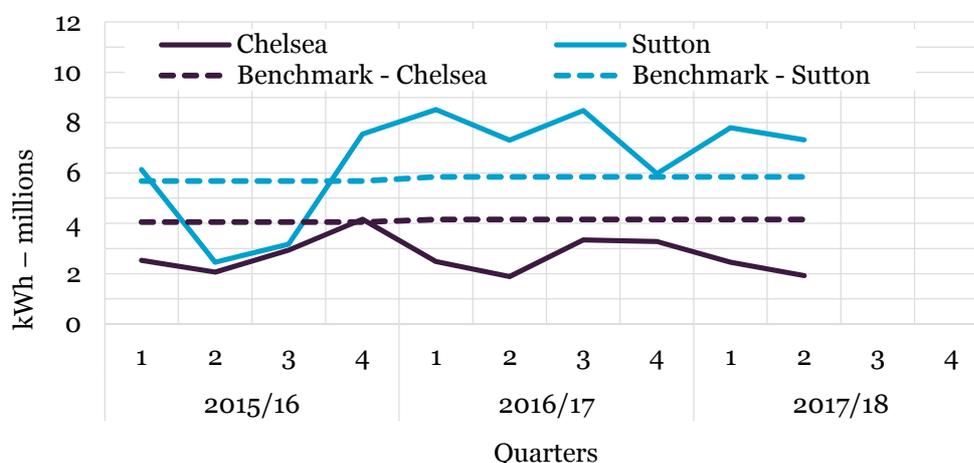


The benchmark used is an average of consumption of five acute trusts in London. The Royal Marsden’s electricity consumption at the Chelsea site is slightly above the benchmark line but the consumption at Sutton is below the benchmark line. The Trust is preparing a feasibility study for on-site generation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

8.8.2. Gas consumption – Chelsea and Sutton

Gas consumption in Quarter Two at Chelsea increased 2% over the same quarter last year and reduced 12% on Quarter One this year. The main reason for increase is increased hot water usage at the hospital. The main reason for reduction is less heating demand due to summer months.

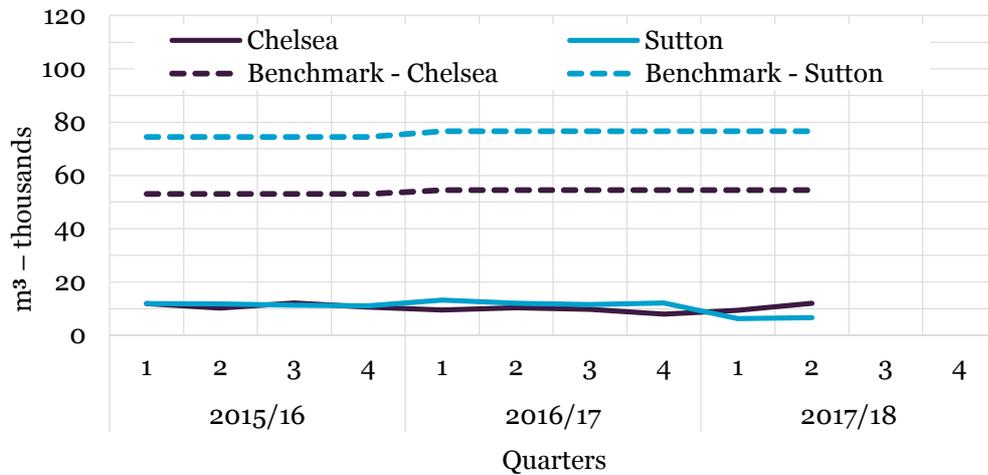
Gas consumption in Quarter Two at Sutton was in line with the same quarter last year and reduced by 7% on Quarter One this year. The reduction is due to more efficient running of the energy centre CHP and boilers.



8.8.3. Water consumption – Chelsea and Sutton

Water consumption in Quarter Two at Chelsea was up 16% on the same quarter last year and increased 27% on Quarter One this year. A faulty water meter was replaced in Quarter One and as a result, more realistic water usage was recorded compared to incorrect consumption recorded in previous quarters. Increased hot water usage and water flushing (to improve hygiene standard) are other main contributors to increased water consumption at the Chelsea site.

Water consumption in Quarter Two at Sutton was reduced 45% on the same quarter last year and increased 6% on Quarter One this year. A faulty water meter is the main reason for not registering actual usage.



8.9. Estate improvements

8.9.1. Radiopharmacy, Sutton

The Radiopharmacy manufactures diagnostic and therapeutic radiopharmaceutical products for the Trust and several external customers.

A new Radiopharmacy laboratory was built on the roof of the outpatients department at Sutton to facilitate service expansion and to undertake further research work in collaboration with the Institute of Cancer Research.



There is a robust Quality Management System in place to provide assurance that the manufactured product is fit for purpose. The building has a metal frame structure with concrete floor and high-pressure laminate plate cladding. The walls are shielded in certain areas for protection.

The unit provides a clean environment with high efficiency particulate air (HEPA) filtered air in rooms having differential pressure to adjoining rooms. All doors and transfer hatches are automatic with time-lapse doors to ensure the integrity of the unit.

This unit has the latest facilities for approval by the Medicines and Healthcare products Regulatory Agency (MHRA) inspector for licencing purposes.

8.9.2. Markus Centre, Chelsea

As part of the Markus Centre project, a report was commissioned on the condition of Lift No.12. The report concluded that the lift, installed in 2001, was nearing the end of its useful life. Refurbishment of the lift was completed in early July and it is operating well.

9. Suitability of staffing

9.1. Human Resources

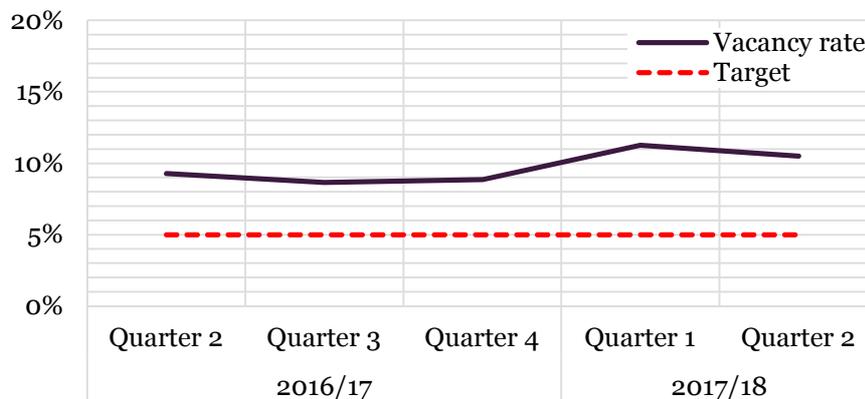
9.1.1. Performance indicators

	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17	Quarter 1 2017/18	Quarter 2 2017/18
Vacancy rate (target 5.0%)					
Trust Total	9.3%	8.6%	8.8%	11.3%	10.5%
Cancer Services	6.4%	5.8%	6.3%	7.2%	7.2%
Clinical Research*				13.0%	3.4%
Clinical Services	9.0%	7.8%	6.9%	11.3%	12.2%
Community Services	15.4%	14.6%	15.7%	17.8%	16.6%
Private Care	19.7%	15.7%	15.7%	18.0%	17.2%
Corporate	5.7%	5.6%	5.7%	8.0%	7.7%
Turnover (target 12.0%)					
Trust Total	14.6%	15.1%	15.2%	15.1%	15.5%
Cancer Services	12.8%	12.1%	12.6%	13.6%	13.9%
Clinical Research*				13.0%	13.5%
Clinical Services	15.6%	15.1%	14.2%	13.3%	14.0%
Community Services	19.7%	22.1%	23.0%	21.0%	21.5%
Private Care	13.0%	15.5%	18.7%	20.9%	21.5%
Corporate	15.5%	14.8%	14.2%	14.5%	15.1%
Sickness absence (target 3.0%)					
Trust Total	2.6%	2.8%	3.5%	2.7%	2.6%
Cancer Services	2.9%	2.4%	3.1%	2.3%	2.7%
Clinical Research*				2.3%	2.1%
Clinical Services	2.2%	2.7%	3.6%	2.6%	2.2%
Community Services	3.2%	3.7%	3.6%	2.1%	3.0%
Private Care	3.4%	3.3%	5.3%	4.8%	3.2%
Corporate	2.8%	3.4%	3.5%	3.1%	2.9%
Appraisal rate (target 90%)					
Trust Total	80.5%	83.5%	86.9%	85.7%	81.7%
Cancer Services	72.3%	79.0%	86.5%	87.2%	77.4%
Clinical Research*				85.0%	78.6%
Clinical Services	85.3%	85.9%	86.8%	85.5%	81.7%
Community Services	76.6%	84.6%	89.0%	85.8%	79.8%
Private Care	80.5%	86.7%	86.2%	81.3%	80.7%
Corporate	87.7%	86.0%	88.1%	86.6%	89.5%
Statutory and mandatory training (target 90.0%)					
Trust Total	91.2%	86.4%	87.8%	89.0%	88.5%
Cancer Services	81.2%	79.4%	81.6%	81.7%	79.1%
Clinical Research*				90.3%	87.2%
Clinical Services	82.6%	88.5%	88.9%	90.4%	90.6%
Community Services	87.7%	88.4%	91.1%	93.3%	94.6%
Private Care	85.2%	87.3%	89.3%	90.4%	90.5%
Corporate	85.1%	90.5%	93.2%	93.1%	94.6%
Local induction (target 80.0%)					
Trust Total	76.0%	72.3%	80.8%	84.2%	83.0%
Cancer Services	74.8%	67.4%	79.6%	82.1%	68.4%
Clinical Research*				86.9%	86.6%
Clinical Services	76.3%	75.2%	84.5%	88.8%	88.0%
Community Services	70.7%	71.3%	78.5%	81.3%	86.0%
Private Care	74.5%	68.1%	69.0%	75.0%	84.1%
Corporate	81.7%	78.3%	83.9%	82.3%	90.0%

* Clinical Research Directorate is included from Quarter 1 2017/18

9.1.2. Vacancy

The Trust vacancy rate has reduced to 10.5% in Quarter Two, above the Trust target of 5.0%.

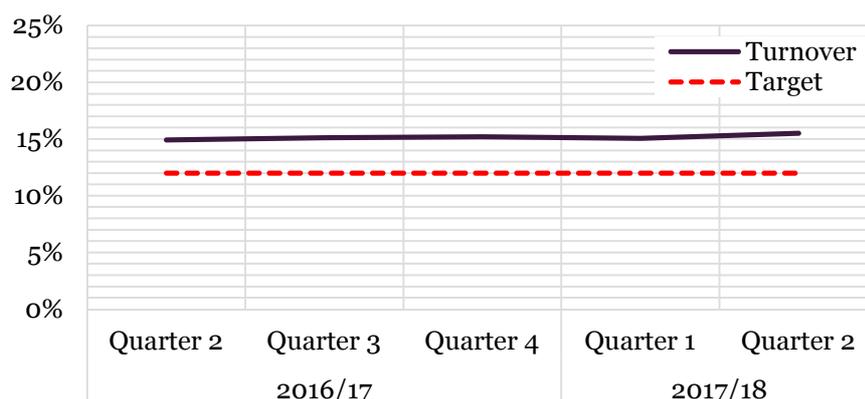


Recruitment activity continues to be a priority for the Trust, with over 130 nurses having been recruited during the first six months of this financial year. The Trust’s Marketing Team has supported a rebranding of recruitment literature and advertising, making it more attractive to the brightest and best applicants and ensuring that they are well informed about the wide range of opportunities for career development available to all Trust staff. Senior nurses and the Nurse Recruitment Team have attended several external recruitment events during the last three months, including an event in Ireland. The Trust has made regular use of social media, tweeting from those events, and sourcing candidates for specialist and hard to fill posts through those sources.

The overall nurse vacancy rate for the Trust at the end of Quarter Two has decreased to 11.5%, with the hospital vacancy rate having reduced to 9.7%, and the Community Services nurse vacancy rate being 22.9%.

9.1.3. Turnover

The turnover rate has increased this quarter to 15.5%, and remains above the Trust target. Attrition continues to be a challenge, with all Divisions experiencing an increase this quarter. A programme of initiatives focusing on all new joiners to the Trust started in the quarter. Time and resource have been allocated to create an innovative on-boarding programme, which addresses feedback from new joiners and longer serving staff about what would help them feel more settled in their early days in the Trust, and give them reason to stay longer. The key components of the programme are described under the headings of, Warmly Welcomed, Inspired and Motivated, Safe to Practice, Equipped and Resourced, and Well Connected.

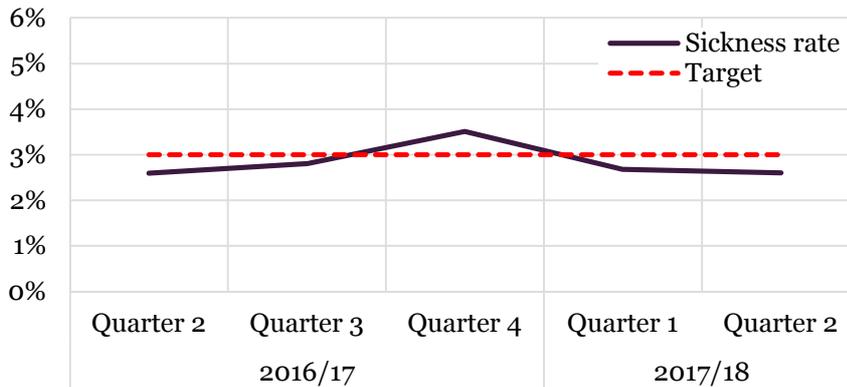


There is feedback that career development is a key consideration in decisions both to join and to leave the Trust, and a programme is in development that invites all staff approaching one year of service to a meeting at which they can discuss their career aspirations and interests.

There continues to be strong support for our staff recognition schemes, with over a 150 nominations received for the awards being presented at this years' Trust Annual Staff Awards ceremony, and 25% of staff having booked a place to attend the ceremony.

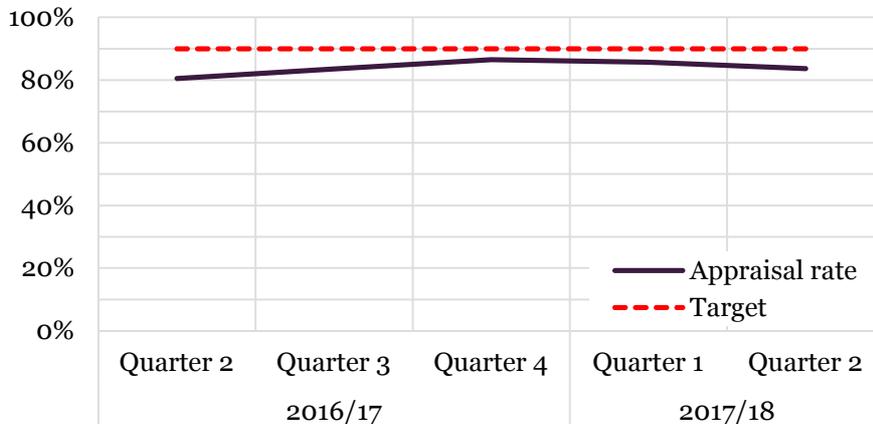
9.1.4. Sickness

The sickness rate has fallen again this quarter to 2.6%, below the Trust target, and continues to follow seasonal trends. Despite being slightly above trust target, Private Care Division has shown significant improvement in reducing their sickness absence by 1.6% this quarter. The Human Resources team provides sickness absence data, and supports the management of long-term sickness and frequent short-term absences. Sickness absence data is reviewed by reason for absence to ensure appropriate provision of occupational health and other support services.



