

The ROYAL MARSDEN
NHS Foundation Trust

Integrated Governance Monitoring Report

October to December 2017

Quarter Three 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 has provided services in Sutton as The Royal Marsden Community Services (which includes Sutton Community Health Services and Sutton Children's Health Services). This is referred to as *Community Services* in this report.
- 1.5. The Care Quality Commission's fundamental standards are intended to help providers of health and social care to comply with the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They are:
 - Person-centred care
 - Dignity and respect
 - Consent
 - Safety
 - Safeguarding from abuse
 - Food and drink
 - Premises and equipment
 - Complaints
 - Good governance
 - Staffing
 - Fit and proper staff
 - Duty of candour
 - Display of ratings.

The fundamental standards are described in more detail on page 130.
- 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 Three 2017/18 (October to December 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

Fourteen 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 105.)

2.1.2. Infection prevention and control

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

There were 22 cases of *Clostridium difficile* toxin (CDT) in the quarter of which 12 were reportable as post 72 hours to the Healthcare-associated Infection Data Capture System (HCA DCS). (Forty-six cases were reportable to the Mandatory Enhanced Surveillance Scheme in the year 2016/17).

Seven patients had confirmed or suspected carbapenemase-producing Enterobacteriaceae (CPE) in the quarter. (*Infection prevention and control*, page 43.)

2.1.3. Fire

There were no actual fires in the quarter.

Seven fire incidents were attributable to the Trust. Six fire incidents had been reported in the previous quarter. (*Fire*, page 53.)

2.1.4. Radiotherapy

There were 45 radiotherapy risk incidents, all risk-rated *low* and *very low* (41 the previous quarter). There were no complaints and 16 letters or cards of praise.

There were 1,363 appointments in the quarter (1,351 in the previous quarter). (*Radiotherapy*, page 83.)

2.1.5. Chemotherapy

One hundred and eighteen incidents were reported, all risk-rated *low* and *very low* (133 in the previous quarter). One hundred and eleven of the incidents referred to medication issues (130 in the previous quarter). There were no complaints in the quarter and ten letters of praise and thanks. (*Chemotherapy*, page 84.)

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.

Sutton CCG has confirmed full payment for achieving the 2017/18 Quarter One, Quarter Two and Quarter Three milestones for both acute and community services.

NHS England has confirmed full payment for achieving the 2017/18 Quarter One and Quarter Two milestones. Confirmation is awaited that The Royal Marsden has achieved the Quarter Three milestones from NHS England. (*Commissioning for quality and innovation (CQUIN)*, page 14.)

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

NICE published 29 items of guidance which were presented to the Integrated Governance and Risk Management Committee in Quarter Three. After the guidance was reviewed five items were deemed relevant and six items were still under review at the time of reporting. Nine quality standards were presented to the committee. Seven of the items were under review at the time of reporting and two of the items have been reviewed and deemed not relevant to The Royal Marsden. (*National Institute for Health and Care Excellence (NICE)*, page 79.)

2.2.3. Sepsis

Eight 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 47.)

2.2.4. Medical devices

There were 40 incidents relating to medical devices this quarter (58 in the previous quarter). The incidents were graded *low* (11) and *very low* (29).

The Clinical Product Review Committee approved 15 proposals to evaluate new equipment and approved one product for purchase. (*Medical devices*, page 48.)

2.2.5. Deaths following anti-cancer-therapy

The number of deaths of those patients who received systemic anti-cancer therapy in the quarter and died within 30 days was analysed. There were 66 deaths out of 4,217 patients (1.6%) compared with 77 out of 4,163 (1.8%) in the previous quarter. (*Deaths following anti-cancer-therapy*, page 75.)

2.2.6. Deaths following surgery and anaesthesia

The number of deaths of those patients who received surgery or anaesthesia in the quarter and died within 30 days was analysed. There were four deaths out of 1,412 patients (0.3%) compared with eight out of 1,409 (0.6%) in the previous quarter. (*Deaths following surgery and anaesthesia*, page 76.)

2.2.7. Deaths following stem cell transplantation

There was one death related to transplant out of 35 adult patients, and there were no deaths out of the nine paediatric patients. There had been one adult death (not transplant related) out of 56, and no deaths among the eight paediatric patients, in the previous quarter. (*Deaths following stem cell transplantation*, page 77.)

2.2.8. Medicines optimisation

Waiting times for prescriptions dispensed for discharge: over 98% of the prescriptions are completed within 60 minutes. Over two thirds are completed within 30 minutes. (*Medicines optimisation*, page 50.)

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 Three the Head of Clinical Legal Services, Complaints and Patient Information received 394 letters of praise (462 in the previous quarter). (*Letters of praise*, page 103.)

2.3.2. Safeguarding of adults at risk

One reported safeguarding concern (and two non-reported safeguarding concerns) was raised at the Trust's Chelsea and Sutton sites (there were nine in Quarter Two). Twenty reported safeguarding concerns were raised in Community Services (18 in Quarter Two).

Eleven urgent applications were made under the Deprivation of Liberty safeguards (the same number in Quarter Two). (*Safeguarding of adults at risk*, page 35.)

2.3.3. Friends and family test

In Quarter Three the Friends and Family Test showed that

- 96% of Royal Marsden inpatients who responded would recommend the Trust. (Of NHS inpatients in England 96% of respondents would recommend their provider.)
- 95% of Royal Marsden outpatients who responded would recommend the Trust. (Of NHS outpatients in England 94% of respondents would recommend their provider.)
- 94% of Royal Marsden community clients who responded would recommend the Trust. (Of NHS community clients in England 96% of respondents would recommend their provider.) (*Friends and Family Test*, page 18.)

2.4. Are staff responsive to people's needs?

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

2.4.1. Concerns and complaints

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

The Trust received 26 new complaints relating to NHS patients and 8 new complaints relating to private patients in Quarter Three. Twenty-five of the complaints relating to NHS patients and seven of the complaints relating to private patients and were acknowledged in three days or less.

Twenty-seven complaints relating to NHS patients and six relating to private patients were completed in Quarter Three. Two complaints relating to NHS patients and one relating to private patients did not receive a response by the agreed deadline. (*Concerns and complaints*, page 94.)

2.4.2. Freedom of information

The Trust received 105 freedom of information requests during Quarter Three (131 in Quarter Two). Of the 105 requests 104 were answered within 20 working days (99%). (*Freedom of information*, page 81.)

2.4.3. Adult Psychological Support Service

During Quarters Two and Three 417 NHS patients were referred to the service and offered a triage appointment. There has been a consistent increase in the number of referrals received each month in comparison to previous years. The Psychiatric Liaison Service assessed and provided support to 132 inpatients in Quarters Two and Three. (*Adult Psychological Support Service*, page 26.)

2.4.4. Clinic waiting times

There has been an increase in activity of from 40,643 to 42,940 between Quarter Three 2016/17 and Quarter Three 2017/18. Over the same period the percentage of patients seen within 30 minutes or less of their appointment time has improved by 3.3 percentage points and those seen after one hour of their appointment time decreased by 1.3 percentage points. This reflects a similar positive trend to last quarter. (*Clinic waiting times*, page 92.)

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

In Quarter Three 0.52% of NHS clinics (26 out of 4,999) and 2.40% of private care clinics (49 out of 2,044) were cancelled less than 15 days before the planned date. The percentage for NHS clinics is the same as last quarter and for private care clinics there has been a small increase. (*Consultant clinics cancelled less than 15 days before planned date*, page 93.)

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 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 117.*)

2.5.2. Human resources

The vacancy rate has reduced to 8.8% (against the target of 5%). A programme of recruitment and marketing activity started earlier in the year and over 190 nurses were recruited in the first nine months of the financial year (with a target of 225 for the year).

The turnover rate is 14.9% and remains above the 12% target.

The sickness rate for the Trust increased from 2.6% to 3.2%, above the target of 3% but in line with seasonal trends.

Appraisal rate compliance is 82.6%, below the target of 90%. (*Human resources, page 58.*)

2.5.3. Information governance

The Trust's current Information Governance Toolkit score is 71% 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. The training compliance rate is 92.18% against a target of 95%. The Learning and Development Team and divisional directors are working together to ensure that the Trust achieves its 95% target. (*Information governance, page 80.*)

2.5.4. Research governance

Nine projects were awarded Trust sponsorship. There were 18 suspected unexpected serious adverse drug reactions (SUSARs), none of which required further action. (*Research governance, page 89.*)

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%	97.0%	97.0%	97.5%	December
% of patients seen within 2 weeks for breast symptoms	93.0%	94.8%	94.8%	95.5%	December
31 days					
First treatment – % treated within 31 days of decision to treat	96.0%	97.7%	97.7%	98.2%	December
Subsequent drugs – % treated within 31 days of decision to treat	98.0%	98.9%	98.9%	99.4%	December
Subsequent surgery – % treated within 31 days of decision to treat	94.0%	96.1%	96.1%	94.8%	December
Subsequent radiotherapy – % treated within 31 days of decision to treat	94.0%	95.4%	95.4%	97.6%	December
62 days					
All cancers – % treated within 62 days of urgent GP referral	85.0%	74.4%	74.4%	77.1%	December
All cancers – % treated within 62 days of urgent GP referral (post reallocation‡)	85.0%	85.0%	85.0%	84.9%	December
Referral from screening – % treated within 62 days of urgent GP referral	90.0%	90.1%	90.1%	90.0%	December
Referral from screening – % treated within 62 days of urgent GP referral (post reallocation‡)	90.0%	89.4%	89.5%	88.1%	December
Consultant upgrade – % treated within 62 days of urgent GP referral	N/A	67.1%	67.2%	76.8%	December

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	-	5,107	3,825	5,403	December
Number of NHS daycase full consultant episodes	-	11,518	8,627	11,295	December
Total NHS elective full consultant episodes	-	16,625	12,452	16,698	December
Number of NHS non-elective inpatient full consultant episodes	-	2,067	1,548	1,820	December
Number of NHS outpatient attendances	-	186,606	139,769	183,034	December

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	December
Referral to treatment (RTT)					
RTT % incomplete pathways within 18 weeks	92.0%	96.7%	96.8%	94.6%	December
RTT number of patients on incomplete pathways waiting longer than 52 weeks	2	12	9	25	December

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%	99.9%	99.9%	99.9%	December

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> ††	-	60	45	46	December
Number of diagnoses of <i>Clostridium difficile</i> (lapses of care 2017/18 identified to date‡‡)	<= 31	3	2		December
Number of diagnoses of meticillin-resistant <i>Staphylococcus aureus</i> (MRSA) bacteraemia	0	0	0	1	December

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	December
Venous thromboembolism (VTE) risk assessment	95.0%	96.3%	96.3%	96.9%	December

* 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.

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, Quarter Two and Quarter Three milestones in year 2017/18.

Scheme	Milestone	Quarter 1	Quarter 2	Quarter 3
Clinical Utilisation Review (CUR)	Quarterly CQUIN report.	Achieved	Achieved	Achieved
Enhanced supportive care	Performance against 2017/18 trajectory.	Achieved	Achieved	Achieved
Dose banding	Performance against 2017/18 trajectory	Achieved	Achieved	Achieved

Scheme	Milestone	Quarter 1	Quarter 2	Quarter 3
Hospital Medicines Optimisation	<p>Ninety per cent of new patients receiving best value generic/biologic product on Quarter 1, Quarter 2 and Quarter 3 list, and 40% of existing patients receiving best value generic/biologic product on Quarter 1 list and 20% of existing patients receiving best value generic/biologic product on Quarter 2 list.</p> <p>Cost Effective Dispensing Routes – assessment against plan.</p> <p>Fully and accurately populated Minimum data set submitted on time with bottom line value from minimum data set matching drugs line on Aggregate Contract Monitoring (subject to Dictionary of Medicines and Devices implementation timetable as agreed with NHS Digital).</p> <p>Fully and accurately populated submission of outcome databases (Systemic Anti-Cancer Therapy (SACT) and intravenous immunoglobulin (IVIg)) in line with agreed timetable (transition plan).</p>	Achieved	Achieved	Achieved
Sustainability and Transformation Plan	<p>Update on RM Partners initiatives and Royal Marsden direct involvement and contribution.</p> <p>Evidence of attendance at Sustainability and Transformation Plan meeting by senior Royal Marsden representative.</p> <p>Carry out prospective audit analysing impact of Clinical Assessment Unit on accident and emergency attendances and admissions.</p> <p>Analyse data from the Royal Marsden Macmillan Hotline.</p> <p>Provide evidence of working with referring Trusts on 62-day pathway.</p>	No milestone in Quarter 1	Achieved	Achieved
Stereotactic Radiotherapy (SRS/T) dataset	Submission of agreed SRS/T dataset.	Achieved	Achieved	Achieved

3.2.6. Acute CCG CQUIN milestones 2017/18

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

Scheme	Milestone	Quarter 1	Quarter 2	Quarter 3
NHS staff health and wellbeing	Staff survey: full update on actions against action plan and present findings of local surveys.	Achieved	Achieved	Achieved
Reducing the impact of serious infections (antimicrobial resistance and sepsis)	Timely identification of sepsis in Clinical Assessment Unit: submit Quarter 3 2017/18 audit. Timely treatment for sepsis in Clinical Assessment Unit: submit Quarter 3 2017/18 audit. Antibiotic Review: submit Quarter 3 2017/18 audit	Achieved	Achieved	Achieved
e-Referrals	90% of referrals to first Outpatient Services (two week rule/breast symptomatic) able to be received through e-Referrals. Appointment Slot Issues (ASI) by service in line with the agreed trajectory set for 2017/18.	Achieved	Achieved	Achieved
Sustainability and Transformation Plan	Update on RM Partners initiatives and Royal Marsden direct involvement and contribution. Evidence of attendance at Sustainability and Transformation Plan meeting by senior Royal Marsden representative. Carry out prospective audit analysing impact of Clinical Assessment Unit on accident and emergency attendances and admissions. Analyse data from the Royal Marsden Macmillan Hotline. Provide evidence of working with referring Trusts on 62-day pathway.	No milestone in Quarter 1	Achieved	Achieved
Risk reserve	No milestone.	No milestone in Quarter 1	No milestone in Quarter 2	No milestone in Quarter 3

3.2.7. Community Services CCG CQUIN milestones 2017/18

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

Scheme	Milestone	Quarter 1	Quarter 2	Quarter 3
NHS staff health and wellbeing	Staff survey: full update on actions against action plan and present findings of local surveys.	Achieved	Achieved	Achieved

Scheme	Milestone	Quarter 1	Quarter 2	Quarter 3
Improving the assessment of wounds	Percentage of staff trained in care bundles. Update on progress against Quarter 4 trajectory.	No milestone in Quarter 1	Achieved	Achieved
Personalised care and support planning	Submit percentage of eligible patients assessment with 75+ Patient Health Check. Progress against trajectory.	No milestone in Quarter 1	Achieved	Achieved

3.2.8. Commissioner confirmation of achievement 2017/18

Acute NHS England

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

Acute CCG

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

Community services

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

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 the Head of Adult Safeguarding to a meeting to describe the work that is underway to improve the care of patients with dementia.
- 4.1.3. The Consultant Dietitian and Catering Operations Manager discussed with members how catering staff are trained about the food that they are serving, in particular about food intolerances.
- 4.1.4. A series of five senses surveys of wards were carried out at night-time by members of the group to identify environmental issues that are might be affecting the experience of patients. Noise was a particular focus of the surveys. The results will be passed to staff to arrange any necessary remedial work.
- 4.1.5. Members considered how privacy at reception desks could be improved for patients. Their suggestions were shared with managers to consider.
- 4.1.6. The Chief Pharmacist and two senior colleagues were invited to brief the group about improvements to waiting times for medicines and other initiatives to improve the experience of patients.
- 4.1.7. Members heard how well The Royal Marsden Macmillan Hotline has run since launching in October 2016. The hotline, run by nurses, is a helpline for patients who may be experiencing the side effects of chemotherapy or have other clinical concerns. Previously, calls were handled on an ad-hoc basis by different staff across different teams in an inconsistent way.
- 4.1.8. Members continued to represent the group on Trust committees and project groups including the Integrated Governance and Risk Management Committee, Consent Steering Group and the Equality, Diversity and Inclusion Steering Group.

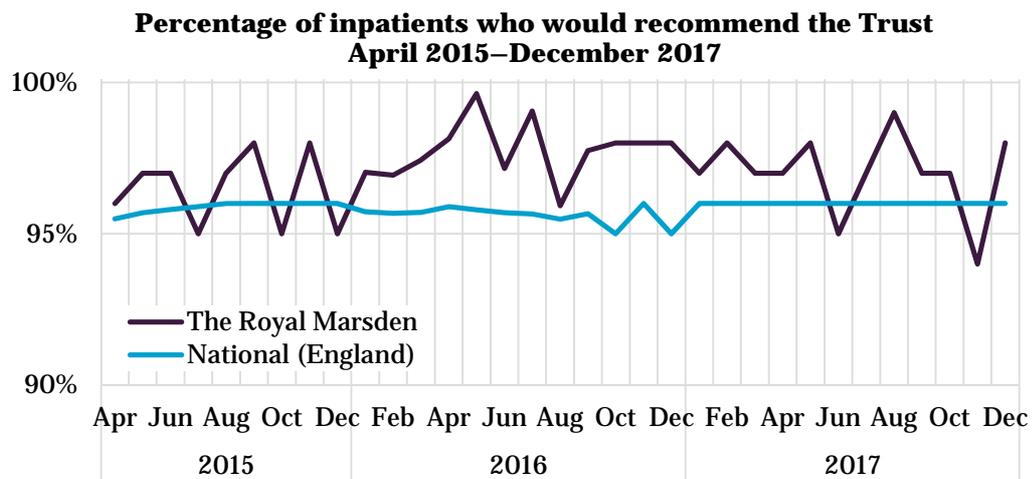
4.2. Friends and Family Test

- 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 Three the Friends and Family Test showed that

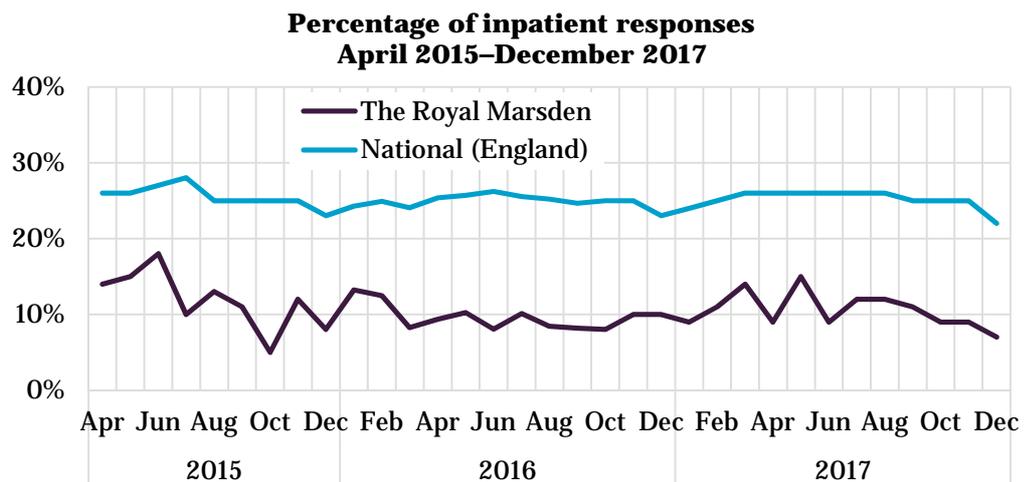
- 96% of Royal Marsden inpatients who responded would recommend the Trust. (Of NHS inpatients in England 96% of respondents would recommend their provider.)
- 95% of Royal Marsden outpatients who responded would recommend the Trust. (Of NHS outpatients in England 94% of respondents would recommend their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



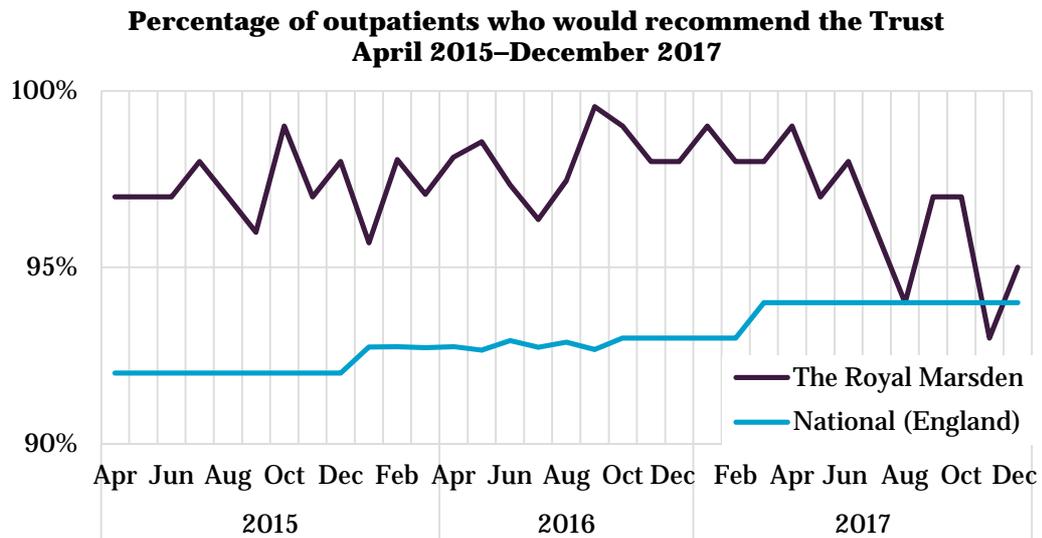
National data from www.england.nhs.uk.

4.2.6. In Quarter Three 1,158 inpatients completed the survey. The chart below shows the **inpatient response** rate of the Trust against the national response rate.



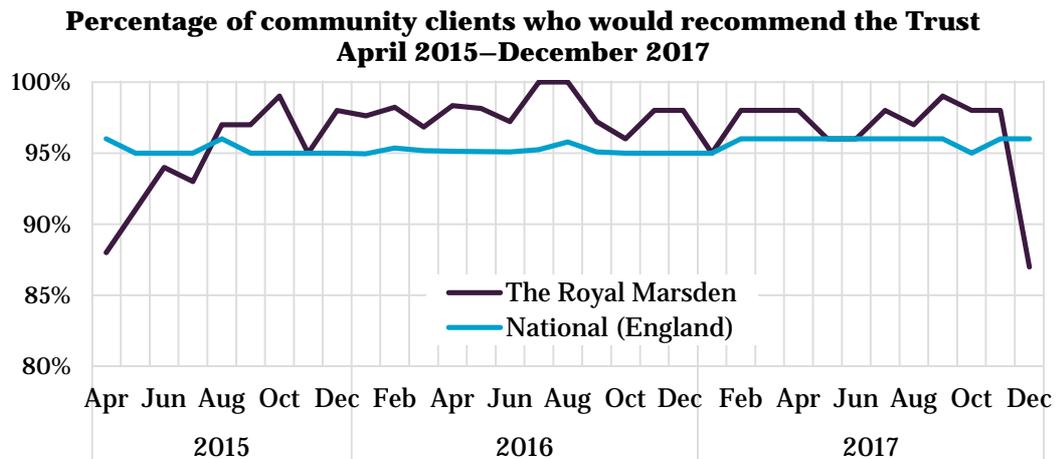
National data from www.england.nhs.uk.

4.2.7. 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 also reviewed at the Clinical Business Units Monthly Performance Review meetings, attended by the Divisional Director, Clinical Lead and Divisional Nurse Director. Actions are taken each month to address any issues. The following are examples of areas that patients suggest require improvement.

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

Inpatients

I'm visiting with my mum - who is the patient, coming in for an op today. We were asked to arrive for 7am, but her surgery wasn't due until 3pm. It would have been better to arrive a little later.

Perhaps coordinate appointments on the same day if possible. Excellent care & attention by ward staff, efficient and friendly and understanding.

Too many patients and not enough nurses. Felt in some instances nurses and doctors under pressure which can make me feel nervous/uncomfortable being rushed for an already stressful process.

Snack was very welcome but I am on a low salt diet after a stroke and the sandwiches were 25% of the daily intake and then the salted peanuts as well. Maybe an alternative?

My only criticism the heating and ventilation in Bud West was poor and inconsistent hot, cold etc.

In day-care we have to be here at 8.15 nil by mouth. I did not get my treatment until 11 o'clock this meant I sat hungry and grumpy for ages. (Children's ward)

Outpatients

I waited 30 minutes in the waiting room without any indication of much longer I would have to wait. I was thinking it could be another hour? Just some indication of the situation would help all concerned. (PET/CT [positron emission tomography/computed tomography] scan)

My only frustration was the process of scheduling my surgery (having missed my initial appointment). Several calls ... over the course of months had no resolution. Messages appeared not to be passed on. The process seemed a bit haphazard. Some communication back to the patient would have eased the wait/put my mind at rest.

The liaison with the district nurse was not very defined – in my earlier visit it took ten days to locate them. Then they did not really know the background to my care, and in three visits did not bring along the correct dressings.

May be more comfortable seating could be provided around while waiting for the doctors.

Daycase

Being diabetic I should be contacted a week before this did not happen. I was more concerned as I was on blood thinners and hence they were concerned it could not be removed. The service was fine. (Endoscopy)

The people are excellent providing an outstanding quality of care. The times in between treatments could be shorter but I appreciate how busy everyone is. (Clinical Assessment Unit)

I was asked to arrive in the department at 9.00am but on arrival was told that I probably wouldn't see a doctor until lunchtime which turned out to be fairly accurate. (Clinical Assessment Unit)

4.2.13. Some positive comments from patients

Comments from those on inpatient wards

Staff are very friendly and they always keep us informed of everything they are doing and why. Moved between departments efficiently.

