
Integrated Governance Monitoring Report

July - September 2018

Quarter Two 2018/19



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1. Introduction

- 1.1. Welcome to The Royal Marsden'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. 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. The fundamental standards are described in detail on page 125.
- 1.6. The Care Quality Commission inspects and assesses organisations against the fundamental standards using five key questions:
 - are they safe?
 - are they effective?
 - are they caring?
 - are they responsive to people's needs?
 - are they well led?
- 1.7. Unless otherwise specified text, tables and charts refer to Quarter Two 2018/19 (July to September 2018).

2. Executive summary

2.1. Is care safe?

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

2.1.1. Incident, complaints and claims investigations

Fourteen new incident investigations were declared this quarter (15 the previous quarter). Eleven incident investigations were completed in the quarter (eight the previous quarter) and remedial actions were identified. (*Incident, complaints and claims investigations and serious incident reporting*, page 99.)

2.1.2. Infection prevention and control

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

There were 28 cases of *Clostridium difficile* toxin (CDT) in the quarter. 'Lapses of care' for the quarter will be evaluated by the commissioners in November. Fifty-two cases in the full year 2017/18 were reportable to the Healthcare-associated infection Data Capture System.

There were 20 cases of *Escherichia coli* bacteraemia in Quarter Two (8 in Quarter One). (*Infection prevention and control*, page 42.)

2.1.3. Fire

There were no actual fires in the quarter. (There were two incidents relating to a single fire in the previous quarter.)

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

2.1.4. Radiotherapy

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.

There were 28 radiotherapy incidents, all risk-rated *low* and *very low* (39 the previous quarter). There were no complaints this quarter; there were 14 letters or cards of praise.

There were 1,350 appointments in the quarter (1,373 in the previous quarter). There were 5,416 appointments in the full year 2017/18. (*Radiotherapy*, page 77.)

2.1.5. Chemotherapy

All 107 incidents reported were risk-rated *low* and *very low* (there were 125 in the previous quarter). Of the 107 incidents 99 referred to medication issues (111 in the previous quarter). There were no complaints in the quarter and there were 50 letters of praise and thanks. (*Chemotherapy*, page 79.)

2.2. Is care effective?

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

2.2.1. Commissioning for quality and innovation (CQUIN) goals

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

Sutton CCG has confirmed 100% achievement for Quarter One for the Community and Acute CCG CQUINs. The Trust awaits final confirmation on Quarter One from NHS England for the NHS England CQUINs.

The Trust submitted its Quarter Two CQUIN reports on 31 October 2018. Sutton CCG have confirmed 100% achievement for the acute CQUINs. The Trust awaits confirmation from Sutton CCG for the community CQUINs and from NHS England for the NHS England CQUINs.

(Commissioning for quality and innovation (CQUIN), page 13.)

2.2.2. Medical devices

There were 45 incidents relating to medical devices this quarter (57 in the previous quarter). All the incidents were risk-rated *low* and *very low*.

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

2.2.3. Deaths following anti-cancer-therapy

Sixty-seven patients who received systemic anti-cancer therapy in the quarter died within 30 days, out of a total of 4,374 (1.5%). There were 76 out of 4,348 (1.7%) in the previous quarter. *(Deaths following anti-cancer therapy, page 70.)*

2.2.4. Deaths following surgery and anaesthesia

Six patients who received surgery or anaesthesia in the quarter died within 30 days, out of a total of 1,424 (0.4%). There were 5 out of 1,448 (0.3%) in the previous quarter. *(Deaths following surgery and anaesthesia, page 71.)*

2.2.5. Deaths following stem cell transplantation

There were 63 stem cell transplants. Two deaths related to transplant out of 54 adult patients and there were no deaths among the nine paediatric patients. In the previous quarter there had been one adult death related to transplant (out of 56), and no deaths among the eight paediatric patients. *(Deaths following stem cell transplantation, page 72.)*

2.2.6. Medicines optimisation

Waiting times for outpatient prescriptions: 75% completed within 30 minutes.

Waiting times for prescriptions dispensed for discharge: over 96% of the prescriptions were completed within 60 minutes and 75% were completed within 30 minutes. (*Medicines optimisation*, page 46.)

2.3. Are staff caring?

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

2.3.1. Letters of praise

In Quarter One the Head of Clinical Legal Services, Complaints and Patient Information received 162 letters of praise (219 in the previous quarter). (*Letters of praise*, page 98.)

2.3.2. Safeguarding of adults at risk

Five reported safeguarding concerns were raised at the Trust's Chelsea and Sutton sites (there were 13 in the previous quarter). Twenty-six reported safeguarding concerns were raised in Community Services (24 in the previous quarter).

Nine urgent applications were made under the Deprivation of Liberty safeguards (seven in the previous quarter). (*Safeguarding of adults at risk*, page 32.)

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 22 new complaints relating to NHS patients and nine new complaints relating to private patients in Quarter Two. All were acknowledged in three days or less.

Twenty-eight complaints relating to NHS patients and five relating to private patients were completed in Quarter Two. Five complaints relating to NHS patients and two relating to private patients did not receive a response by the agreed deadline. (*Concerns and complaints*, page 89.)

2.4.2. Freedom of information

The Trust received 143 freedom of information requests during Quarter Two (132 in Quarter One). Of the 143 requests 131 were answered within 20 working days (92%). (*Freedom of information*, page 76.)

2.4.3. Paediatric and Teenage Psychological Support Service

During Quarters One and Two the service received 162 new referrals and provided 1020 therapeutic sessions. The number of referrals is continuing to increase. (*Paediatric and Teenage Psychological Support Service*, page 22.)

2.4.4. Clinic waiting times

There has been an increase in activity of from 42,487 to 44,145 between Quarter Two 2017/18 and Quarter Two 2018/19 – an increase of 1,658 (3.9%). Over the same period the number of patients seen within 30 minutes of their appointment time has increased from 35,660 to 39,246, an increase of 3,586 (10.1%). (*Clinic waiting times*, page 87.)

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

In the quarter 0.85% of NHS clinics (44 out of 5,157) and 1.63% of private care clinics (36 out of 2,203) were cancelled less than 15 days before the planned date. (*Consultant clinics cancelled less than 15 days before planned date*, page 88.)

2.5. Are staff well led?

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

2.5.1. Reports to NHS Improvement and accounts

Clear leadership assures the sustainability of the Trust's financial position. NHS Improvement, the regulator of NHS trusts and foundation trusts, has given the Trust a Use of Resources rating of 1, which means the Trust is considered low risk in financial terms and is one of those providers with maximum autonomy. (*Reports to NHS Improvement and accounts*, page 110.)

2.5.2. Human resources

The vacancy rate has increased to 10.3% (against the target of 7%), but shows a slight improvement over the vacancy rate for the same quarter 2017/18 (10.5%).

Voluntary turnover reduced in Quarter Two, to 12.4%, but remains just above the trust target of 12%.

The Trust sickness rate this quarter has risen this quarter to 3.4%, with only two Divisions meeting the trust target. (*Human resources*, page 57.)

2.5.3. Research governance

Six projects were awarded Trust sponsorship. There were 23 suspected unexpected serious adverse drug reactions (SUSARs), none of which required further action. (*Research governance*, page 84.)