9.1.5. Appraisals

Quarter Two compliance has fallen to 81.7%, and close monitoring will be required to ensure progress towards the 90% target by the end of the year. A new streamlined reporting system, which allows managers to self-report on completed appraisals, is still on track to be rolled out later this year.



9.2. Mandatory training

9.2.1. Part of the strategy to improve mandatory training compliance has focused on seven core topics: *Adult basic life support, Fire awareness, Safeguarding vulnerable adults, Safeguarding children, Information governance, Paediatric basic life support and Infection prevention and control*. In addition to the ongoing use of the WIRED mandatory training and appraisal 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 Two.

Mandatory training topics	Update frequency requirement (in years)	Target	Hospital Services compliance rate	Community Services compliance rate	Overall Trust compliance rate Quarter 1 2017/18	Overall Trust compliance rate Quarter 2 2017/18	Trend
Adult basic life Support	1	90%	82%	88%	83%	83%	
Blood transfusion (generic update)	2	90%	92%	Not applicable	93%	91%	
Conflict resolution for frontline staff	3	80%	77%	86%	79%	79%	
Consent awareness (medical staff)	2	90%	82%	Not applicable	81%	82%	
Equality and diversity	3	90%	91%	95%	91%	92%	
Fire awareness	1 (clinical) 2 (other)	90%	87%	89%	88%	88%	
Infection prevention and control	1 (clinical) 3 (other)	90%	90%	91%	88%	89%	
Information governance	1	95%	92%	97%	94%	90%	
Medicines management (clinical staff)	1	90%	86%	76%	86%	85%	
Medicines management (medical staff)*	3	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	
Manual handling – back care awareness (non-patient handling)	3	90%	88%	94%	89%	88%	
Manual handling (patient handling)	1	90%	84%	85%	84%	84%	

Mandatory training topics	Update frequency requirement (in years)	Target	Hospital Services compliance rate	Community Services compliance rate	Overall Trust compliance rate Quarter 1 2017/18	Overall Trust compliance rate Quarter 2 2017/18	Trend
Paediatric basic life support	1	90%	82%	88%	83%	83%	
Risk management awareness	1 (managers) 3 (other)	90%	92%	93%	90%	88%	
Risk Training for Senior Managers	1 (managers)	90%	70%	67%	70%	71%	
Safeguarding vulnerable adults (level 1)	3	90%	92%	97%	93%	92%	
Safeguarding vulnerable adults (level 2)	3	90%	85%	97%	87%	86%	
Safeguarding children (level 1)	3	90%	89%	94%	92%	91%	
Safeguarding children (level 2)	3	90%	89%	86%	90%	89%	
Safeguarding children (level 3)	3	90%	78%	83%	89%	89%	
Venous thrombo-embolism and pressure ulcers (clinical staff)	1 (clinical)	90%	87%	67%	86%	86%	
Venous thrombo-embolism (medical staff)	Once only	90%	63%	Not applicable	66%	58%	

* *Medicines management for medical staff* is no longer a mandatory training requirement for all consultants (as agreed by the Mandatory Training Monitoring Group, February 2017). Updates and relevant information are circulated to those consultants to whom this is applicable as and when required.

9.2.3. The compliance rates show the percentage of staff trained in line with the Trust’s mandatory training needs analysis.

9.2.4. The training compliance targets are agreed locally in line with national guidance. Typically, 90% is the target for mandatory training topics, benchmarked against London trusts (as referenced in the pan-London streamlining project February 2016). Ninety-five per cent is the national requirement for Information Governance training, 80% has been agreed locally for Conflict Resolution and Local Induction.

- 9.2.5. A compliance rate of 90% or above has been achieved in five topic areas and 80% or above in the remaining topics areas with the exception of three topics.
- 9.2.6. Overall compliance rates have remained relatively stable.
- 9.2.7. Resuscitation training remains a focus area for increasing compliance. Additional sessions continue to be scheduled since quarters three and Four 2016/17. These have helped to maintain compliance in *Paediatric basic life support* (83%) and *Adult basic life support* training (83%).
- 9.2.8. *Safeguarding vulnerable adult's level 1 and 2* training compliance has decreased slightly despite following a targeted non-compliance reminder to staff conducted in the last quarter.
- 9.2.9. Compliance with these topics has decreased slightly since Quarter One:
- *Risk Management* by 2%
 - *Blood Transfusion* 2%
 - *Information Governance* 4%
 - *Medicines Management (Clinical Staff)* 1%
 - *Manual Handling Back Care Awareness* 1%
 - *Safeguarding Children Level 1* 1%
 - *Safeguarding Children Level 2* 1%
 - *Safeguarding Vulnerable Adults Level 1* 1%
 - *Safeguarding Vulnerable Adults Level 2* 1%
 - *VTE Medical Staff* 8%.
- This equates to an average of 2% over the ten topics.
- 9.2.10. In the areas where a decrease in compliance has been identified 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 of topics that are decreasing or not meeting targets in order to improve compliance. This will continue to be the strategy of the Learning and Development Team over the next quarter.

9.3. Induction

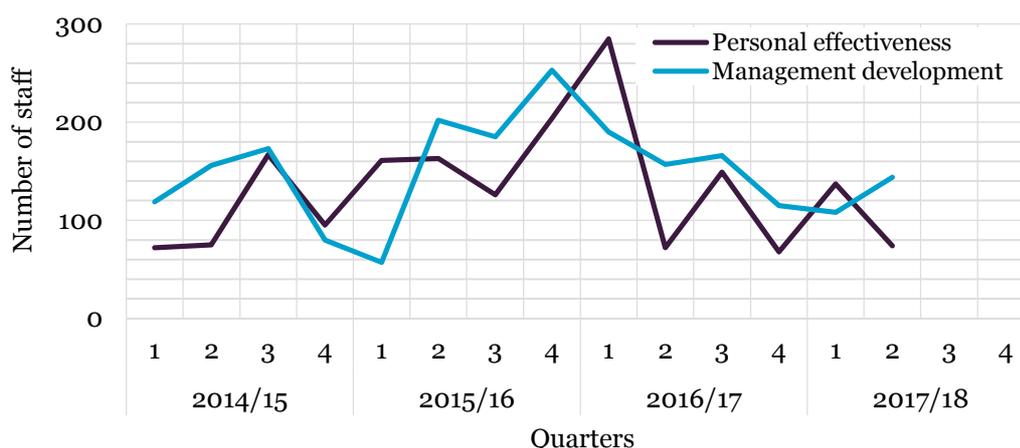
9.3.1. The compliance rate for local induction (83%) has continued to exceed the target of 80% for the sixth consecutive month. Regular three-monthly targeted follow-up with line managers remains the key strategy for maintaining the local induction compliance rate. This will continue with monthly reminders targeted at those individuals who are not compliant to further increase compliance.

9.3.2. The compliance rate for attendance at Trust Induction has remained stable with a slight decrease to 89%, 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 in two months of their booked start date. Auditing of new starters against attendance highlights where new joiners have not attended and are followed up.

Due to an increase in recruitment of nurses, additional clinical induction sessions have been scheduled to meet the extra demand.

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.



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. In Quarter Two numbers trained tend to be lower as fewer courses are offered during the summer holiday season as many staff are on annual leave and uptake is generally lower.

9.4.2. During Quarter Two the following workshops were delivered:

- *Communicating assertively*
- Information technology sessions in *Microsoft Word, Excel and PowerPoint*
- *Meetings and minute taking*
- *Performance appraisal*
- *Project management*
- *Introduction to supervisory skills*
- *Managing sickness absence*
- *Resilience for leaders.*

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

- 9.4.3. The Learning and Development Team supports internal trainers and educators by offering a portfolio of training and presentation skills workshops. In Quarter Two an innovative workshop focused on Presentation Skills, giving the participants the confidence to design and deliver their message effectively was delivered.
- 9.4.4. In the quarter, the Specialist Facilitators within the Learning and Development Team designed and facilitated a successful team event in the Community Services Division. This enabled participants to recognise, understand and value the contribution of their colleagues, supporting motivation and team productivity. Specialist facilitators also helped a number of managers and supervisors to identify learning needs and team challenges through effective diagnostic processes and assisted with designing bespoke programmes to facilitate positive change.

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

10.1. Clinical audit

- 10.1.1. The Clinical Audit Committee coordinates, evaluates and reviews all clinical audits and Quality Improvement Projects (QIPs) in the Trust.
- 10.1.2. One national audit was registered in Quarter Two:
 - Royal College of Physicians: Physiotherapy Hip Fracture Sprint Audit.
- 10.1.3. Eighteen new clinical audit proposals and two re-audit proposals were approved by the committee to be commenced in Quarter Two.
- 10.1.4. Two national audit reports were presented in Quarter Two:

- *RCS National Audit of Breast Cancer in Older Patients 2017 Annual Report (NABCOP)*

The audit looked at what operations women were having in England and Wales between 2011 and 2015, using existing information from the Office for National Statistics and NHS hospitals in England and health boards in Wales.

All breast cancer units in English NHS hospitals and Welsh health boards were invited to take part in a survey that looked at how services and care of breast cancer are organised. The survey looked particularly at services used by older women. One hundred and twenty-nine out of 142 units responded – 123 NHS trusts in England and six health boards in Wales.

The audit recommendations were reviewed and discussed by the Breast Unit.

- *National Oesophago-Gastric Cancer Audit (NOGCA) Clinical Outcomes Publication 2017*

The National Oesophago-Gastric Cancer Audit Clinical Outcomes Publication 2017 contains site and consultant-specific data concerning curative oesophagectomies and gastrectomies which took place on patients diagnosed with oesophago-gastric cancer between April 2013 and March 2016. Patients with palliative surgical intent, open-and-shut procedures, and bypass procedures are excluded. Overall, data from 67 oesophagectomies and 75 gastrectomies was recorded for this audit.

Outcomes were discussed at the Surgical Audit Group. No actions were required for The Royal Marsden.

- 10.1.5. The mortality audit is done every quarter and the aim of this audit is to review all inpatient deaths occurring at The Royal Marsden in that quarter. The audit evaluates four standards:
 - The patient's death was reasonably to be expected given their clinical condition
 - The patient's preferred place of death was achieved
 - Referrals to the Symptom Control and Palliative Care Team were timely
 - There were no failures of care identified following the full Structured Judgement Review (SJR) in accordance with guidelines from the Royal College of Physicians.

Following review of the data by Palliative Care and Anaesthetics Consultants, all four standards were achieved and the Trust was performance-rated green for Quarter Two.

10.1.6. Fourteen local audit and QIP reports were presented and approved by the committee in Quarter Two.

10.1.7. Audits conducted at Chelsea and Sutton

Title	Action plan, learning and outcomes
Evaluation of patient reported provision of information on medication side effects	To increase sample size and investigate counselling perception across the Trust on all sites. To review current provision of medicine management technicians in the discharge counselling process.
Audit to evaluate reliability of current snapshot method of data collection for use of Medication Safety Thermometer tool	Current data collection method tightened to ensure data collected on allergies addresses the need to evaluate whether documentation of the name of the allergen, date of reaction and severity of reaction as per National Institute for Health and Care Excellence (NICE) guidance. Data collection to continue as a snapshot method but day of data collection varies each month. An audit of medication omission rates to be undertaken to understand this fully across the Trust.
Re-audit of Pharmacy’s compliance with the Procurement and Supply of Unlicensed Medicines and Licensed Medicines use outside of their Product License Pharmacy Procedure	All outstanding monographs under review should be finalised. Monographs in Medicines Information and on On-call laptop once updated. Missing paperwork identified, retrieved and filed accordingly. To run frequent snapshot audits and highlight the main findings of the audit to named patient/unlicensed medicines and dispensary leads. This will reinforce the importance of adherence to the Trust’s policy and pharmacy Standard Operation Procedure for patient safety, in particular the importance of documentation to dispensary staff and/or refresh dispensary staff training on Drug Authorisation Forms.
Neutropenia rates in breast cancer patients receiving fixed-dose GCSF	Ensure all patients over 80kg receive filgrastim 480µg, as per Drug and Therapeutics Committee recommendations. Re-audit to determine the rate of patients over 80kg who received the appropriate dose of filgrastim. Determine whether there were differences in neutropenia rates between the two cohorts once weight-based dosing is fully implemented. Potentially extend these recommendations to other tumour sites.