The overall care at this hospital was excellent. The doctors, nurses were very caring and excellent bedside manner. Made you feel reassured. Thanks to all the staff.

Comments from those attending as outpatients

Given the excellent care & service I received it's rather difficult to suggest any improvements Thank you!! (Radiotherapy Chelsea)

Having to have 33 treatments I meet many different members of the RT team each & everyone gave me excellent treatment, they listened to any problems and dealt with them. They all treated me with understanding. They are truly and excellent team of people and I couldn't fault them in anyway. (Radiotherapy Chelsea)

Daycase

Staff are so warm and caring despite the fact that they are so busy they take time to chat and put you at ease. Everything is efficient and all steps of the procedure clearly explained. It is impossible to recommend any improvements. (Endoscopy)

The Royal Marsden Chelsea is outstanding for many reasons of course for its state of the art technology and surgery but equally important the superb nursing and staff.

Absolutely brilliant service. I came on the wrong day and the staff managed to fit me in for biopsy.

Comments from those attending in community services

Children's Occupational therapy

Paid attention to detail, very professional and polite. Very good I would recommend.

Developed good relationship with my child early on in the session. My child enjoyed his time during the session.

Health visiting

Asked all relevant questions to make sure myself and my baby were doing okay. Really caring lady.

The health visitor helped me to feed my baby in a good position and she explained a lot of things I didn't know, she was good.

Staff are always helpful and friendly. Good advice given and followed up. Improvement would be to continue to offer drop in sessions.

CRISIS team

I wish to express my sincere thanks to all the staff for their care and kindness and encouragement shown to me. How fortunate this facility is available. Also my thanks go to the kitchen staff for the very tasteful and varied meals.

The rehab team provided me excellent care and made me get better with mobility and arranged carers for me to go home soon.

Early Supported Discharge team

Excellent service. Kind and patient, very helpful. Good to have consistency regarding personal care. Very impressed.

Overall the care from both Occupational therapist and physiotherapist was very good. Service was always with the same person so you built up a good relationship. [The therapist] was very good with me and was always on time. I was treated with both respect and care at each visit.

Respiratory service

The exercise sessions have made me feel more confident that I am in control of my breathlessness and also have made me attempt things I didn't think I was able to do i.e. running. I also enjoyed the sessions as I felt I wasn't pushed into doing anything beyond me. The staff and other patients also made them enjoyable and informative.

Very little could be improved. The course has made me meet other people with similar illness to mine. Feel that my health relating to my illness has improved. My confidence relating to my illness has improved. My admiration of the Therapist is of the highest order. Well done the NHS.

Questions answered in full, giving confidence in knowledge of nurse. Nurse asked how my new medication was working to check it was best for me. I feel all staff were helpful and understood my concerns. I was helped by having rehab and other outside support groups.

4.3. Patient Information Service

4.3.1. Activity for the quarter:

Type	New title/ new edition	Revision	Total
Booklets	0	7	7
Factsheets	1	18	19
Leaflets	7	16	23
Total	8	41	49

4.3.2. Leaflets reviewed this quarter include *Having a PET/CT scan* and *Having a medical tattoo*.

- 4.3.3. Booklets reviewed and updated this quarter include *Having a colonoscopy* and *Chemotherapy; your questions answered*.
- 4.3.4. New leaflets produced this quarter include *Education in hospital* and *Low dose prostate brachytherapy*.
- 4.3.5. In November 2017, the Patient Information service initiated the process of sending monthly updates to senior staff and teams across the Trust, informing them of both reviewed and new titles.

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	11	1	12
Asian Indian	67	15	82
Asian Pakistani	20	9	29
Asian (other)	62	10	72
Black African	60	9	69
Black Caribbean	60	3	63
Black (other)	8	0	8
Chinese	24	4	28
Mixed White and Asian	12	2	14
Mixed White and Black African	6	1	7
Mixed White and Black Caribbean	6	1	7
Mixed (other)	16	3	19
White British	1,606	269	1,875
White Irish	62	12	74
White (other)	241	56	297
Other	120	113	233
Not disclosed	66	58	124
Total	2,447	566	3,013
Ethnic origin information completed*	2,381	508	2,889
Ethnic origin information completed (%)*	97.3%	89.8%	95.9%

*All values except *Not disclosed*

5. Personalised care, treatment and consent

5.1. Operating theatres and endoscopy

- 5.1.1. The Royal Marsden Theatres team won the 2017 Clinical Team Award. This has been a milestone to recognise the dedication and teamwork from everyone within the team to achieve excellence in service to Royal Marsden patients.
- 5.1.2. The 2017 endoscopy patient survey was completed in October. Seventy-nine per cent of respondents rated their care from the endoscopy suite excellent.
- 5.1.3. The 2017 endoscopy staff survey was completed with a view to review areas on staff support, work life balance, training and working environment. Staff felt that there is good support in place in their professional development and work life balance. There is ongoing improvement in endoscopy scheduling to review efficiency while maintaining good support for the workforce to achieve work/life balance. There was strong engagement of staff in decision-making in delivery of care to patients with more than 93% of respondents feeling that their ideas were listened to and acted on.
- 5.1.4. Monthly Friends and Family test feedback continued to be the service improvement indicators for the Endoscopy Team.
- 5.1.5. The Royal Marsden is continuing its international recruitment drive and local recruitment to fill the vacancies in theatres and endoscopy. It remains challenging to recruit qualified experienced Operating Department Practitioners/Anaesthetic Nurses in London. The Royal Marsden continues to be part of the Health Education England *CapitalNurse* programme working collaboratively with other major London trusts in developing a standardised approach to higher education studies in the field of operating theatres.
- 5.1.6. The Royal Marsden continues to improve on the overseas nursing recruitment programme. Theatres education team is working closely with Trust Education Leads and Recruitment Leads to develop a robust programme in helping the newly recruited overseas nurses to undertake the Objective Structured Clinical Examination (OSCE), which assesses the ability to competently apply professional skills and knowledge in practice. Local recruitment drives will continue in 2018 to recruit qualified skilled theatre practitioners.
- 5.1.7. Theatres and Endoscopy services will be focusing on quality and cost containment in 2018 in delivering good care within an affordable budget to Royal Marsden patients. The department has successfully implemented an inventory management solution to capture high cost consumables and this will continue to be improved in 2018.
- 5.1.8. Theatres and Endoscopy units continues to delivering good care within the current capacity with smart planning of theatres scheduling working in partnership with multidisciplinary colleagues in delivering world-class service to Royal Marsden private patients and NHS patients.
- 5.1.9. A working group to review perioperative patient care pathway documentation is underway as part of the Royal Marsden's transformation project to streamline paper documentation. The aim of this project is to ensure safe care is delivered to patients with efficient documents during the perioperative period.

- 5.1.10. There has been an improvement in Local Safety Standards for Invasive Procedures (LocSIPPs) compliance. This will continue to be monitored monthly with six-monthly reports presented to the Integrated Governance and Risk Management Committee.
- 5.1.11. The Improving Outcomes Through Enhanced Non-Technical Skills In Surgical Teams (SaINTT – Safety in Numbers Team Training) Programme was attended by surgical colleagues, anaesthetic colleagues and theatre staff in November as part of the initiative to build a stronger safety culture in the department. The half-day training provided the teams with practical tools that can be adapted and used in their own work environment to improve reliable team processes and help improve patient safety.
- 5.1.12. Theatres and Endoscopy services will be the first to launch the Quality Safety Board as part of The Royal Marsden Quality Safety Project. This will be integrated in the morning five-minute team ‘huddle’. The ‘message of the week’ will focus on shared learning with a ‘theme of the week’ used to generate conversation from staff as part of the initiative to promote a culture of learning and championing safety at all times.

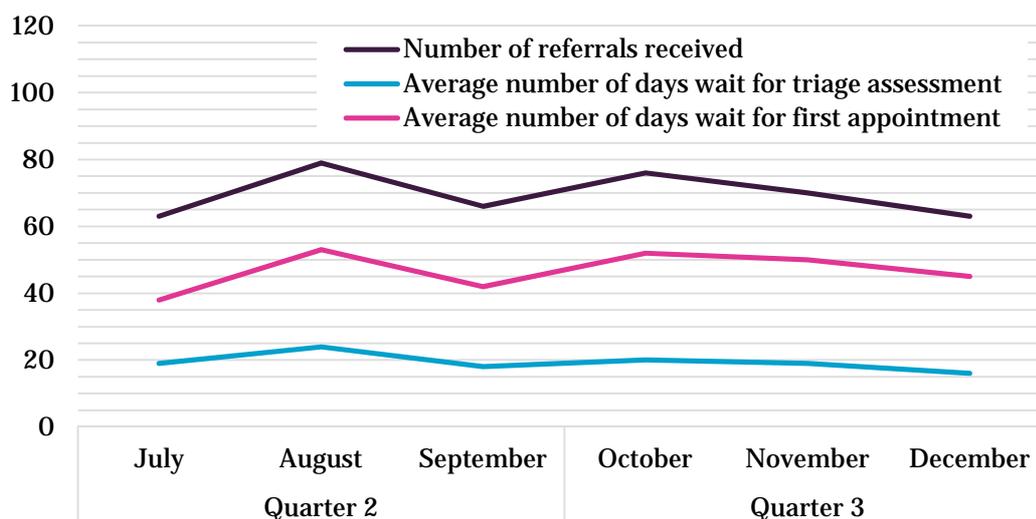
5.2. Adult Psychological Support Service

The Trust provides a confidential psychological support service for patients treated at the hospital. The service offers support particularly in helping individuals and those close to them to adjust to the emotional impact of a cancer diagnosis. This section reports on activity in the period July to December 2017 (Quarters Two and Three 2017/18).

5.2.1. Adult Psychological Support Team activity

During the period 443 referrals for NHS patients were made to the service. Of these 417 referrals (188 in Chelsea, 229 in Sutton) met eligibility criteria and were offered a triage appointment. There has been a consistent increase in the number of referrals received each month in comparison to previous years.

The introduction of a triage system in Quarter One has meant that patients receive a screening telephone call on average within three weeks of referral. This is within the target set by the department. The graph below shows the average triage response time per month against the number of referrals received. As the number of referrals increase, so the length of time before a triage call increases. The figures have also been impacted by staff sickness. Over the six-month period, the average wait time between referral and first appointment has been six weeks. As expected, there is a correlation between this and the number of referrals received.

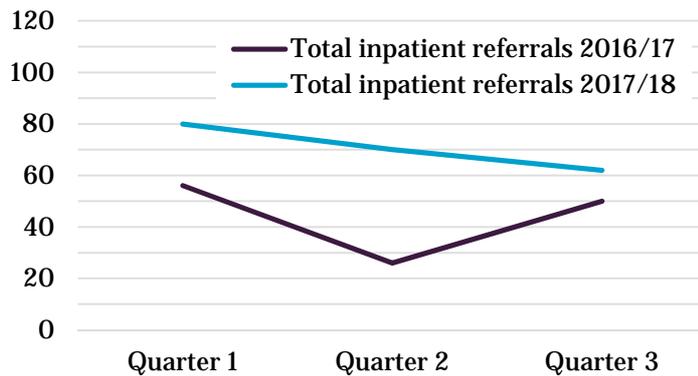


During the period *Learning to be Mindful: A Skills Base Course for Patients* was piloted on the Sutton site of the hospital. This six-session course focused on helping the participants to develop the skill of paying attention and being present in each moment. It is known that this can improve the ability to cope with difficult thoughts and unwanted or unpleasant experiences. Seven patients signed up to attend this course and evaluated it highly. There was some indication that attending increased their ability to be mindful. There are plans to run another course in the spring.

5.2.2. Psychiatric Liaison Service

The Psychiatric Liaison Team – two Psychiatric Liaison Nurses, a Consultant Liaison Psychiatrist and Speciality Doctor – provide mental health assessment to inpatients with challenging psychological needs and arrange ongoing support either through advice to the clinical team, direct care to the patient, or through onward referral to other services such as Psychological Support Service or community mental health teams. During the period they assessed and provided support to 132 inpatients – 73 in Chelsea and 59 in Sutton.

As the graph below shows, this is a considerable increase from the previous year.



National standards indicate that referrals in core hours (Monday to Friday, 9 to 5) are responded to within 24 hours. There was 84% compliance for Quarter Two and 92% compliance for Quarter Three.

5.2.3. Family support

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

	Chelsea	Sutton	Total
Inpatients	9	6	15
Outpatients	7	19	26
Total	16	25	41

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

5.2.4. Chaplaincy services

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

	Quarter 2			Quarter 3			Period total
	Chelsea	Sutton	Total	Chelsea	Sutton	Total	
Church of England	133	114	247	112	87	199	446
Roman Catholic	65	60	125	73	83	156	281
Christian (other)	55	59	114	47	74	121	235
Muslim	71	36	107	87	21	108	215
Not religious	20	39	59	20	39	59	118
Religion not known	12	14	26	18	12	30	56
Hindu	8	3	11	6	1	7	18
Sikh	5	0	5	6	0	6	11
Buddhist	0	0	0	0	2	2	2
Jewish	2	0	2	0	0	0	2
Jain	1	0	1	0	0	0	1
Total number of patients	372	325	697	369	319	688	1,385

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

During the last six months, the chaplaincy team made 2,596 visits to 1,285 patients. Of these 1,383 visits were made on the Chelsea site and 1,213 visits were made on the Sutton site.

The Chaplaincy team have a commitment to developing healthcare chaplains for the future. The hospital setting provides a very particular context for students to learn and to practise their pastoral care skills. Over the last five years the Chaplaincy department at The Royal Marsden has welcomed theology students on short and longer-term placements and curates following ordination. During the last six months, there have been four students on placement – two at each site of the hospital.

5.2.5. Staff Support Team

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

	One-to-one counselling	One-to-one supervision	Debriefing	Supervision groups
Quarter 2	499	63	2	43
Quarter 3	561	53	0	51
Total	1,060	116	2	94

During the period the team received an average of 21 new referrals a month. The reasons for attending counselling are

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

The greatest number of referrals is for work-related issues (6.3 a month) and the lowest number is for bullying in the workplace (1.5 a month).

Mindfulness sessions have continued on both sites with good attendance. On World Mental Health Day (10 October) the team went into the workplace to raise awareness of how staff can look after their mental health.

5.3. Symptom control and palliative care

5.3.1. 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. The first three months' worth of data collection (July to Sept 2017) has been analysed. This data collection will allow the team to monitor interventions, guide service delivery, and may in future act as a trigger for referral.

5.3.2. Hospital support

The Symptom Control and Palliative Care Team is now nine 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 the new Triggers tool (which allows assessment of patients' needs at an earlier stage, with the potential to refer them to specialist palliative care and active treatment) together with validated symptom assessment.

Data from the previous quarter, Quarter Two, shows that the Triggers tool is running well with the target of 50% review rate exceeded. The service is identifying a population of patients with palliative care needs. RM Partners has funded short-term expansion. The plan is to expand the Triggers tool to upper gastrointestinal clinics from January 2018 and to gather formal patient and staff feedback about the Triggers tool following submission of an updated Service Evaluation proposal for Trust approval.

5.3.3. 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 the use of drugs in end of life care.

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

Annual external and biannual internal palliative care update days are held covering topics related to end of life care. The last Palliative Care Update Day was held on Monday 16 November.

5.3.4. Strategic developments

The Symptom Control and Palliative Care Team is progressing well with the national Commissioning for Quality and Innovation (CQUIN) for Enhanced Supportive Care, and the Trust has met the quarterly CQUIN targets to date. The team has attended three meetings of Enhanced Supportive Care leads to share best practice, with the next day scheduled for January 2018, and has visited The Christie NHS Foundation Trust to view an outpatient clinic in action.

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

5.3.5. Supportive Care Home Team

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

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

6. Eating and drinking

6.1. Nutrition and catering patient surveys

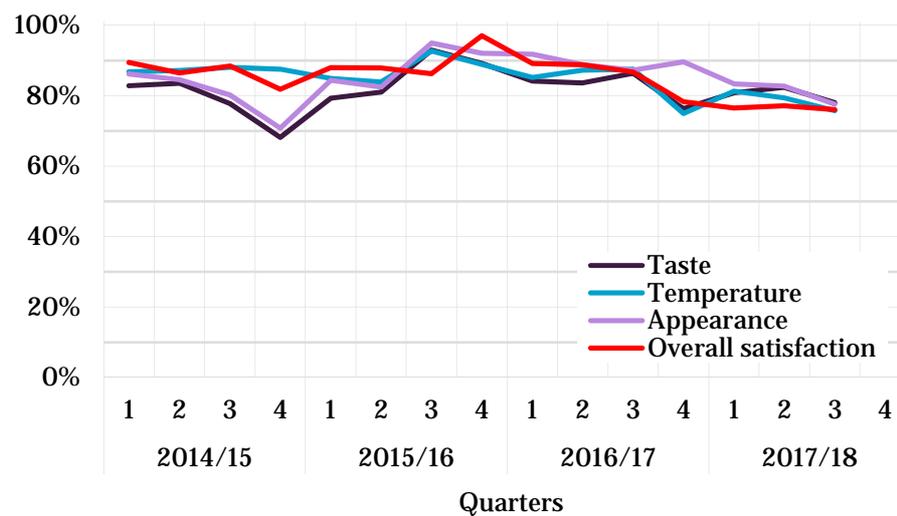
Patient surveys are undertaken at the Chelsea and Sutton sites. The patients' comments are regularly reviewed and particular points are actioned.

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? (100 responses this quarter)
- How would you rate the temperature of the food? (95 responses this quarter)
- How would you rate the appearance of the meals? (98 responses this quarter)
- How would you rate your overall satisfaction with the catering service? (75 responses this quarter).

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

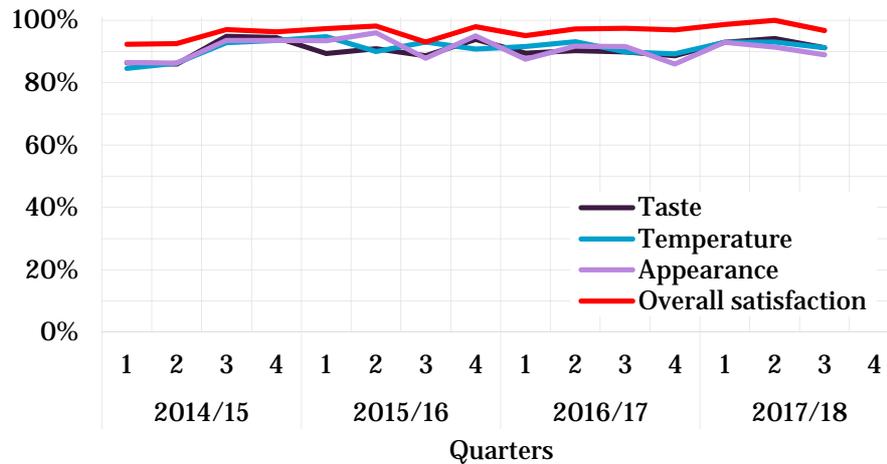


6.1.2. Patient survey results – Sutton

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

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



6.1.3. Recognition of nutrition practitioners and teams

In October the Catering Supervisor at the Oak Centre for Children and Young People received an “Outstanding professional” award from Prince Harry at the WellChild Awards.

In November, following a food hygiene inspection, the Sutton site retained its maximum five star food hygiene rating.

In November the Catering Team (Sutton and Chelsea) won the “Working Together” award in the non-clinical category at the Royal Marsden’s annual Staff Achievement Awards.

7. Safeguarding and safety

7.1. Safeguarding adults at risk

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 Three 21 formal safeguarding adults concerns were raised across the Trust in relation to concerns of abuse or neglect that patients reported experiencing outside of the Trust. A further two safeguarding concerns were also identified, however the patient declined for a referral to be made to the local authority.

Number of concerns raised: Chelsea and Sutton	Quarter 2 2017/18	Quarter 3 2017/18
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Number of referrals to local authority	9	1
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In Quarter Three one safeguarding concern was raised from the Trust's Chelsea and Sutton sites. However, there were in addition two cases where safeguarding concerns were identified but the patient declined for a formal safeguarding concern to be made. This was a reduction from Quarter Two where nine concerns were referred.

Community Services	Quarter 2 2017/18	Quarter 3 2017/18
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Number of referrals to local authority	18	20
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In Quarter Three there were 20 safeguarding concerns raised by Community Services, an increase of 11% since Quarter Two. Community teams continue to raise the highest number of safeguarding concerns within the Trust, having raised 20 of the 21 referrals this quarter.

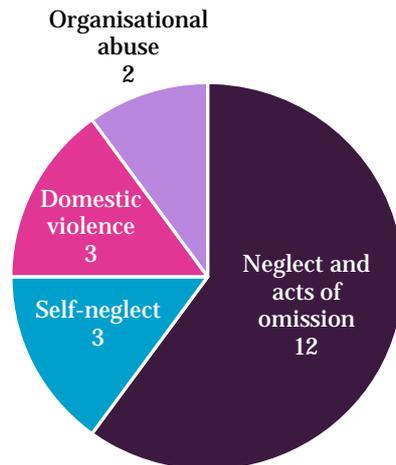
All multiple grade 2, grade 3 and grade 4 pressure ulcers are screened using the Safeguarding Pressure Ulcer Protocol and two of these from Community Services, were reported to the local authority under the safeguarding adult procedures. There was one safeguarding concern raised relating to an attributable pressure ulcer from community services during this quarter.

7.1.1. Categories of Abuse

A safeguarding concern may identify more than one category of abuse for a single referral. There were 21 reported concerns this quarter, 20 in Community Services and one in the hospital-based sites.

7.1.2. Community Services

In Community Services, neglect and acts of omission continue to be the highest reported category of abuse. The chart shows the number of reported concerns in each category.



7.1.3. Hospital-based sites (Chelsea and Sutton)

In the hospital-based sites the single reported concern was related to domestic violence. All concerns in Quarter Three (including two non-reported concerns) related to domestic violence. This has prompted an awareness campaign of national domestic violence services across the Trust sites.

7.1.4. Mental Capacity Act and Deprivation of Liberty Safeguard (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 The Royal Marsden Community Services.

In Quarter Three bespoke Mental Capacity Act and Deprivation of Liberty Safeguards training continued to be provided to staff within Community Services. One hundred and forty-one staff have been trained (73% of the identified cohort), and further sessions are planned for Quarter Four. Level 2 safeguarding adults training also includes training on the Mental Capacity Act and Deprivation of Liberty Safeguards and Community Services compliance was 87% 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 Three. This is the same number of applications as in Quarter Two.

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* (as a 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 adults boards and *Prevent* networks as well as having links with the local Channel panel, which discusses and monitors referrals. There have been no referrals made to Channel (an early intervention multi-agency panel designed to safeguard vulnerable individuals from being drawn into extremist or terrorist behaviour) 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 3	Number of compliant staff	Percentage compliance
Basic awareness	1,087	3,694	92.5%
Workshop to raise awareness of <i>Prevent</i> (WRAP)	38	150	37%

During Quarter Three five WRAP sessions were delivered in the Trust and eight sessions are planned for Quarter Four. The Trust has a *Prevent* training plan in place which includes schedule of WRAP training sessions being provided to identified 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 Buddies 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.

The Trust is continuing to review the Patient Led Assessment of the Care Environment (PLACE) results 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, including 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 friends’ sessions. Sessions are one-off for staff and offered as a part of induction (Tier 1) for clinical staff or professional development (Tier 2).

Dementia training	Number of staff completed within the Trust to date
Tier 1	872
Tier 2	35

7.1.7. Key achievements and new initiatives

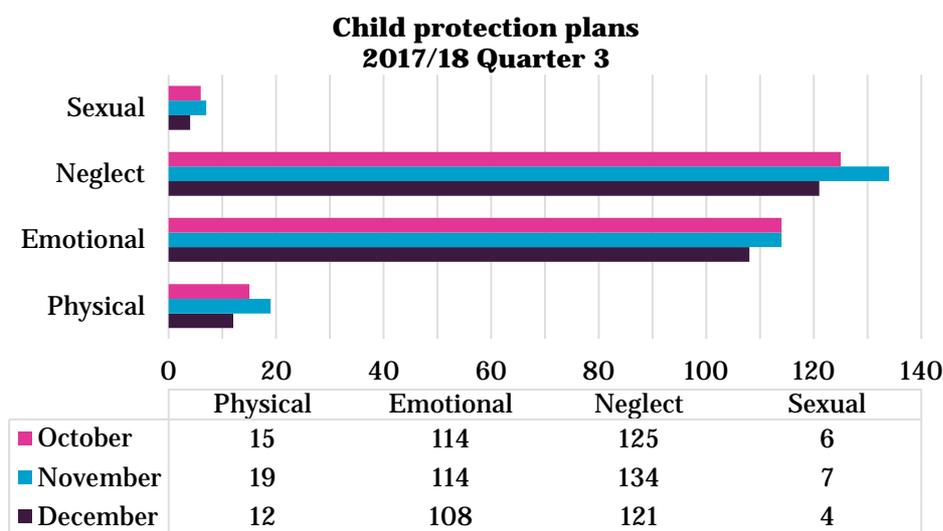
- Specialist Safeguarding Adults Advisor commenced in post in November
- safeguarding adults A5 cards outlining the categories of abuse and key safeguarding contracts developed and distributed for staff
- 141 (73%) community services clinical staff have completed Level 3 Mental Capacity Act Training
- *Mental Capacity Act Forum for Consultants and Senior Decision Makers* was held in December
- Level 3 Safeguarding adults training sessions were delivered to identified staff.

7.2. Protection and identification of vulnerable children and young adults

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

- to ensure the child is safe from harm and prevent him or her from suffering further harm
- to promote the child's health and development
- to support the family and wider family members 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.