2.6. Conclusion

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

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

3.1. Performance indicators

National Cancer Plan targets

Indicator	Target*	2018/19 (projected)†	2018/19 year to date	2017/18	2018/19 cumulative month
2 weeks					
% of patients seen within 2 weeks of urgent GP referral	93.0%	86.1%	86.1%	96.0%	September
% of patients seen within 2 weeks for breast symptoms	93.0%	87.6%	87.6%	94.4%	September
31 days					
First treatment – % treated within 31 days of decision to treat	96.0%	97.4%	97.4%	97.6%	September
Subsequent drugs – % treated within 31 days of decision to treat	98.0%	98.4%	98.4%	98.8%	September
Subsequent surgery – % treated within 31 days of decision to treat	94.0%	96.0%	96.0%	95.8%	September
Subsequent radiotherapy – % treated within 31 days of decision to treat	94.0%	95.3%	95.3%	95.4%	September
62 days					
All cancers – % treated within 62 days of urgent GP referral	85.0%	76.4%	76.4%	74.7%	September
All cancers – % treated within 62 days of urgent GP referral (post reallocation‡)	85.0%	82.6%	82.6%	85.6%	September
Referral from screening – % treated within 62 days of urgent GP referral	90.0%	85.4%	85.4%	85.2%	September
Referral from screening – % treated within 62 days of urgent GP referral (post reallocation‡)	90.0%	85.3%	85.3%	89.2%	September
Consultant upgrade – % treated within 62 days of urgent GP referral	N/A	72.2%	72.2%	69.6%	September

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

Activity data

Indicator	Target*	2018/19 (projected)†	2018/19 year to date	2017/18	2018/19 cumulative month
Number of NHS elective inpatient full consultant episodes	-	5,170	2,585	5,076	September
Number of NHS daycase full consultant episodes	-	11,322	5,661	11,681	September
Total NHS elective full consultant episodes	-	16,492	8,246	16,757	September
Number of NHS non-elective inpatient full consultant episodes	-	1,828	914	2,037	September
Number of NHS outpatient attendances	-	192,338	96,169	187,956	September

National access targets

Indicator	Target*	2018/19 (projected)†	2018/19 year to date	2017/18	2018/19 cumulative month
Cancelled operations					
Number of last minute cancelled operations for non-clinical reasons not admitted within 28 days**	0	4	2	0	September
Referral to treatment (RTT)					
RTT % incomplete pathways within 18 weeks	92.0%	98.1%	98.1%	96.8%	September
RTT number of patients on incomplete pathways waiting longer than 52 weeks	2	12	6	10	September

Other national indicators – data quality

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

Other national indicators – infection prevention and control

Indicator	Target*	2018/19 (projected)†	2018/19 year to date	2017/18	2018/19 cumulative month
Number of diagnoses of <i>Clostridium difficile</i> ††	-	58	29	57	September
Number of diagnoses of <i>Clostridium difficile</i> (lapses of care 2018/19 identified to date‡‡)	<= 30	8	4***	6	September
Number of diagnoses of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) bacteraemia	0	0	0	0	September

Other national indicators

Indicator	Target*	2018/19 (projected)†	2018/19 year to date	2017/18	2018/19 cumulative month
Number of occurrences of patients in breach of sleeping accommodation guidelines	0	0	0	0	September
Venous thromboembolism (VTE) risk assessment	95.0%	95.5%	95.5%	96.4%	September

* Target is based on NHS England targets where published.

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

‡ In line with the national reallocation policy The Royal Marsden reallocated breaches to referring trusts when referrals are received late in the 62 day pathway (after day 38) and the Trust treats within 24 days of referral. This is reflected in the 62 day reallocated position and is reported to NHS Improvement and NHS England.

** 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.

*** One *C. difficile* lapse of care was not reported in the Performance indicators section of the Quarter One 2018/19 Integrated Governance Monitoring Report – it has been added in this report. The lapse of care was correctly reported in the executive summary and in the Infection Prevention and Control section of the Quarter One report.

3.2. Commissioning for Quality and Innovation (CQUIN)

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

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

3.2.3. Cancer specialist services

NHS England Acute CQUIN Schemes

- Nationally standardised dose banding for adult intravenous systemic anti-cancer treatment
- Hospital medicines optimisation
- Enhanced supportive care access for advanced cancer patients
- Sustainability and transformation plan
- Stereotactic radiotherapy services (SRS) dataset.

CCG CQUIN Schemes

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

3.2.4. Community Services

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

3.2.5. Acute NHS England CQUIN milestones 2018/19

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

Scheme	Quarter 2 Milestone	Quarter 1	Quarter 2
Dose banding	Ensure that 90% of medicine doses are delivered in accordance with national tables.	Achieved	Achieved
Hospital medicines optimisation	90% of new patients receiving best value generic/biologic product on the 2017/18 list and the 2018/19 Quarters 1 and 2 list. 20% of existing patients receiving best value generic/biologic product on 2018/19 Quarter 1 list. 80% of existing patients receiving best value generic/biological product on 2017/18 Quarters 3 and 4 list. Submit OS Pharmacy Questionnaire.	Achieved	Achieved

Scheme	Quarter 2 Milestone	Quarter 1	Quarter 2
Enhanced supportive care	Percentage of eligible patients are referred to or assessed by the Supportive care team in Renal and Gynaecology – performance against plan. Percentage of eligible patients are referred to or assessed by the Supportive care team in Upper Gastrointestinal and Lung – performance against plan.	Achieved	Achieved
Sustainability and transformation plan	Update on RM Partners programmes that The Royal Marsden is leading on. Design patient information for colorectal risk stratified pathway. Carry out initial patient experience survey to inform continued development of colorectal risk stratified pathway. Secure space and resource for risk stratified pathway and submit a plan for implementation.	Achieved	Achieved
Stereotactic radiotherapy services (SRS) dataset	Submission of agreed SRS dataset.	Achieved	Achieved

3.2.6. Acute CCG CQUIN milestones 2018/19

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

Scheme	Quarter 2 milestone	Quarter 1	Quarter 2
NHS staff health and wellbeing	Provide full update on initiatives outlined in Quarter 1 action plan and include feedback from any local surveys carried out.	Achieved	Achieved
Reducing the impact of serious infections (antimicrobial resistance and sepsis)	Perform audit to establish baseline performance. Specify trajectory for improvement over remaining quarters.	Achieved	Achieved
Preventing ill health by risky behaviours – alcohol and tobacco	Provide update on Royal Marsden performance against improvement targets specified in Quarter 1 submission.	Achieved	Achieved
Sustainability and transformation plan	Update on RM Partners programmes that The Royal Marsden is leading on. Design patient information for colorectal risk stratified pathway. Carry out initial patient experience survey to inform continued development of colorectal risk stratified pathway. Secure space and resource for risk stratified pathway and submit a plan for implementation.	Achieved	Achieved

3.2.7. Community Services CCG CQUIN milestones 2018/19

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

Scheme	Quarter 2 milestone	Quarter 1	Quarter 2
NHS staff health and wellbeing	Provide full update on initiatives outlined in Quarter 1 action plan and include feedback from any local surveys carried out.	Achieved	Achieved
Children with special educational needs and disabilities	<p>Agree quality framework for Education, Health and Care Plan (EHCP) reports which include specific, measurable, achievable and realistic outcomes.</p> <p>Design a review tool to assist with the writing and review of ECHP reports.</p> <p>Review 10 previously submitted EHCPs against quality criteria defined in framework and review tool to establish baseline performance.</p> <p>Write up results and agree improvement targets.</p> <p>Undertake local training to enshrine new standards and update relevant policies, procedures and templates as required.</p> <p>Introduce quality assurance tool into everyday practice.</p>	Achieved	Achieved
Oral medications administration	<p>Set up project group and identify eligible patient cohort.</p> <p>Set out action plan, including baseline key performance indicators.</p>	Achieved	Achieved

3.2.8. Commissioner confirmation of achievement 2018/19

Sutton CCG has confirmed 100% achievement for Quarter One for the Community and Acute CCG CQUINS. The Trust awaits final confirmation on Quarter One from NHS England for the NHS England CQUINS.