Title	Action plan, learning and outcomes
Audit of hospital handovers	<p>Findings distributed to outreach leads and admissions teams.</p> <p>All missing attendees continue to be telephoned by the CSP and the start of the handover meeting is delayed until they arrive.</p> <p>The SpR continues to contact the consultant in charge of each patient discussed at handover that has no clear escalation plan in place.</p> <p>The Night SHO continues to telephone the relevant SpR (post-meeting) to gain clarity with regards to their patient's escalation strategy if the SpR is not sufficiently familiar with the patient.</p>
Gemcitabine and docetaxel chemotherapy in advanced synovial sarcoma	<p>Dissemination of the audit findings to the sarcoma unit.</p> <p>Consideration of modifications to local chemotherapy guidelines so that gemcitabine /docetaxel is not recommended in synovial sarcoma.</p> <p>Publication of results combined with patient cohort from another centre to enable dissemination of findings to wider sarcoma community.</p>
Point prevalence study of antimicrobials	<p>To use review sticker to prompt review of antimicrobials, especially intravenous to oral switching and adjusting to microbiology results.</p> <p>Key findings and areas for improvement emailed to prescribers, nursing team and pharmacy team.</p> <p>Results incorporated into Core Medical Trainee training on antimicrobial stewardship.</p> <p>Improvement attendance of pharmacists and medical teams at microbiology ward rounds.</p>
Quality improvement project to improve administration of controlled drugs at The Royal Marsden	<p>This audit has highlighted the need for ongoing education and training for those administering medications, especially the difference between morphine and other types of controlled drugs. The importance of prescribers receiving this education is also recognised. Overall staff confidence is good in the administration of controlled drugs however could be improved by securing controlled drug champions on the clinical units.</p>

10.1.8. Audits conducted at Chelsea

Title	Action plan, learning and outcomes
Audit to measure current practice of critical illness rehabilitation against the recommendations in the NICE (National Institute for Health and Care Excellence) guideline	<p>To update ICIP (IntelliSpace Critical Care & Anaesthesia information system) rehabilitation documentation to include details about information provided, rehabilitation booklets and rehabilitation plans.</p> <p>Staff education with dissemination of results to the Critical Care multidisciplinary team and the physiotherapy team.</p> <p>To liaise with Critical Care Outreach Team/Critical Care Unit audit team to identify a way to document discharge information.</p> <p>“How to...” guide for weekend physiotherapy staff to complete Short clinical assessments introduced.</p> <p>Rehabilitation folders on Critical Care Unit and wards standardised to increase compliance.</p>
Tracheostomy Scoping Project	<p>Awareness of the pathway with the wider multidisciplinary teams for timely identification of patients raised at ward rounds.</p> <p>Care plan for low risk patients developed.</p> <p>To consider other professional groups performing needs assessment.</p>

10.1.9. Audits conducted at Sutton

Title	Action plan, learning and outcomes
Audit of The Royal Marsden MRI guided vacuum assisted breast biopsy service	<p>Best practice confirmed.</p> <p>To continue to audit referral patterns and numbers and feedback to team.</p>
Audit of Clinical Nurse Specialist (CNS) voicemail messages on the Children’s and Young Persons Unit	<p>The audit findings to be disseminated to the CNS team through the senior nurses meeting for discussion and actioning.</p> <p>CNSs should review their answerphone voicemail message daily, if in attendance, to ensure that up-to-date information is given to families who call them.</p> <p>CNSs should include in their answerphone voicemail messages a request to callers to give a return call phone number, and also, for the caller to specify their reason for calling so as to facilitate CNS prioritisation of tasks.</p> <p>Expected call back time to be added to all answerphone voicemail messages.</p> <p>The outgoing CYPOONS (Children and Young People’s Outreach Oncology and Symptom Care Nurse Specialist) team message is not recorded daily but directs all out of hours calls to the team via switchboard. This does not comply with the standard but is currently working for the team. Discussion to be held with the CYPOONS team around the suitability of this practice.</p>

10.1.10. Audits conducted in Sutton Community Health Services

Title	Action plan, learning and outcomes
To assess the uptake and DNA rate for all DESMOND* referral to tier 3 diabetes service	<p>GP practices not referring patients to DESMOND to be targeted to create more awareness.</p> <p>To be explored whether GP practices are referring <u>all</u> the newly diagnosed patients to DESMOND</p> <p>To consider DESMOND awareness day hold both for GPs and the public.</p> <p>DESMOND flyers to be sent to all GP practices for display in the waiting area</p> <p>To consider running DESMOND at evening time or Saturdays to accommodate patients with work commitment.</p>
Community documentation audit (adults services), includes records management, pressure ulcer, leg ulcer, medication/transcribing audit	<p>All team sisters and senior nurses to attend in-house audit training.</p> <p>Standard operating procedure to be developed for expected assessments to be completed on first visit and reviews.</p> <p>Recording of clinical baseline observations should be undertaken on all patients during first visit (in specific O2 levels).</p> <p>Required Medicines Assessments should be completed as required on first face to face visit.</p> <p>Source of referral should be recorded.</p> <p>Patients' religious and/or spiritual beliefs to be recorded during holistic assessment.</p>

* DESMOND: Diabetes Education and Self Management for Ongoing and Newly Diagnosed – a programme for improving opportunities for learning and support for people with or at risk of developing Type 2 diabetes and the health care professionals involved with them.

10.1.11. Clinical Audit Competition

The annual Clinical Audit Competition entries were reviewed and the first prize was awarded for an audit titled *Cervical cancer soft-tissue image guided radiotherapy verification: Development of a training programme to facilitate radiographer review*. The runners-up were two highly commended projects: *Audit to assess the uptake and DNA rate for all DESMOND (Diabetes education for self-management of ongoing and newly diagnoses diabetes) referral to tier 3 service* and *Venous thromboembolism (VTE) - a repeat audit of verbal and written information received by patients*.

10.2. Deaths following anti-cancer therapy

10.2.1. 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).

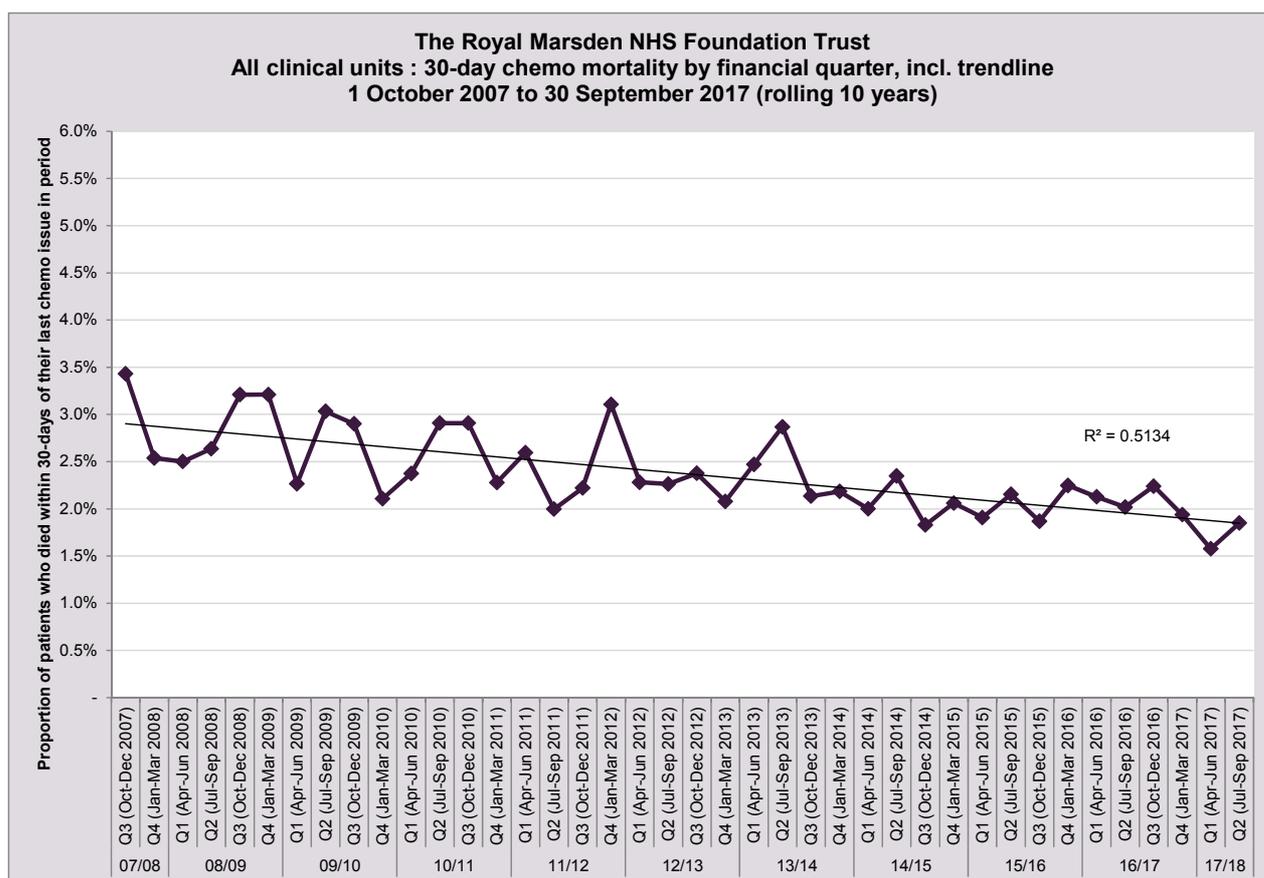
10.2.2. Aim

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 2007/8 to Quarter Two 2017/18.

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.

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 Two there were 77 deaths out of 4,163 patients (1.8%) analysed compared to 63 out of 4,063 (1.6%) in Quarter One.



Source: raw data from Trust Information Department. The last matching using data from the Office for National Statistics (ONS) was carried out on 3 November 2017.

10.3. Deaths following surgery and anaesthesia

10.3.1. Purpose

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

10.3.2. Aim

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

10.3.3. Key points from 30-day deaths trend analysis

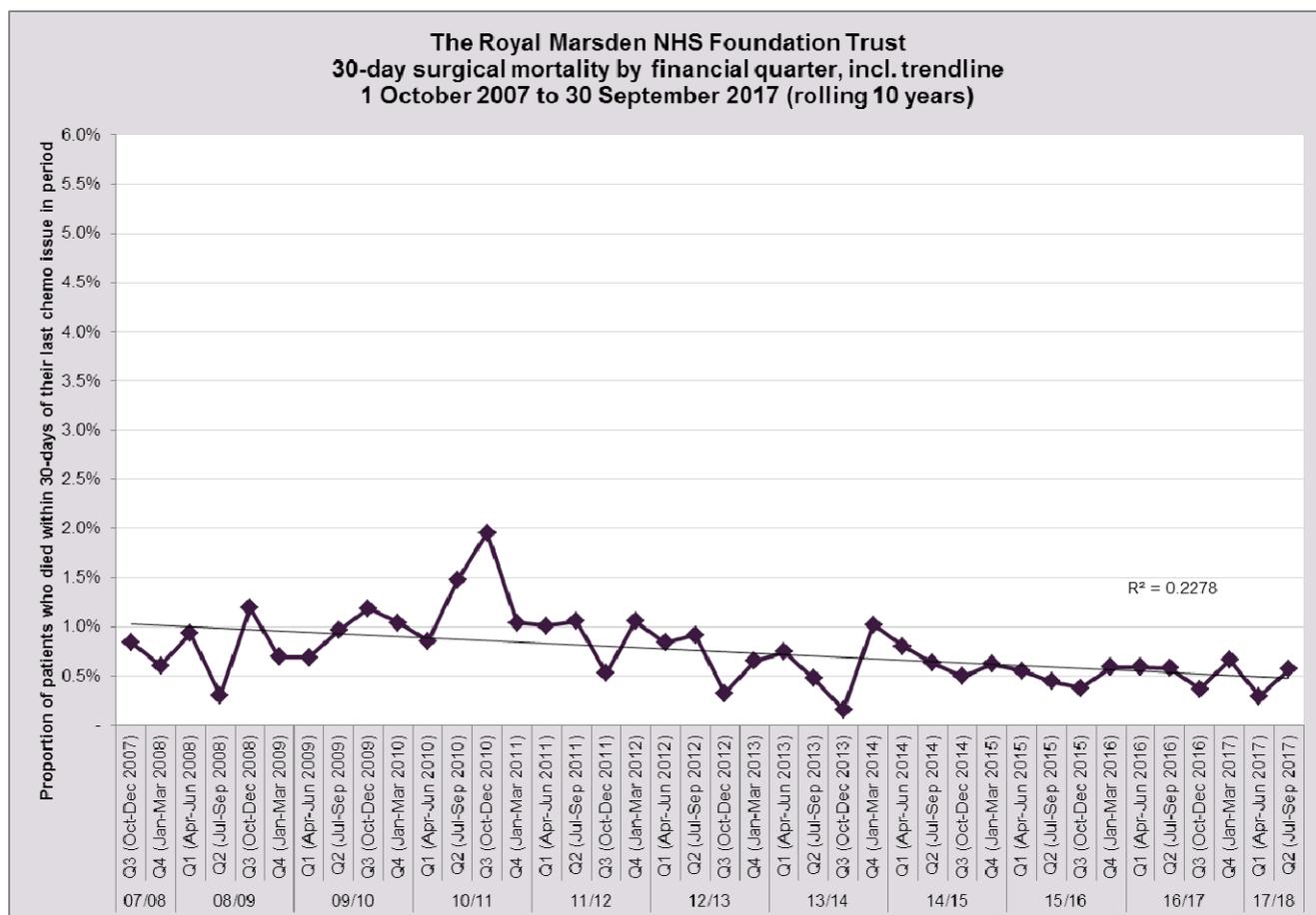
- Data are presented quarterly from Quarter Two 2007/8 to Quarter Two 2017/18.
- The overall 30 days death rate has been stable.

- In Quarter Two 2017/18 there were eight deaths out of 1,409 patients (0.6%), compared to four deaths out of 1,360 in Quarter One.

10.3.4. 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.

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



Source: raw data from Trust Information Department. The last matching using data from the Office for National Statistics (ONS) was carried out on 3 November 2017.

10.4. Deaths following stem cell transplantation

10.4.1. 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.

10.4.2. 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.

- 10.4.3. The number of transplants recorded in this quarter (July to September 2017) was 42 but to analyse 100-day mortality it is necessary to consider the transplants undertaken in the previous quarter (April to June 2017). 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 30th June 2017 would reach 100 days on 8th October 2017.
- 10.4.4. The final number of recorded transplants carried out from April to June 2017 was 64 (56 adult and 8 paediatric patients).
- 10.4.5. The breakdown of transplant types, number of deaths within 100 days of transplant and the cause of death for April to June 2017 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†	42	1	0%	2%
Allogeneic‡ (all types)	14	0	0%	0
– Allogeneic – unrelated donor	4	0	0%	0
– Allogeneic – related donor	8	0	0%	0
– Allogeneic – cord blood	2	0	0%	0

Paediatric

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

* TRM: Transplant related mortality

† Autologous transplant: the patient’s own cells are returned.

‡ Allogeneic transplant: a donor’s cells are used.

- 10.4.6. The adult patient who died within 100 days following the transplant received an autologous transplant for a diffuse large B-cell lymphoma but died at day 87 from multiple organ failure.
- 10.4.7. There were no deaths recorded for paediatric patients receiving a Stem Cell Transplant during the April to June period.

10.4.8. 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.

10.4.9. 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.

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

- 10.5.1. 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.
- 10.5.2. NICE standards assist the Trust in reviewing current practice against the latest standards and ensuring is safe, effective and responsive to people’s needs.
- 10.5.3. NICE published 25 items of guidance which were presented to the Integrated Governance and Risk Management Committee (IGRM) in Quarter Two. After the guidance was reviewed, five items were deemed relevant and six 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	3	2	0	0	0
Diagnostics guidance	1	0	1	0	0	0
Highly Specialised Technologies	1	0	1	0	0	0
Interventional procedures	8	0	8	0	0	0
Medical technologies	1	0	0	1	1	0
NICE guideline	6	1	2	3	2	1
Public Health	3	2	0	1	1	0
Total	25	6	14	5	4	1

* For items deemed relevant

10.5.4. The IGRM committee also allocates NICE quality standards to clinical leads to review. During Quarter Two there were 12 quality standards published by NICE.