7.2.1. Safeguarding supervisor

From December The Royal Marsden employed a full time safeguarding supervisor for children. The Safeguarding Supervisor will support the Named Nurse in providing expertise and assurance to effectively safeguard children. There are currently no children in inpatient services who are subject to a child protection plan or who are ‘looked after’. Safeguarding advice has been provided this month for ten children of whom two required a referral to the Multi-Agency Safeguarding Hub (MASH) and one required an adult safeguarding concern to be raised.

7.2.2. Multi-Agency Safeguarding Hub (MASH)

The Multi-Agency Safeguarding Hub (MASH) seeks to enable the sharing of information so risks to children can be identified at an early stage and is the ‘front door’ for all referrals with concerns for a child’s welfare. It is a link between universal services such as schools and general practice, community services and statutory services such as police and social care. The number of MASH referrals to the Health Navigator remained stable between Quarter Two and Quarter Three.

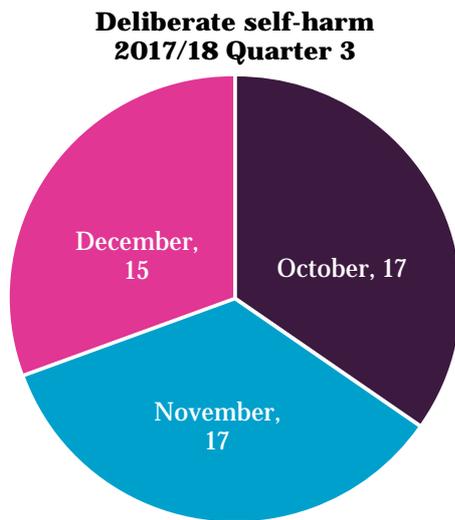
7.2.3. Strategy meetings

Strategy meetings are multi-agency meetings used to share available information to agree what action is required to safeguard and promote the welfare of a child. The safeguarding team attends all strategy meetings on behalf of the Trust. There has been a slight decrease in Quarter Three of the number of strategy meetings being convened which is probably attributable to the London Borough of Sutton internally reviewing their criteria for cases that require a strategy meeting.



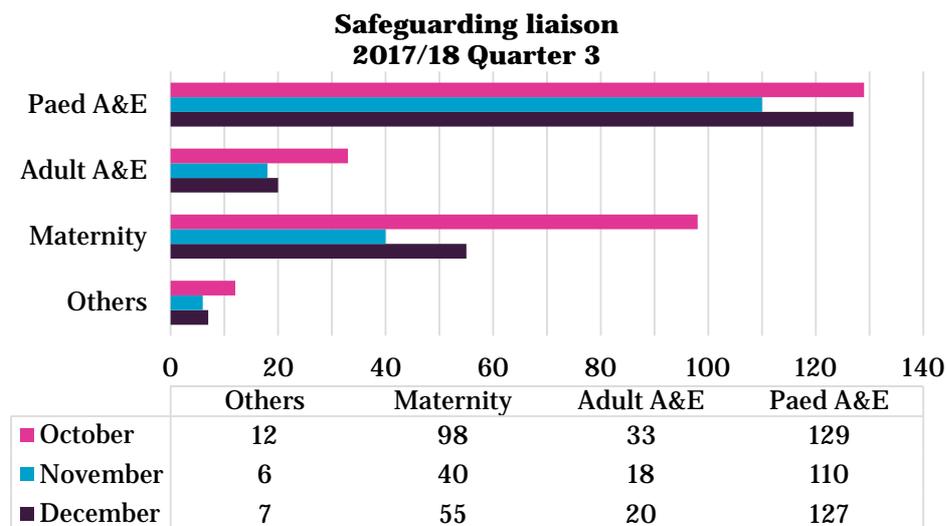
7.2.4. Deliberate self-harm

The London Borough of Sutton has a fortnightly partnership review meeting to scrutinise the assessment and care pathway of all young people identified as at risk of self-harm/suicide. The Quarter Three figures demonstrate that the number of young people being identified with self-harm has stabilised with minimal fluctuation in comparison to Quarter Two. The Local Safeguarding Children’s Board reviewed its protocol for the management of self-harm in November.



7.2.5. Community liaison

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



7.2.6. Family Nurse Partnership (FNP)

This service was de-commissioned in November. Locally-agreed guidance was followed in the transfer of clients in agreement with the Named Nurse Safeguarding Children and meetings took place in November between the Family Nurse, Health Visitor and Health Visiting Safeguarding Supervisor.

All handovers concluded with an action plan for the family, allocation on a health visiting enhanced caseload and the requirement that the case was reviewed with the Safeguarding Supervisor in the practitioner’s next two supervision sessions. A final summative report regarding the decommissioning of the FNP and the caseload safe handover to the health visiting services has been written by the Family Nurse Supervisor and shared with the London Borough of Sutton Lead Commissioner and the Named Nurse and Health Visiting Service Manager.

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)

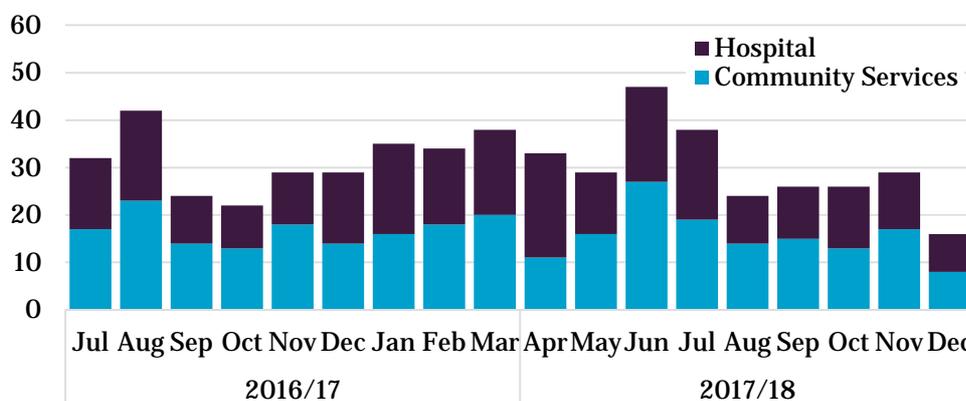
7.3.3. Since June 2015, category 4 pressure ulcers that cause severe harm to the patient and are attributable to the Trust have required reporting under the national serious incident reporting system.

7.3.4. In Quarter Three, no hospital patients and no community services patients developed a category 4 pressure ulcer that was attributable to the Trust. From 1st April 2016 community services data only contains pressure ulcers reports 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.

	October	November	December
Number of patients with pressure ulcers attributable to the Trust	26	29	16
Number of patients with pressure ulcers attributable to the hospital	13	12	8
Number of patients with pressure ulcers attributable to Community Services	13	17	8
Number of patients with attributable pressure ulcers Category 1	8	10	8
Number of patients with attributable pressure ulcers Category 2	18	19	7
Number of patients with attributable pressure ulcers Category 3	0	0	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**



7.3.6. Since November 2017 the Trust is trialling reporting in line with the European Pressure Ulcer Advisory Panel (EPUAP) guidance of six categories of pressure ulcers, including Unstageable and Suspected Deep Tissue Injury (DTI). Reporting of this data will be included in the Quarter One 2018/19 Integrated Governance Monitoring Report.

8. Premises and equipment

8.1. Infection prevention and control

8.1.1. Mandatory surveillance

Indicator	Quarter 3 DCS* reportable	Quarter 3 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	12	5	39	20	42		
VRE†† bacteriaemia	0	0	1	1	N/A	N/A	
<i>Klebsiella</i> species bacteriaemia	7	2	22	6	29		
<i>Pseudomonas aeruginosa</i> bacteriaemia	6	3	11	3	16		

	Quarter 3	Quarter 3 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	22	12	41	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

†† VRE: vancomycin-resistant enterococci.

8.1.2. Hand hygiene

The overall hand hygiene compliance score for the Trust in Quarter Three is 91%. The Chelsea site compliance score is 90%, Sutton is 92% and Kingston 90%.



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

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

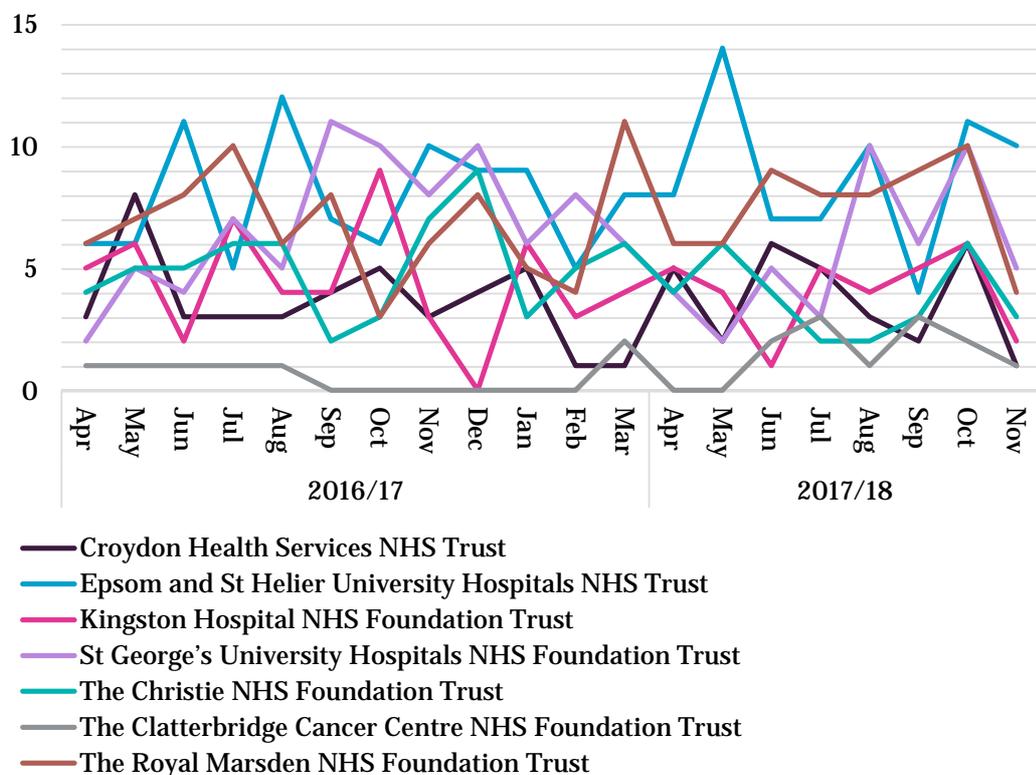
8.1.4. *Clostridium difficile* infection

All stool samples found to be *Clostridium difficile* toxin (CDT) positive are reported to the 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 22 cases of CDT in Quarter Three. Of these 12 were 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 December.



8.1.5. Carbapenemase-producing Enterobacteriaceae (CPE)

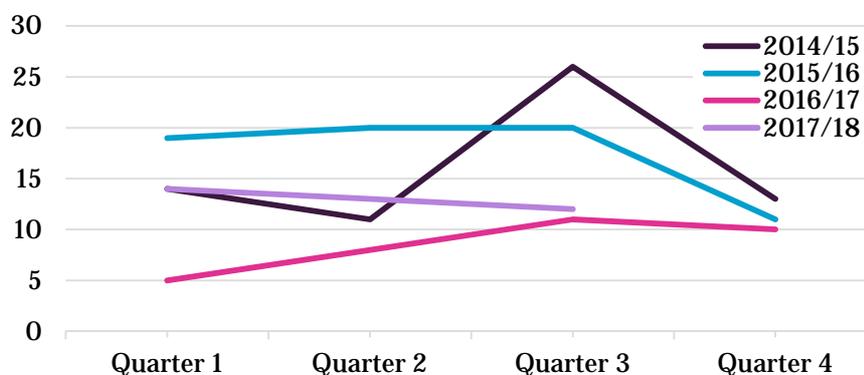
There were seven new suspected patients with confirmed or probable carbapenemase-producing Enterobacteriaceae (CPE) in Quarter Three.

8.1.6. *Escherichia coli* bacteraemia

There is now a new requirement for reporting of *Escherichia coli*, *Klebsiella* species and *Pseudomonas aeruginosa* bacteraemia onto 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 are also increasingly prone to 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.

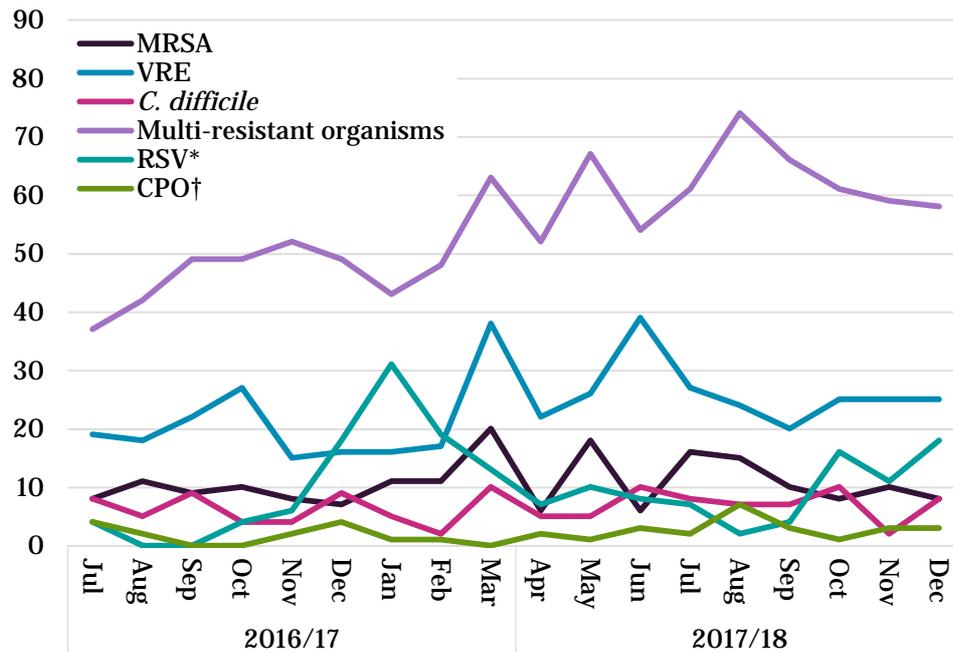
The Infection Prevention and Control Team at The Royal Marsden has previously noted a 27% decline in *E. coli* bacteraemia since 2014 which may be due to use of Ciprofloxacin prophylaxis in neutropenic patients or introduction in late 2015 of the film dressings for vascular access devices. Most cases 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 continues to review each case in line with the new guidance. A workshop focussing on preventing *E. coli* sepsis through improved urological care was held in December and work is being planned with The Christie NHS Foundation Trust to look at this further from an oncology perspective.

8.1.7. *E. coli* bacteraemia – reportable



8.1.8. Multi-Resistant Gram Negative (MDRGN) Organisms

The chart below shows incidence of new high-risk organisms per month. The largest burden is from patients with multi-resistant organisms. These include *E. coli*, *Klebsiella* species and many non-speciated organisms. They represent colonisation in the bowel and there is no attributable mortality. The reason these organisms are seen is twofold, firstly the Trust sees a lot of patients from overseas including places like the Middle East where these organisms are endemic in the population and secondly, a high proportion of the patients receive antibiotics which are essential to enable treatment for patients with cancer but which can select out more resistant organisms in the gut.



* RSV: respiratory syncytial virus
 † CPO: carbapenemase-producing organisms.

Patients with MDRGN organisms can account for up to a third of the Trust’s inpatients at any given time. This puts a lot of pressure on beds as ideally these patients should be source isolated. This is particularly important if the patient has devices which need a lot of handling such as an indwelling urethral catheter or if they have diarrhoea. Where isolation is not possible those patients with diarrhoea are given priority. Room decontamination is seen as essential in preventing cross infection after these cases. The Trust uses a third-party decontamination management service provider (prioritising the highest risk cases such as CPE and *C. difficile*) or uses ultraviolet light. Ultraviolet light has been shown to be very effective in a physically clean room for these types of organisms and has a much quicker turnaround.

From February 2018 the decontamination management service will be available on both Chelsea and Sutton hospital sites seven days a week.

8.1.9. Contract review meetings and audit

The new Fulham Road Collaborative facilities contract start date is 15 January 2018.

Monthly contract review meetings are held to monitor any concerns and ensure that actions are followed through.

8.1.10. Flu

Staff flu vaccination uptake has met the Commissioning for Quality and Innovation (CQUIN) target.

8.2. Sepsis

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

8.2.2. The leads are working on gap analysis to implement over 150 recommendations following National Institute for Health and Care Excellence (NICE) guideline 51 *Sepsis: recognition, diagnosis and early management* (published July 2016). 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. Work is being done to incorporate NEWS 2 scoring into the Trust. NEWS 2 is the latest version of the national early warning score (NEWS) – an early predictor of deterioration.

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

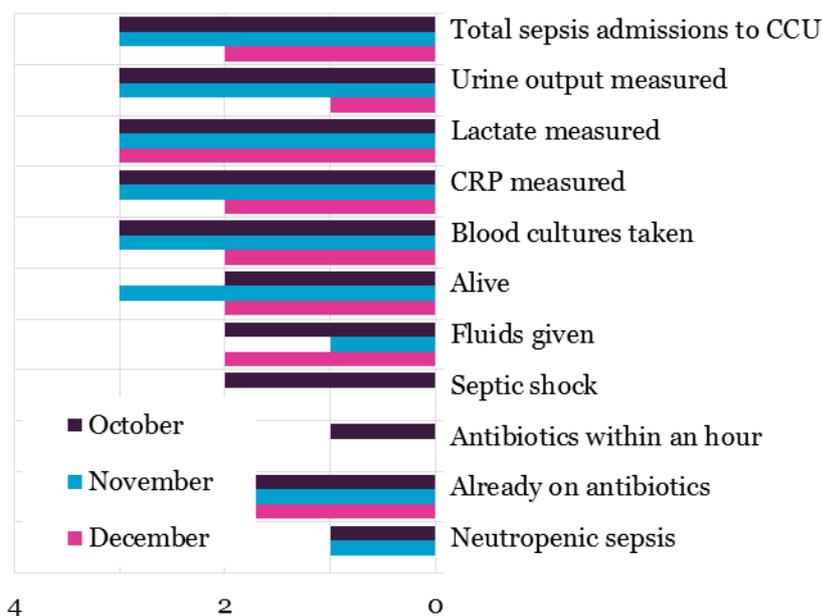
8.2.4. Data collection

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

Only eight patients were admitted to CCU in the quarter with sepsis. One patient died in CCU. Two had neutropenic sepsis and two had septic shock. The neutropenic sepsis audit was completed by the Acute Oncology Service (AOS) team. Of the eight patients (neutropenic and non-neutropenic), all had a C-reactive protein (CRP) measured. All had lactate measured. All the patients were already receiving antibiotics, or received antibiotics within the first hour of presenting with sepsis. This is suggestive that progress achieved with the *Sign Up to Safety* campaign is being maintained.

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

8.2.5. Sepsis admissions to CCU – October to December 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) of 4 or above with a suspected infection should be referred to CCU Outreach (24/7), a clinical site practitioner or an on-call junior doctor for immediate review. If sepsis is suspected it must be escalated to a senior clinician for immediate review. As the NEWS 2 score is rolled out, thresholds will be published for sepsis suspicion and escalation.
- 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.*

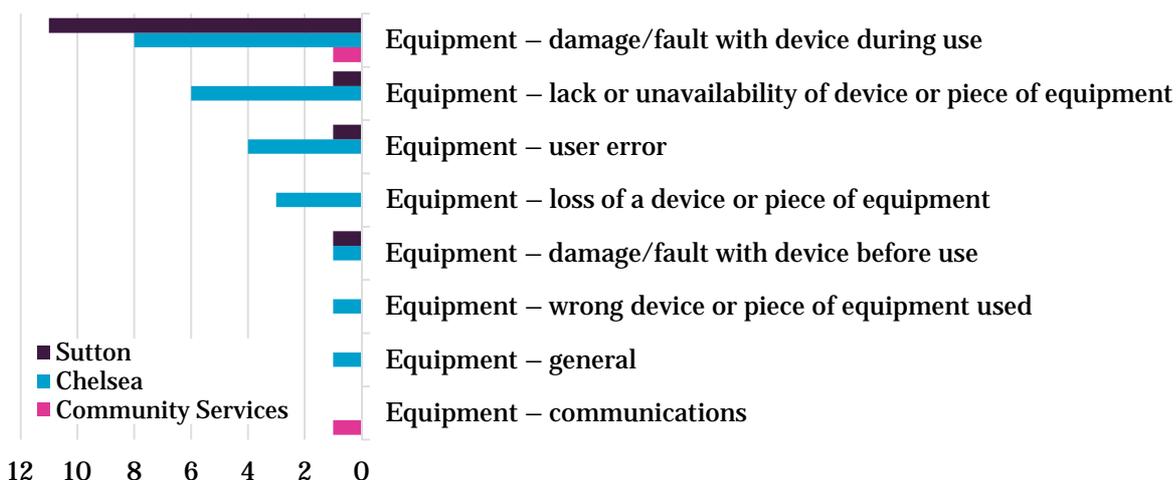
There were 40 incidents relating to medical devices this quarter (there were 58 in the previous quarter).

The main device incidents included:

- 10 involving various non-specified equipment
- 5 involving computed tomography (CT)/SYS
- 5 involving beds (including mattresses)
- 4 involving Radiotherapy equipment.

No incidents were graded *moderate* or above, 11 were graded low and 29 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	10
Computed tomography (CT)/SYS	5
Bed (including mattress)	5
Radiotherapy equipment such as simulator, magnetic resonance imaging (MRI)	4
Administration and giving set	3
Pump/syringe driver	3
Surgical instrument	3
Dialysis	1
Endoscope	1
Facilities	1
Fridge/freezer	1
Pathology equipment	1
Physiotherapy equipment	1
Thermometer	1
Wound drain	1
Total	41*

* 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 15 proposals to evaluate new equipment. One product was approved for purchase.

8.3.5. Clinical Product Review Committee medical device proposals

Form A (low risk)	4
Form B (proposal to evaluate)	15
Form D (risk assessment - device not evaluated)	5
Approved for purchase	1
Total	25

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 third 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 quarter in 2016/17 through to the third quarter of 2017/18.



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

8.4.3. Allergy documentation

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

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



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

8.4.4. Omission of critical medicines

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

8.4.5. Electronic prescribing

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

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

The table shows the eChemo system prescribing metrics.

	Quarter 4 2016/17	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18
eChemo prescriptions prescribed more than 5 days in advance	75%	74%	71%	71%
Available eChemo prescriptions screened more than 4 days in advance	92%	93%	91%	92%

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 86% of prescriptions are completed within 30 minutes. The average waiting times between October and December were 24 minutes (Sutton) and 14 minutes (Chelsea).

Outpatients Minutes	October		November		December	
	Sutton	Chelsea	Sutton	Chelsea	Sutton	Chelsea
0 to 30	81%	94%	82%	97 %	67%	96%
31 to 60	18%	6%	17%	3%	27%	4%
61 or more	1%	0%	1%	0%	6%	0%

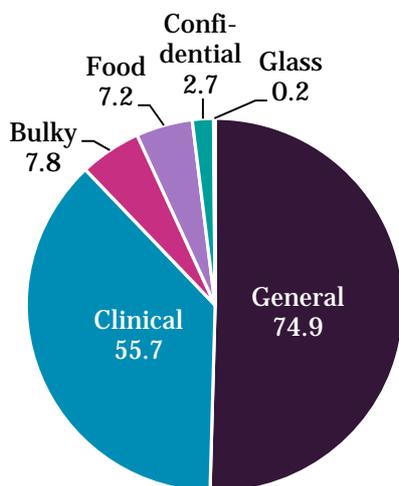
Waiting times for prescriptions dispensed for discharge are shown in the table below. It shows that over 98% of discharges were completed within 60 minutes with over two thirds completed within 30 minutes. Average waiting times from October to December were 24 minutes (Sutton) and 16 minutes (Chelsea).

Discharges Minutes	October		November		December	
	Sutton	Chelsea	Sutton	Chelsea	Sutton	Chelsea
0 to 30	77%	88%	75%	93%	69%	92%
31 to 60	19%	12%	20%	7%	25%	8%
61 or more	4%	0%	5%	0%	6%	0%

8.5. Waste management

The combined volume of waste disposed of in Quarter Three was approximately 364 tonnes across both sites. A breakdown for each site is provided below.

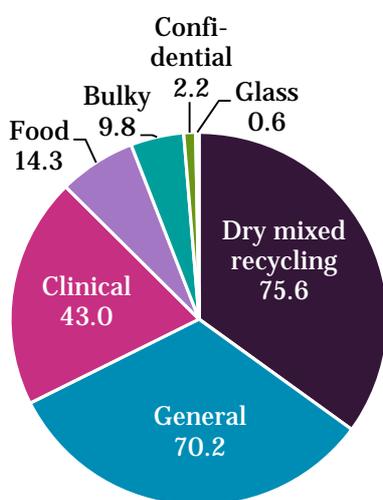
8.5.1. Chelsea



The volume of waste disposed of in Quarter Three was approximately 149 tonnes. A further breakdown in tonnes is provided below.

Month	Dry mixed recycling	General waste	Glass	Clinical waste	Confidential waste	Bulky waste	Food waste	Total
October	0.00	25.6	0.00	16.84	0.97	2.52	2.46	48.39
November	0.00	27.2	0.10	21.05	0.98	2.52	2.46	54.30
December	0.00	22.12	0.10	17.80	0.75	2.80	2.27	45.84
Total	0.00	74.92	0.20	55.69	2.70	7.84	7.19	148.53

8.5.2. Sutton



The volume of waste disposed of in Quarter Three was approximately 215 tonnes. A further breakdown in tonnes is provided below.