The Trust submitted its Quarter Two CQUIN reports on 31 October 2018. Sutton CCG have confirmed 100% achievement for the acute CQUINS. The Trust awaits confirmation from Sutton CCG for the community CQUINS and from NHS England for the NHS England CQUINS.

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 chair 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 discussed with the Head of Pastoral Care and Psychological Support the psychosocial support that patients and their families receive. The service is receiving increasing referrals for support.
- 4.1.3. Members heard from Teenage Cancer Trust Lead Nurse (Teenage and Young Adults) how the Teenage and Young Adults Unit is getting its patients involved in developing its services.
- 4.1.4. Members of PCAG took part in the annual Patient-Led Assessment of the Care Environment earlier this year. The nationally ratified results were presented to the group's meeting in July. Members heard how all areas of the assessment including catering, cleanliness and privacy/dignity/wellbeing scored higher than the national averages. Dementia and disability provision was shown to have significantly improved since the previous year.
- 4.1.5. Waiting times to receive chemotherapy and prescriptions were explored with the pharmacy team.
- 4.1.6. Two members of PCAG reported to the group about the improvements being made to the rooms where family members view deceased relatives. The two members had recommended a number of suggestions that have been adopted by the Trust.
- 4.1.7. Members continued to represent the group on Trust committees and project groups including the Consent Steering Group, Integrated Governance and Risk Management Committee and on a working group developing a patient-facing pressure-ulcer record.

4.2. Friends and Family Test

- 4.2.1. The Friends and Family Test asks all patients the question
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?
- 4.2.2. The test is for providers of NHS funded acute services for inpatients including independent sector organisations and for outpatients, community services, dental, ambulance, accident and emergency, maternity, mental health and general practices.
- 4.2.3. At The Royal Marsden patients being discharged from wards or leaving outpatient areas are given a questionnaire that can be completed anonymously and left in a box on the ward or outpatient area.

- 4.2.4. In Quarter Two the Friends and Family Test showed that
- 97% 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.)
 - 93% of Royal Marsden community clients who responded would recommend the Trust. (Of NHS community clients in England 96% of respondents would recommend their provider.)

The data is calculated from files at the webpage www.england.nhs.uk/fft/friends-and-family-test-data Friends and Family Test data on NHS England's website (webpage retrieved 6 December 2018).

- 4.2.5. 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.
- 4.2.6. The results are examined and reviewed by the Royal Marsden's Patient Experience and Quality Account Group (chaired jointly by the Deputy Chief Nurse and a Royal Marsden governor). The group has a membership of Royal Marsden governors, Healthwatch representatives, representatives of the Royal Marsden's Patient and Carer Advisory Group, and representatives of the Royal Marsden's clinical staff.
- 4.2.7. The feedback can be attributed to an individual ward or department. Ward sisters and matrons review the data at least once a month. The data 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.

4.2.8. Patients' comments on areas where improvement could be made

Inpatients

It took a little while to establish timings of visits which were most convenient for the feeding regimen and bedtime but it is well managed now.

Outpatients

I felt that some things are not as good as they used to be. There are often problems with blood tests and not all results are with the doctor in clinic. There is now no continuity with the doctors and you always seem to see a different one each time. Originally I always saw the consultant when I attended the clinic. If not every time always every other time. Now you hardly see one.

Community Services

I felt very uncomfortable that the door to them room was left open during consultation and being next to the waiting area I was informed ... that every word and question could be heard by the whole patient waiting area. I had no problem the door to outside being open but felt the consulting room door should have been closed.

4.2.9. Some positive comments from patients

Inpatients

Everyone on the ward was caring and understanding. Everyone was friendly and treated me with dignity and respect at all times. There was great teamwork and a generally happy atmosphere. My medication was given on to me and everything explained to me carefully.

Outpatients

The nurses and doctors are very kind and understandable. Nothing could be better because it's already brilliant!

Community Services

The care was first class. I am really glad I came ... the help was great. Also happy with transport, grateful for this.

4.3. Patient Information Service

4.3.1. Activity for the quarter:

Type	New title/ new edition	Revision	Total
Booklets	1	4	5
Factsheets	4	19	23
Leaflets	1	25	26
Total	6	48	54

- 4.3.2. Leaflets reviewed and updated this quarter include *MRI scan* and *Young adult psychological support*.
- 4.3.3. Booklets reviewed and updated this quarter include *Clinical trials* and *Coping with persistent pain*.
- 4.3.4. New factsheets produced this quarter include *Having a skin biopsy* and *Cryotherapy*.

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	19	3	22
Asian Indian	105	26	131
Asian Pakistani	27	11	38
Asian (other)	76	22	98
Black African	99	8	107
Black Caribbean	76	3	79
Black (other)	10	2	12
Chinese	29	17	46
Mixed White and Asian	8	0	8
Mixed White and Black African	5	4	9
Mixed White and Black Caribbean	13	0	13
Mixed (other)	26	8	34
White British	2,161	415	2,576
White Irish	69	11	80
White (other)	361	88	449
Other	177	175	352
Not disclosed	84	73	157
Total	3,345	866	4,211
Ethnic origin information completed*	3,261	793	4,054
Ethnic origin information completed (%)*	97.5%	91.6%	96.3%

* All values except *Not disclosed*.

5. Personalised care, treatment and consent

5.1. Operating theatres and endoscopy

- 5.1.1. The Endoscopy Suite has completed another year of accreditation by the Royal College of Physicians' Joint Advisory Group on gastrointestinal endoscopy (JAG) in August. The team works with clinicians and patients to ensure that high standard of service is delivered that conforms to British Society of Gastroenterology (BSG) standards.
- 5.1.2. Monthly Friends and Family Test scores for the Endoscopy Service were above 95% in Quarter Two, demonstrating the quality of care given to patients and their families.
- 5.1.3. Two overseas nurses joined the Endoscopy Team in August 2018. They have completed their induction and passed the Objective Structure Clinical Examination (OSCE) with full registration status, and are now active team members.
- 5.1.4. Ten overseas nurses have successfully been recruited into the Theatres/Endoscopy team since May 2018. Nine practitioners have successfully obtained their professional registration following their OSCE. The results from OSCE reflect the professional talent from the recruited nurses and support from the Trust's Education Team.
- 5.1.5. The Theatres Team works closely with the Procurement Team to review quality in equipment replacement and cost efficiency procurement. This provides the service with good quality indicators to meet with the high level of financial demand while delivering quality safe care to patients at The Royal Marsden.
- 5.1.6. The Theatres Team worked with the wider clinical areas in monitoring patient safety with a six-monthly Local Safety Standards for Invasive Procedures (LocSIPPs) report submitted to the Trust's Integrated Governance and Risk Management Committee.
- 5.1.7. Security work in both Sutton and Chelsea Theatres has been completed and includes the installation of closed-circuit television (CCTV) as part of the surveillance monitoring, and implementation of restricted access into the critical areas.

5.2. Symptom control and palliative care

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

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

Initial data has revealed an unmet need relating to psychological distress. This has informed the development of health and wellbeing events which have been received well.