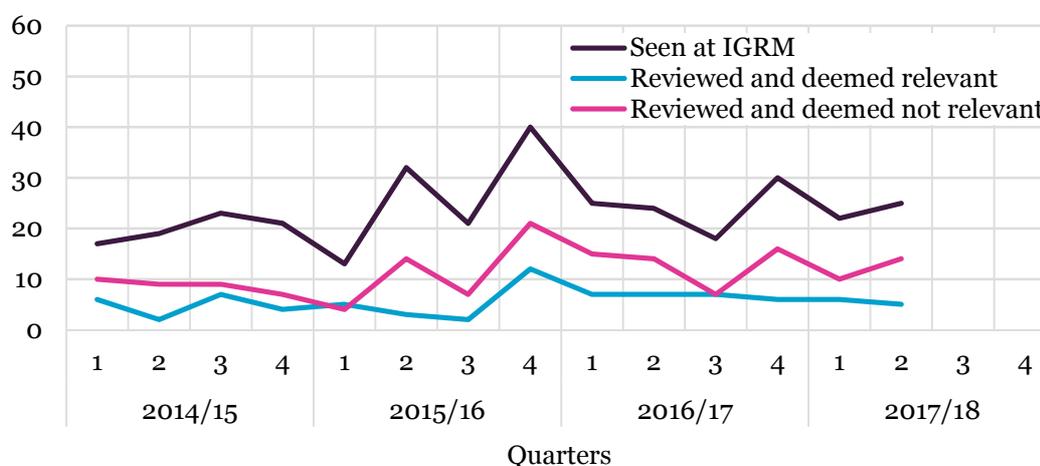
Type of guidance	Seen at IGRM	Under review	Reviewed and deemed not relevant	Reviewed and deemed relevant	Fully compliant*	Partially compliant*
Quality standards	12	6	2	4	1	3

* For items deemed relevant

10.5.5. 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.

10.5.6. 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.

10.5.7. The chart shows the number of items of guidance and quality standards from NICE reviewed since 2014/15 by quarter.



10.6. Information governance

10.6.1. Information Governance Committee

The Trust Information Governance training compliance is currently 88.8% against the target of 95%. This is a drop from the March 2017 figure and the Learning and Development Team is working with divisional directors to increase compliance now that the summer holiday months are over.

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 two meetings of the committee in Quarter Two.

10.6.2. Information Governance Toolkit

The Information Governance Toolkit is an assessment tool that NHS Digital requires NHS organisations to submit annually in order to measure compliance against information governance standards. The Trust's submission at the end of March 2017 was 88%.

This year's submission consists of two stages throughout the financial year:

- baseline and performance update (end of October)
- final submission (end of March).

The Trust's October performance update will be 66% which is consistent with last year's submission. This figure will rise over the coming months as scheduled audits take place and more evidence becomes available. The Trust is currently on track to achieve 88% for the final March submission.

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

- NHS Digital
- NHS Improvement
- The Care Quality Commission
- The Information Commissioner's Office.

10.6.3. Incident management and enforcement

The Information Commissioner's Office (ICO) is the UK's independent authority set up to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals.

The ICO is able to issue fines of up to £500,000 for serious breaches of the Data Protection Act and Privacy and Electronic Communications Regulations. The ICO has had the powers to fine organisations since 2010. The Royal Marsden has not incurred any fines.

The ICO has powers to issue undertakings and enforcement notices to organisations in breach of legislation, requiring them to take specified steps to ensure that they comply with the law. The Trust reported one level two incident to the ICO in September 2017. After investigation, the ICO decided to take no action and consider the incident closed. To date The Royal Marsden has not been subjected to a monetary penalty.

10.7. Freedom of information

- 10.7.1. The Freedom of Information Act 2000 gives the public a general right of access to information held by public authorities about their activities. The Trust has a legal obligation to provide access to the information it holds and respond to such requests within 20 working days.

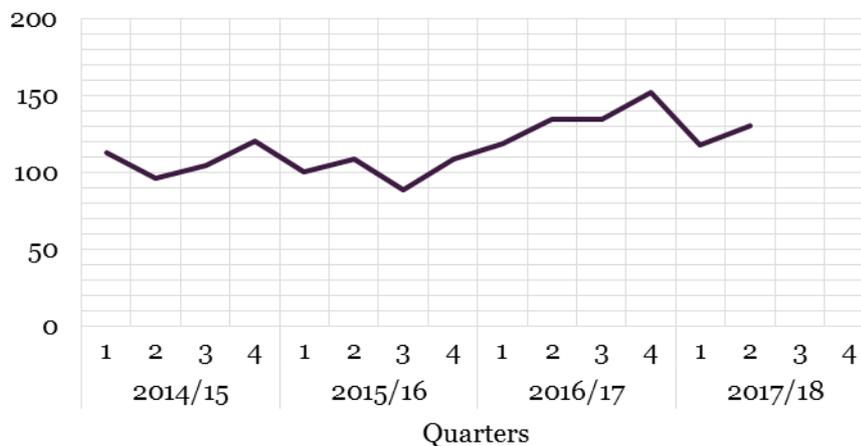
10.7.2. Requests received under the Freedom of Information Act 2000

10.7.3. The Trust received 131 requests during Quarter Two, compared to 118 in Quarter One. Of the 131 requests received in Quarter Two 130 were answered within 20 working days (99.2%).

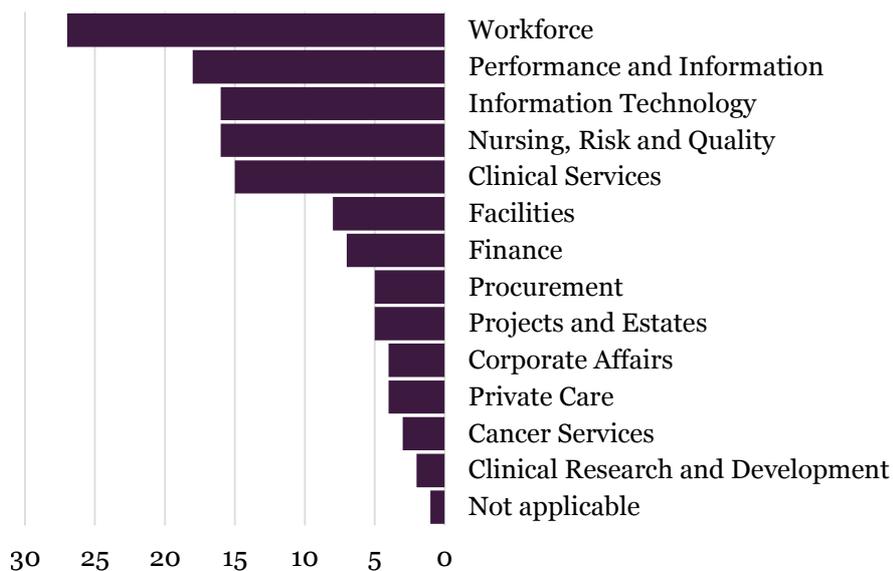
10.7.4. The requests in Quarter Two had the following outcomes:

Disclosed	96
Not applicable to The Royal Marsden	21
Partial	11
Information not held or clarification sought	2
Refused – exemption or too expensive to answer	1
Total	131

10.7.5. Number of requests received by quarter

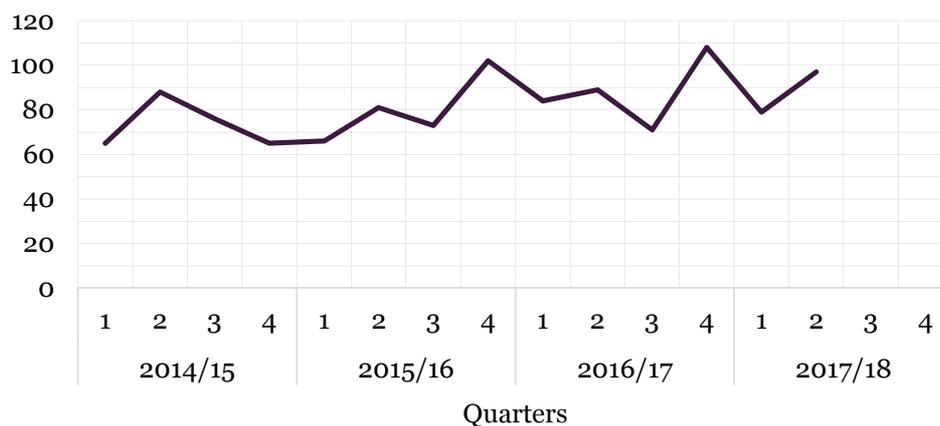


10.7.1. Number of requests by directorate and division



10.8. Access to patient records

- 10.8.1. The Data Protection Act 1998 requires that patients be given the right of access to and copies of their own medical records.
- 10.8.2. This quarter the Trust received 97 requests for personal disclosure of medical records for hospital patients. (This excludes notes required by other hospitals and those required for litigation purposes.)
- 10.8.3. The chart shows the number of requests received for hospital patients each quarter since 2014/15.



10.9. Radiotherapy

- 10.9.1. The Radiotherapy Service is certified to the ISO9001:2008 quality standard by the British Standards Institute (BSI) and is assessed by an external auditor twice a year.
- 10.9.2. Since the ‘readiness review’ audit was conducted in February 2017 work has continued to transition the current Quality Management System to the latest ISO9001:2015 standard. The last assessment from the British Standards Institute (BSI) was completed in September at the Sutton and Chelsea sites.
- 10.9.3. No non-conformances were raised and the work completed over the summer was found to satisfy all the requirements of the new ISO9001:2015 quality standard. Consequently, a recommendation has been made for the radiotherapy service to be re-certified.
- 10.9.4. Radiotherapy has been recognised with a 100% compliance rating and no addition transition actions are needed before the next assessment, booked for March 2018.
- 10.9.5. Six internal audits were completed during the quarter covering selected patient pathways and two new audits addressed the requirement of ISO9001:2015. Seven minor non-conformities were raised which have all been closed.
- 10.9.6. Forty-one incidents were raised (compared with 33 in the previous quarter). Incidents are coded using the *Towards Safer Radiotherapy* classification system, which allows comparable reporting across the industry. Nine were graded *low* severity and thirty-two *very low* severity. These were reviewed and discussed at the Multiprofessional Team Quality Assurance (Radiotherapy) Committee (MPT QART) as part of root cause analysis and agreement was reached on the appropriate corrective actions.

- 10.9.7. No complaints relating to Radiotherapy were received but 22 letters or cards of praise for the service were recorded within the quarter.
- 10.9.8. Since April 2005, all Radiotherapy waiting times for both palliative and radical treatment have been within the 14 day and 28 day targets set out in the Manual of Cancer Standards.
- 10.9.9. The table below shows the number of radiotherapy appointments for Quarters One and Two 2017/18.

		2017/18					
Appointments (number)		Apr	May	Jun	Jul	Aug	Sep
Chelsea	Palliative*	49	29	37	41	40	29
	Radical†	126	126	106	130	130	141
	Urgent‡	5	2	1	2	0	3
	Total	180	157	144	173	170	173
Sutton	Palliative	65	71	76	74	60	64
	Radical	180	204	221	226	201	198
	Urgent	2	9	6	2	3	6
	Total	247	284	303	302	264	268
Grand total		427	441	447	475	434	441

* 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.

- 10.9.10. The table below shows radiotherapy waiting times for Quarters One and Two 2017/18.

			2017/18					
Average waiting time (days)			Apr	May	Jun	Jul	Aug	Sep
Chelsea	Radical	All*	14.1	15.4	15.2	14.0	11.7	12.7
	Radical	No delay*	18.3	18.5	18.7	16.4	16.1	16.4
	Palliative	All	4.4	3.8	4.3	3.3	4.1	4.7
	Palliative	No delay	4.9	4.3	5.3	4.6	4.4	5.1
Sutton	Radical	All	17.9	17.5	15.9	16.4	13.4	12.7
	Radical	No delay	23.7	24.1	22.5	21.8	19.5	18.9
	Palliative	All	4.7	5.3	5.2	4.7	3.7	3.9
	Palliative	No delay	5.3	6.7	5.7	5.1	4.6	4.6

* **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).

10.10. Chemotherapy

- 10.10.1. The Chemotherapy service is certified to the ISO9001:2008 quality standard and is assessed by an external auditor from the British Standards Institute (BSI) twice a year.
- 10.10.2. Changes to the quality documentation, auditing method and agenda of the ISO Chemotherapy Committee have continued. This was in response to recommendation from BSI following the 'readiness review' conducted in February 2017 to assess compliance to the latest ISO9001:2015 standard.
- 10.10.3. The latest assessment was completed in September. Since this was only a one-day assessment, the time available was insufficient to complete the ISO9001:2015 transition. Compliance was very good for the areas that were checked but the transition will be completed at the March 2018 assessment visit and will be combined with the three-year strategic review.
- 10.10.4. The quarter saw a high emphasis on internal auditing with six audits completed covering ward and pharmacy areas using the new audit method required by ISO9001:2015. This resulted in the identification of eleven minor non-conformances, which have all since been closed.
- 10.10.5. Incidents are reported in accordance with Trust policy using the Datix incident reporting system, which is used to analyse incident details. In the quarter, 133 incidents relating to the multidisciplinary chemotherapy service were recorded compared to 98 in the previous quarter. Seventy-two were graded *very low* and 61 *low*.
- 10.10.6. One hundred and thirty 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 ISO Chemotherapy Committee
- 10.10.7. Two complaints were received in the quarter and 25 letters of praise and thanks from patients were logged. The complaints were related to staff attitude and an issue in the administration of medication. Both have been addressed and resolved by the Complaints Team.
- 10.10.8. Waiting times have been monitored for a number of years and discussed at the ISO Chemotherapy 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.
- 10.10.9. 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).
- 10.10.10. One stop patients wait longer as chemotherapy cannot be given until all preparation tasks are complete which typically takes three to five 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.

10.10.11. 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 narrowly missed at six per cent as shown in the Tables below, although individual units show some fluctuations.

10.10.12. The table below shows the number of chemotherapy appointments with waiting times longer than four hours for Quarters One and Two 2017/18.