Month	Dry mixed recycling	General waste	Glass	Clinical waste	Confidential waste	Bulky waste	Food waste	Total
October	26.39	26.88	0.30	14.54	0.58	2.88	4.91	76.48
November	26.40	21.26	0.00	15.20	0.86	3.46	4.91	72.09
December	22.80	22.08	0.30	13.27	0.77	3.48	4.45	67.15
Total	75.59	70.22	0.60	43.01	2.21	9.82	14.28	215.73

8.6. Fire

8.6.1. Fire risk assessments

All fire risk assessments were conducted at the required time giving The Royal Marsden 100% compliance.

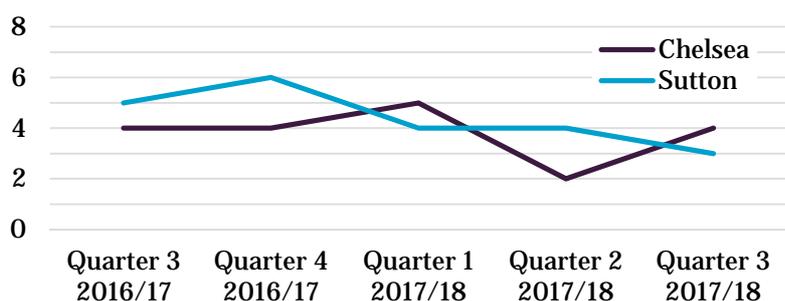
8.6.2. Number of fires

None.

8.6.3. Fire-related incidents

The below graph and table shows the number of attributable fire-related incidents throughout the Trust over the past five quarters. There has been a 16.6% increase (from six to seven incidents) in fire related incidents throughout the Trust since Quarter Two and a 22.2% decrease (from nine to seven) in fire related incidents when comparing to the same period last year (Quarter Three 2016/17 to Quarter Three 2017/18).

8.6.4. Fire-related incidents by site



8.6.5. Fire-related incidents by subcategory

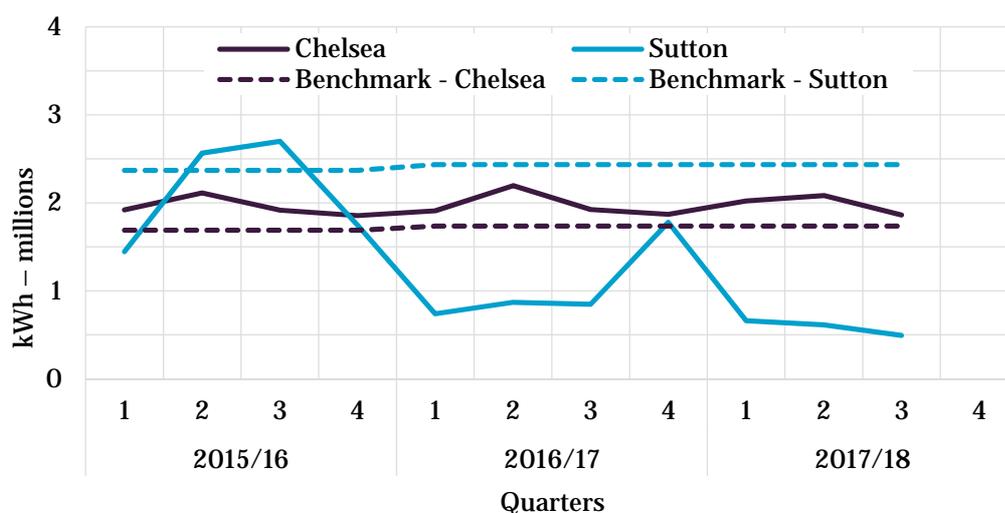
	Quarter 3 2016/17	Quarter 4 2016/17	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18	Total
Detector activated – dust, smoke, building works	4	2	3	0	4	13
Detector activated – kitchens	3	0	0	2	0	5
Call point activated – accidentally operated	0	2	0	1	1	4
Fire safety deficiency	0	0	0	2	1	3
Detector activated – electrical equipment	0	1	1	1	0	3
System fault – fault on fire alarm system	1	0	2	0	0	3
General fire issue	0	1	0	0	1	2
Actual fire	0	2	0	0	0	2
Damage – call points	0	0	1	0	0	1
Damage – detectors	0	1	0	0	0	1
Detector activated – overheating of area	1	0	0	0	0	1
Detector activated – water leak	0	1	0	0	0	1
Fire escape blocked	0	0	1	0	0	1
System fault – detectors covered	0	0	1	0	0	1
Total	9	10	9	6	7	41

8.7. Energy use

8.7.1. Electricity consumption – Chelsea and Sutton

Electricity consumption in Quarter Three at Chelsea reduced by 3 % on the same quarter last year and 11% on Quarter Two this year. The main contributors for the reductions are implemented energy efficiency measures and reduced to load of air conditioning cooling systems.

Electricity grid consumption in Quarter Three at Sutton reduced by 42% on the same quarter last year and 20% on Quarter Two this year. The reliable 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.

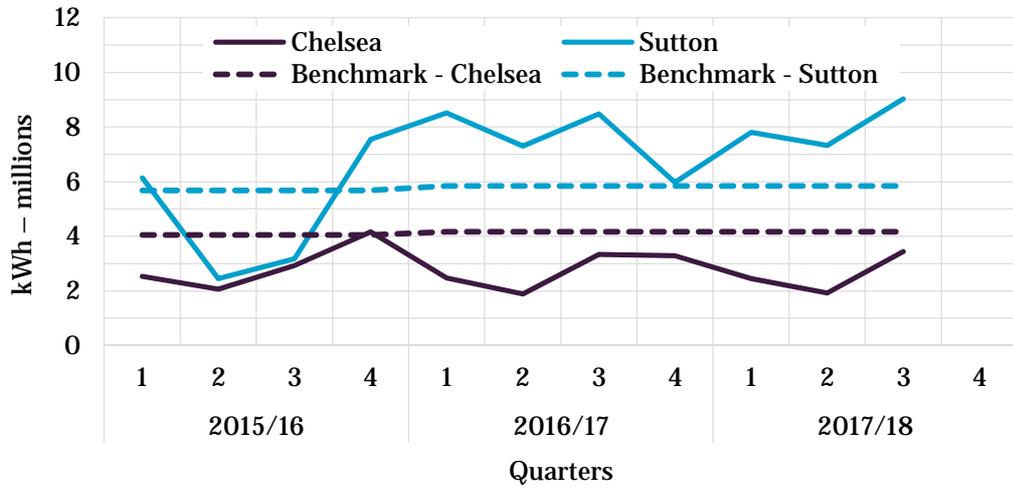


The benchmark used is an average of consumption of five acute trusts in London. The Royal Marsden's electricity consumption at the Chelsea site is slightly above the benchmark line but the consumption at Sutton is below the benchmark line. The Trust is preparing a feasibility study for on-site generation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

8.7.2. Gas consumption – Chelsea and Sutton

Gas consumption in Quarter Three at Chelsea increased 3% over the same quarter last year and increased 79% on Quarter Two this year. The main reason for increase is start of heating season (two weeks earlier than the previous year) and increased hot water usage at the hospital.

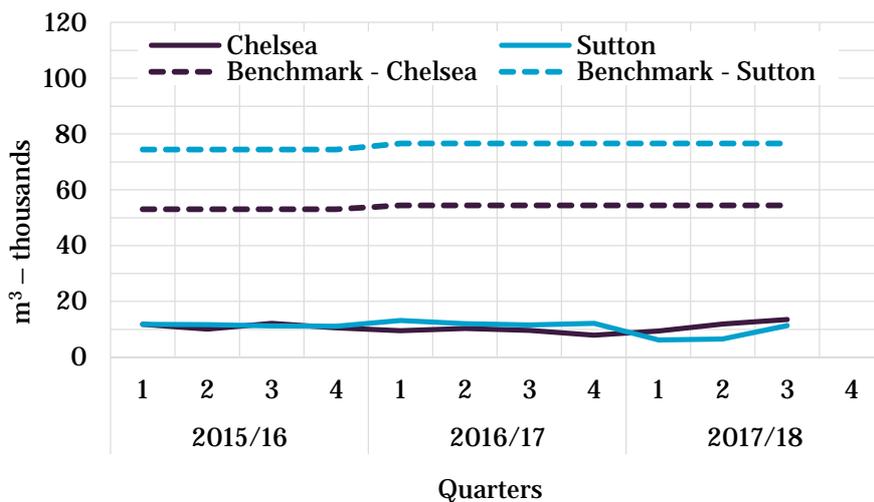
Gas consumption in Quarter Three at Sutton was increased 6% over the same Quarter last year and increased by 23% on Quarter Two this year. Increased running hours of the CHP for the heating season is the main contributor for the increased gas consumption.



8.7.3. Water consumption – Chelsea and Sutton

Water consumption in Quarter Three at Chelsea was up 40% on the same quarter last year and increased 13% on Quarter Two 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 Three at Sutton was reduced 1% on the same quarter last year and increased 72% on Quarter Two this year. A faulty water meter is the main reason for not registering actual usage in Quarter Two this year.



8.8. Estate improvements – Chelsea

8.8.1. Planning CT

The Siemens Confidence computed tomography (CT) scanner is a state-of-the-art dedicated radiotherapy multi-slice CT scanner. It enables axial, helical and four-dimensional computed tomography (4D CT) scan acquisitions with rapid real-time reconstruction, producing high quality images for radiotherapy planning. The advance detectors and reconstruction algorithms allow for significant artefact reduction, further enhancing image quality. Dose reduction is also enhanced through current and voltage modulation, and with its integrated intravenous contrast delivery, it will allow for a high patient throughput with excellent image quality for all body sites.



9. Suitability of staffing

9.1. Human Resources

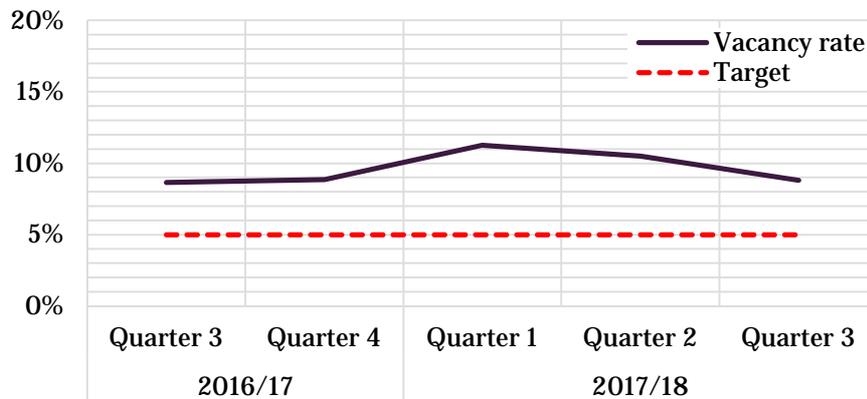
9.1.1. Performance indicators

	Quarter 3 2016/17	Quarter 4 2016/17	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18
Vacancy rate (target 5.0%)					
Trust total	8.6%	8.8%	11.3%	10.5%	8.8%
Cancer Services	5.8%	6.3%	7.2%	7.2%	6.4%
Clinical Research*			13.0%	3.4%	0.6%
Clinical Services	7.8%	6.9%	11.3%	12.2%	10.1%
Community Services	14.6%	15.7%	17.8%	16.6%	14.4%
Private Care	15.7%	15.7%	18.0%	17.2%	15.2%
Corporate	5.6%	5.7%	8.0%	7.7%	6.8%
Turnover (target 12.0%)					
Trust total	15.1%	15.2%	15.1%	15.5%	14.9%
Cancer Services	12.1%	12.6%	13.6%	13.9%	12.8%
Clinical Research*			13.0%	13.5%	12.9%
Clinical Services	15.1%	14.2%	13.3%	14.0%	13.9%
Community Services	22.1%	23.0%	21.0%	21.5%	18.7%
Private Care	15.5%	18.7%	20.9%	20.7%	19.0%
Corporate	14.8%	14.2%	14.5%	15.1%	15.9%
Sickness absence (target 3.0%)					
Trust total	2.8%	3.5%	2.7%	2.6%	3.2%
Cancer Services	2.4%	3.1%	2.3%	2.7%	2.7%
Clinical Research*			2.3%	2.1%	2.7%
Clinical Services	2.7%	3.6%	2.6%	2.2%	2.9%
Community Services	3.7%	3.6%	2.1%	3.0%	3.3%
Private Care	3.3%	5.3%	4.8%	3.2%	4.6%
Corporate	3.4%	3.5%	3.1%	2.9%	3.9%
Appraisal rate (target 90.0%)					
Trust total	83.5%	86.9%	85.7%	83.7%	82.6%
Cancer Services	79.0%	86.5%	85.8%	81.8%	77.0%
Clinical Research*			85.0%	80.3%	72.9%
Clinical Services	85.9%	86.8%	85.5%	83.4%	83.5%
Community Services	84.6%	89.0%	85.8%	80.6%	86.3%
Private Care	86.7%	86.2%	81.3%	84.0%	84.0%
Corporate	86.0%	88.1%	86.6%	89.7%	89.7%
Statutory and mandatory training (target 90.0%)					
Trust total	86.4%	87.8%	89.0%	89.0%	89.2%
Cancer Services	79.4%	81.6%	81.7%	80.9%	80.6%
Clinical Research*			90.3%	89.9%	88.4%
Clinical Services	88.5%	88.9%	90.4%	90.6%	91.6%
Community Services	88.4%	91.1%	93.3%	93.6%	93.6%
Private Care	87.3%	89.3%	90.4%	91.1%	92.2%
Corporate	90.5%	93.2%	93.1%	93.9%	94.1%
Local induction (target 80.0%)					
Trust total	72.3%	80.8%	84.2%	82.2%	84.0%
Cancer Services	67.4%	79.6%	82.1%	69.4%	76.6%
Clinical Research*			86.9%	86.7%	84.6%
Clinical Services	75.2%	84.5%	88.8%	86.8%	87.2%
Community Services	71.3%	78.5%	81.3%	82.9%	85.7%
Private Care	68.1%	69.0%	75.0%	83.6%	82.9%
Corporate	78.3%	83.9%	82.3%	87.9%	89.3%

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

9.1.2. Vacancy

The Trust vacancy rate has reduced to 8.8% in Quarter Three, but is above the Trust target of 5.0%.



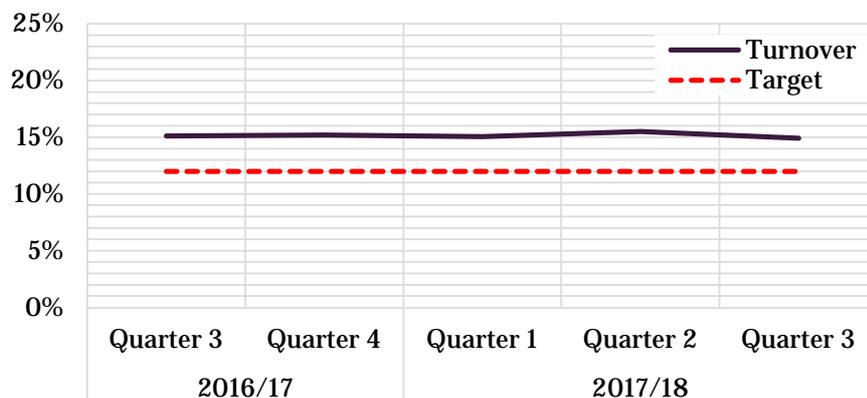
Recruitment activity continues to be a priority for the trust. More than 190 nurses were recruited during the first nine months of this financial year, and a target of 225 has been set for the year.

A high profile external advertising and social media campaign for community nursing took place during the quarter. The campaign generated a good response rate for both Community Services and the hospital, and contributed to a highly successful Recruitment Open Day which attracted a record number of attendees, resulting in 14 offers of employment.

9.1.3. Turnover

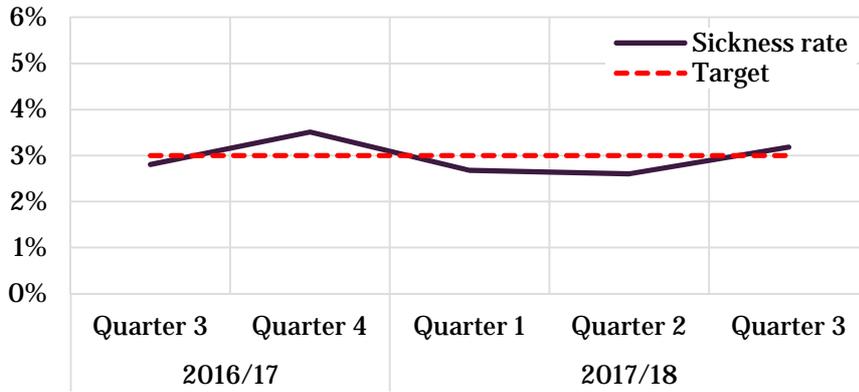
The turnover rate has decreased this quarter to 14.9%, but remains above the Trust target. Turnover decreased in all divisions with the exception of the Corporate Services Division. The Workforce team’s ‘On-Boarding’ project continues to focus on identifying the needs and expectations of new recruits, and meeting those expectations. Feedback gathered shows that developing and learning new skills is a key consideration in both the decision to join and to leave the trust, and responding to this has resulted in clearer career pathways, career coaching and mentoring, as well as opportunities for shadowing and rotations.

The *Above and Beyond* staff recognition scheme continues to receive good support from managers, with a good level of nominations being made for staff demonstrating exceptional care and performance in their roles.

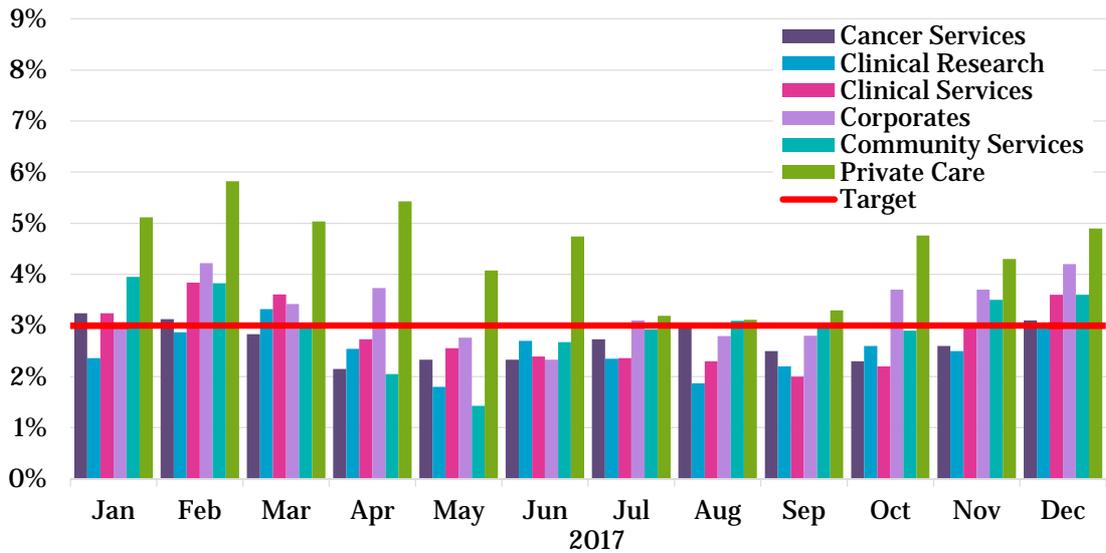


9.1.4. Sickness

The sickness rate increased this quarter to 3.2%, which is above Trust target but in line with seasonal trends. Three divisions have maintained levels of absence below the 3% target, which are Cancer Services, Clinical Research and Development, and Clinical Services. Long-term sickness absence cases continue to be reviewed and targeted support is provided to both management and staff members by the Human Resources and Occupational Health teams.

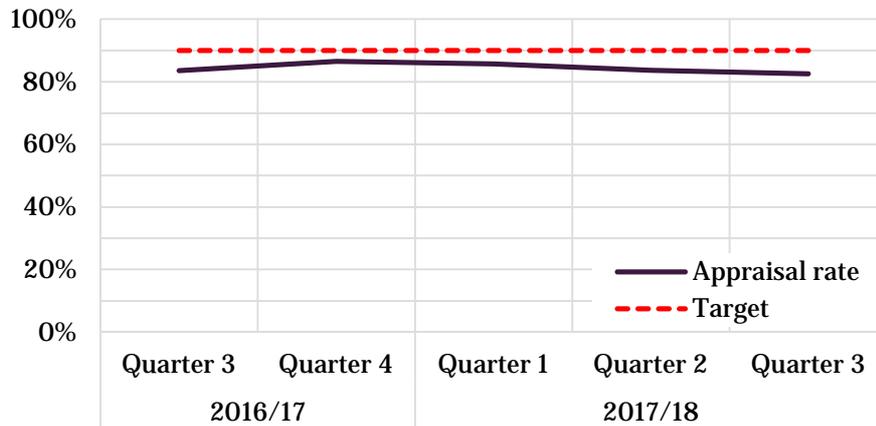


The following chart shows the monthly sickness rate by division for the calendar year 2017.



9.1.5. Appraisal

Quarter Three compliance decreased to 82.6%, and close monitoring will be required to ensure progress towards the 90% target by the end of the year. Piloting of a self-service appraisal software is taking place, and if successful will be rolled out trust-wide in Quarter One 2018/19. Providing feedback on performance and completing personal development plans are key parts of the Trust’s retention strategy, and it is important this takes place for all staff.



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 Three.

Mandatory training topics	Update frequency requirement (in years)	Target	Hospital compliance rate	Community Services compliance rate	Overall Trust compliance rate Quarter 2 2017/18	Overall Trust compliance rate Quarter 3 2017/18	Trend
Adult basic life Support	1	90%	84%	86%	83%	85%	▲
Blood transfusion (generic update)	2	90%	92%	Not applicable	91%	92%	▲
Conflict resolution for frontline staff	3	80%	79%	81%	79%	79%	■
Consent awareness (medical staff)	2	90%	78%	Not applicable	82%	78%	▼
Equality and diversity	3	90%	92%	97%	92%	93%	▲
Fire awareness	1 (clinical) 2 (other)	90%	88%	91%	88%	90%	▲
Infection prevention and control	1 (clinical) 3 (other)	90%	90%	93%	89%	90%	▲
Information governance	1	95%	92%	97%	90%	92%	▲
Medicines management (clinical staff)	1	90%	89%	66%	85%	86%	▲
Manual handling – back care awareness (non-patient handling)	3	90%	90%	98%	88%	91%	▲
Manual handling (patient handling)	1	90%	87%	80%	84%	87%	▲

Mandatory training topics	Update frequency requirement (in years)	Target	Hospital compliance rate	Community Services compliance rate	Overall Trust compliance rate Quarter 2 2017/18	Overall Trust compliance rate Quarter 3 2017/18	Trend
Paediatric basic life support	1	90%	84%	95%	83%	87%	▲
Risk management awareness	1 (managers) 3 (other)	90%	91%	93%	88%	91%	▲
Risk training for senior managers	1 (managers)	90%	77%	100%	71%	78%	▲
Safeguarding vulnerable adults (level 1)	3	90%	92%	97%	92%	93%	▲
Safeguarding vulnerable adults (level 2)	3	90%	86%	96%	86%	88%	▲
Safeguarding vulnerable adults (level 3)	3	90%	81%	N/A	N/A	81%	N/A
Safeguarding children (level 1)	3	90%	66%	94%	91%	92%	▲
Safeguarding children (level 2)	3	90%	90%	96%	89%	90%	▲
Safeguarding children (level 3)	3	90%	81%	89%	89%	84%	▼
Venous thrombo-embolism and pressure ulcers (clinical staff)	1 (clinical)	90%	91%	56%	86%	88%	▲
Venous thrombo-embolism (medical staff)	Once only	90%	65%	N/A	58%	65%	▲

- 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, and 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 ten topic areas and eight topics achieved 80% or above in the remaining topic areas with the exception of two topics, one of which has remained static.
- 9.2.6. Overall compliance rates have increased and the Trust is now reporting 90% compliance in the focus on the seven core topics.
- 9.2.7. *Safeguarding Vulnerable Adults* level 3 training compliance has been reported for the first time (81%) with targeted communication to the audience and sessions arranged in order to increase compliance.
- 9.2.8. Two topics decreased slightly since Quarter Two: *Consent for Medical Staff* and *Safeguarding Children* Level 3 which saw a decrease of 5% in the quarter. Staff who are non-compliant against these subjects will receive a notification and additional training has been scheduled in Quarter Four to increase the compliance rate.
- 9.2.9. 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 for all topics to improve compliance and sessions are scheduled accordingly. This will continue to be the strategy of the Learning and Development Team over the next quarter.
- 9.2.10. *Venous Thromboembolism for Medical Staff* remains the lowest area of compliance. Medical teams will be engaged in the next quarter to improve compliance in this area.

9.3. Induction

9.3.1. The compliance rate for local induction (87%) has continued to exceed the target of 80% for the tenth consecutive month. Regular three-monthly targeted follow-up with line managers remains the key strategy for maintaining the local induction compliance rate with monthly reminders to staff to complete the local induction checklist and inform the Learning and Development Team. Regular communications in the weekly bulletin to remind staff to return dates of completion have further helped improve overall compliance. This will continue with monthly reminders targeted at those individuals who are not compliant to further increase compliance.

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

9.3.2. Following a review that looked at induction and the new joiner experience, a new Trust induction and on-boarding programme was launched in October. The review was launched in April 2017 and looked at best practice from other NHS trusts, the private sector and academia.