5.2.2. Hospital support

The Symptom Control and Palliative Care Team is now over 18 months into a pilot scheme for Lung Unit outpatients to support early advanced care planning and timely referral to specialist palliative care using defined triggers. The project expanded to the Upper Gastrointestinal Unit in January and is supported by RM Partners, a cancer alliance across north west and south west London (part of the national cancer vanguard). Its aims are to improve integration between oncology and palliative care, to increase early referral to palliative care, and to increase the use of urgent care planning in patients with lung cancer who attend the outpatient department. These aims will be achieved by the introduction of a new triggers tool together with validated symptom assessment.

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

The Darzi Fellowship Project to support the Triggers project has been successfully recruited to and is due to start at the beginning of October 2018.

Mixed methods Triggers research, validation of Trigger tool and assessment of patient and staff experience of Integrated Palliative Care Service based on the Triggers tool has now received approval by the Committee for Clinical Research and is awaiting final ethics approval.

5.2.3. Education and mandatory training

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

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

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

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

5.2.4. Strategic developments

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

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

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

5.2.5. Supportive Care Home Team

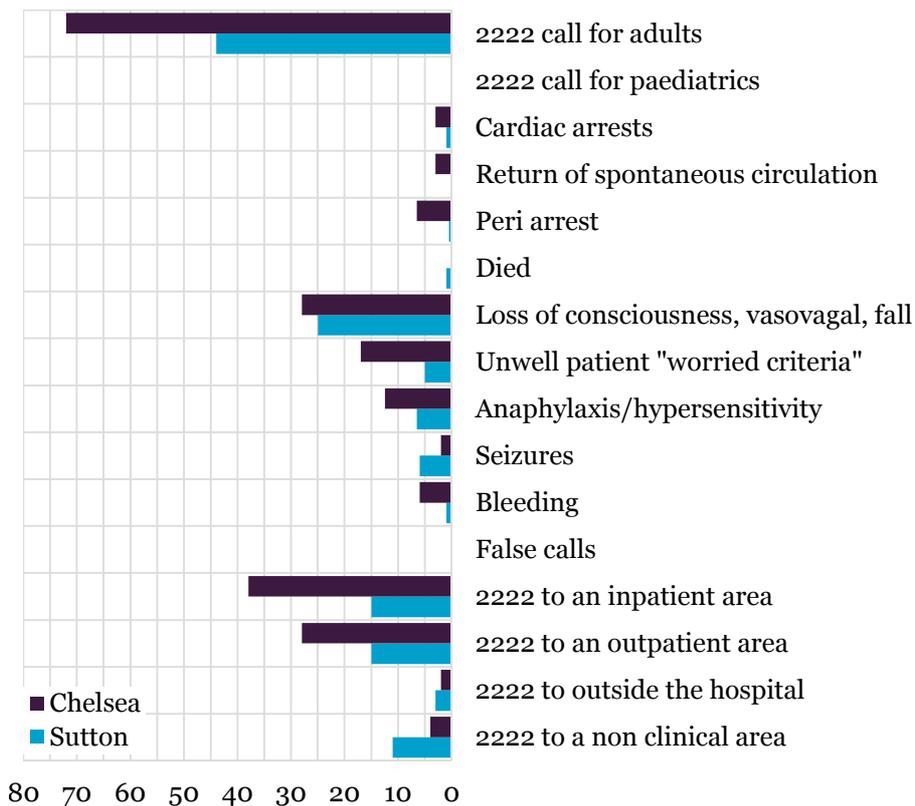
The Supportive Care Home Team delivers end of life care education, training and clinical support to all residential homes and nursing homes in Sutton.

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

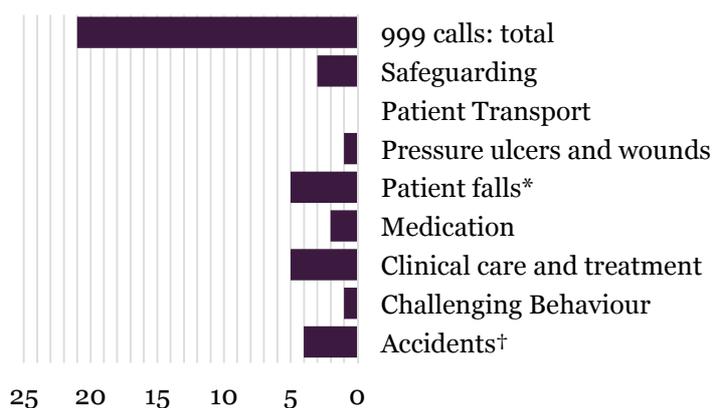
5.3. Resuscitation

This section covers Quarters One and Two 2018 (April to September 2018).

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



5.3.2. 999 calls – Community Services



* Patient falls including trips and slips.

† Accidents including body fluid exposure and needlestick.

5.3.3. Analysis

Chelsea

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

There were 72 adult emergency response 2222 calls, which included seven peri-arrest calls for deteriorating patients, 28 for loss of consciousness, vasovagal and falls, 17 for unwell patients or “worried criteria”, thirteen for anaphylaxis and hypersensitivity and two for seizures.

Thirty-eight of the calls were for inpatient areas, 28 were in outpatient areas, four were in non-clinical areas, and two were outside the hospital building.

Three calls were actual cardiac arrests: all three patients had return of spontaneous circulation.

There were no false calls.

Sutton

The patients involved were mostly medical.

There were 44 emergency response 2222 calls, of which none was for paediatrics. These included one peri-arrest call, 25 for loss of consciousness, vasovagal and falls, five for unwell patients or “worried criteria” and seven for anaphylaxis and hypersensitivity.

Fifteen of the calls were for inpatient areas, 15 were in outpatient areas, 11 were in a non-clinical area, and three were outside the hospital building.

One call was for an actual cardiac arrest; the patient died.

There were no false calls.

Community Services

Twenty-one 999 calls were made in the six-month period.

The most frequent reasons for 999 ambulance calls were for clinical care and treatment of which there were five and five falls. There were two accidents recorded, and two medication incidents.

There were three safeguarding incidents and one challenging behaviour reported. There was only one grade 1 pressure sore incident in which the patient was admitted back to hospital.

5.3.4. Training

The overall Trust compliance rates for *Adult* and *Paediatric basic life support* have decreased from 86% in the previous quarter to 84%. The Resuscitation Team are working closely with the Learning and Development Team to analyse and establish the most appropriate way to deliver this training in 2019 to ensure more staff are captured and increase compliance further. This may involve new ways of delivering the training.

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

The Resuscitation Team has successfully run a two-day Advanced Life Support Course in Quarter two. Half of the delegates on the course were staff from The Royal Marsden. A joint European Paediatric Advanced life support (EPALS) course with the Royal Brompton Hospital has been planned for quarter three.

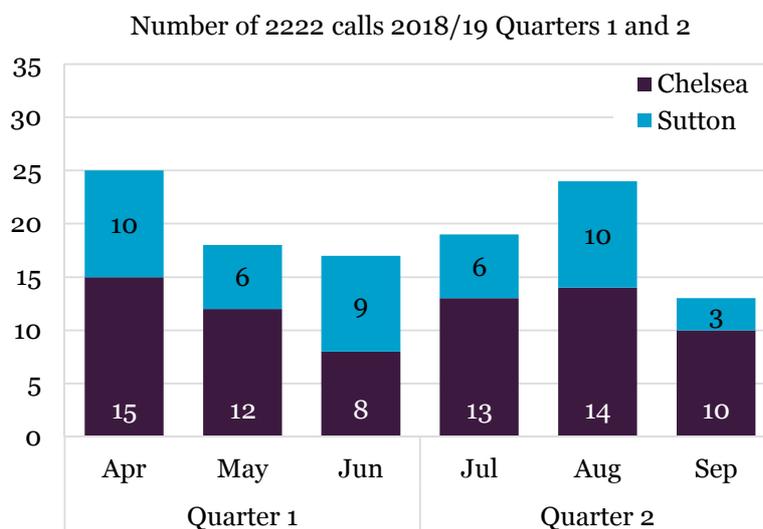
The Resuscitation Team continues to run two Immediate Life Support (ILS) courses and one Paediatric Life Support Course each month.