Appointments	Total appointments	Appointment waits over 4 hours	Percentage waits over 4 hours
Medical Day Unit (Chelsea)	4,605	615	13%
Granard House Day Unit	2,639	217	8%
Homecare	40	0	0%
Private Care Centre	233	10	4%
Wiltshaw Ward Consulting Room	2	0	0%
Ambulatory Inpatients (Bud Flanagan West)	71	25	35%
Children's Day Unit	1,919	56	3%
Bud Flanagan Ambulatory Care Unit	1,224	134	11%
Kennaway Day Unit	909	4	<1%
Medical Day Unit (Sutton)	4,522	8	<1%
Robert Tiffany Day Unit	1,381	6	<1%
West Wing Day Unit	761	3	<1%
Oak Day Unit	209	126	60%
Mobile Chemotherapy Unit	128	0	0%
IV Services (Sutton)	0	0	-
Teenage Cancer Trust Unit	0	0	-
Sir William Rous Unit	1,583	3	<1%
Total	20,226	1,207	6%

10.10.13. The table below shows chemotherapy waiting times (from patient’s arrival in clinic to start of treatment) for Quarters One and Two 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)	495	2,266	544	280	405	380	173	60	2
Granard House Day Unit	141	701	667	593	320	152	47	16	2
Homecare	4	36	0	0	0	0	0	0	0
Private Care Centre	19	83	51	47	23	7	2	1	0
Wiltshaw Ward Consulting Room	1	1	0	0	0	0	0	0	0
Ambulatory Inpatients (Bud Flanagan West)	5	33	5	0	3	4	17	4	0
Children’s Day Unit	376	734	457	219	77	32	17	7	0
Bud Flanagan Ambulatory Care Unit	167	431	267	139	86	78	34	22	0
Kennaway Day Unit	96	703	81	19	6	4	0	0	0
Medical Day Unit (Sutton)	236	3,849	384	34	11	3	2	3	0
Robert Tiffany Day Unit	252	901	165	44	13	2	3	1	0
West Wing Day Unit	27	570	135	22	4	2	0	1	0
Oak Day Unit	8	17	14	21	23	51	48	26	1
Mobile Chemotherapy Unit	19	106	3	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	150	1,286	135	9	0	2	1	0	0
Total	1,996	11,717	2,908	1,427	971	717	344	141	5

10.11. Research governance

10.11.1. Research sponsor

Trust sponsorship was awarded to the following 11 projects:

Reference number	Title	Single or multiple centre
CCR4673	POLEM: Avelumab plus 5-FU based chemotherapy as adjuvant treatment for stage 3 MSI-High or POLE exonuclease domain mutant colon cancer: A phase 3 randomised study.	Multiple
CCR4767	SOLLID: Simplification of low level internal dosimetry	Single
CCR4723	COMET Concordance Between MRI and Pathology in the Diagnosis of Extranodal Tumour Deposits	Multiple
CCR4684	ROLo: Phase II study of ROS1 targeting with crizotinib in advanced E-cadherin negative, ER positive lobular breast cancer or diffuse gastric cancer	Multiple

Reference number	Title	Single or multiple centre
CCR4679	TITAN: A Phase I/II Study of the Safety and Efficacy of Talimogene Laherparapvec (T-VEC) delivered by Intratumoural Injection in Combination with Isolated Limb Perfusion with Melphalan and Tumour Necrosis Factor- α in Patients with Advanced Extremity Tumours Including metastatic Melanoma	Single
CCR4585	ViOLA: A phase II study of study of single agent avelumab (anti-PD-L1) or avelumab in combination with other cancer immunotherapies in solid tumours according to somatic mutational load	Single
CCR4702	LIESL: London Investigation into the diElectric Scanning of 4 lesions	Single
CCR4797	CONCEPT: COlorectal caNCer moLEcular subtyPes collaboraTion	Multiple
CCR4795	FEM: Family history of lung cancer - in patients with EGFR/alk mutated lung cancer	Single
CCR4799	DONATE-GI: Development of OrgaNoids from lethAl meTastasEs – Gastrointestinal Tract	Single
CCR4808	The use of a combination of double staining immunohistochemistry to determine if specific staining patterns of follicular dendritic cell meshworks aid in grading follicular lymphoma	Single

10.11.2. Suspected unexpected serious adverse drug reactions

The following is a breakdown by study of the nine 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
ATr1	2	0	0	0
JLo4	1	0	0	0
NT2	1	0	0	0
RB1	1	0	0	0
SJ6	1	0	0	0
SR1	1	0	0	0
UB15	1	0	0	0
UB16	1	0	0	0

10.12. Human Tissue Authority – human application licence

10.12.1. 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 will take place in 2018.

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 carried out 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.

A number of cellular therapy trials are under discussion at present, which involve apheresis and storage of cellular therapy products taking place under the HTA licence. Procedures are being put in place to ensure that the Trust maintains adherence to regulatory requirements.

The department has gone out to tender for the procurement of a specialist stem cell transplant information technology system that will meet the requirements of United Kingdom law concerning the labelling of stem cell products. This will also ensure that the transplant programme is able to meet JACIE standards.

10.12.2. Quality improvement – audits

Audits are integral to the stem cell transplant quality management programme in the laboratory and clinical areas. In the human application sector, quality assurance and improvement is a requirement of the HTA.

A number of annual records audits were performed during the quarter:

- *Records audits: harvest form completion, record update following viability testing, worksheet completion, infusion records – cryopreserved and fresh and disposal records.*

No significant non-conformances were found and this provides assurance that records are maintained and updated as necessary.

- *Critical process audits: cryopreservation of stem cells, collection of stem cells from clinical areas and sampling of stem cell products.*

The cryopreservation and collection processes were performed according to standard operating procedures. A minor non-compliance was observed during sampling and further training given. A repeat audit has shown full compliance.

- *Labelling of bags containing cryopreserved cells*

It is essential that product bags are labelled accurately to ensure full traceability of products. This audit found that all bags were correctly labelled.

- *User satisfaction survey*

An annual satisfaction survey is performed to seek the views of nurses, transplant co-ordinators and other members of the transplant team to ensure that the stem cell laboratory offer a high quality service and take note of feedback from users to make quality improvements. Feedback was excellent.

10.12.3. 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 to comply with HTA regulations. During the quarter no incidents occurred that required reporting to the HTA.

10.13. Clinic waiting times

10.13.1. Standard

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

10.13.2. Waiting times

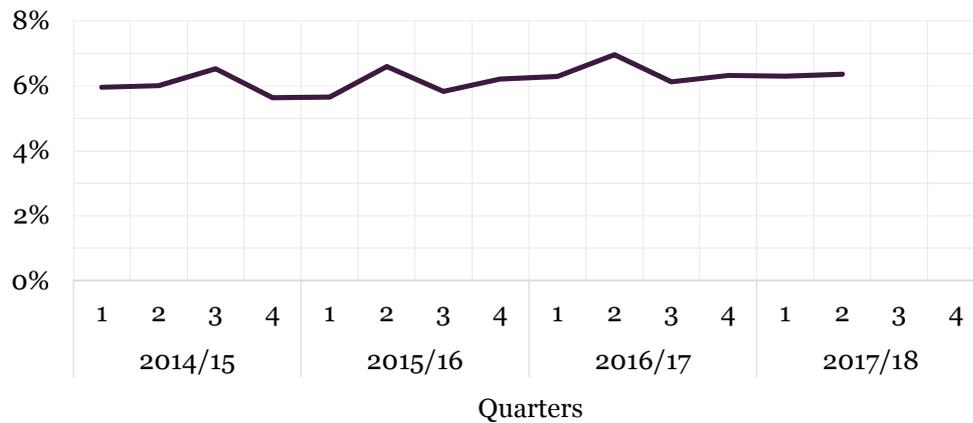
	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17	Quarter 1 2017/18	Quarter 2 2017/18
Total (all patients seen in outpatient clinics)	41,352	40,643	42,933	41,725	42,487
Patients seen in 30 minutes or less	34,256 (82.8%)	34,146 (84.0%)	36,433 (84.9%)	34,856 (83.5%)	35,660 (83.9%)
Patients seen after 30 minutes and up to 1 hour	4,515 (10.9%)	4,215 (10.4%)	4,404 (10.3%)	4,693 (11.2%)	4,583 (10.8%)
Patients seen after 1 hour	2,581 (6.2%)	2,282 (5.6%)	2,096 (4.9%)	2,176 (5.2%)	2,244 (5.3%)

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.

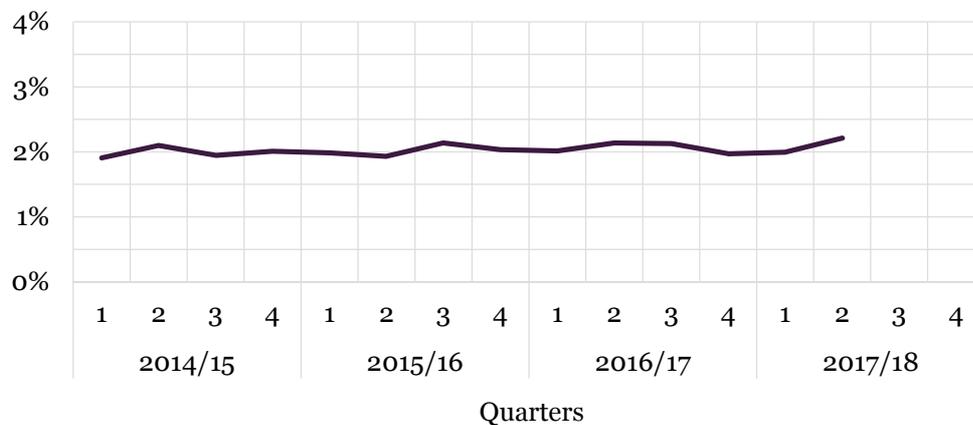
- 10.13.3. There has been an increase in activity of from 41,352 to 42,487 from Quarter Two 2016/17 compared to Quarter Two 2017/18. Over the same period the percentage of patients seen within 30 minutes or less of their appointment time has improved by 1.1 percentage points and those seen after one hour of their appointment time decreased by 0.9 percentage points. This reflects a similar positive trend to last quarter.
- 10.13.4. These improvements have been driven by ongoing initiatives in the outpatient department such as administrative co-ordinators supporting clinics to help improve the flow and efficiency, the introduction of multi-professional authorisation of chemotherapy clinics and responsiveness of the Information Technology Department to resolve problems which impact on the clinic.

10.14. Outpatient non-attendances

10.14.1. Non-attendance at first appointment



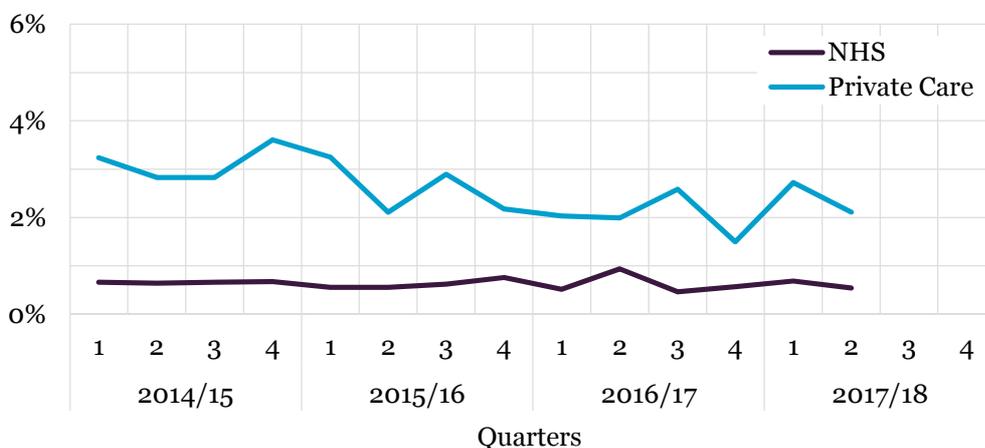
10.14.2. Non-attendance at subsequent appointment



10.14.3. A business case is being proposed to extend the use of appointment reminders across the majority of outpatient clinics. A pilot demonstrated an improvement in non-attendance ('did not attend' – DNA) rates and if rolled out further would allow appointments to be utilised more effectively.

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

10.15.1. In Quarter One 0.54% of NHS clinics (27 out of 4,693) and 2.11% of private care clinics (43 out of 1,580) were cancelled less than 15 days before the planned date. The percentage for both NHS and private care clinics has decreased since last quarter.



10.15.2. 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	16	64	38	138	54	202
Doctor attending meeting	5	19	3	5	8	24
Doctor attending conference	3	13	1	1	4	14
Clinic day changed	2	14	0	0	2	14
Doctor on study leave	1	1	1	2	2	3
Total	27	111	43	146	70	257

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	39	34	2	75
Concerns relating to private care patients	3	0	Not applicable	3
Total	42	34	2	78

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

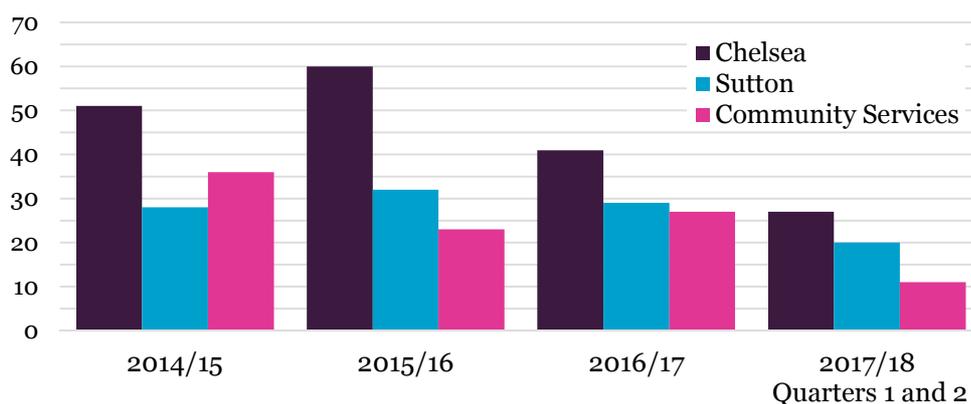
It is a Trust standard that all complainants receive

- 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	14	10	4	28
Complaints acknowledged within three working days	14 (100%)	8 (80%)	4 (100%)	26 (93%)

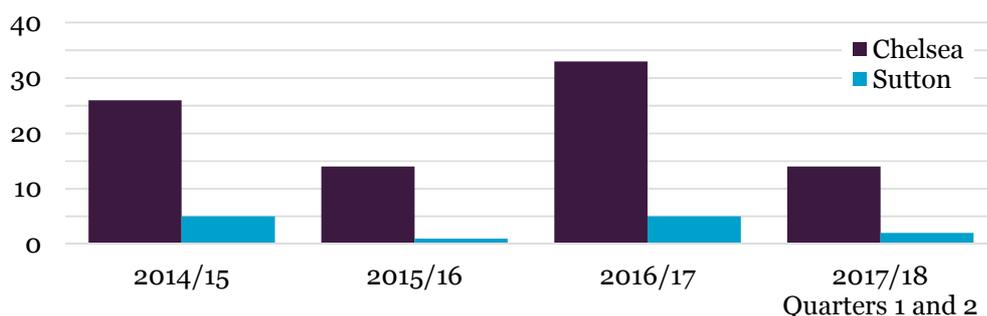
11.1.6. Number of complaints by financial year and site (NHS patients)



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

	Chelsea	Sutton	Total
Complaints received	5	1	6
Complaints acknowledged within three working days	5 (100%)	1 (100%)	6 (100%)

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

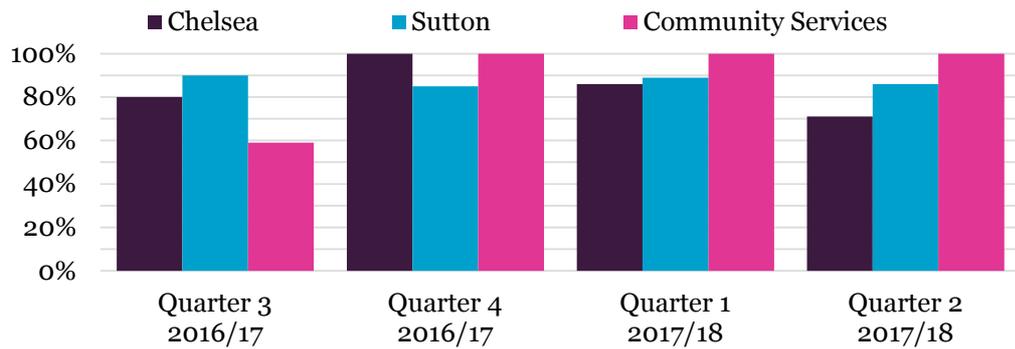


11.1.9. Number of complaints completed this quarter (NHS patients)

	Chelsea	Sutton	Community Services	Total
Complaints completed	14	14	7	35
Complainants receiving a response within agreed deadline	10 (71%)	12 (86%)	7 (100%)	29 (83%)

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 we work to a 25 working day timescale for investigations, this is not always possible and will be agreed with the complainant.