The new induction programme which is known as *The Royal Marsden Welcome* together with the on-boarding process has five goals to ensure all new staff are

- warmly welcomed
- inspired and motivated
- safe to practice
- equipped and resourced
- well connected.

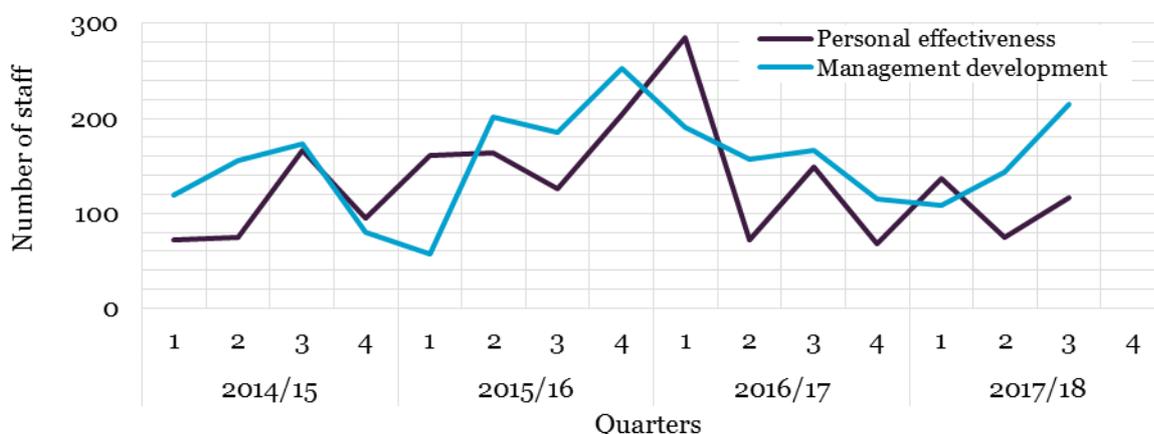
Feedback to date has been positive. A radiotherapist attending the event reported: ‘It was an excellent induction day ... that reflected my feeling that The Royal Marsden will be a great place to work’.

9.3.3. *The Royal Marsden Welcome* is supported by a new guide for new members of staff and a new guide for managers of new member of staff, the *New staff welcome and on-boarding framework* and the *Manager’s guide to welcoming and on-boarding new staff* respectively. Three further on-boarding sessions are run on a quarterly basis across all sites:

- *The Royal Marsden tour*: an opportunity to explore our sites and see services
- *In your shoes ... with the Leadership Team*: an opportunity to talk about experience as a new starters
- *Because You Matter*: a bite-sized workshop focused on personal development and resilience.

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. Quarter Three was marked by an uplift in the number of training places being offered following the summer holiday period, with around 70% of the 300 management development training places being taken up.

9.4.2. During Quarter Three the following workshops were delivered:

Personal Effectiveness:

- Building resilience
- Communicating assertively
- Information technology sessions in Microsoft Word, Excel and PowerPoint
- Meetings and minute taking
- Planning for retirement
- Training and presentation skills: psychological growth in the training room

Management Development:

- Honest conversations
- Learning to lead
- Performance appraisal and development (for managers)
- Project management
- Introduction to supervisory skills
- Managing sickness absence
- Managing HR investigations
- Managing poor work performance
- Recruitment and selection
- Resilience for leaders
- Supervisory skills.

Feedback from participants suggests that the trainers' approach to learning and expertise has enabled participants to put their learning into practice 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 Three, an individual coaching programme enabled practice educators to redesign a key nurse development programme and deliver it effectively using more learner-led training methods. The Learning and Development Team also worked closely with the Practice Education Team to develop a new training session for new healthcare support workers, which prepares them to be future role models by exploring common stressors and developing resilience strategies for dealing with them. Further training was developed and delivered to support senior Healthcare Assistants to become mentors to future cohorts of Care Certificate students.
- 9.4.4. In this quarter the Learning and Development Team also designed and facilitated several team development days using structured tools such as Belbin and Myers-Briggs Type Indicators (MBTI) to help teams explore and analyse how they work together; teams used these insights to facilitate more effective team working.
- 9.4.5. During the next quarter as well as continuing to offer personal effective and leadership skills programs, cohort four of the Paired Learning Programme will be launched.

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 in the Trust.
- 10.1.2. Two national audits were registered in Quarter Three:
- Use of gabapentinoids in UK Perioperative Pain Management (PAIN-TRAIN)
 - The NeST study (neoadjuvant systemic therapy in breast cancer): a prospective multicentre audit
- 10.1.3. Sixteen new clinical audit proposals and one re-audit proposal were approved by the committee in Quarter Three.
- 10.1.4. One national audit report was presented in Quarter Three: Third Patient Report of the National Emergency Laparotomy Audit (NELA).

NELA is an ongoing national clinical audit of patients having emergency bowel surgery, which is a surgical procedure with high associated mortality. The quality of care and outcomes for patients can be improved through planning and delivering care based on a comprehensive assessment of each patient's risk of death. This was the Third Patient Report of NELA. The full NELA report provides achievement of key process measures in each hospital and can be found at www.nela.org.uk/reports.

- 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 problems in care identified following the full Structured Judgement Review 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' overall for Quarter Three.

- 10.1.6. Details of the 27 local audit and quality improvement project reports presented and approved by the Clinical Audit Committee in the quarter are shown in the following table.

10.1.7. Audits conducted at Chelsea and Sutton

Title	Action plan, learning and outcomes
Re-audit of repatriation/referral of higher familial breast cancer women from The Royal Marsden into the National Health Service Breast Screening Programme (NHSBSP)	<p>Findings shared with patients referred to NHSBSP. Information about contact details for NHSBSP and advice regarding how to access medical attention if they detect a breast lump included.</p> <p>Results published in a national journal to highlight importance of adherence to guidelines regarding screening of high-risk women within the NHSBSP.</p> <p>All repatriated/referred patients are on the central NHSBSP database for higher risk women confirmed.</p> <p>All future patients referred to the higher risk NHSBSP programme are made aware of what the service offers, what it doesn't offer and how to access clinical advice between screening appointments.</p>
Review of prescription compliance at The Royal Marsden to phase one of the national dose banding project	<p>Completion of dose banding roll out to lymphoma and myeloma clinical units.</p> <p>Two identified proformas within Head and Neck Unit updated in order to address reasons for non-compliance.</p> <p>Non-compliance doses challenged by clinical pharmacists with the prescriber as they appear.</p> <p>Dose reductions should also comply with the nationally recommended doses.</p>
Audit of outcome following breast surgery patients contact with The Royal Marsden Macmillan Hotline	<p>Algorithm updated to include drains/dressings.</p> <p>Clerking proforma developed.</p> <p>Post-breast surgery frequently asked questions developed.</p> <p>Re-audit planned in 2018.</p>
Audit of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)	<p>Continue with DNACPR information during nurse and doctor basic life support training to increase awareness of the policy and its pertinent points.</p> <p>Spend more time on DNACPR during the doctors' basic life support sessions.</p> <p>Ensure the provision of original red forms continues.</p> <p>Ensure that where to place the completed form is mentioned in all basic life support training, including scanning the document onto the electronic patient records and to send a trust wide email reminding staff of the importance of this.</p> <p>Email report to all members of the Resuscitation Committee and all ward sisters.</p> <p>Possibility of e-learning package for DNACPR considered.</p>

Title	Action plan, learning and outcomes
Radiology patient experience survey	<p>Audit results presented to the Radiology Department.</p> <p>Audit tool discussed with all modality leads to ensure all information is relevant to area.</p> <p>Survey amended in order to gain more in-depth information regarding the types of delay in the department.</p> <p>Good practice reinforced in radiographers meetings.</p> <p>Good practice reinforced with modality updates.</p> <p>Alternative means of communication considered to see whether text/email appointment reminders can be sent out to patients.</p> <p>Discuss with departmental leads about improving response rate to the survey.</p> <p>'You talked, we listened' poster updated to inform patients of latest results.</p>
Audit of whether the use of sub-cutaneous alfentanil outside the Critical Care Unit (CCU) setting is compliant with local guidelines	<p>Junior doctor induction revised to include specific guidance on prescribing of alfentanil.</p> <p>Pharmacy now check dose conversion involved, verification that there has been documentation of discussion with the pain or palliative care team and that a senior team member has checked any dose conversion calculations as documented on the electronic patient record.</p>
An audit of the palliative care electronic multidisciplinary team (MDT) record	<p>Palliative care MDT will now define a 'new' patient as one not discussed before during their current admission.</p> <p>Operational policy clarified and disseminated to the team.</p> <p>Two sessions of the weekly palliative care team teaching will now be dedicated each year to consultant led teaching/updates on how to approach Advance Care Planning.</p> <p>For those sessions where a core MDT member is present via a video link, a member of the team also present at the MDT will be responsible for recording the core member's attendance in the register.</p> <p>Engagement with the wider MDT including the welfare support, psychological support, and chaplaincy support teams to identify barriers to attendance rates and increase engagement and documentation of input.</p> <p>Re-audit data by December 2018.</p>
Audit review of inpatient nutritional screening tool	<p>Liaise with ward staff to identify potential barriers in achieving best practice.</p> <p>Tool re-launched to increase staff awareness and address potential barriers in achieving best practice.</p>

Title	Action plan, learning and outcomes
Audit of parenteral nutrition in palliative care patients	<p>All patients should have a performance status recorded when consideration is given for home parenteral nutrition.</p> <p>A teaching session will be organised with palliative care for dietitians on how to record performance status in the electronic patient record.</p> <p>All patients with no further planned anti-cancer therapy who are being considered for home parenteral nutrition should be referred to palliative care with clear documentation on prognosis.</p> <p>Home parenteral nutrition considered for an outpatient set-up.</p> <p>Development of a cross-site video multidisciplinary team meeting with the Intestinal Failure Team at St George's University Hospitals NHS Foundation Trust to support the discharge of patients explored.</p> <p>Standard proforma developed for those considered for home parenteral nutrition.</p> <p>Ongoing prospective audit of parental nutrition in palliative patients planned for January 2018.</p>
Audit of non-diagnostic specimen from ultrasound guided aspiration of thyroid nodules, lymph nodes and superficial lesions	<p>Business case for a new cyto-technician is underway.</p> <p>Audit findings fed back to clinical unit as well as the cytology and surgical leads.</p> <p>Two new consultants appointed in September 2017 since the audit started.</p>
A radiology audit of the breast MDT function against Trust MDT operational policy	<p>MDT to be informed of audit findings by the radiology MDT lead for breast imaging to put into action areas for improvement.</p> <p>Re-audit planned by December 2018 to ensure compliance.</p> <p>MDT co-ordinators will be given immediate feedback when lists are sent late or imaging reports are not available.</p>
Hospital audit of consent to examination or treatment (including patient information)	<p>Audit results discussed at the Consent Steering Group, Clinical Audit Committee and Surgical Audit Group.</p> <p>Audit report forwarded to consultants whose patients were audited.</p> <p>Re-audit next year by June 2018 for surgical patients treated during March 2018.</p>

10.1.8. Audits conducted at Chelsea

Title	Action plan, learning and outcomes
Granulocyte colony stimulating factor (GCSF) support for palliative care chemotherapy regimens	<p>Results of audit disseminated to the sarcoma team for review and comments.</p> <p>Results of audit sent to and discussed with the Drugs and Therapeutics Committee with the aim of approving GCSF at cycle one.</p> <p>Re-audit by December 2018.</p>

Title	Action plan, learning and outcomes
Endoscopy suite patient experience survey	The comfort level audit planned for December 2018. Poster for this survey displayed in the endoscopy suite. Agreed action plan reviewed at Endoscopy Unit Group committee meetings.
Endoscopy unit staff experience survey	Staff changing facilities reviewed. Staff rest room improved by providing small dining table with chairs for staff to sit to have meals during breaks. Current endoscopy operational scheduling process reviewed with the service leads.
Patient experience survey – prostate cancer support service	Best practice confirmed.

10.1.9. Audits conducted at Sutton

Title	Action plan, learning and outcomes
Osteoporosis assessment in prostate cancers on long duration androgen deprivation therapy	Audit findings disseminated to the prostate uro-oncology team at Sutton. Proforma created for use in prostate cancer oncology clinics. Re-audit January 2018.
The use of intravenous nurse controlled analgesia (NCA) and patient controlled analgesia (PCA) for children/teenagers experiencing pain as a side effect of treatment and disease	Nursing education programme to develop ward based nursing teaching with practice nurse educator regarding the use of NCA/PCA. Develop case based learning for junior doctors around decision-making regarding the use of NCA/PCA. Results presented at the Clinical Quality Forum.

10.1.10. Audits conducted in Sutton Community Health Services (SCHS)

Title	Action plan, learning and outcomes
Audit of the support and advice provided by Sutton Community Health Services to help mothers sustain breastfeeding	Awareness about how 'to bridge the gap' raised via a local newsletter for staff. Offer all mothers an appointment at health promotion workshop on 'starting solids' at the 6-8 week check. Discuss with management the possibility of using a texting service to remind parents of the optimal time to introduce solids. Include information into staff training day. Assess staff knowledge and skills during annual staff assessments.

<p>Community documentation audit (adults services), including records management and transcribing of medicines audits</p>	<p>Results discussed at monthly senior community nurse meetings and local nursing team meetings. Areas for improvement identified in transcription errors - transcription can be a contributing factor or a source of medication errors. Categories of medication error checked and reported on Datix for discussion.</p>
<p>Summary of Mental Capacity Act (MCA) Audits in Sutton Community Health Services</p>	<p>The MCA Compliance Audit (paper patient records audit):</p> <ul style="list-style-type: none"> - Audit tool improved to make questions clearer with regard to addressing the aims and objectives of the audit. - Ensure sample of ten paper records for the re-audit is for a random selection of patients who are suitable for the MCA audit. - The MCA trigger tool adopted. - New safeguarding MCA champion appointed. <p>The MCA staff survey:</p> <ul style="list-style-type: none"> - Repeat staff survey by April 2018. - Next time send the survey to more staff members to improve response rate.
<p>Records management community documentation audit (adult services)</p>	<p>All team sisters and senior nurses to attend in-house audit training.</p> <p>Asking and recording patients' religious and/or spiritual beliefs during holistic assessment.</p> <p>Recording clinical baseline observations for all patients during first visit.</p> <p>Completion of medicines assessments as required on first face-to-face visit.</p> <p>Standard operating procedure developed for expected assessments on first visit.</p> <p>Recording source of referral.</p>
<p>Transcription of medicines chart and transcribing of medicines community documentation audit (adult services)</p>	<p>October 2017 results discussed at monthly senior community nurse meetings and local nursing team meetings.</p> <p>The areas for discussion to minimise the opportunity for errors are</p> <ul style="list-style-type: none"> - transcriptions written in upper case (Carshalton) - dosages written in full with no use of decimal points (Wallington) - self-administered medication clearly listed on the back page (Sutton and Cheam) - second check system (Wallington and Carshalton). <p>Review data on transcription errors reported on Datix.</p> <p>Actions agreed at the monthly senior community nurse meetings and local nursing team meetings entered on the community nursing rolling action plan.</p>

<p>Pressure ulcer care bundle community documentation audit (adults services) (October 2017)</p>	<p>To review areas identified for improvement and raise awareness on:</p> <ul style="list-style-type: none"> – Importance of recording allergies and sensitivities to reduce risk of reactions (Sutton and Cheam, Carshalton) – All patients with pressure ulcer to their feet and heels should have a Doppler assessment carried out to assess arterial status as per the leg ulcer management policy for heel ulcers (Carshalton) – Completion of checklist to support assessment of a patient with a pressure ulcer (Sutton and Cheam, Carshalton) – Documentation of patient/carer participation in care plan to be documented (Sutton and Cheam, Carshalton) – Community clinical risk advisor informed that over half of Datix web numbers are not documented on front cover of the pressure ulcer bundle (Sutton and Cheam, Wallington, Carshalton) – Community nursing rolling action plan developed to identify any changes to practice.
<p>Transcription of medicines chart and transcribing of medicines community documentation audit (adults services, including night team) (November 2017)</p>	<p>The areas identified for discussion and improvement are:</p> <ul style="list-style-type: none"> – allergy, sensitivities and drug reaction (Sutton and Cheam) – transcription written in upper case (Sutton and Cheam) – self-administered medication clearly listed on the back page (Sutton and Cheam) – each transcribed medication on the chart has been double checked (Sutton and Cheam, Carshalton).
<p>Pressure ulcer care bundle community documentation audit (adults services) (November 2017)</p>	<p>The areas identified discussion and for improvement are:</p> <ul style="list-style-type: none"> – Datix web number documented on front cover of the pressure ulcer bundle (Sutton and Cheam, Wallington) – Doppler assessment carried out (Sutton and Cheam, Wallington)
<p>Community audit of consent to examination or treatment (including patient information)</p>	<p>Audit report discussed at the Consent Steering Group and the Clinical Audit Committee. Audit report forwarded to clinicians and service managers whose patients were audited. Consent forms should be scanned onto community electronic patient records (RiO). Patient information documents should be produced in accordance with the Trust policy and procedure and be published and archived accordingly. Re-audit by June 2018.</p>

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

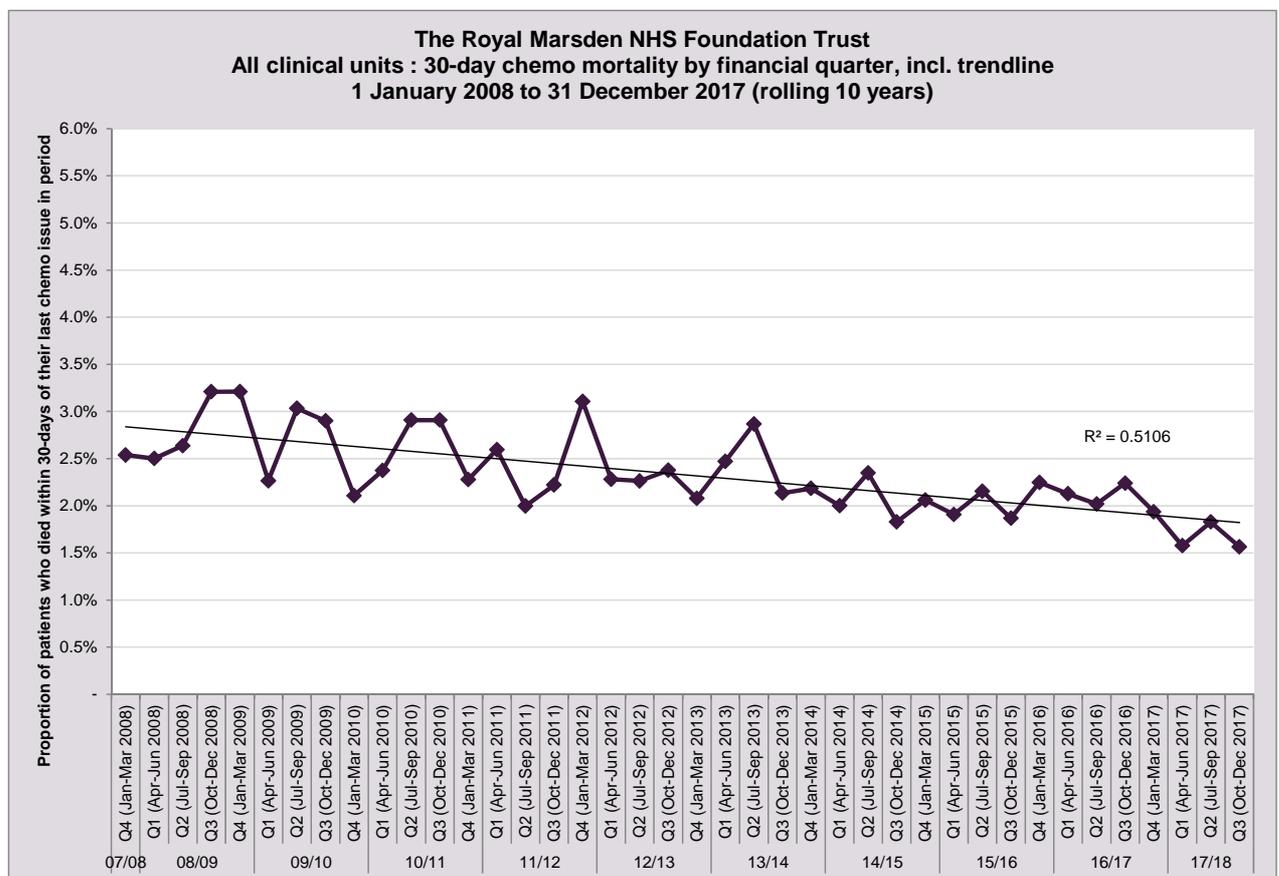
To track trends in the number of deaths within 30 days of receiving SACT at the Trust and deaths reported to the Trust from Quarter Four 2007/8 to Quarter Three 2017/18.

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.

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

10.2.3. Key points from 30-day deaths trend analysis

- Quarterly graphic representation of trends for 30-day deaths.
- The overall trend has remained stable.
- In Quarter Three there were 66 deaths out of 4,217 patients (1.6%) analysed. (In Quarter Two there were 77 deaths out of 4,163 patients (1.8%) analysed.)



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.

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

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

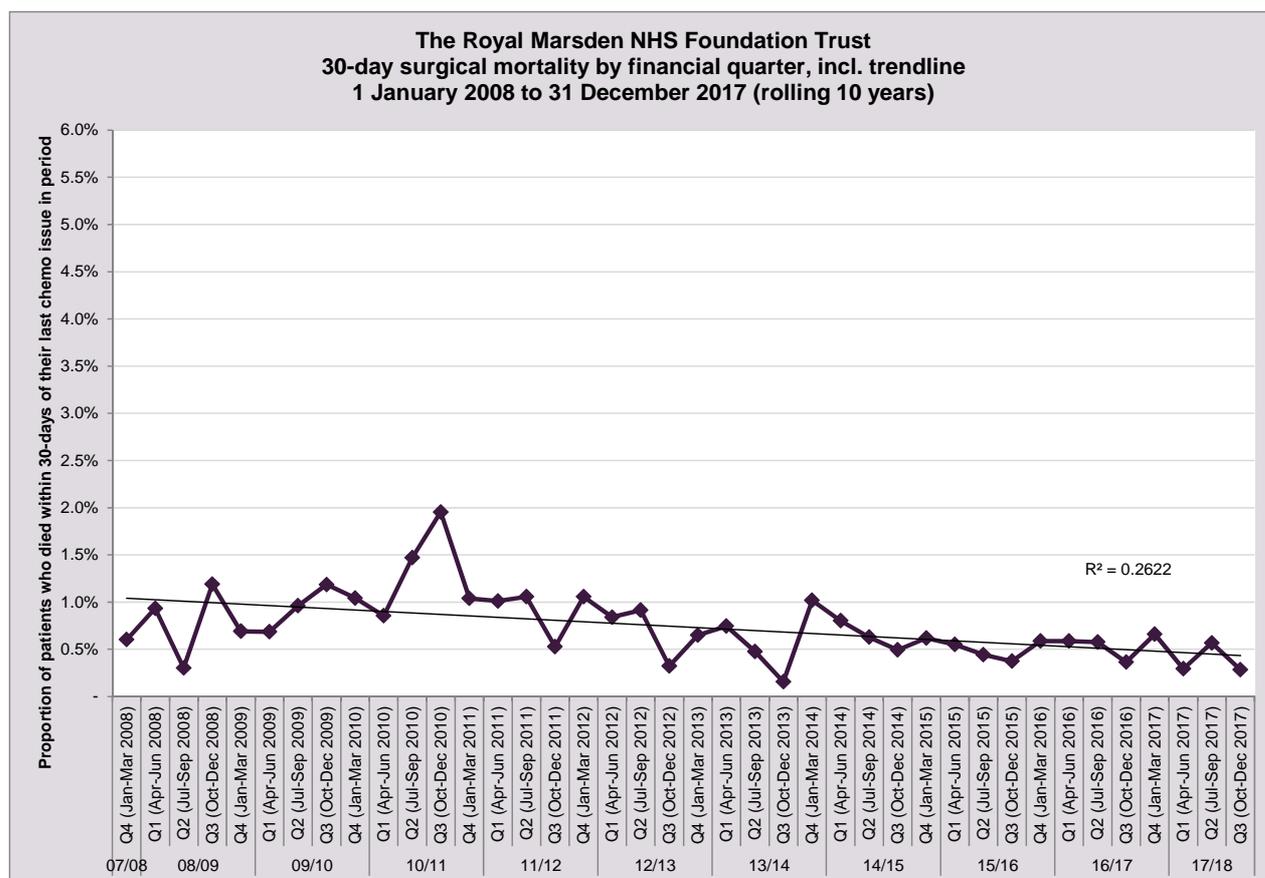
10.3.3. Key points from 30-day deaths trend analysis

- Data are presented quarterly from Quarter Four 2007/8 to Quarter Three 2017/18.
- The overall 30 days death rate has been stable.
- There was no observed trend.
- In Quarter Three there were four deaths out of 1,412 patients (0.3%). (In Quarter Two there were eight deaths out of 1,410 patients (0.6%).)

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)



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.

The number of transplants recorded in this quarter (October to December 2017) was 65 but to analyse 100-day mortality it is necessary to consider the transplants undertaken in the previous quarter (July to September 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 September 2017 would reach 100 days on 8 January 2018.

The final number of recorded transplants carried out from July to September 2017 was 44 (35 adult and 9 paediatric patients).