A new Resuscitation Officer joined the team in Quarter two working 11.5 hours a week.

5.3.5. 2222 calls 2018 – Chelsea compared to Sutton

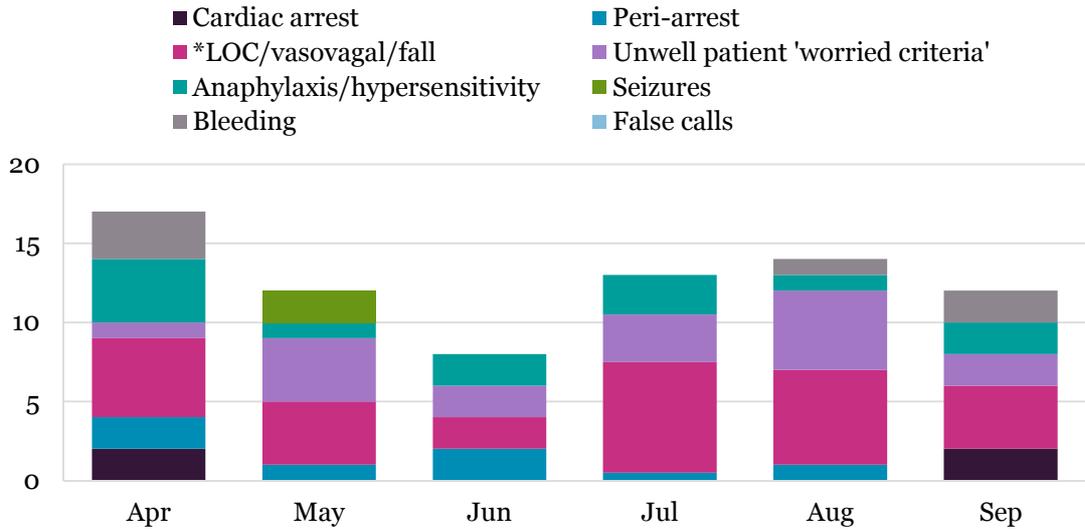
2222 calls, Chelsea: 72

2222 calls, Sutton: 44



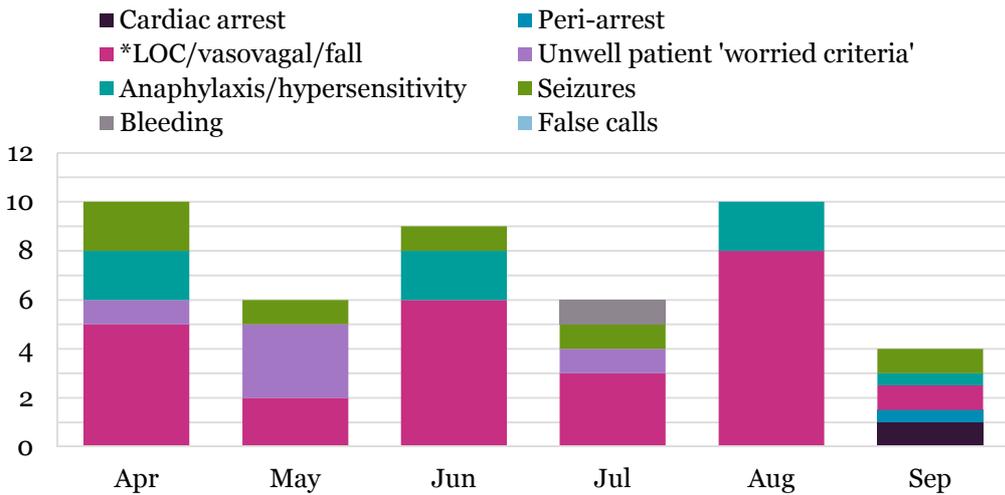
5.3.6. 2222 calls 2018 – by type of resuscitation call

Chelsea 2222 calls 2018/19 Quarters 1 and 2



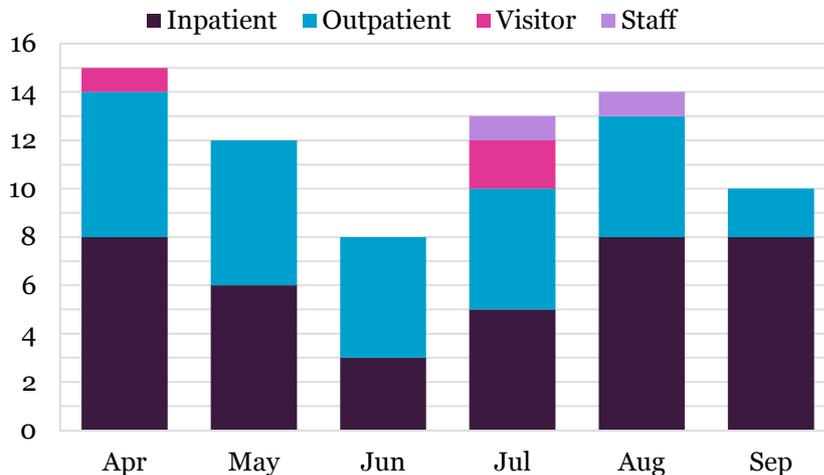
* LOC: loss of consciousness

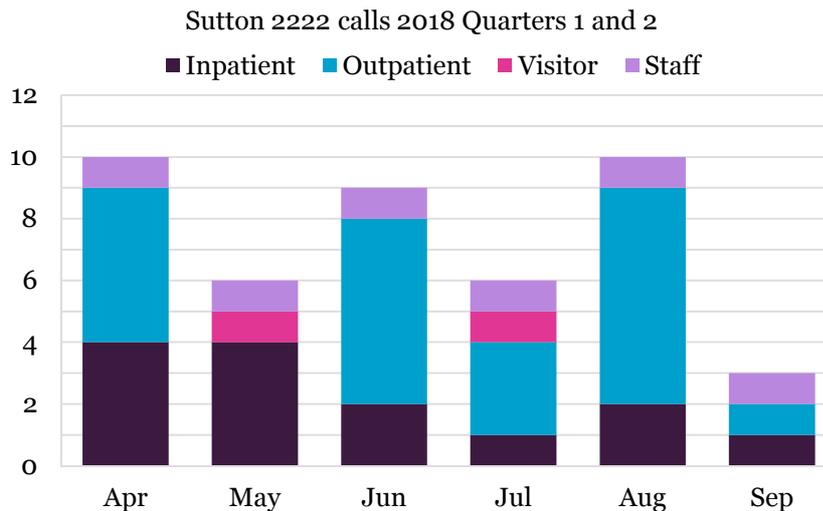
Sutton 2222 calls 2018/19 Quarters 1 and 2



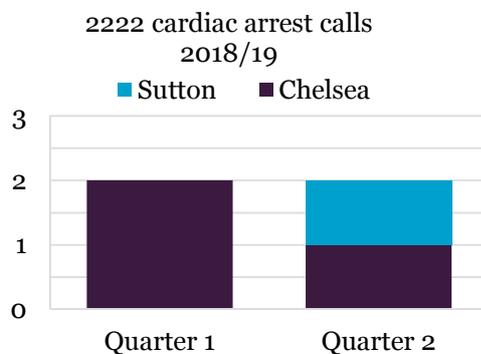
5.3.7. 2222 calls 2018 – by patient group

Chelsea 2222 calls 2018 Quarters 1 and 2





5.3.8. 2222 calls 2017/18 – cardiac arrest



Chelsea

Total four calls for cardiac arrest:

- three were inpatients; 2 were in CCU and one in Endoscopy
- All three had return of spontaneous circulation (ROSC)
- Two died.