11.1.10. Responses within agreed deadline (NHS patients)

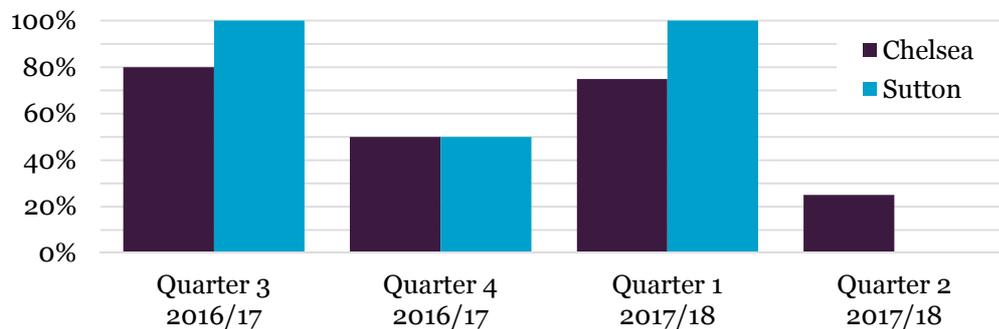


11.1.11. Number of complaints completed this quarter (private care patients)

	Chelsea	Sutton	Total
Complaints completed	4	0	4
Complainants receiving a response within agreed deadline	1 (25%)	N/A	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)



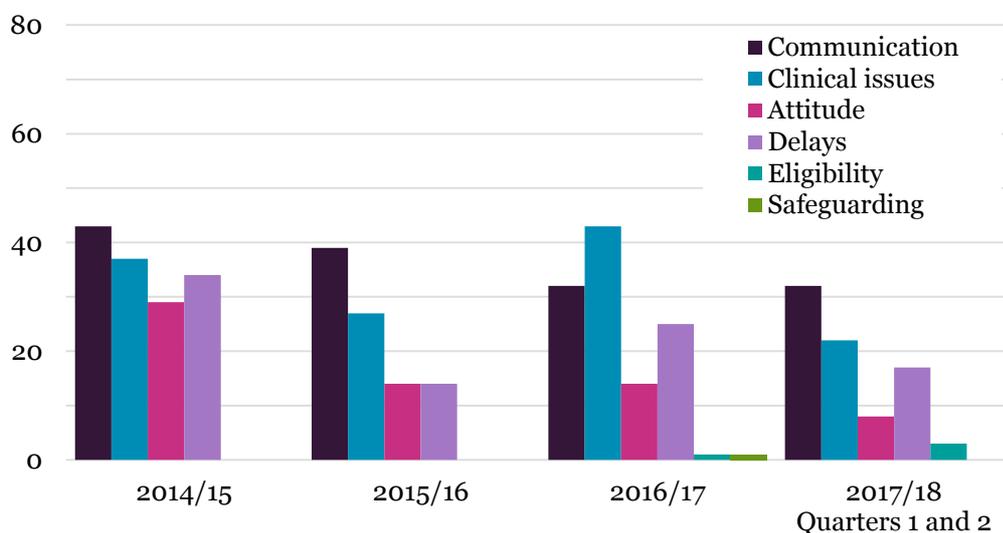
11.1.13. NHS complaints by patients' clinical commissioning groups (CCGs)

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 Brighton and Hove	1
NHS Canterbury and Coastal	1
NHS Coastal West Sussex	2
NHS Croydon	2
NHS East Surrey	1
NHS Hammersmith and Fulham	1
NHS Hillingdon	1
NHS Merton	1
NHS North East Hampshire and Farnham	1
NHS Oxfordshire	1
NHS Richmond	2
NHS Southend	1
NHS Surrey Downs	3
NHS Sutton	4
NHS Wandsworth	3
NHS West London	1
Unknown (not recorded)	1
Total	28

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

To ensure that all users of the Trust are able to access the Complaints Service, The Royal Marsden now collects ethnicity data for all complainants. 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	0
Black Caribbean	0
Black (other)	0
Chinese	1
Mixed White and Asian	0
Mixed White and Black African	0
Mixed White and Black Caribbean	0
Mixed (other)	0
White British	13
White Irish	1
White (other)	2
Other	0
Not disclosed	17
Awaiting confirmation	0
Total	34

11.1.16. Complaints completed this quarter – Chelsea

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Breast	Low	Clinical issues	Delay in identifying recurrence	Reviewed by clinical director and appropriate clinical treatment was given.	Not upheld
Endoscopy	Low	Delays in care	Delay on day in completing endoscopy	Staff reminded of clear communication and to ensure environment is comfortable.	Partly upheld
Gastro-intestinal	Very low	Clinical issues	Lack on information regarding clinical trials	Explanation given to patients regarding process for trails.	Not upheld

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Gastro-intestinal	Low	Delays in care	Delay in administering fluorouracil	Delay was due to kink in line. No action required.	Not upheld
General oncology	Very low	Communication	Lack of communication regarding delays and tests to be undertaken	More administration staff coverage. Staff to liaise more closely with internal departments to improve communication.	Partly upheld
Gynaecology	Very low	Clinical issues	Blood tests not performed and concern that this resulted in renal failure	Blood tests were booked however patient deteriorated before undertaken. No action required.	Not upheld
Gynaecology	Very low	Attitude	Attitude of staff	Apology made and explanation of service given.	Not Upheld
Histo-pathology	Low	Delays in care	Delays in tests results being received which resulted in the patient having to chase up	Patients to remain on multidisciplinary team lists until results are received and communicated.	Upheld
Histo-pathology	Very low	Delays in care	Delay in biopsy results being received	Delay due to referral hospital not sending slides in timely manner. No action required.	Not upheld
Medical Day Unit	Very low	Attitude	Attitude of staff when arranging appointment	Apologies given and staff reminded to be courteous at all times.	Not upheld
Sarcoma	Very low	Delays in care	Delay in ultrasound being arranged.	Patient was not being treated at The Royal Marsden and made appropriate referral. No action required.	Not upheld
Urology	Very low	Communication	Change of address not processed despite a number of requests.	Apologies given. Additional fields added to electronic patient record.	Not upheld
Urology	Very low	Communication	Poor delivery of prognosis and correspondence incorrectly sent	Apologies given and staff reminded to update electronic patient records in a timely manner.	Partly upheld
Urology	Low	Clinical issues	Delay in treatment and identifying recurrence.	Staff to check discharge summaries before being sent.	Not upheld

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Private Care	Low	Delays in care	Delay in prostate-specific antigen (PSA) results being available	Further training for new staff on preparation for clinics. New pathology equipment introduced.	Upheld
Private Care	Very low	Communication	Patient feels they were forced to be treated as a private patient	Staff reminded of the need for clearer communication around up-front payments.	Partly upheld
Private Care	Very low	Attitude	Attitude of staff	Apologies given and staff member has reflected for future practice.	Partly upheld
Private Care	Low	Delays in care	Delay in ultrasound on the day. Incorrect correspondence to insurers.	Apologies for delay given. Staff reminded to double check records to ensure invoices are communicated correctly.	Partly upheld

11.1.17. Complaints completed this quarter – Sutton

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Breast	Very low	Attitude	Attitude of staff when making appointment	Apologies given and staff reminded of importance of good communication.	Partly upheld
Clinical trials	Low	Delays in care	Delay in blood results resulting in patient being unable to enter trial	Two week period introduced between consenting and randomisation.	Partly upheld
Facilities	Very low	Communication	Lack of communication around relative accommodation. Lack of facilities.	Drink making facilities introduced as well as information leaflet around accommodation.	Partly upheld
Gastro-intestinal	Very low	Communication	Manner in which diagnosis was communicated.	Explanation of clinic given as well as apologies for communication. No action required.	Not upheld
Gastro-intestinal	Low	Clinical issues	Concerns round treatment plan and delay in scan being undertaken	Review of information provided for computed tomography (CT) scans.	Partly upheld

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Gastro-intestinal	Very low	Clinical issues	Unhappy with second opinion	Explanation of service given as well as multi-disciplinary team (MDT) function. No action required.	Not upheld
Haematology	Very low	Delays in care	Wait times for clinical treatment	Staff reminded to communicate and delays to appointment times.	Partly upheld
Head and Neck	Very low	Clinical issues	Concerns around care delivered on ward and patients deterioration	Importance of clear documentation in medical records reiterated to staff as well as clear communication on handover.	(Re-opened) Not upheld
Leukaemia and Myeloma	Low	Clinical issues	Concerns regarding recurrence	Appropriate assessments and reviews undertaken.	Not upheld
Medical records	Very low	Communication	Access to records	Explanation of policy given. No action requires.	Not upheld
Outpatients	Low	Communication	Clinic letters sent incorrectly	Apologies given and additional function added to electronic record system.	Upheld
Paediatrics	Low	Clinical issues	Lack of discharge arrangements	All required assessments and reviews undertaken. No action required.	Not upheld
Rapid Diagnostic and treatment	Low	Clinical issues	Manner in which procedure was undertaken	Explanation and apologies given. No action required.	Not upheld
Urology	Low	Clinical issues	Delay in identifying further cancer	Pathways under review. Outpatient letter to be updated to ensure clearer communication.	Not upheld

11.1.18. Complaints completed this quarter – Community Services

Service area	Risk grade	Subject	Concern	Action taken	Outcome
District Nursing	Low	Clinical issues	Incident involving specialist bed at home resulted in amputation of toes. Relates to incident investigation 63 closed in Quarter 1 2017/18.	Correct clinical assessments undertaken but reiteration of risk assessments communicated to staff.	Not upheld
Health visiting	Low	Delays in care	Delay in referral to paediatric service	Apologies given and team reminded to ensure that referrals are processed in timely manner.	Not upheld
Physiotherapy	Very low	Attitude	Attitude of staff and no available seats other than for patients	Explanation and apologies given. More seating has been introduced.	Upheld
Podiatry	Very low	Communication	Attitude of staff when requesting change of bandages	Review of pathway underway and commissioning of services explained.	Not upheld Closed 12 April.
Podiatry	Low	Clinical issues	Excess skin removed which resulted in infection	Review of referral pathway for patients with known disabilities.	Not upheld
Podiatry	Very low	Communication	Nail cutting service no longer provided	Explanation of commissioned services given.	Not upheld
Podiatry	Very low	Communication	Difficulty in contacting service	Correct telephone contact details provided.	Not 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 One 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	19,759	26,948	25,878	8,685	7,723	9,470	20,829
NHS England London	3,060	4,796	4,543	1,522	1,412	1,609	3,313
The Royal Marsden	15	40	40	11	13	16	15
The Christie NHS Foundation Trust	5	15	18	12	4	2	2
University College London Hospitals NHS Foundation Trust	128	196	211	72	89	50	113
Chelsea and Westminster Hospital NHS Foundation Trust	173	124	165	100	35	30	132
St George's University Hospitals NHS Foundation Trust	98	209	139	139	–	–	168

From webpage digital.nhs.uk/catalogue/PUB30079 *Data on written complaints in the NHS, 2017-18 Quarter 1, Experimental* on the NHS Digital website (published 14 September 2017; retrieved 20 October 2017).

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 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

Review of clinical letters to ensure that patients are aware of what the appointment is for and that they can be accompanied if they wish.

Delays

Patients to remain on multidisciplinary team lists until the results are received to prevent delays in follow up care being communicated and ensure that patients are not missed.

Clinical issues

Patients will not be considered or consented into certain clinical trials unless there is a minimum of two weeks between consent and randomisation; allowing all screening investigations to be performed beforehand.

Attitude of staff

Although seats should be made available to patients first, staff have been reminded to ensure that this is communicated in a professional manner to visitors and the reasoning given.

11.1.21. Parliamentary and Health Service Ombudsman referrals

There was one new referrals to the Parliamentary and Health Service Ombudsman in Quarter Two.

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

One final report was received in the quarter. This related to a complaint which was not upheld and was closed with 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 462 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

HorderWard

Thank you so much for all your amazing care over the last two weeks. You are such a great team and the kindness and genuine care that I have felt from everyone has been so important with my recovery. Your patience, warmth and compassion along with smiles and giggles have been the best medicine and I feel nurtured and I'm human again. I am so grateful to you all that I have been so well looked after.

Ellis Ward

Just like to thank you all for the attention you gave me and the care, nothing being too much trouble. You always make my husband feel at ease. Please be proud of yourselves, you are special people who we will never forget.

11.2.4. Sutton

Medical Day Unit

I just wanted to thank most sincerely all nurses and staff. I appreciate the kindness and concern shown to me, more than words can say. Without your care and commitment to nursing where would we all be?

Paediatrics

Just wanted to add my thanks for being such a fantastic caring, kind and professional group of people. You should be very proud of your team as you have not only supported us tremendously but also put up with me!

11.2.5. Community Services

Crisis team

I am writing to let you know how grateful I was to ... the community nurses. Their expertise and care were a great help and comfort especially during stressful times. Your humour helped cheer us up tremendously especially when we were feeling low and depressed. You have a great team so please pass on my thoughts and appreciation to them all.

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 10	Death by natural causes in the community	RCA undertaken, no issues identified awaiting Coroners report.
Investigation 11	Incorrect swab count	Panel 16 November 2017.
Investigation 12	Patient transfer	Panel 16 October 2017.
Investigation 13	Pressure ulcer	Panel 14 September 2017.
Investigation 14	Known complication of procedure	No panel or investigation required, Duty of Candour completed.
Investigation 15	Clinical care and treatment	RCA undertaken. For clinical review to confirm whether additional investigation is required.
Investigation 16	Medication	RCA completed with report to go to IGRM November 2017.
Investigation 17	Medication	RCA completed with report to go to IGRM October 2017.

Investigation number	Description	Investigation update/panel date
Investigation 18	Delay in providing clinical care	RCA underway, clinical review to determine the harm caused and whether a panel meeting is required.
Investigation 19	Information governance breach	Report to go to IGRM November 2017.
Investigation 20	Pressure ulcer	Panel 12 October 2017.
Investigation 21	Medication	For RCA and review.
Investigation 22	Delay in surgery	For RCA and review.

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 40 (Orange)	Care of diabetic patients	Resubmission to IGRM. Blood tests not completed prior to starting chemotherapy.	Wider review of diabetic provision in the Trust is required.
Investigation 72b (Unconfirmed)	Triage	Resubmission to IGRM following review at Radiology Discrepancy.	No further actions identified.
Investigation 82 (SI)	Standard of care	Delay in providing a diagnostic imaging scan.	Review the escalation process and capacity for urgent imaging under GA for patients under normal working hours.
Investigation 83 (Green)	Pathology report	Human error - timely review of histopathology alert.	Historical histopathology incidents to be reviewed to agree process moving forward.
Investigation 89 (Red)	Suicide	Unavoidable event that has identified areas for action regarding the Health Needs Analysis (HNA).	Compliance to be reviewed at the HNA Steering Group and outcome and proposed action plan to be fed back to IGRM.