The breakdown of transplant types, number of deaths within 100 days of transplant and the cause of death for July to September 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†	23	0	0%	0
Allogeneic‡ (all types)	12	1	8%	0
– Allogeneic – unrelated donor	9	0	0%	0
– Allogeneic – related donor	2	0	0%	0
– Allogeneic – cord blood	1	1	100%	0

Paediatric

Transplant type	Number of transplants	Number of paediatric deaths at 100 days post-transplant	Overall TRM* percentage	Disease relapse or progression
Autologous†	1	0	0%	0
Allogeneic‡ (all types)	8	0	0%	0
– Allogeneic – unrelated donor	4	0	0%	0
– Allogeneic – related donor	3	0	0%	0
– Allogeneic – cord blood	1	0	0%	0

* TRM: Transplant related mortality

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

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

The adult patient who died within 100 days following the transplant received an allogeneic cord blood transplant for acute myeloid leukaemia but died at day 8 from transplant related gram negative sepsis.

There were no deaths recorded for paediatric patients receiving a stem cell transplant during the July to September period.

10.4.3. 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.

10.4.4. 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 29 items of guidance which were presented to the Integrated Governance and Risk Management Committee (IGRM) in Quarter Three. 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	7	3	3	1	1	0
Diagnostics guidance	1	0	0	1	1	0
Highly Specialised Technologies	0	0	0	0	0	0
Interventional procedures	8	0	8	0	0	0
Medical technologies	0	0	0	0	0	0
NICE guideline	11	3	6	2	1	1
Public Health	2	0	1	1	1	0
Total	29	6	18	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 Three there were nine quality standards published by NICE.

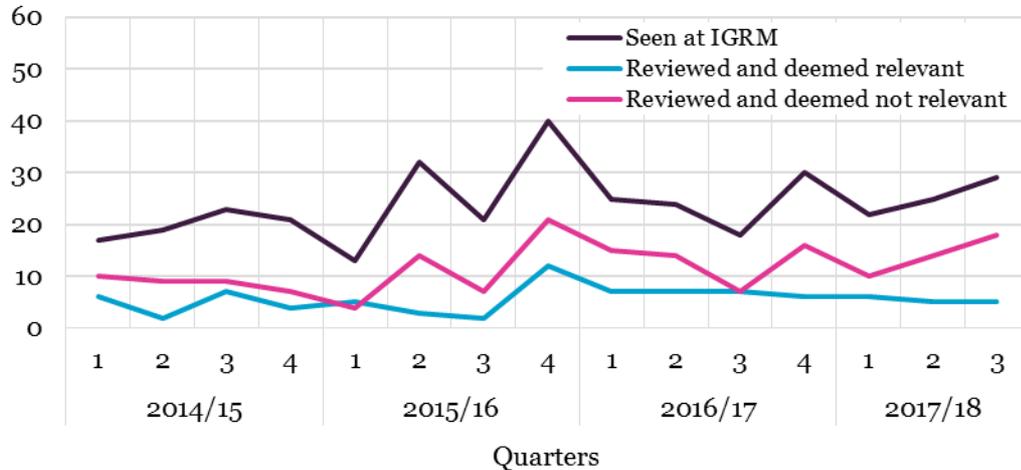
Type of guidance	Seen at IGRM	Under review	Reviewed and deemed not relevant	Reviewed and deemed relevant	Fully compliant*	Partially compliant*
Quality standards	9	7	2	0	0	0

* 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 92.18% against the target of 95%. This is an increase from the last quarter figure of 88.8%. The Learning and Development Team will identify those staff who are either non-compliant now or will be before the end of March and email them a reminder to update their training. The Learning and Development Team will work with divisional directors to ensure the Trust meets its target of 95%.

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 was one meeting of the committee in Quarter Three.

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).

Work is continuing with leads to update evidence where necessary and the current score is 71%. This figure will rise over the next 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 received a complaint from a patient, via the ICO, of an alleged breach of confidentiality. This related to a document sent to the General Medical Council (GMC). The dispute was about a picture the patient did not want released to the GMC. Additionally the CD the picture had been sent on had not been encrypted. The Trust has responded to the ICO's questions and after investigation, the ICO decided to take no action and consider the incident closed.

10.7. Freedom of information

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

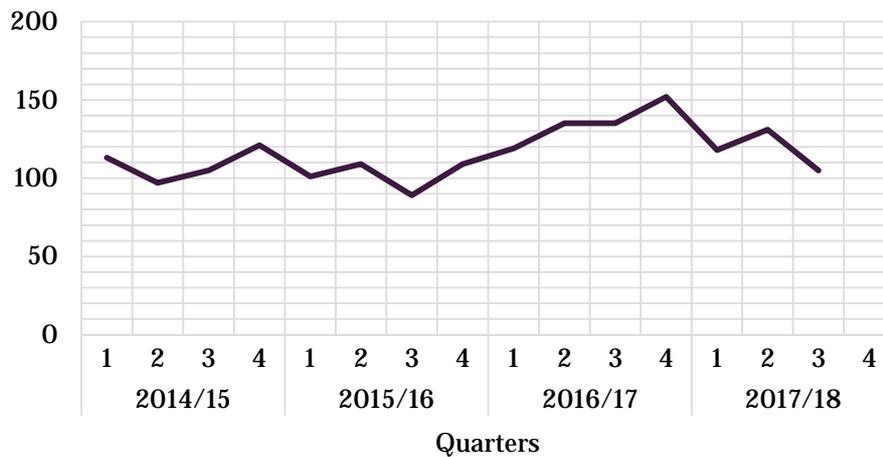
10.7.1. Requests received under the Freedom of Information Act 2000

The Trust received 105 requests during Quarter Three, compared to 131 in Quarter Two. Of the 105 requests received in Quarter Three, 104 were answered within 20 working days (99%).

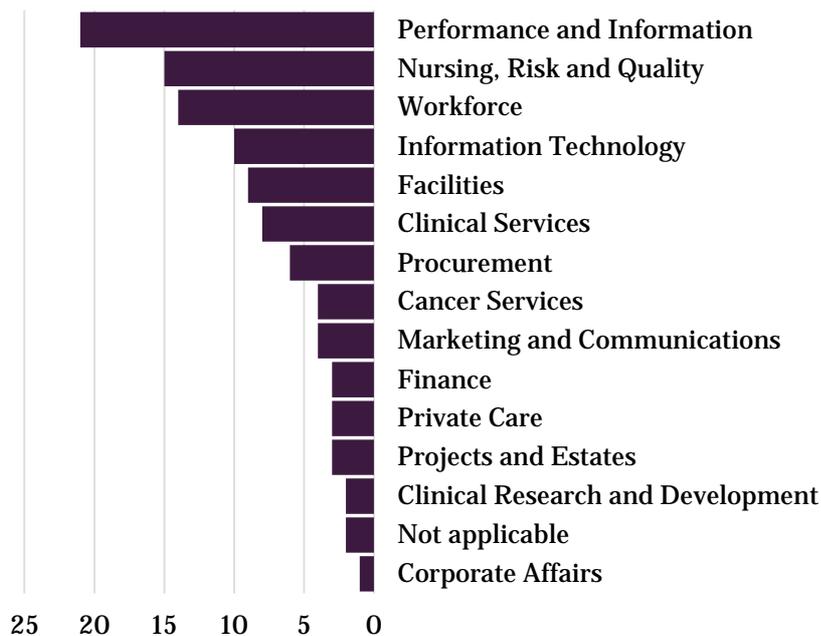
The requests in Quarter Three had the following outcomes:

Disclosed	63
Not applicable to The Royal Marsden	22
Partial	15
Information not held or clarification sought	3
Refused – exemption or too expensive to answer	2
Total	105

10.7.2. Number of requests received by quarter

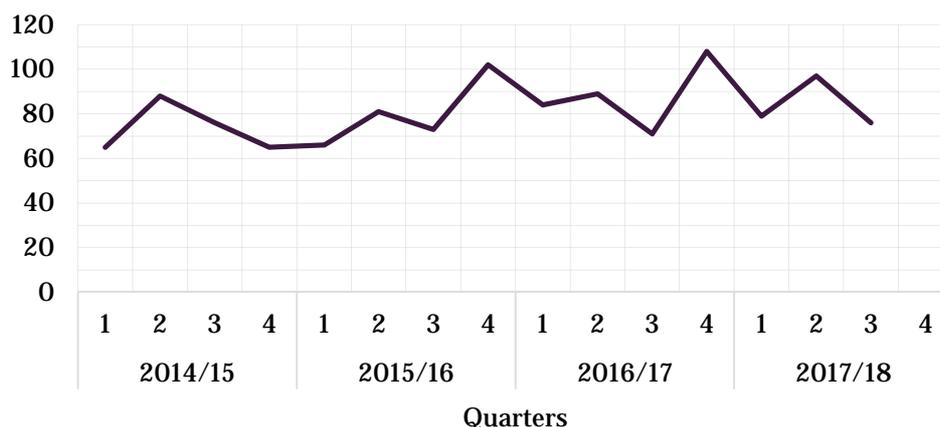


10.7.3. Number of requests by directorate and division



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 76 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 ISO9001:2015 quality standard by the British Standards Institute (BSI) and is assessed by an external auditor twice a year.
- 10.9.2. The next assessment visit has been confirmed for March 2018. There are no outstanding conformance actions to be closed before this meeting. A final agenda will be circulated during February once agreed with BSI.
- 10.9.3. Internal auditing continued with two internal audits completed during the quarter covering patient pathways for palliative care and head and neck cancers. Two minor non-conformances were raised which were both corrected promptly.
- 10.9.4. Forty-five incidents were raised in the Trust's incident monitoring system for the quarter (compared with 41 in the previous quarter). Incidents are coded using the Towards Safer Radiotherapy classification system, which allows comparable reporting across the industry. Ten were graded as *low* severity and thirty-five as *very low*. These were reviewed and discussed at the latest Multiprofessional Team Quality Assurance (Radiotherapy) Committee (MPT QART) as part of root cause analysis and agreement reached on any appropriate corrective actions required.
- 10.9.5. There were no reportable radiation incidents in the quarter.
- 10.9.6. No complaints relating to Radiotherapy were received. Sixteen letters or cards of praise for the service were recorded within the quarter.
- 10.9.7. 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.

10.9.8. The table below shows the number of radiotherapy appointments for Quarters One, Two and Three 2017/18 2017/18.

		2017/18									
Appointments (number)		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Chelsea	Palliative*	49	29	37	41	40	29	37	41	29	
	Radical†	126	126	106	130	130	141	144	145	102	
	Urgent‡	5	2	1	2	0	3	1	2	3	
	Total	180	157	144	173	170	173	182	188	134	
Sutton	Palliative	65	71	76	74	60	65	70	67	82	
	Radical	180	204	221	226	201	198	237	215	167	
	Urgent	2	9	6	2	3	6	6	6	9	
	Total	247	284	303	302	264	269	313	288	258	
Grand total		427	441	447	475	434	442	495	476	392	

* 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.

10.9.9. The table below shows radiotherapy waiting times for Quarters One, Two and Three 2017/18.

			2017/18									
Average waiting time (days)			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Chelsea	Radical	All*	14.1	15.4	15.2	14.0	11.7	12.7	14.2	14.9	12.7	
	Radical	No delay*	18.3	18.5	18.7	16.4	16.1	16.4	17.0	17.0	16.8	
	Palliative	All	4.4	3.8	4.3	3.3	4.1	4.7	4.9	4.2	4.2	
	Palliative	No delay	4.9	4.3	5.3	4.6	4.4	5.1	5.5	5.0	4.1	
Sutton	Radical	All	17.9	17.5	15.9	16.4	13.4	12.7	14.3	14.3	15.2	
	Radical	No delay	23.7	24.1	22.5	21.8	19.5	18.9	20.3	19.3	19.6	
	Palliative	All	4.7	5.3	5.2	4.7	3.7	3.8	4.2	4.2	4.4	
	Palliative	No delay	5.3	6.7	5.7	5.1	4.6	4.6	5.0	5.2	5.2	

* **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. The next assessment has been booked for three days in March 2018. This includes an additional day to ensure sufficient time to complete the transition to the new ISO9001:2015 standard and carry out the three-year strategic review.

- 10.10.3. Internal auditing was suspended during Quarter Three following a high number completed in Quarter Two plus the need to divert resource into two other major regulatory inspections. An audit plan for 2018 has been prepared that will increase audit activity in preparation for the March BSI assessment visit.
- 10.10.4. Incidents are reported in accordance with Trust policy using the Datix incident reporting system, which is used to analyse incident details. In the quarter 118 incidents relating to the multidisciplinary chemotherapy service were recorded compared to 133 in the previous quarter. Sixty were graded *very low* and 58 as *low*.
- 10.10.5. One hundred and eleven of the incidents related to medication issues. In accordance with Trust policy actions were agreed to ensure lessons are learned following any incident. The incidents will be reviewed at the next ISO Chemotherapy Committee.
- 10.10.6. No complaints were received in the quarter and ten letters of praise and thanks from patients were logged.
- 10.10.7. 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.
- 10.10.8. Total wait time is largely dependent on whether a patient chooses to have all these steps on the same day (one stop) or whether the cycle of chemotherapy is given on a separate day after preparation (two stop).
- 10.10.9. 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.
- 10.10.10. The number of chemotherapy appointments is rising across all sites. The overall target of no more than five per cent of patients waiting more than four hours for treatment was narrowly missed at six per cent as shown in the Tables below, although individual units show some fluctuations.

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

Appointments	Total appointments	Appointment waits over 4 hours	Percentage waits over 4 hours
Medical Day Unit (Chelsea)	6,932	942	14%
Granard House Day Unit	4,166	242	6%
Homecare	73	0	0%
Private Care Centre	372	11	3%
Wiltshaw Ward Consulting Room	2	0	0%
Ambulatory Inpatients (Bud Flanagan West)	102	35	34%
Children's Day Unit	3,010	86	3%
Bud Flanagan Ambulatory Care Unit	1,856	203	11%
Kennaway Day Unit	1,368	5	<1%
Medical Day Unit (Sutton)	6,868	10	<1%
Robert Tiffany Day Unit	1,953	12	1%
West Wing Day Unit	1,220	13	1%
Oak Day Unit	333	181	54%
Mobile Chemotherapy Unit	222	0	0%
IV Services (Sutton)	0	0	-
Teenage Cancer Trust Unit	0	0	-
Sir William Rous Unit	2,329	4	0%
Total	30,806	1,744	6%

10.10.12. The table below shows chemotherapy waiting times (from patient's arrival in clinic to start of treatment) for Quarters One, Two and Three 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)	747	3,416	822	393	612	594	255	91	2
Granard House Day Unit	262	1,595	942	740	385	172	52	16	2
Homecare	8	65	0	0	0	0	0	0	0
Private Care Centre	22	176	71	64	28	7	3	1	0
Wiltshaw Ward Consulting Room	1	1	0	0	0	0	0	0	0
Ambulatory Inpatients (Bud Flanagan West)	6	47	6	3	5	6	24	5	0
Children's Day Unit	616	1,123	722	332	131	52	24	10	0
Bud Flanagan Ambulatory Care Unit	229	655	398	228	143	117	54	32	0
Kennaway Day Unit	149	1,048	128	32	6	4	1	0	0
Medical Day Unit (Sutton)	497	5,758	535	50	18	4	3	3	0
Robert Tiffany Day Unit	403	1,213	242	68	15	6	5	1	0
West Wing Day Unit	38	838	249	63	19	10	1	2	0
Oak Day Unit	22	39	24	34	33	71	74	35	1
Mobile Chemotherapy Unit	39	180	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	230	1,887	192	14	2	3	1	0	0
Total	3,269	18,041	4,334	2,021	1,397	1,046	497	196	5

10.11. JACIE accreditation

10.11.1. This section covers the period April to December 2017 (Quarters One, Two and Three 2017/18).

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

- 10.11.3. The Stem Cell Transplant service underwent a full inspection in November 2017. The verbal report from the inspection team was very positive with no major non-conformities raised and considerable praise for a number of aspects of the service. The inspection team did identify a number of areas for further improvements required to the labelling system (procurement of an upgraded IT system is in progress) and to the fabric of the building, especially the space and facilities available to staff working in the Stem Cell Laboratory. The JACIE office have confirmed that the final written report will be issued in the last week of February. Once renewed the new accreditation certificate will be valid until 2022 conditional on satisfactory annual reports and an interim audit.
- 10.11.4. Audits of the quality of processes are carried out regularly. Nine audits were carried out in Quarter One, 17 in Quarter Two, and ten in Quarter Three (48 in total) The audits covered all aspects of the service and the various parts of the JACIE standard.
- 10.11.5. The Haematopoietic Stem Cell Transplant unit continued to identify, evaluate and report errors, accidents, and suspected reactions, which are reported through the Trust's electronic incident reporting system (Datix) and discussed at the HSCT Committee and at the Haemato-oncology Risk Management Committee. During Quarters One, Two and Three 111 incidents attributable to transplant patients were raised. These incidents were graded *very low* (64), *low* (46) and *moderate* (1). The largest categories of incidents were: 36 (32%) medication incidents, 13 (12%) pressure ulcers and wounds and 24 (22%) patient falls.
- 10.11.6. Deviations from standard operating procedures are brought to the HSCT Committee for discussion and sign off. Within the period of this report the following number of deviations were raised. Quarter One – three, of which two were planned and one unplanned. Quarter Two – three, again two were planned and one unplanned. Quarter Three – eleven, of which four were classed as planned deviations and six as unplanned with one being re-classified on review as an incident to be logged to the Datix system.
- 10.11.7. During the period one complaint relating to the transplant service was received.

10.12. Imaging Services Accreditation Scheme (ISAS)

- 10.12.1. The Imaging Services Accreditation Scheme (UKAS) inspection team have issued an interim report detailing the 11 mandatory actions and 13 recommendations made following the inspection in November. Work is now proceeding to address each of these. A central register of required actions has been produced to track progress and a new assessment has been opened on the UKAS web-based tool.
- 10.12.2. To date four of the 11 required actions have been closed with evidence uploaded to the UKAS website and all those remaining are in the process of being addressed. The Trust is well on track to meet the requirements by the February deadline.
- 10.12.3. The system used for document review and management has highlighted that a number of policies and standard operating procedures became due for review during December and these have been updated.

- 10.12.4. A programme of internal auditing has begun with five audits covering three modalities already done and reports uploaded to UKAS. These audits have raised 13 minor issues and opportunities for improvement of which ten have been closed and three are in the process of being addressed.
- 10.12.5. Incidents are reported in accordance with Trust policy using the Datix incident reporting system, which is used to analyse incident details. In the quarter, 48 incidents relating to imaging services were recorded compared to 38 in the previous quarter. Thirty-four were graded *very low* and 14 as *low*.
- 10.12.6. Over the last quarter, no complaints relating to imaging services were received.
- 10.12.7. Quality Assurance in Diagnostic Imaging Services (QADIS) Meetings continued with further meetings held in November and December. A further programme of these meetings has been planned for 2018 which will consider the ongoing development of the ISAS quality management system (QMS) to include reviews of document management, internal audit, external regulatory submissions and inspections, incidents, complaints and waiting times.

10.13. Research governance

10.13.1. Research sponsor

Trust sponsorship was awarded to the following nine projects:

Reference number	Title	Single or multiple centre
CCR4820	MALIMAR: Development of a machine learning support for reading whole body diffusion weighted magnetic resonance imaging (WB-MRI) in myeloma for the detection and quantification of the extent of disease before and after treatment	Multiple
CCR4835	REA - Radiation Exposure Awareness from patients undergoing nuclear medicine diagnostic 99m Tc-MDP bone scans and 18F-FDG PET/CT scans	Single
CCR4839	Cognitive Function Study - The impact of targeted therapies given within Phase I trials on the cognitive function of patients with advanced cancer	Single
CCR4840	SIGCO - Sigmoid Cancer Incidence and Outcomes	Single
CCR4745	EMERGE: Epigenetic Modulation of the immunE Response in GastrointEstinal cancers	Multiple
CCR4781	TRAP: Targeted Radiotherapy in Androgen-suppressed Prostate cancer patients	Multiple
CCR4640	Apple: Avelumab and hyPofractionated PaLliative radiotherapy in metastatic soft-tissuE sarcoma	Single
CCR4853	Evaluation of a children and young person's pain clinic	Single
CCR4852	ICEMAN The Effect of Neoadjuvant Radiotherapy on the Immunogenicity of Primary Extremity Soft Tissue Sarcomas	Single

10.13.2. Suspected unexpected serious adverse drug reactions

The following is a breakdown by study of the 18 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*
AB1	5	5	0	0
IC2	2	2	0	0
JB55	1	1	0	0
JLo4	3	3	0	0
NT2	4	4	0	0
SR1	2	2	0	0
UB17	1	1	0	0

* Research ethics committee

10.14. Human Tissue Authority – human application licence

10.14.1. Compliance

The Stem Cell Transplant facility is licensed by the Human Tissue Authority (HTA) for the use of stem cells in human application. The last inspection took place in September 2016 resulting in renewal of the licence. The next inspection 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 performed safely and effectively following proper consent. Compliance requires an appropriately qualified team of personnel working to high standards to ensure the best possible service provision.

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 introduced to ensure that the Trust maintains adherence to regulatory requirements.

The procurement of a specialist stem cell transplant information technology system is underway. This will ensure that the Trust meets the requirements of UK law concerning the labelling of stem cell products and will enable the transplant programme to meet the latest JACIE standards.

10.14.2. Quality improvement – audits

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

Audits carried out during the quarter:

- *Donor eligibility records audits:*
The date was missing from one eligibility record but apart from this minor non-conformance all records were complete.
- *Laundry rotation audit*
Specialist clean room clothing is supplied by a company who also provide a specialist laundry service. It is important for the laboratory to rotate laundered items to ensure that clothing is used in turn. The audit showed that the laboratory manage this successfully.
- *Suppliers' provision of reagents and consumables*
An audit of the main suppliers providing consumables and reagents used within the laboratory is performed annually. The audit confirmed that the suppliers met requirements and that the correct consumables and reagents were received in good condition and with adequate expiry dates.
- *Audit of temperature, humidity and microbial contamination in the clean room*
This audit examined temperature and humidity in the clean room to see if these influenced that amount of microbial contamination detected and was performed to check that local limits set for temperature and humidity were appropriate. The results confirmed that levels and limits were acceptable.
- *Audit of the supply of liquid nitrogen*
A reliable supply of liquid nitrogen is essential for the stem cell laboratory to ensure that stem cell products are stored safely at the appropriate temperature. The audit showed that the provider of nitrogen consistently met delivery requirements.

10.14.3. Adverse events, reactions and incidents

Under the European Union Tissue and Cells Directive (EUTCD) the HTA maintains a system for tissue establishments to report serious adverse events and reactions. The Stem Cell Transplant Laboratory collates, evaluates and investigates errors, accidents and incidents according to Trust protocols and to comply with HTA regulations. During this quarter no incidents occurred that required reporting to the HTA.

10.15. Clinic waiting times

10.15.1. Standard

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

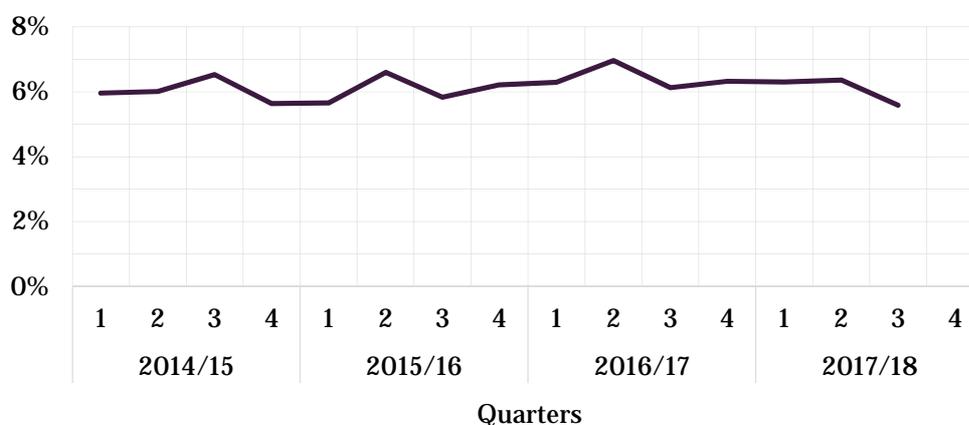
10.15.2. Waiting times

	Quarter 3 2016/17	Quarter 4 2016/17	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18
Total (all patients seen in outpatient clinics)	40,643	42,933	41,725	42,487	42,940
Patients seen in 30 minutes or less	34,146 (84.0%)	36,433 (84.9%)	34,856 (83.5%)	35,660 (83.9%)	37,491 (87.3%)
Patients seen after 30 minutes and up to 1 hour	4,215 (10.4%)	4,404 (10.3%)	4,693 (11.2%)	4,583 (10.8%)	3,597 (8.4%)
Patients seen after 1 hour	2,282 (5.6%)	2,096 (4.9%)	2,176 (5.2%)	2,244 (5.3%)	1,852 (4.3%)

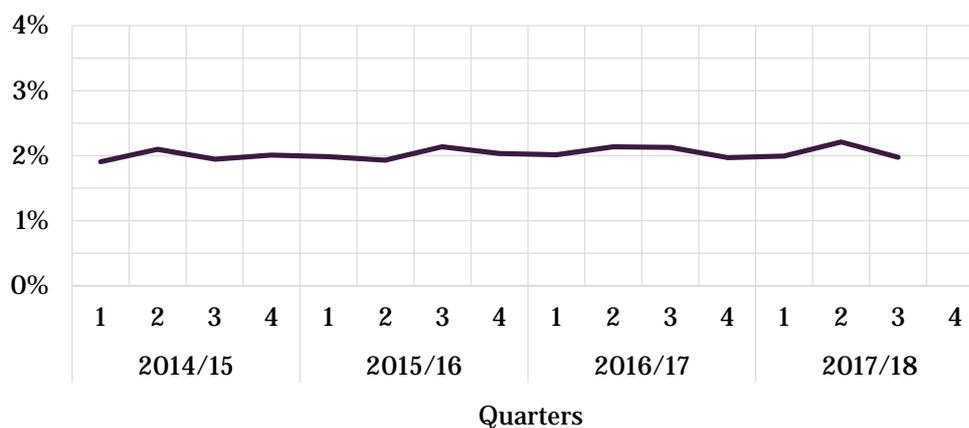
Monitoring sample: NHS patients included in the computerised booking system (excluding Bud Flanagan outpatients and invalid records) including the clinic types: consultant, nurse and professions allied to medicine e.g. physiotherapy.