Sutton

Total one call for cardiac arrest:

- one inpatient on TCT
- Died

5.4. Paediatric and Teenage Psychological Support Service

- 5.4.1. Patients and their families are supported in coping emotionally with their care, treatment or condition by their clinical team and the Psychological Support Service, which includes the Paediatric and Teenage Psychological Support Service.
- 5.4.2. The service regularly assesses the needs of children, young people, parents and staff to create and plan services and research accordingly.
- 5.4.3. The service received 162 new referrals and provided 1020 therapeutic sessions in the first and second quarters combined.

5.4.4. In addition to the individual (one-to-one) supervision the service provides couple and family work, group work, clinical supervision, and staff support groups (for staff in the Paediatric Unit, the Teenage Cancer Trust Unit and the Family Nursing Partnership in Community Services), some of which are run jointly with members of the staff support team.

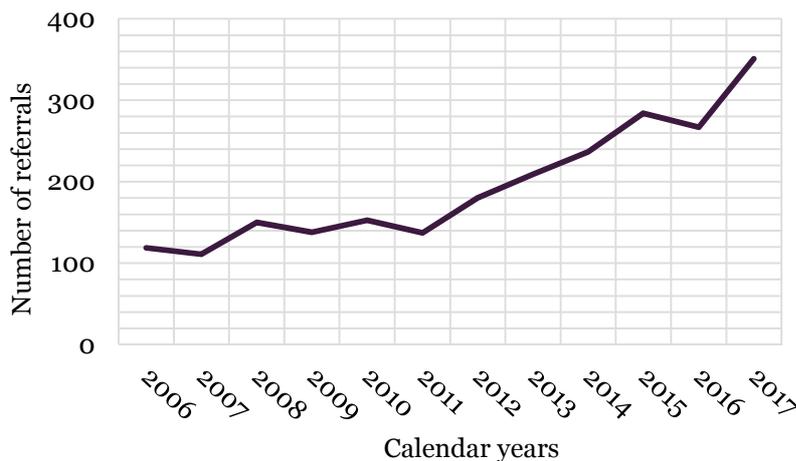
Quarter 1 and 2 2018/19 combined

Clinical supervision groups	21
Staff support groups	15
One-to-one supervision	103
Debriefs/complex case discussion	4

5.4.5. Referrals

The service continues to increase in terms of numbers of referrals, both for patients, family members and staff supervision and support. Innovative ways of addressing the increases are being considered, whilst acknowledging this reflects increase in mental health problems in children and young people nationally, alongside local mental health services constricting their acceptance criteria.

The chart shows the number of referrals for each calendar year.



5.4.6. Patient groups

For each of the last six years a confidential, closed group for bereaved parents has been set up, and, as planned, the groups from previous years now meet independently as parent-run support groups. The current closed bereavement group started Spring 2018 and is ongoing with excellent attendance and participation. There continues to be a large number of parents wanting to take part and given the large numbers consideration may be given next year if two concurrent groups, or groups with different focus may be offered..

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

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

A joint multidisciplinary alongside dieticians, physiotherapy, occupational therapy, ward and play teams initiative is being planned to involve motivating patients to become more active and get out of beds, is currently in the planning stage

5.4.7. Training/teaching

The Paediatric and Teenage Psychological Support Service is planning to put on again jointly with the paediatric and Teenage Neuro Clinical Nurse Specialist in information and education day for school teachers of our patients and this will be planned to run this as an annual event with separate days for primary and secondary schools

The neurocognitive late effects training will also be extended to train educational psychologists and SENCO (special needs co-ordinators) and is being planned for later this year.

5.4.8. Research/service implementation

Research initiatives include the development of a short paediatric neuropsychological pathway to ensure all newly diagnosed paediatric and teenage patients with brain tumours are offered neurocognitive testing as part of their treatment pathway. Charity funding was obtained to ensure continued funding for the project and implementation of regular neurocognitive testing at regular intervals for at least the next two years which is ongoing and has been assessed through a service evaluation project with very positive results from both patient parent and school points of view.

The research project investigating the development and validation of a paediatric and teenage distress and learning and memory thermometer (part of holistic needs assessment) is now been validated and a paper is in preparation for submission for publication in a peer reviewed journal. Operational guidelines about how to use the holistic needs thermometer have been rolled out and implementation commenced in June 2018, this is still early days as administration will become an integral part of the patient pathway.

The novel multidisciplinary team approach to paediatric and teenage chronic persistent pain (CHAMP) service continues weekly and is being evaluated through robust use of outcome measures through a research project. Multidisciplinary input including psychology, physiotherapy, massage, and nursing and medical input is co-ordinated and provided both on an individual, family and group approach in a weekly clinic. A planned patient education day is in development to be run as a rolling programme.

Consideration is being given to piloting the new stress burnout and resilience tools within the paediatric oncology staff, to monitor wellbeing and stress levels, the timing of which is to be determined.

A closed joint youth group for girls and young women offering peer support, body image and coping strategies has been reported to have been very successful. This is being evaluated and the next group is being planned.

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

- how to parent effectively
- what behaviours to expect
- impact on siblings
- impact on parents
- night-time problems
- specific cognitive late effects and compensatory strategies.

6. Eating and drinking

6.1. Nutrition and catering patient surveys

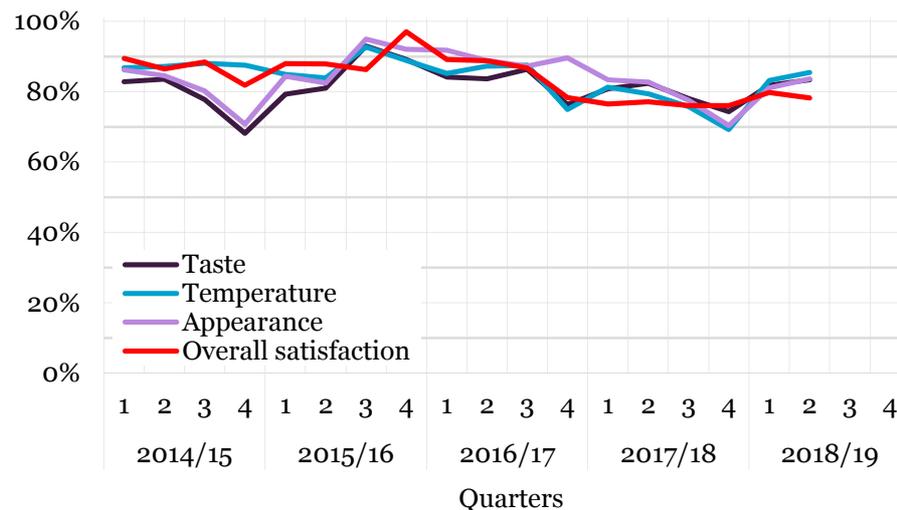
Patient surveys are undertaken at the Chelsea and Sutton sites. The patients' comments are regularly reviewed and particular points are actioned.

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? (66 responses this quarter)
- How would you rate the temperature of the food? (62 responses this quarter)
- How would you rate the appearance of the meals? (61 responses this quarter)
- How would you rate your overall satisfaction with the catering service? (55 responses this quarter).