Investigation number and incident grade	Description	Outcome of investigation	Action taken following investigation include:
Investigation 90 (Yellow)	Delay in follow up	Human error - the clinic appointment was erroneously made for one year instead of six months.	Discuss the outcome of the investigation with the patient and provide a copy of the final report.
Investigation 91 (Green)	Standard of care	Computed tomography (CT) scan cannot always be performed out of hours within 30 minutes with the on-call radiology provision.	Standard operating procedure for patients requiring urgent transfer for neurosurgical intervention to be amended.
Investigation 3b (Orange SI)	Pressure ulcer	Care and service delivery issues were highlighted that require action.	Ongoing plan of action to address pressure ulcer care within the organisation.
Investigation 4 (Green)	Standard of care	No care and service delivery issues identified.	Discuss findings of the investigation with the patient's mother.
Investigation 6 (Green)	Compliance	Two part process for the documentation of patient deaths was not being completed appropriately.	Highlight the issue at Clinical Advisory Group and include in medical induction.

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 audit compliance against the requirements of the Duty of Candour six monthly. The audit was undertaken again July 2017 and the comparative scores are below.

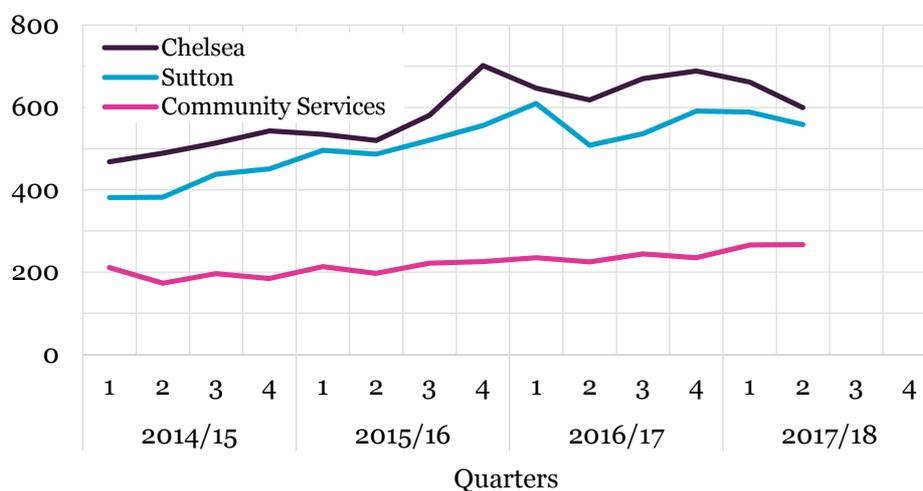
Patient electronic records document that:	July to December 2015	January to June 2016	July to December 2016	January to June 2017
The incident has been discussed	93%	100%	100%	96%
It is recorded at the time of the incident *	91%	92%	97%	92%
An apology has been given	84%	97%	97%	100%
Designation of staff recorded	93%	100%	100%	100%
Patient has been offered a written apology	89%	89%	78%	94%
Letter has been sent if required	88%	95%	100%	100%

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

11.5. Incident statistics

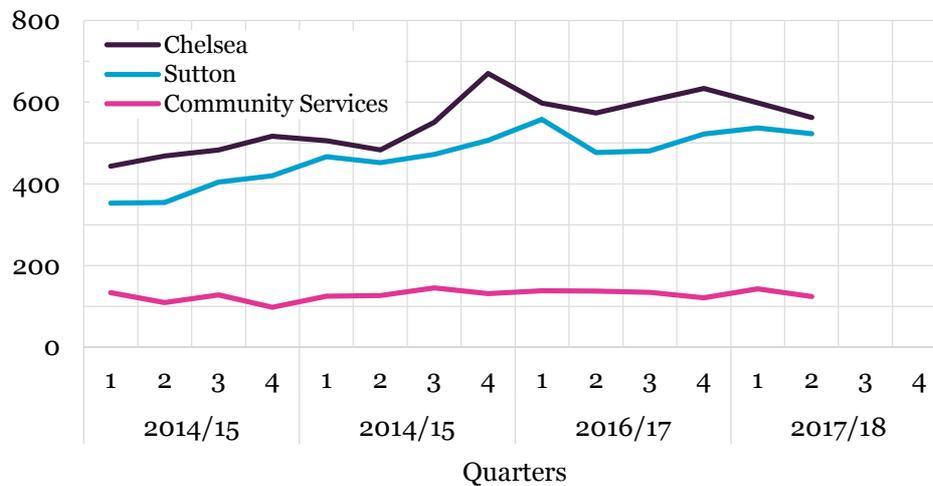
This section displays incident statistics for services which are currently run by The Royal Marsden NHS Foundation Trust. Historical data relating to services now commissioned by other healthcare providers have been excluded.

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.

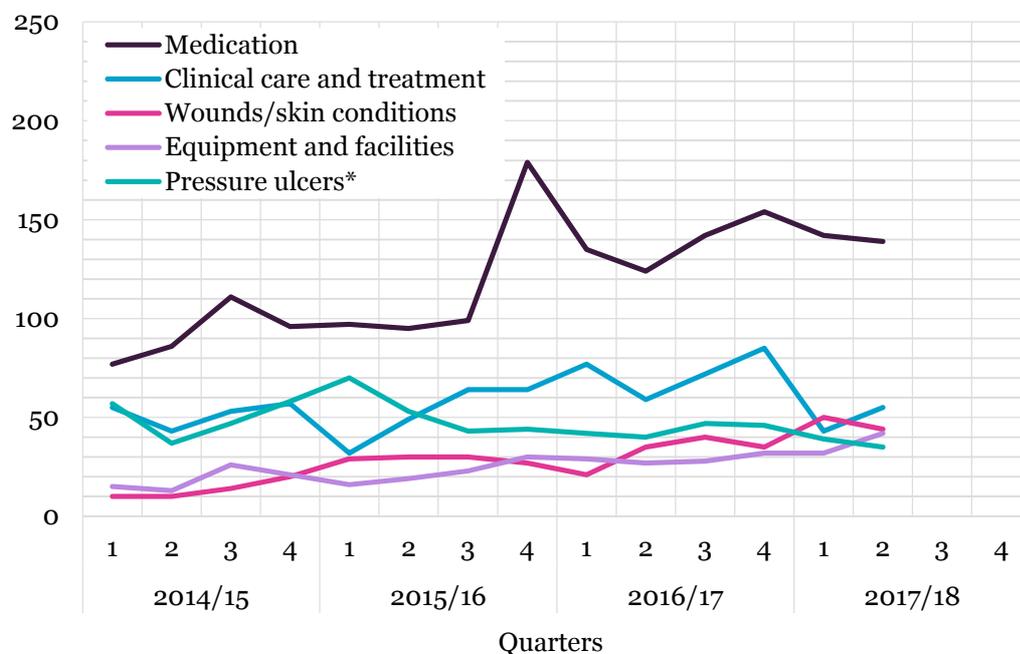


11.5.3. Patient safety incidents – top five categories

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

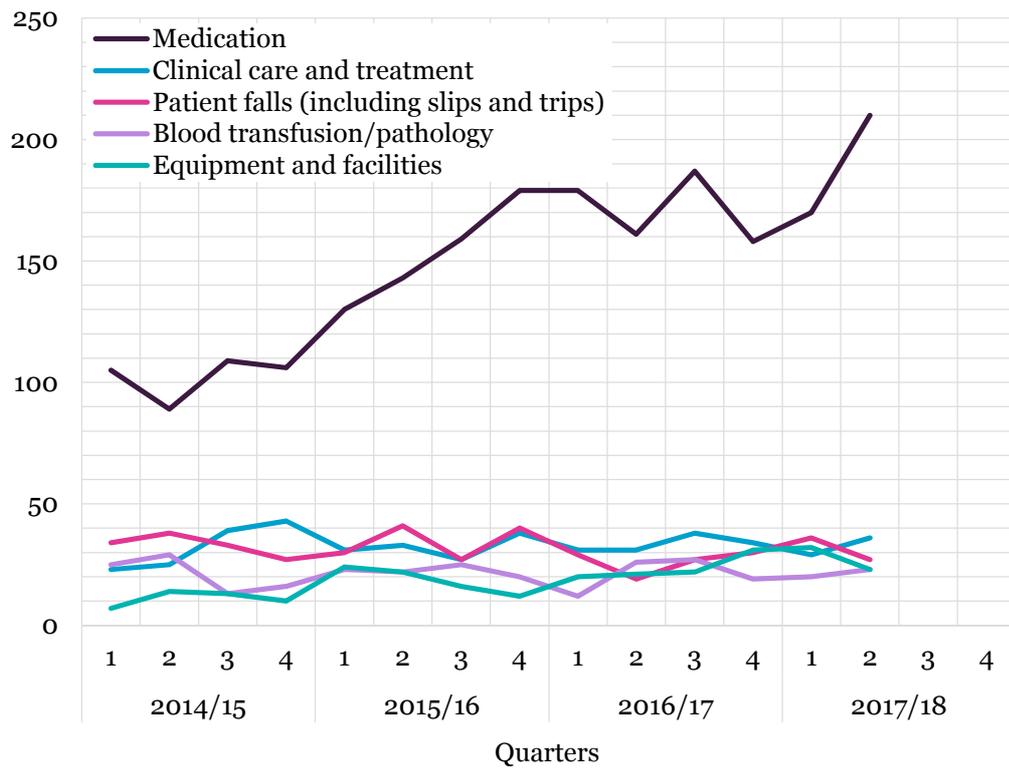
The charts show the five categories with the largest number of incidents in Quarter Two, and the number of incidents for these categories in previous quarters.

Chelsea

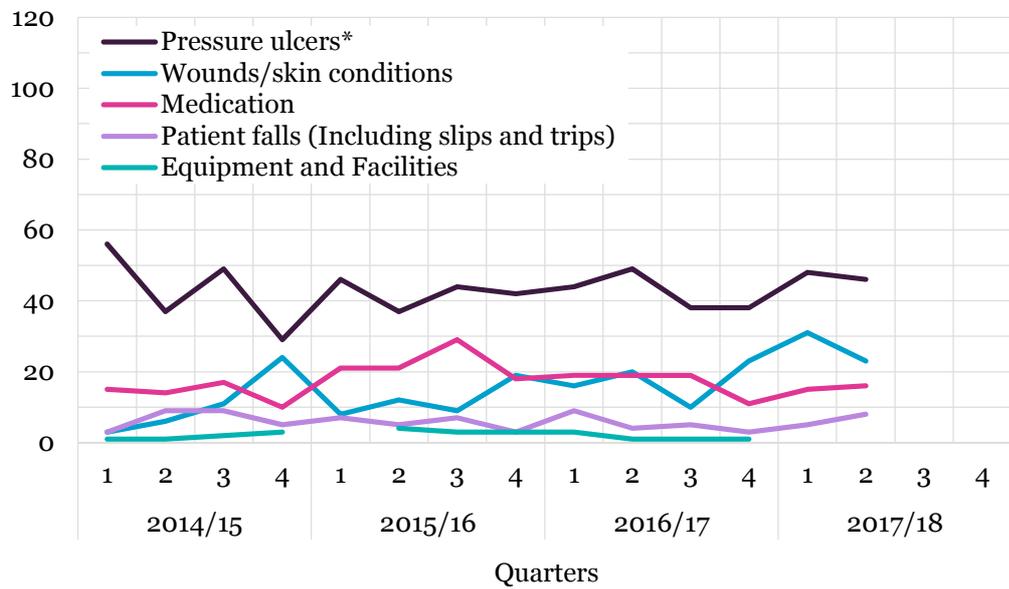


* One incident may represent more than one pressure ulcer.

Sutton



Community Services



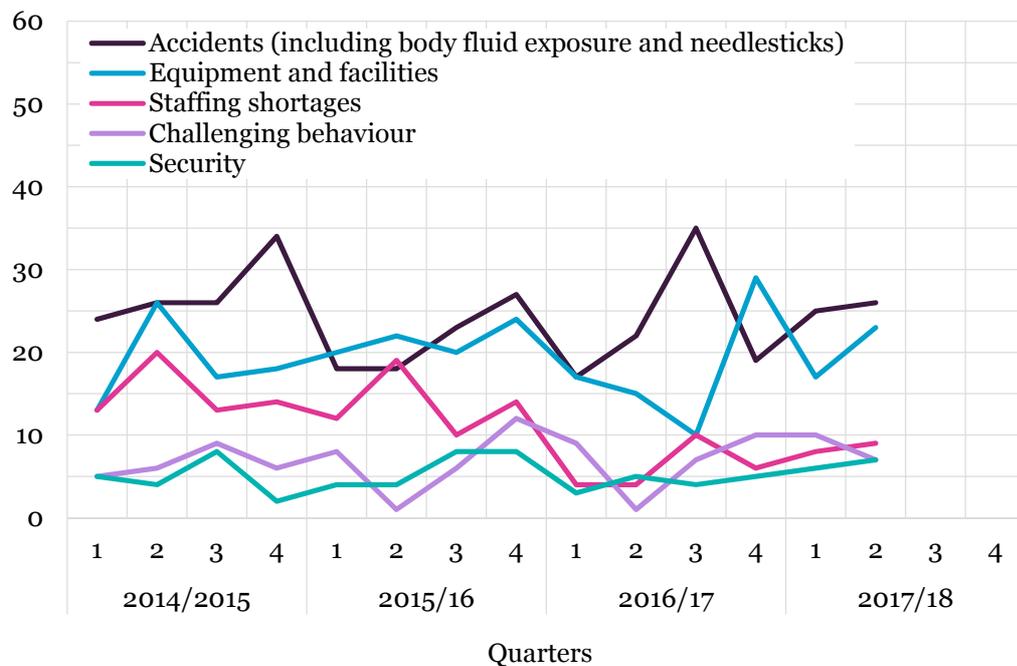
* One incident may represent more than one pressure ulcer.