10.16. Outpatient non-attendances

10.16.1. Non-attendance at first appointment

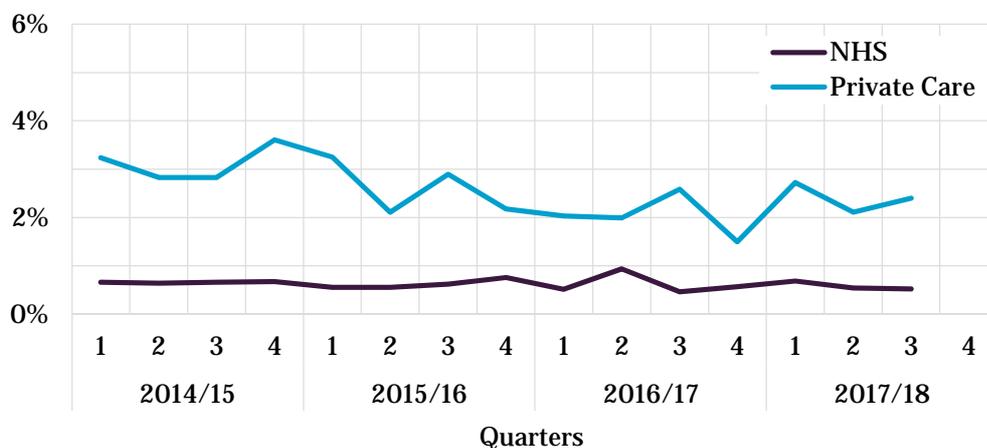


10.16.2. Non-attendance at subsequent appointment



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

10.17.1. In the quarter 0.52% of NHS clinics (26 out of 4,999) and 2.40% of private care clinics (49 out of 2,044) were cancelled less than 15 days before the planned date. The chart shows the percentages of clinics cancelled less than 15 days before planned date for the most recent financial years.



10.17.2. Reasons for cancellation this quarter

Reason	NHS		Private care		Total	
	Clinics cancelled	Appointments affected	Clinics cancelled	Appointments affected	Clinics cancelled	Appointments affected
Doctor on annual leave	17	82	31	107	48	189
Doctor attending meeting	4	10	11	27	15	37
Unexpected emergency	2	21	0	0	2	21
Doctor attending conference	1	1	2	8	3	9
Doctor on study leave	1	4	1	1	2	5
Clinic day changed	1	1	1	3	2	4
Bank holiday	0	0	2	3	2	3
Staff sick leave	0	0	1	2	1	2
Total	26	119	49	151	75	270

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	38	54	8	100
Concerns relating to private care patients	6	1	Not applicable	7
Total	44	55	8	107

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

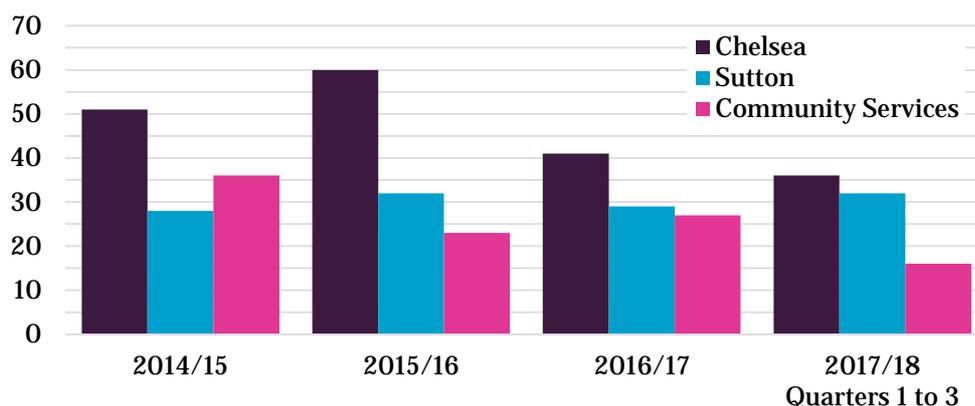
It is a Trust standard that all complainants receive

- 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	9	12	5	26
Complaints acknowledged within three working days	9 (100%)	12 (100%)	4 (80%)	25 (96%)

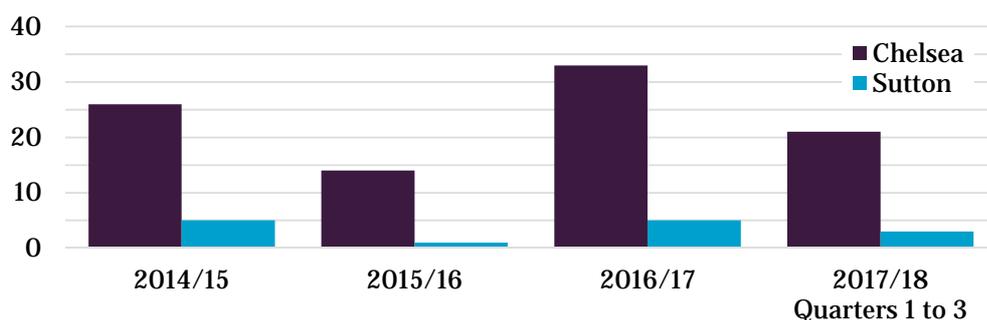
11.1.6. Number of complaints by financial year and site (NHS patients)



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

	Chelsea	Sutton	Total
Complaints received	7	1	8
Complaints acknowledged within three working days	6 (86%)	1 (100%)	7 (88%)

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

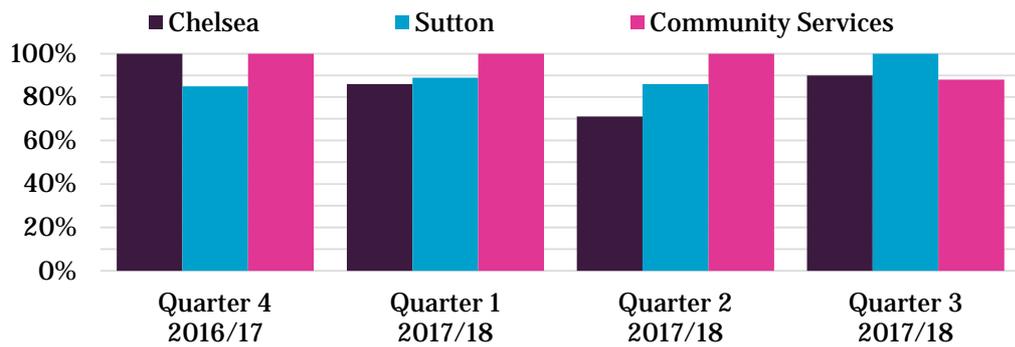


11.1.9. Number of complaints completed this quarter (NHS patients)

	Chelsea	Sutton	Community Services	Total
Complaints completed	10	9	8	27
Complainants receiving a response within agreed deadline	9 (90%)	9 (100%)	7 (88%)	25 (93%)

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)

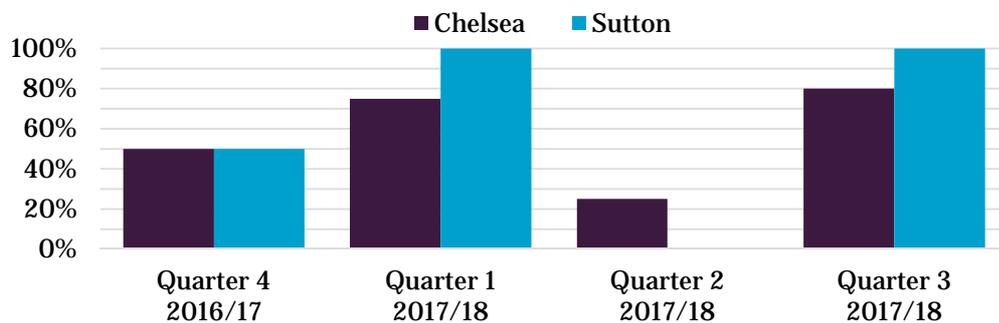


11.1.11. Number of complaints completed this quarter (private care patients)

	Chelsea	Sutton	Total
Complaints completed	5	1	6
Complainants receiving a response within agreed deadline	4 (80%)	1 (100%)	5 (83%)

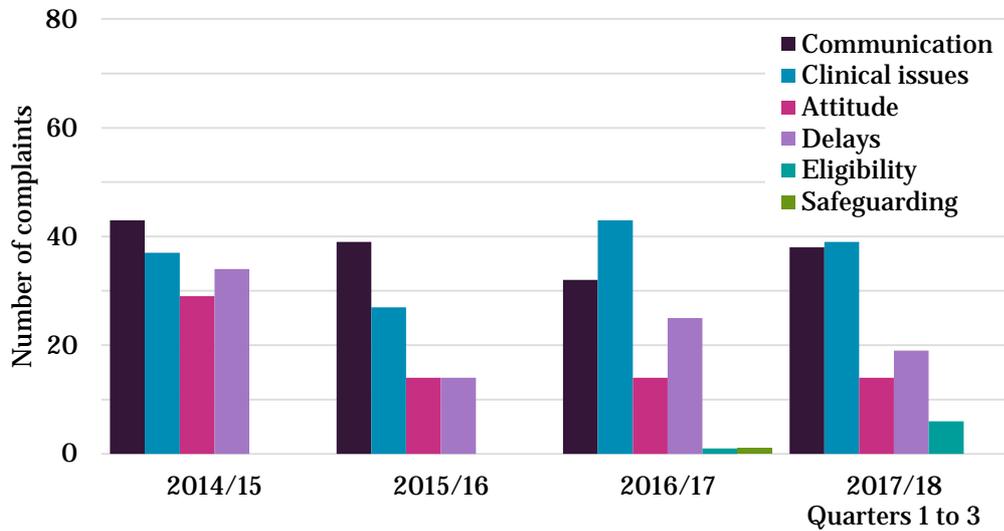
Complaints performance has been measured on complaints closed within the quarter to provide a definitive performance indicator. The breach was due to length of investigation and awaiting final signature.

11.1.12. Responses within agreed deadline (private care patients)



11.1.13. 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.



11.1.14. 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 collects ethnicity data for complainants. Together with other data, it helps the service understand who is using the complaints process. The increased knowledge helps to continually improve the service. The Trust sends out a questionnaire in the acknowledgment for all new complaints received. The return rate has consistently remained low and ways of improving it are being investigated. The questionnaire has recently been updated to include more information around why this information is important and what the Trust uses it for.

Ethnic origin of complainant	Number of complaints
Asian Bangladeshi	0
Asian Indian	2
Asian Pakistani	0
Asian (other)	1
Black African	0
Black Caribbean	0
Black (other)	1
Chinese	0
Mixed White and Asian	0
Mixed White and Black African	0
Mixed White and Black Caribbean	0
Mixed (other)	0
White British	6 (2)*
White Irish	0
White (other)	2
Other	1
Not disclosed	21 (19)
Total	34

* The number in bracket is the number of complainants where the complainant is not the patient.

11.1.15. Complaints completed this quarter – Chelsea

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Skin and melanoma	Very low	Clinical issues	Incorrectly advised GP that the patient has refused treatment	Apologies given to patient.	Not upheld
Lymph-oedema	Very low	Eligibility	Unhappy about providing evidence of eligibility for treatment	Staff reminded of clear communication	Not upheld

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Projects	Low	Eligibility	Unhappy with the decision regarding ineligibility for free NHS care	Relevant staff within Accounts, Billing and Credit Control to undergo training.	Not upheld
Anaesthetics Unit	Low	Clinical issues	Patient dissatisfied with outcome of surgery	Consultant has written to patient's GP. Patient reassured no connection between current medical problems and treatment provided.	Not upheld
Sarcoma	Very low	Communication	Concerns regarding pre- and post-operative care	Information provided to patients reviewed.	Partly upheld
Diagnostic radiology	Very low	Communication	No reason provided regarding length of wait and X-ray not performed	Reception staff reminded to confirm with patients on their arrival if they have any other appointment they need to attend in the Trust.	Local resolution
Macmillan Hotline	Very low	Communication	Unhelpful advice provided and no return of call	Monthly audit of telephone calls.	Local resolution
Facilities	Very low	Communication	Inconsistent information provided by cashiers desk	Review information provided to patients in relation to the Hospital Travel Cost Scheme.	Partly upheld
Urology	Moderate	Delays	Failure to diagnose recurrence	Apology provided and explanation provided.	Not upheld
Breast	Very low	Communication	Insufficient care and attention received during treatment	Apology made and reassurance provided to the patient.	Partly upheld
Private Care	Very low	Clinical issues	Prescribed incorrect dose of medication affecting prostate-specific antigen (PSA) level	Encourage the use of trained interpreters with patients.	Partly upheld
Private Care	Very low	Communication	Dissatisfied with the payment policy	Upon discretion and escalation, waive advance payment requests based on the long-term payment history.	Partly upheld

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Private Care	Very low	Communication	Wrong site provided for appointment	Apology made and further appointment booked.	Partly upheld
Private Care	Very low	Clinical issues	Lack of honesty and poor staff attitude	Teaching sessions at handover on clinical issues.	Partly upheld
Private Care	Very low	Environment	Dissatisfaction with facilities	Review of all facilities on the Ward and additional training for staff.	Upheld

11.1.16. Complaints completed this quarter – Sutton

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Paediatrics	Very low	Clinical issues	Unhappy with decision to undergo chemotherapy	Plan of treatment formulated	Partly upheld
Gynaecology	Very low	Attitude	Attitude of staff	Issues raised discussed with student mentor	Partly upheld
Radiotherapy	Very low	Clinical issues	Treatment received has caused permanent paralysis	Explanation of treatment provided. No further action	Not upheld
Lung	Low	Clinical issues	Scan misinterpreted	Review to identify methods for improving efficiency of multidisciplinary teams by developing a triage process.	Partly upheld
Pharmacy	Very low	Delays	Waiting times for prescription collection	Review of prescription pathway. Recruitment of additional team member.	Upheld
Breast	Very low	Clinical issues	Lack of clarity regarding management of dressing and battery.	Training for staff in relation to bandage technique.	Partly upheld
Leukaemia and myeloma	Very low	Communication	Attitude of staff member	Review how patients are allocated. Ensure patients are aware of expected turnaround time for test results.	Local resolution

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Breast	Very low	Attitude	Attitude of staff member	Individual reflection. Incorrect information on clinical record corrected.	Not upheld
Lung	Very low	Attitude	Unhappy with consultation	Staff reflection.	Not upheld
Private Care	Very low	Delays	Appointment delayed by two hours	Additional capacity will be made available within private care outpatients department.	Upheld

11.1.17. Complaints completed this quarter – Community Services

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Musculo-skeletal service	Very low	Delays	Long waiting list	Team reminded of the process for booking appointments.	Upheld
Podiatry	Very low	Commissioning	Nail cutting services stopped	Apology made and service explained.	Not upheld
Health Visiting	Very low	Attitude	Attitude of staff member	Apology and reflective practice session provided.	Upheld
Neuro intermediate care	Very low	Commissioning	Stroke sufferers support group loss of funding	Review of model of provision.	Not upheld
Occupational Therapy Children's service	Low	Eligibility	Unable to access Occupational Therapy Service due to age	Patient was offered therapy sessions.	Upheld
Physiotherapy Outpatients	Very low	Clinical issues	Dissatisfied with the treatment received	Staff to undertake additional training.	Partly upheld
District Nursing	Low	Clinical issues	Lack of consistency regarding administration of medication	District nurse visit moved to a more convenient time for the patient.	Upheld

Physiotherapy Children's	Very low	Delays	Delay in appointment	Administrative staff have been reminded to pay particular attention to the address and registered GP of all referrals to ensure that the referrals received are within the catchment area.	Upheld
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11.1.18. 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 Two 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 resolved	Total resolved	Number upheld	Number partially upheld	Total not upheld	Total carried forward
NHS England	19,431	29,152	27,104	9,198	8,150	9,756	21,479
NHS England London	2,993	4,987	4,742	1,471	1,575	1,696	3,238
The Royal Marsden	15	35	29	4	10	15	21
The Christie NHS Foundation Trust	4	21	13	6	1	6	12
University College London Hospitals NHS Foundation Trust	100	254	203	54	96	53	151
Chelsea and Westminster Hospital NHS Foundation Trust	130	133	141	56	51	34	122
St George's University Hospitals NHS Foundation Trust	168	245	213	213	-	-	200

From webpage digital.nhs.uk/catalogue/PUB30158 *Data on written complaints in the NHS, 2017-18 Quarter 2, Experimental* on the NHS Digital website (published 6 December 2017; retrieved 31 January 2018).

11.1.19. Learning from complaints

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

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

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

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

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

Communication

There has been a review of the information provided to patients regarding the order arrangement of the operating list and discharge times.

Delays

Haematology appointment letters to now include information in relation to potential delays whilst blood test results are analysed.

Clinical issues

A review is underway to identify methods for improving efficiency of multidisciplinary team meetings by development of a triage process for patients with more complex needs.

Attitude of staff

Staff have been reminded to ensure that they communicate in a professional and courteous manner as well as providing reasons for any delays.

11.1.20. Parliamentary and Health Service Ombudsman referrals

There were no new referrals to the Parliamentary and Health Service Ombudsman in Quarter Three.

The Trust currently has two complaints under investigation by the Ombudsman. For one of these complaints the Trust has received the draft report and are awaiting the final report.

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 394 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

Critical Care

The skill dedication and wonderful patient-centred care received was second to none. The expertise has enabled successful surgery with a very positive result. They insured the best possible treatment while under their care and for this we are very grateful. Critical care is an extremely efficient, professionally organised well run unit. Consultants were on hand to ensure best treatment was administered and they extended their supportive, compassionate, friendly attitude to us as a family as we tried to cope with our anxieties. The skill and dedication of the nursing staff managed by the matron was amazing.

Ellis ward

Thank you so much for the amazing care you so kindly bestow on us, the patients. You really are living stars that deserve so much more than you reap. I greatly appreciate all that you do.

11.2.4. Sutton

Day Care

The one word that describes the care I received while having Chemotherapy treatment at The Royal Marsden Hospital, Sutton was INCREDIBLE. Your professionalism, linked with the smiles and positive attitude you showed on each day of my treatment, makes all of you a real asset to the hospital and a credit to the leadership. Your caring attitude has made my chemotherapy days almost a pleasure!

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?

11.2.5. Community Services

Pulmonary rehabilitation service

Just a note to thank you and the other physios and lecturers who have been involved in the lung foundation course, which I have been attending for the past six weeks. Your knowledge, advice, help and kindness has been very much appreciated by me, and I know the course has helped me tremendously.

Heart failure nurses

I want to thank you for your help, guidance and support. This was instrumental in my recovery. It was very re-assuring to be able to talk things through with you in a relaxed manner where we had plenty of time to cover all the medical and lifestyle issues. The doctor told me in hospital how important the community nurse role was in giving me the best chance of making a good recovery. I didn't really know what to expect but I can now support his view wholeheartedly.

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 23 (SI)	Medication	Report to IGRM January 2018.
Investigation 24 (SI)	Triage	Completed, see details section 11.3.2.
Investigation 25	Pressure ulcer	No panel or investigation required (diabetic foot ulcer).
Investigation 26	Treatment pathway	For RCA and review.
Investigation 27	Allergic reaction	No panel or investigation required.
Investigation 28	Community referrals	For RCA and review.
Investigation 29	Patient fall	Report to IGRM January 2018.
Investigation 30	Pressure ulcer	No panel or investigation required. (moisture lesion).
Investigation 31	Suicide	For RCA and review.
Investigation 33	Patient fall	For RCA and review.
Investigation 34	Radiologically-inserted gastrostomy (RIG) tube	For RCA and review.
Investigation 36	Staff fall	For RCA and review.
Investigation 35	Surgical equipment	For RCA and review.
Investigation 37	Pressure ulcer	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 84 (Yellow)	Test results	Lack of information delayed the validation of test result.	Blood request forms to be fully completed. Updated contact information to be made available to staff.
Investigation 1 (Green)	Delay in follow up	Further discussion at multidisciplinary team meeting did not occur, lesion thought to be benign.	Patients to remain on the list until closure at multidisciplinary team meeting.
Investigation 9 (Orange)	Lost to follow up	No mechanism that monitors/tracks inpatients following discharge.	Process of follow up for inpatients to be reviewed.
Investigation 17 (Yellow)	Medication	Incorrect weight documented, resulting in increased dose of medication.	Review of height and weight policy.
Investigation 11 (Green)	Incorrect swab count	Swab count identified missing swab. Correct process followed, retrieved prior to patient leaving theatre.	Review of Standard Operating Procedure (SOP) and development of policy.
Investigation 12 (Green)	Patient transfer	Delay in escalation process for deteriorating patient.	Situation Background Assessment Recommendation (SBAR) tool to be used when escalating a patient's condition. Consider escalation of clinically deteriorating patients as part of medical trainees' induction.
Investigation 18 (Green)	Delay in providing clinical care	Patient admitted to local hospital as no beds available at The Royal Marsden.	Review <i>Patient access policy</i> to include an algorithm for escalation when no beds are available.
Investigation 16 (Green)	Medication	Medication not checked correctly prior to administration.	Staff reminded that they must adhere to the five checks prior to the administration of medication.
Investigation 19 (SI)	Information governance breach	Patient identifiable information in document not deleted before sending externally.	Human error. Staff member aware of process.

Investigation number and incident grade	Description	Outcome of investigation	Action taken following investigation include:
Investigation 24 (SI)	Triage	Patient symptoms not triaged in accordance with the triage assessment tool.	Review medical and specialist nursing support and develop specific Situation Background Assessment Recommendation (SBAR) tool.

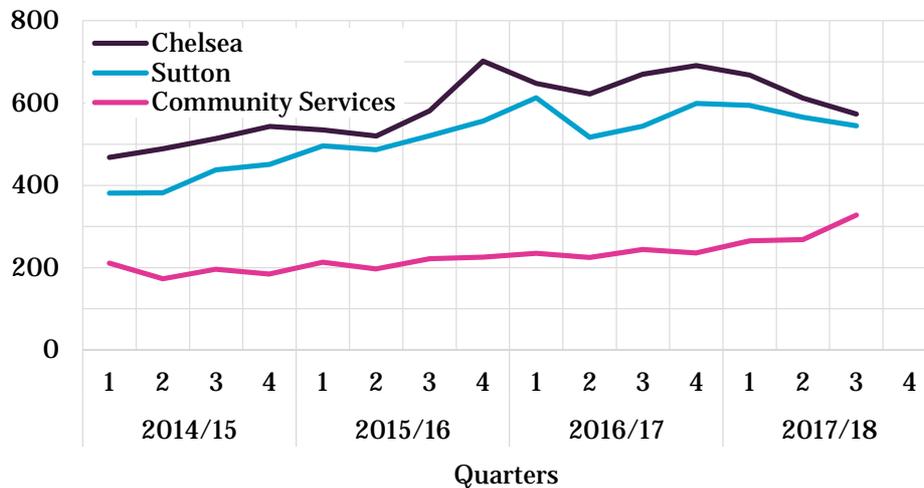
11.4. Contractual Duty of Candour and Regulation 20 – Care Quality Commission

- 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.

11.5. Incident statistics

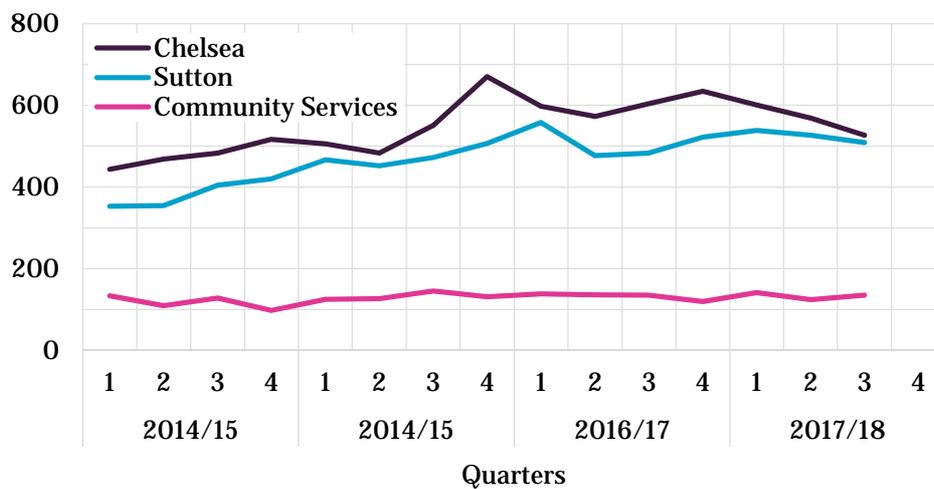
This section displays incident statistics for services which are currently run by The Royal Marsden NHS Foundation Trust. Historical data relating to services now commissioned by other healthcare providers have been excluded.

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.