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

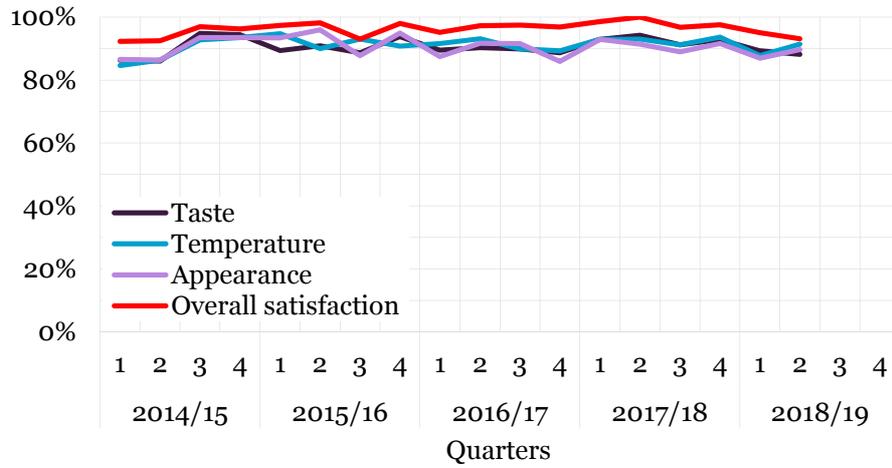


6.1.2. Patient survey results – Sutton

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? (84 responses this quarter)
- How would you rate the temperature of the food? (94 responses this quarter)
- How would you rate the appearance of the meals? (84 responses this quarter)
- How would you rate your overall satisfaction with the catering service? (84 responses this quarter).

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



7. Safeguarding and safety

7.1. Safeguarding adults activity

Safeguarding adults at risk from abuse is everyone's responsibility. Safeguarding requires commitment from within the organisation and partnerships to ensure that there are safeguards against harm, abuse, neglect and poor practice. During Quarter Two, 31 formal safeguarding adults concerns were raised across the Trust, this is a reduction from 37 safeguarding adults concerns raised in Quarter One.

Number of concerns raised Chelsea and Sutton	Quarter 1 2018/19	Quarter 2 2018/19
Number of referrals to local authority	13	5

In Quarter Two there were 5 safeguarding concerns raised from the Trust's Chelsea and Sutton sites. This is a decrease from Quarter One when 13 concerns were raised, however there has been an increase in the number of enquiries for advice relating to safeguarding adults concerns from acute care staff over this quarter. Safeguarding adult's surgeries continued during this quarter within acute services, to provide an opportunity for staff to discuss complex safeguarding cases and to seek advice and support from the safeguarding adult's team.

Number of concerns raised Community Services	Quarter 1 2018/19	Quarter 2 2018/19
Number of referrals to local authority	24	26

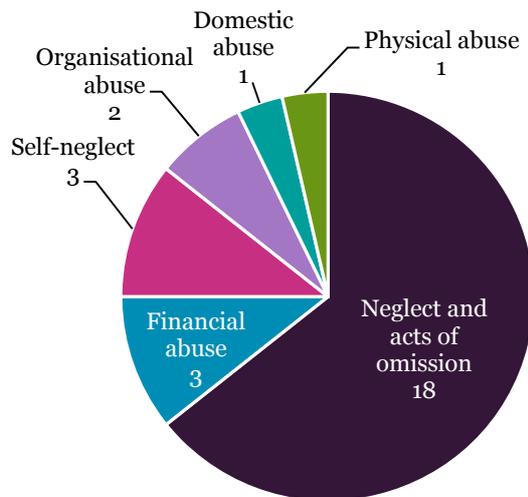
In Quarter Two there were 26 safeguarding adults concerns raised by Community Services, an increase on Quarter One where 24 concerns were raised. Safeguarding adult's surgeries also continued during this quarter within community services, again providing staff with an opportunity to discuss complex safeguarding cases and seek advice and support from the safeguarding adult's team.

7.1.1. Categories of abuse

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

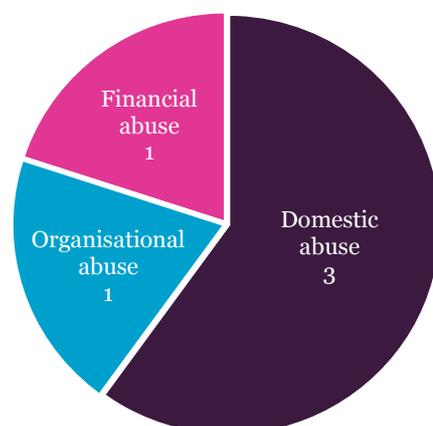
Community Services

In Community Services, neglect and acts of omission continues to be the highest reported category of abuse and this is consistent from previous quarters. In response to this, the Trust continues to work with local partners in Sutton around recognising and supporting improvements in the quality of care in local care homes (both residential and nursing) as well as by commissioned care agencies. Financial abuse, self-neglect and organisational abuse are the other 3 highest categories of abuse recognised and reported in the last quarter.



Hospital-based sites (Chelsea and Sutton)

Within the hospital-based sites, domestic abuse continues to be the highest reported category of abuse in Quarter Two, which is consistent with previous quarters. In response to this, the Trust is an active member of the Sutton Domestic Violence Transformation board and Health partners network, which has an aim to develop robust policies and practice, pathways and training for staff across the health sector around responding to disclosures of domestic abuse.



7.1.2. **Mental Capacity Act and Deprivation of Liberty Safeguards**

In Quarter Two, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training has continued to be delivered as a part of the hospital nurses' mandatory training for 2018 and the Community Services induction programme. It is also included within Level 2 safeguarding adult's mandatory training. Three-hour bespoke sessions have also been delivered for appropriate staff during this quarter in Community Services.

DoLS applications are made when the team caring for the patient (over 18 years of age) consider the patient lacks the capacity to consent to care and treatment and meet the acid test (i.e. is not free to leave and is subject to constant supervision). During Quarter Two, nine urgent applications were made for DoLS and 1 standard authorisation request from Cedar Lodge (Community Services). This is a slight increase from Quarter One 2018/19 when nine requests were made.

	Quarter 1 2018/19	Quarter 2 2018/19
Urgent DoLS applications	7	9
Standard authorisation requests	2	1
Total	9	10

7.1.3. **Prevent**

All NHS staff that are in contact with patients and the public are required to have basic Prevent awareness training. The aim of *Prevent* (as a part of CONTEST – the 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 and engages with local safeguarding adult's boards and *Prevent* networks as well as having links with the local Channel panel, which discusses and monitors referrals. There have been no referrals made to Channel during this period by the Trust. Awareness training is provided in two levels: basic awareness and the Workshop to Raise Awareness of *Prevent* (WRAP) and the compliance target of 85% has been maintained.

Prevent training Quarter Two	Percentage compliance
Basic awareness	91.94%
Workshop to raise awareness of <i>Prevent</i> (WRAP)	88.1%

7.1.4. **Dementia and learning disabilities**

The Trust's Dementia Champions and Learning Disabilities Buddies networks continue 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 through the Learning Disability Buddy network and Dementia Champions network and training. During this quarter, activity boxes have been developed for patients by our dementia buddies and are available for patients who are admitted on both our Chelsea and Sutton sites.

The Trust facilitates training staff for dementia through Tier 1 and 2 training as well as through bespoke dementia friend's sessions. Sessions are one-off for staff and offered as a part of induction (Tier 1) for clinical staff or professional development (Tier 2).