11.5.4. Non-patient safety incidents – top five categories

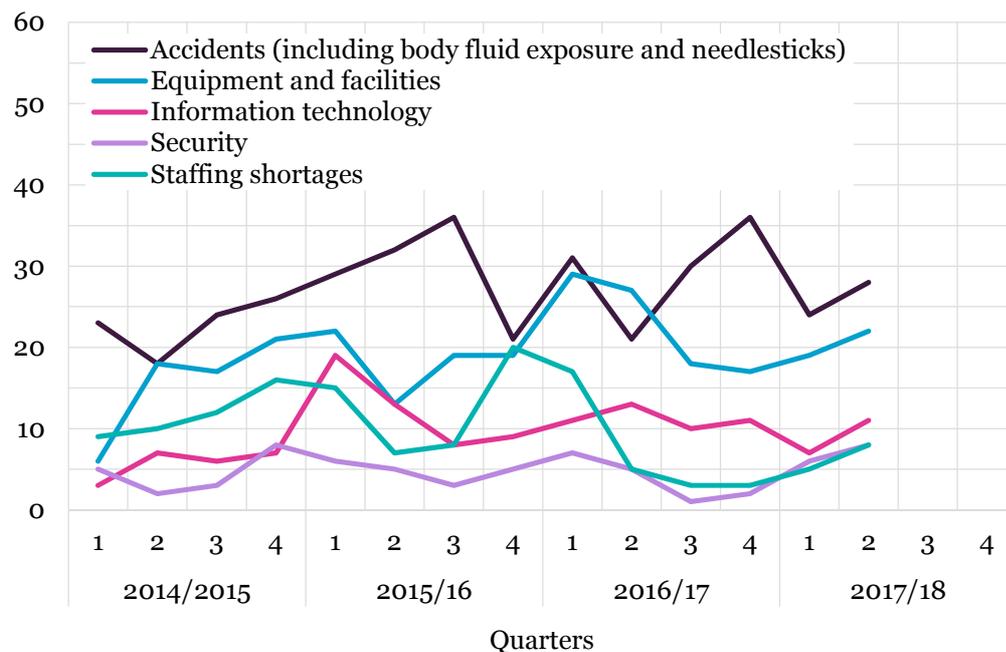
Non-patient safety incidents are those incidents that do not directly involve a patient.

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

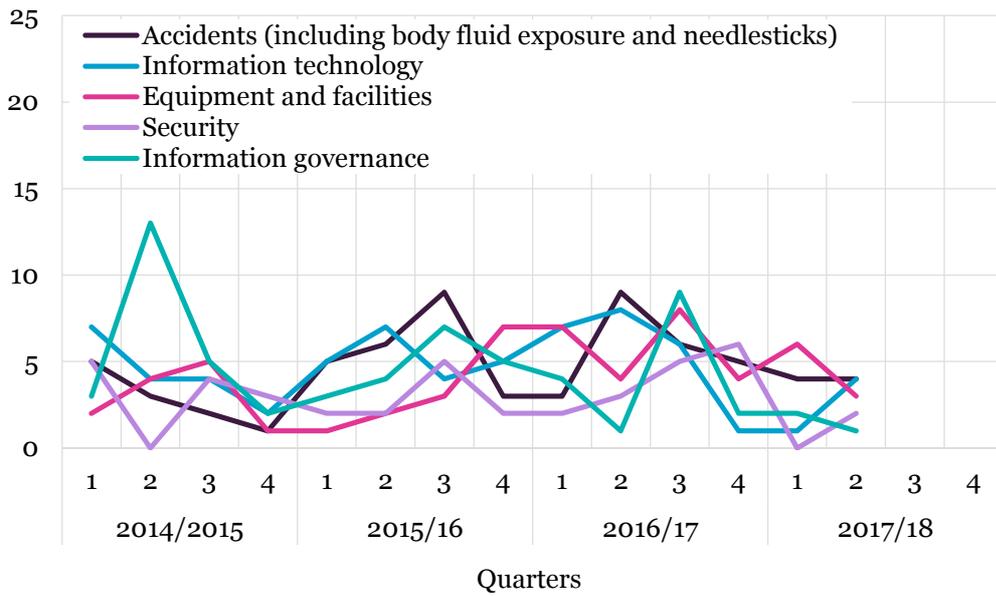
Chelsea



Sutton

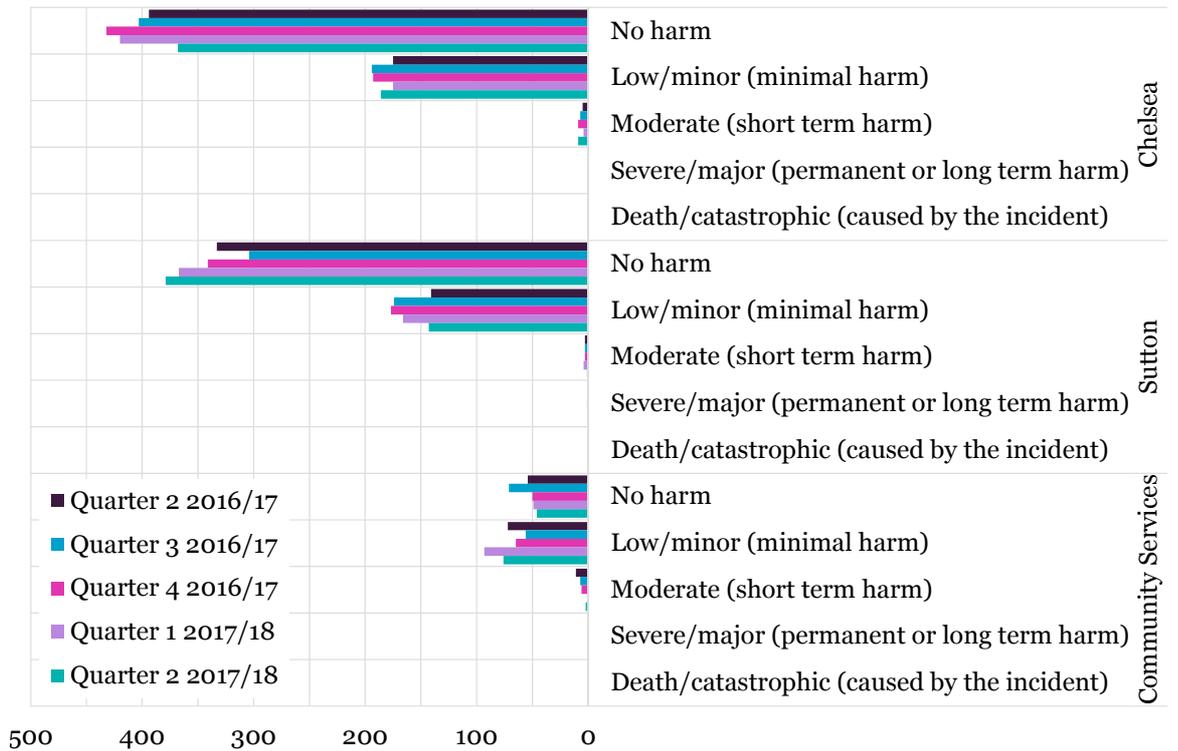


Community Services



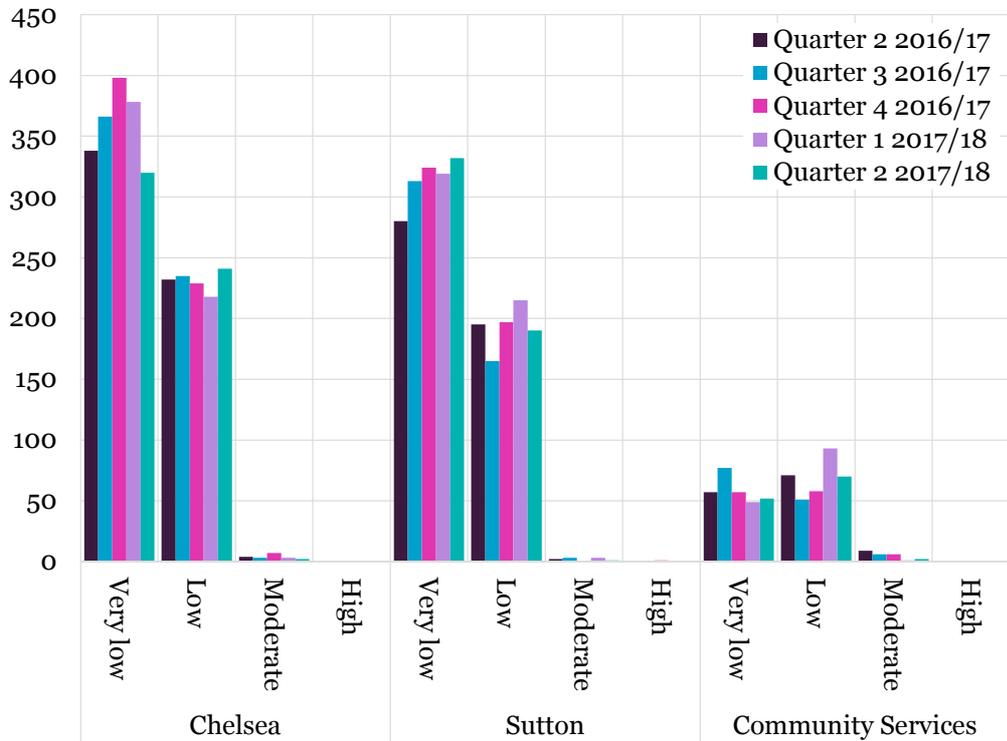
11.5.5. Severity

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



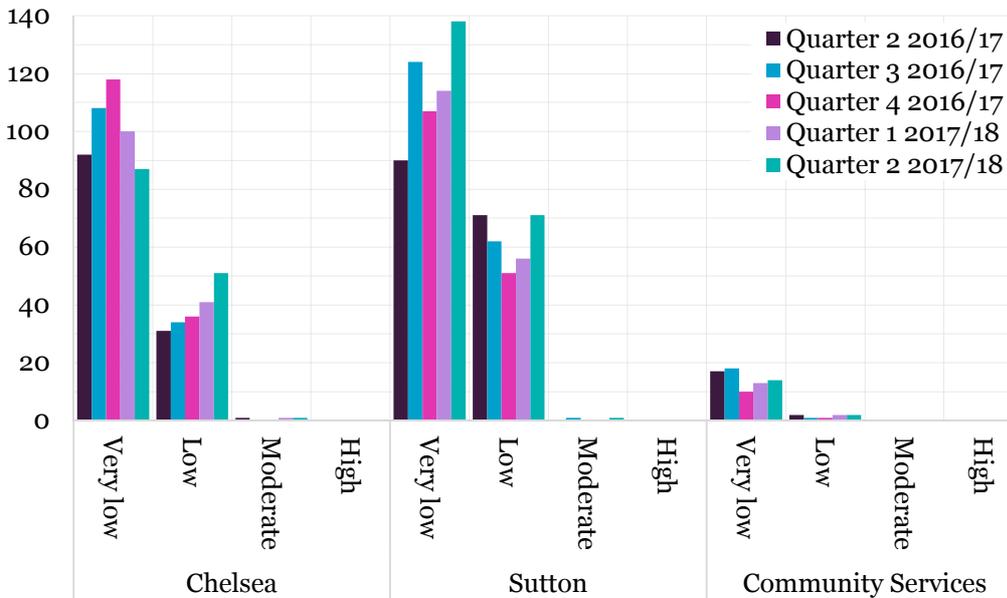
11.5.6. Risk grade

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.



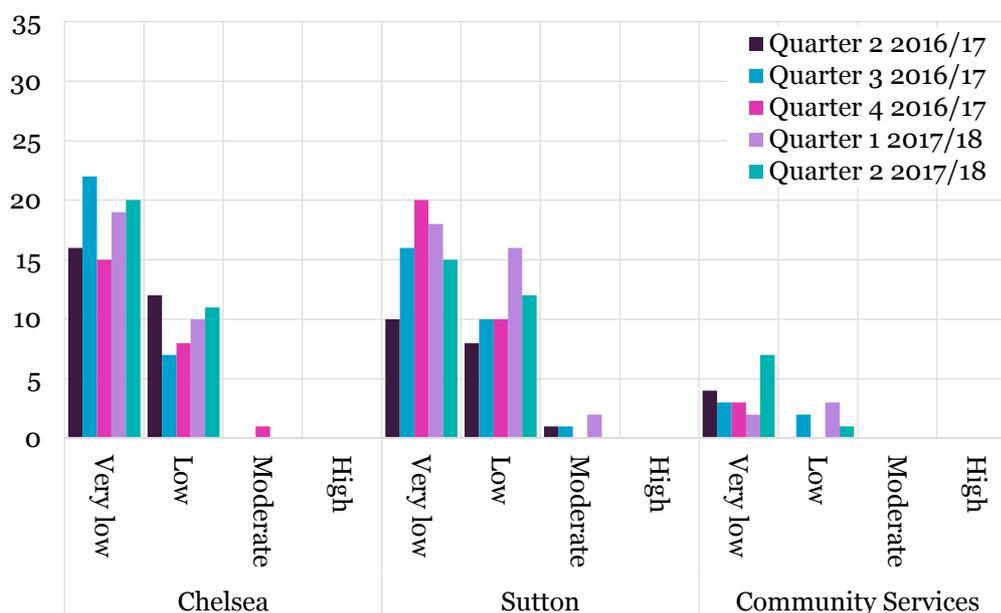
11.5.7. Medication incidents by risk grade

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 incidents involving staff reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
- A member of the nursing staff caught their wrist between a chair and the patient which resulted in a fracture.
 - An administrative staff member tripped over a bag left on the floor and suffered injuries from the fall that required them to be off work for more than seven days.
 - The stairs from the roof garden were slippery and a member of staff fell and suffered a bone injury to their leg, which required more than seven days away from work. The area was cordoned off until remedial works were completed.

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

From this quarter, the Clinical Legal Services section will appear every six months, in Quarters One and Three.

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 Two 2017/18 the Trust submitted the following finance and governance reports as part of the requirements:
- 2016/17 Annual Report and Accounts Presented to Parliament, sent to NHSI on 12 July 2017
 - Month Three 2017/18 In Year Quarterly Financial Reporting return and commentary sent to NHS Improvement on 17 July 2017
 - Month Four 2017/18 In Year Quarterly Financial Reporting return and commentary sent to NHS Improvement on 15 August 2017
 - Month Five 2017/18 In Year Quarterly Financial Reporting return and commentary sent to NHS Improvement on 15 September 2017
 - Month Three 2017/18 Workforce return sent to NHS Improvement on 17 July 2017
 - Month Four 2017/18 Workforce return sent to NHS Improvement on 18 August 2017
 - Month Five 2017/18 Workforce return sent to NHS Improvement on 25 September 2017
 - 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 Two 2017/18 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.

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.

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.

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'.

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*.

FTC

See *Foundation Trust Consolidation (FTC) files*.

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.

HSC

See *haematopoietic stem cell (HSC)*

ICR

See *Institute of Cancer Research (ICR)*.

IGRM

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

Information Governance Toolkit

An online tool that enables organisations to measure their performance against the information governance requirements.

It draws together the legal rules and central guidance set out by Department of Health policy and presents them in a single standard as a set of information governance requirements.

The relevant organisations are required to carry out self-assessments of their compliance.

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 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.

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'.

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)*.

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)*.

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.

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)*.

PICC line

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

pilot study

A small-scale trial run of a particular approach.

positron emission tomography (PET)

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

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.

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.

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.

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 have come together in 44 areas covering all of England to develop proposals and 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.

TUPE

Transfer of Undertakings (Protection of Employment) Regulations 1981.

TYA

Teenage and young adult.

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 10 October 2017).

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:

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