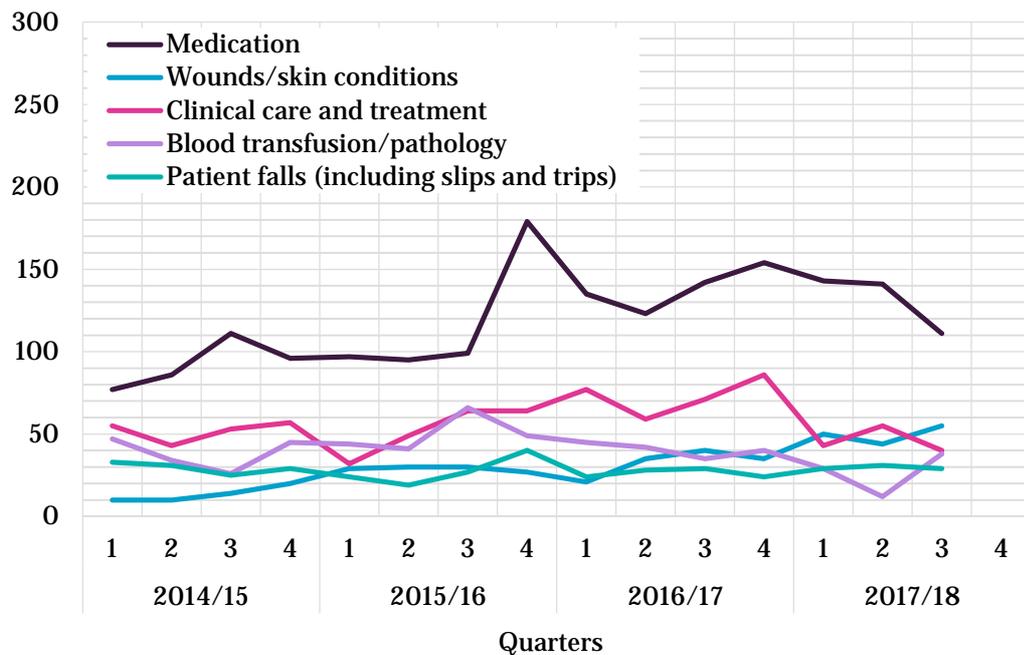


11.5.3. Patient safety incidents – top five categories

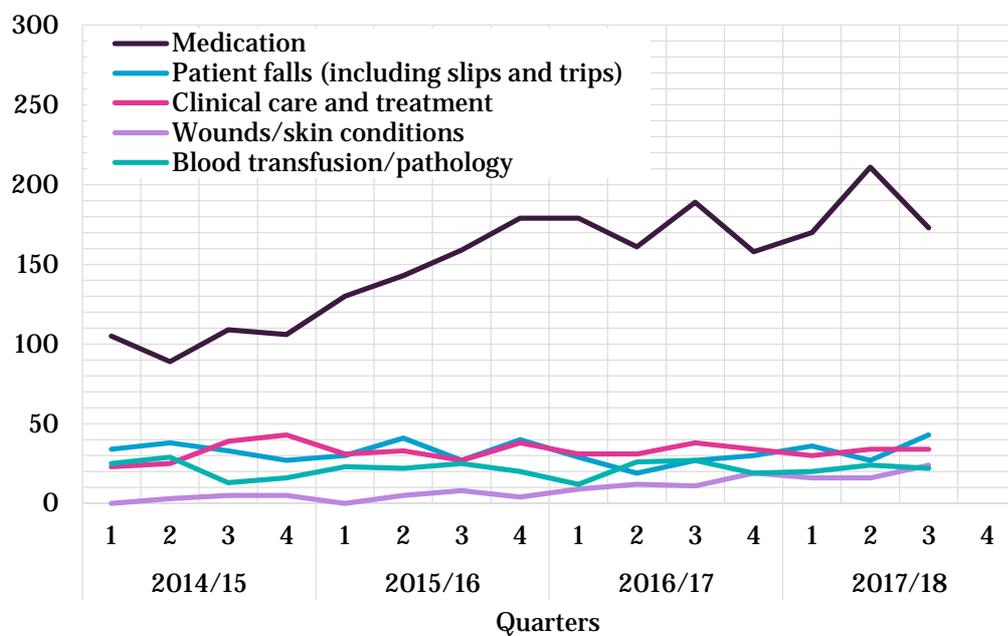
Patient safety incidents are those incidents that could have or did lead to harm for one or more patients.

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

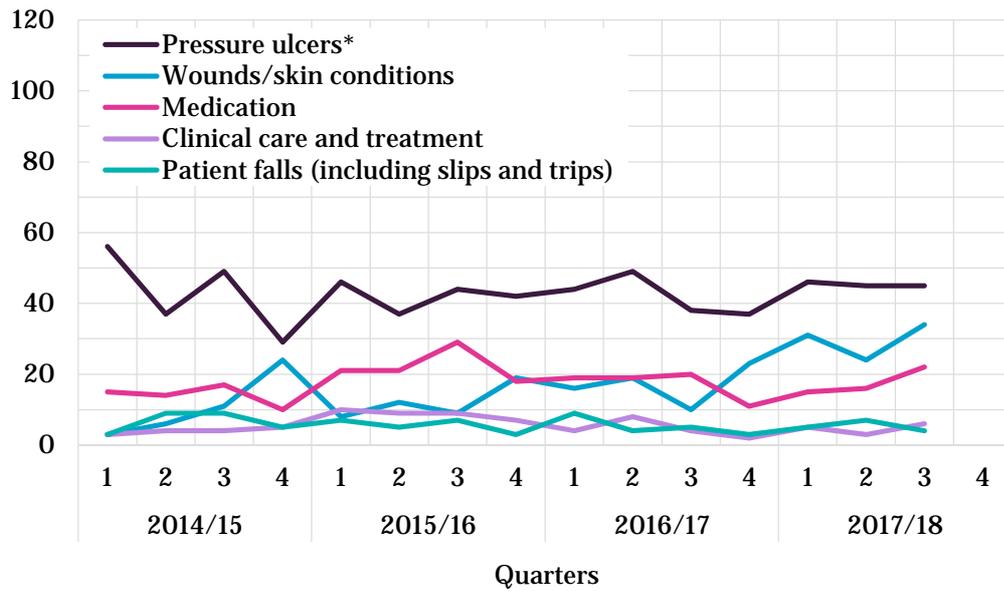
Chelsea



Sutton



Community Services



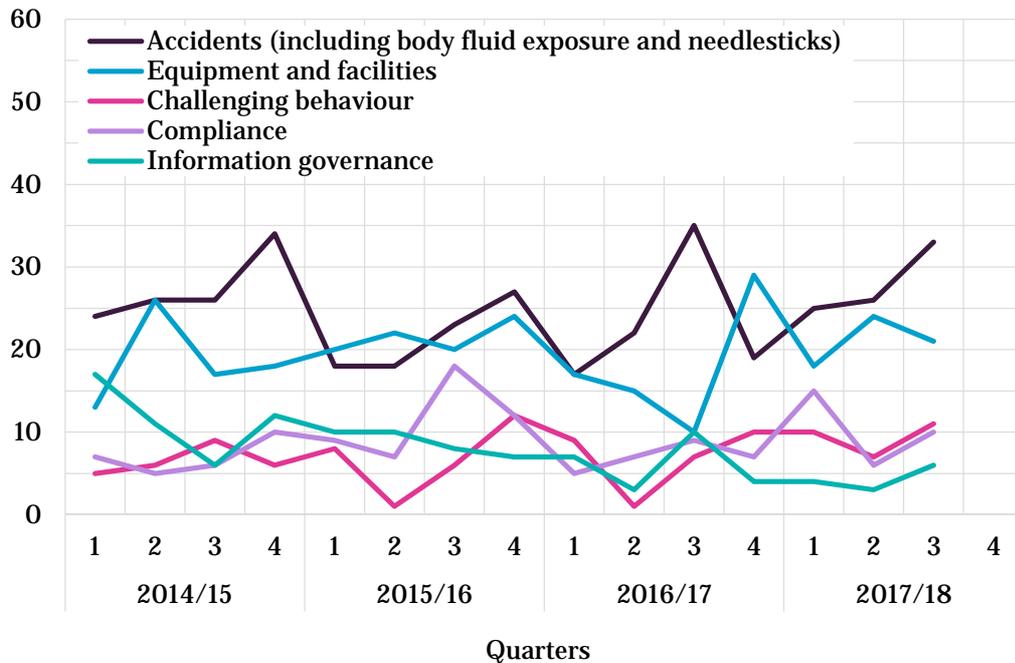
* One incident may represent more than one pressure ulcer.

11.5.4. Non-patient safety incidents – top five categories

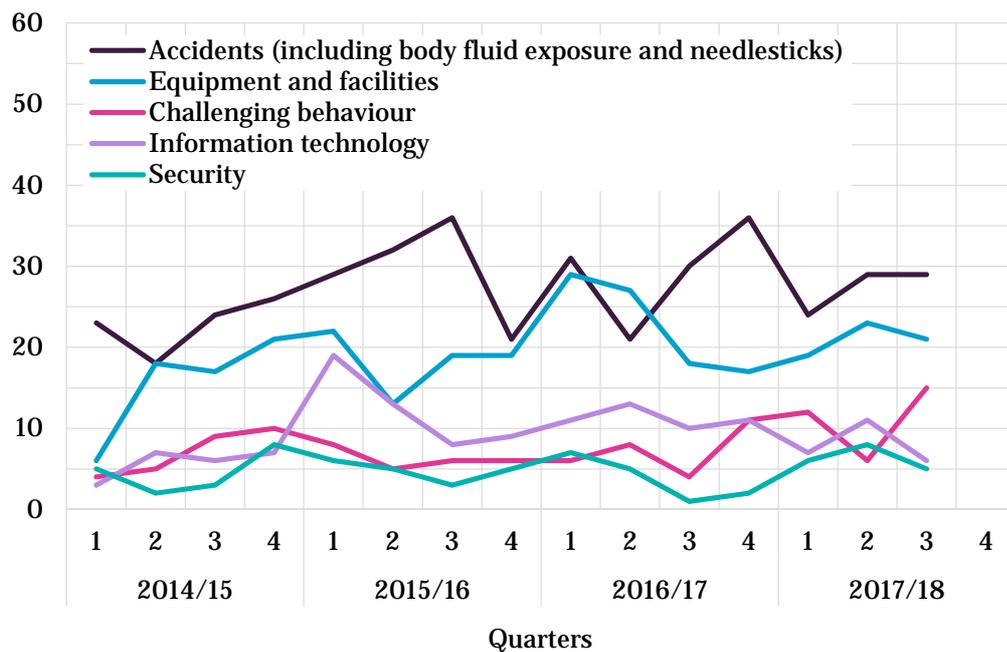
Non-patient safety incidents are those incidents that do not directly involve a patient.

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

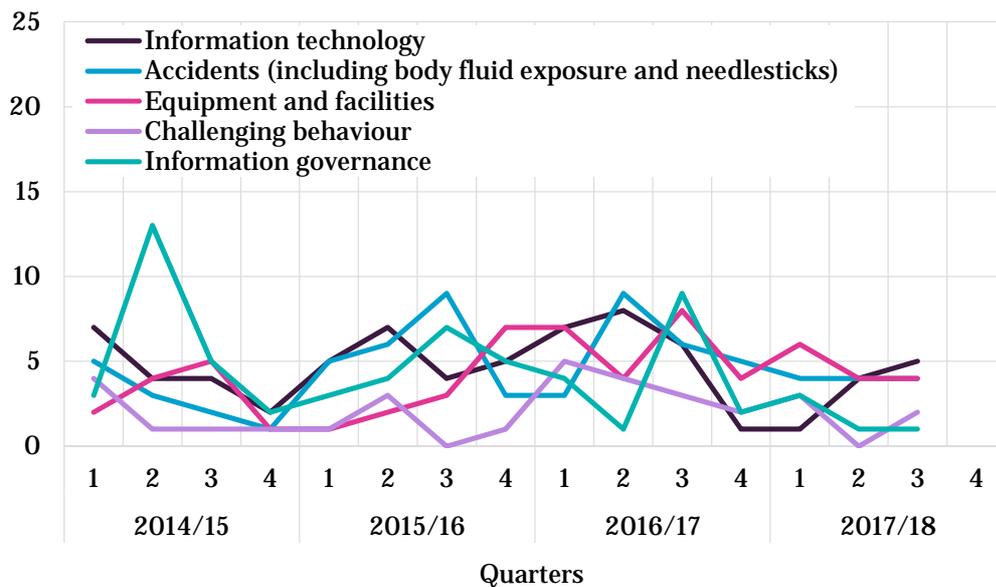
Chelsea



Sutton



Community Services

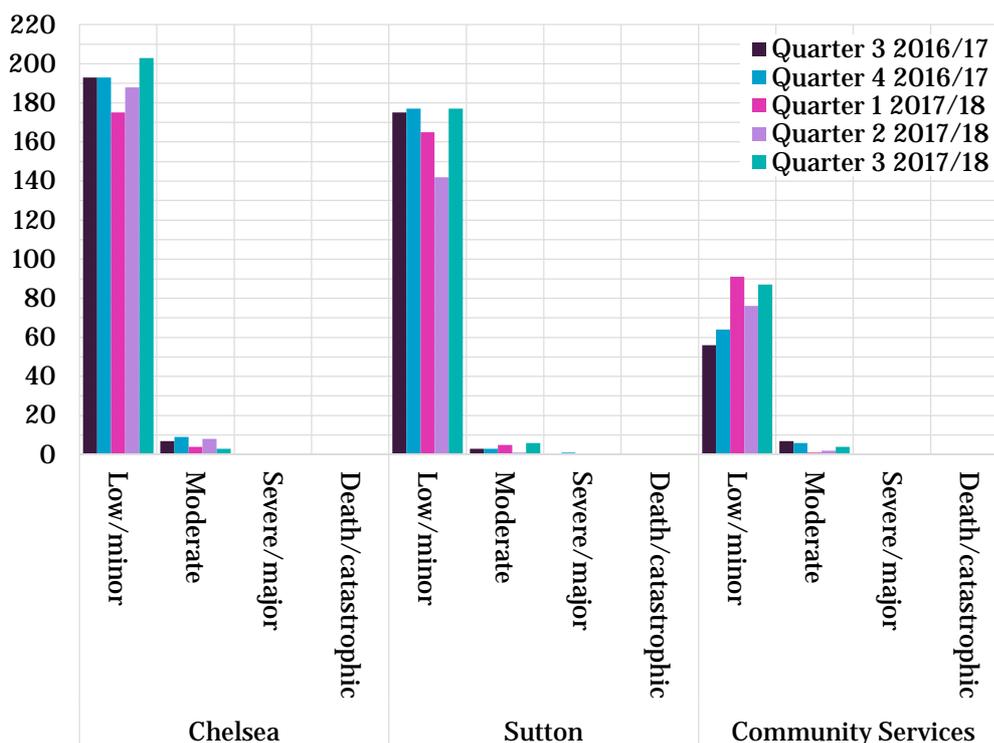


11.5.5. Severity

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

The categories are:

- No harm
- Low/minor (minimal harm)
- Moderate (short term harm)
- Severe/major (permanent or long term harm)
- Death/catastrophic (caused by the incident).

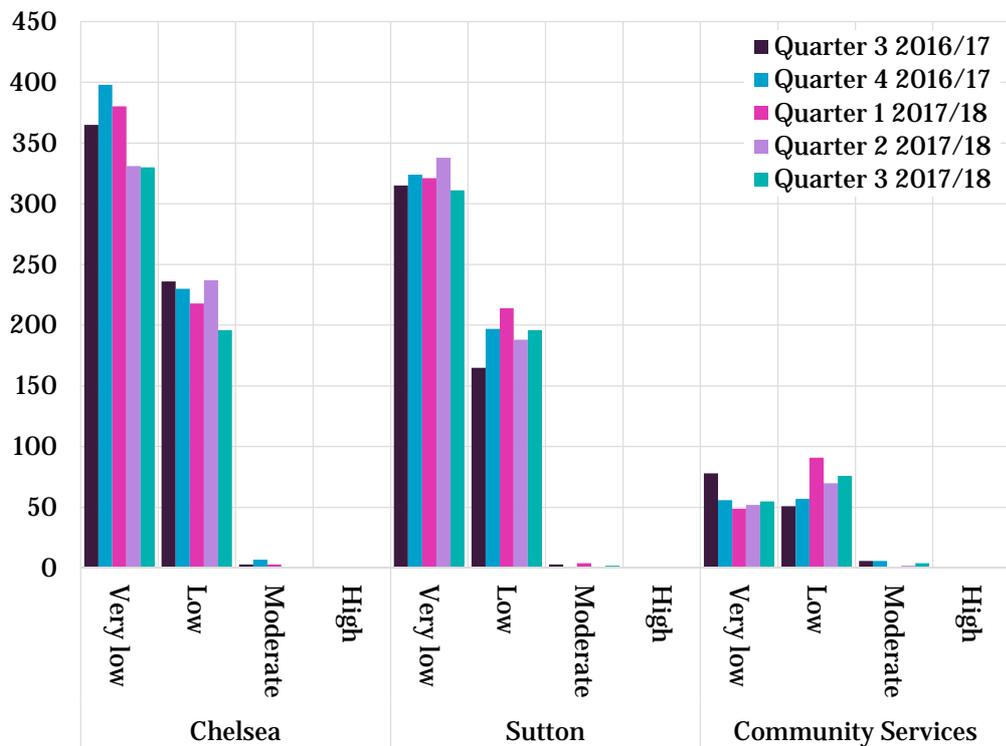


The table shows the number of incidents for each level of harm.

		Quarter 3 2016/17	Quarter 4 2016/17	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18
Chelsea	No harm	404	433	422	373	321
	Low/minor	193	193	175	188	203
	Moderate	7	9	4	8	3
	Severe/major	0	0	0	0	0
	Death/catastrophic	0	0	0	0	0
Sutton	No harm	305	341	369	384	326
	Low/minor	175	177	165	142	177
	Moderate	3	3	5	1	6
	Severe/major	0	1	0	0	0
	Death/catastrophic	0	0	0	0	0
Community Services	No harm	72	49	49	46	44
	Low/minor	56	64	91	76	87
	Moderate	7	6	1	2	4
	Severe/major	0	0	0	0	0
	Death/catastrophic	0	0	0	0	0

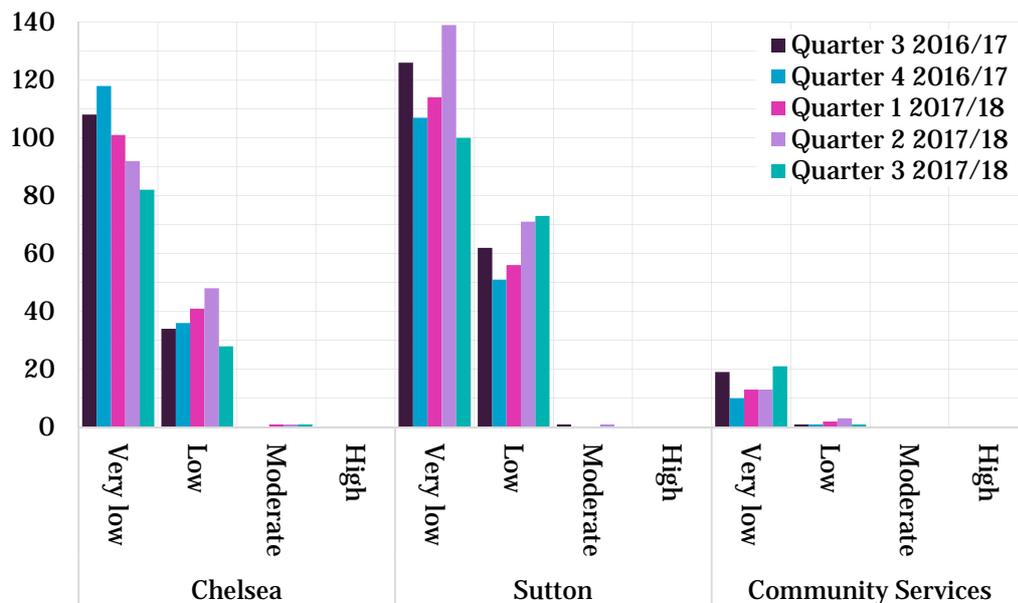
11.5.6. Risk grade

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



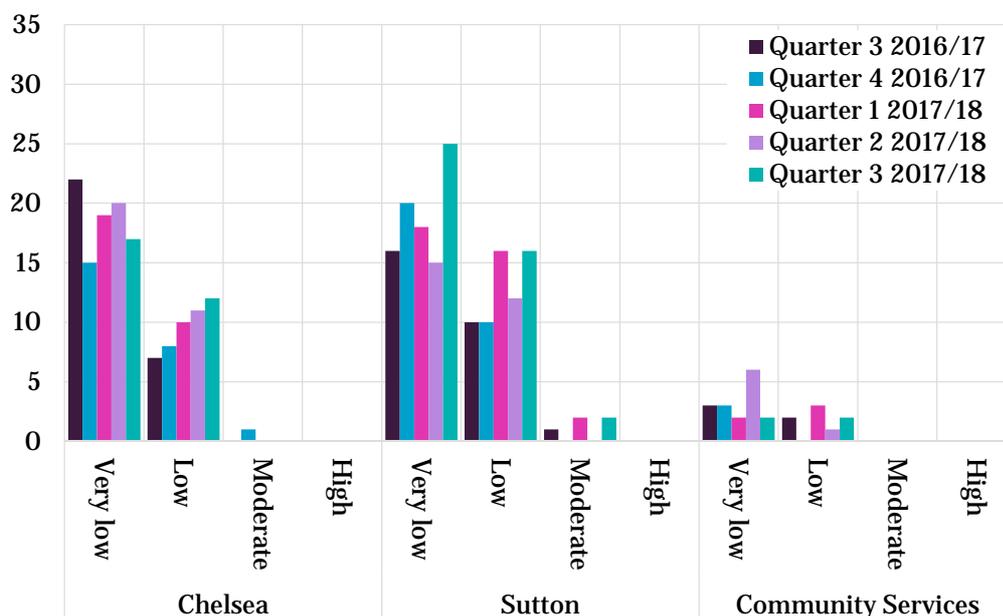
11.5.7. Medication incidents by risk grade

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



11.5.8. Patient fall incidents by risk grade

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



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

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

- A volunteer whilst walking in a corridor lost footing and fell resulting in a fractured elbow.
- A member of nursing staff whilst caring for an unresponsive patient tripped over an IV stand and injured their back requiring them to be off work for more than seven days.
- An administrative member of staff fell from a height whilst exiting a vehicle and suffered a fractured femur. Further risk assessment undertaken, for panel investigation 36.

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

11.8.1. Claims received during Quarters Two and Three

The Trust received three requests for medical records, intimating claims, five inquest notifications and five claims made against the Trust.

11.8.2. Open claims during Quarters Two and Three

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

Stage	Sub-stage	Total	Description of sub-stage
Pre-action			
	Request for medical records	15	Request where claim intimated against the Trust
	Letter before action/claim/notification of claim	0	Pre-action letter detailing allegations likely to be subject to court proceedings
	Letter of Claim	5	Response to the allegations as set out in the Letter of Claim
	Letter of response	5	Response to the allegations as set out in the letter before action/claim
	Negotiating settlement	2	Attempts to reach settlement without recourse to the court
Issued claims			
	Claim form served	0	Formal court proceedings sent to the Trust
	Particulars of claim served	1	Formal allegations sent to the Trust and court
	Defence served	0	Trust provides formal response to allegations denying all or some of the allegations made
	Negotiating Settlement	0	Attempts to reach settlement without recourse to the court
	Structured payment	1	Claim settled and annual payments made to Claimant
	Discontinued	0	Claimant withdrew claim. Legal costs to be confirmed
Total		29	

11.8.3. Open live files by category

Of the 29 live claims, 25 claims relate to clinical negligence claims and four are personal injury claims.

11.8.4. Closed claims in Quarters Two and Three

Claim withdrawn	16	Claimant notifies Trust that they no longer intend to proceed with claim or length of time since last contact suggests claim withdrawn.
Claim Repudiated	5	Claims repudiated by NHS Resolution
Settled pre-action	1	Damages were paid (with, or without an admission of liability) before court proceedings
Settled out of court	0	Damages were paid (with, or without an admission of liability) after court proceedings have been issued
Judgment for Trust	0	Trust wins claim at court
Judgment for claimant	0	Claimant wins claim at court
Total	22	

Amongst the five repudiated claims, three claims were made by patients and two were personal injury claims.

11.8.5. Inquests notifications received in Quarters Two and Three

The Trust received notification of five inquests for Quarters Two and Three.

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

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

11.8.6. Inquests concluded during Quarters Two and Three

Five inquests were closed during Quarters Two and Three. Three inquests were discontinued and the remaining two notifications were listed for inquest.

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 Three 2017/18 the Trust submitted the following finance and governance reports as part of the requirements:
- Month six 2017/18 In Year Quarterly Financial Reporting return and commentary sent to NHS Improvement on 16 October 2017
 - Month seven 2017/18 In Year Quarterly Financial Reporting return and commentary sent to NHS Improvement on 15 November 2017
 - Month eight 2017/18 In Year Quarterly Financial Reporting return and commentary sent to NHS Improvement on 15 December 2017
 - Month six 2017/18 Workforce return sent to NHS Improvement on 16 October 2017
 - Month seven 2017/18 Workforce return sent to NHS Improvement on 24 November 2017
 - Month eight 2017/18 Workforce return sent to NHS Improvement on 14 December 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 Three 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)*.

NEWS 2

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

See *National Early Warning Scores (NEWS)*.

NHS Improvement

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

NHS Litigation Authority (NHS LA)

See *NHS Resolution*.

NHS Resolution

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

NHS standard contract

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

NICE

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

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.

Triggers tool

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

TUPE

Transfer of Undertakings (Protection of Employment) Regulations 1981.

TYA

Teenage and young adult.

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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Life demands excellence



Radiotherapy and
Chemotherapy Services
FS38021 & FS38022