Dementia training	Number of staff completed to date
Tier 1	1135
Tier 2	35

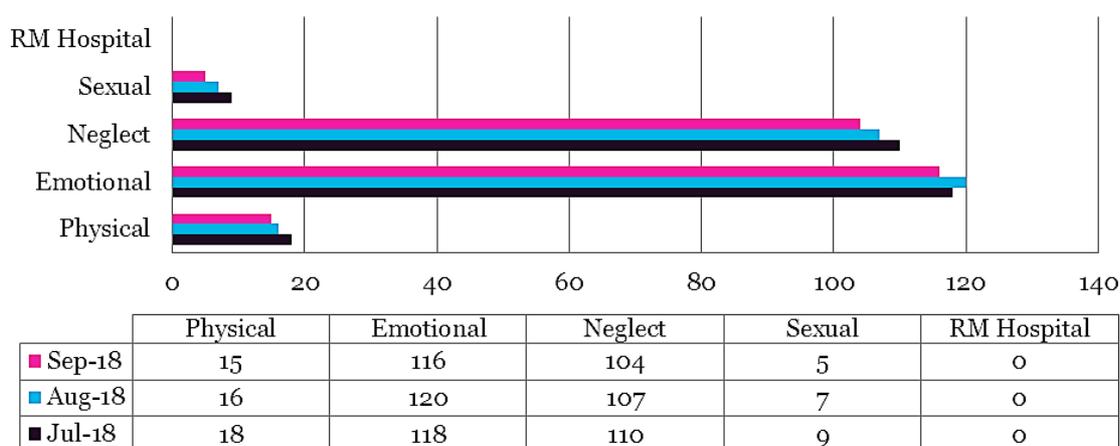
7.1.5. New investments and key achievements

- Safeguarding adults surgeries continued across the Trust.
- Continued to engage and be an active member of the Sutton Safeguarding Adults Board and Bi-Borough Safeguarding Adults Executive Board and relevant subgroups.
- Completed a Safeguarding adults record keeping audit as a part of the annual audit plan.
- Achieved above national average for dementia in the Patient-led assessment of the care environment (PLACE).
- Improvements in staff understanding of their roles and responsibilities under the Mental Capacity Act 2005 were recognised in the Care Quality Commission (CQC) inspection of The Royal Marsden, with an overall Trust rating of *outstanding*.

7.2. Protection and identification of vulnerable children and young adults

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

Child Protection Plans Q2 (Community Services)



The number of children subject to a Child Protection Plan has decreased by 14% between Quarter One and Quarter Two. There has been a 23% decrease in children being made subject to a plan under the category of physical abuse, a 16% decrease for emotional abuse, a 36% decrease for sexual abuse and a 10% increase for children subject to a plan under the category of neglect.

7.2.1. Hospitals

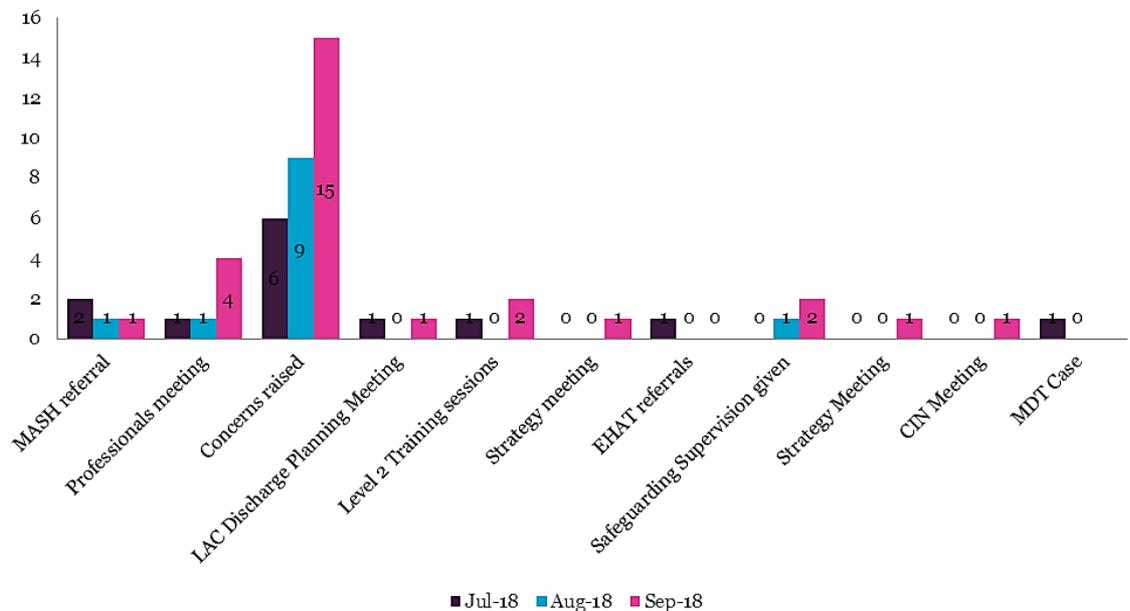
Safeguarding activity has remained consistent between Q1 and Quarter Two with staff regularly raising safeguarding concerns. However, safeguarding concerns being raised by staff in Quarter Two between July to September increased by 60%.

The Trust is currently providing care to one child subject to a Child Protection plan and the specialist Safeguarding Nurse is representing the Trust at case conferences and core group meetings. This child (and siblings) have been accommodated as a Looked after Child with a Section 20 agreement and identifying a foster placement that could support the child’s medical needs has proved challenging. A number of staff have been involved in assessing the identified foster carer’s competency to provide aspects of care to ensure she is competent enough to supervise the care provided by the child’s mother. The Trust is also providing care to a child subject to a Child in Need (CIN) plan and the Specialist Safeguarding nurse attends CIN meetings on behalf of the Trust to liaise information to the relevant nursing teams.

In Quarter Two safeguarding concerns were considered relating to two children requiring palliative care. These cases were extremely complex and required legal advice to be sought from the Trust on a number of occasions and notifying the Chief Nurse of the circumstances. This is reflected in the number of professionals meetings convened in Quarter Two. The Named Nurse for Safeguarding Children and Young People implemented a case escalation to an external local authority in an attempt to support case management in one case.

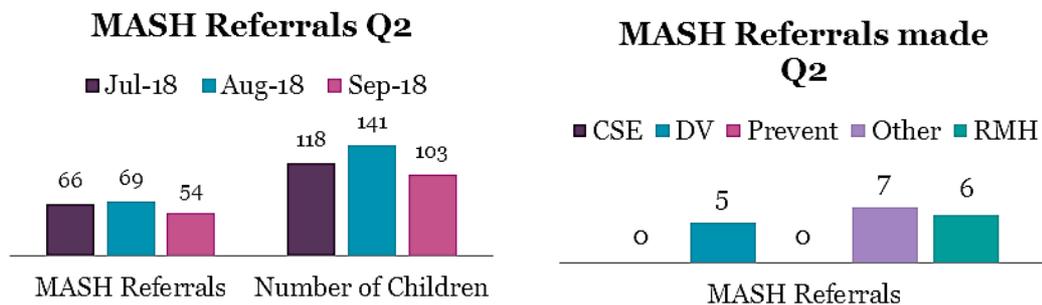
In Quarter Two the safeguarding service has established an offer of individual safeguarding supervision to staff who feel this may be beneficial. Three staff (clinical nurse specialist's) have sought this in Quarter Two and there is a draft proposal in place to offer all staff working with children an opportunity to attend monthly safeguarding case based discussion and learning events.

The safeguarding service provided Level 2 training to all new staff members joining the Children's Unit to facilitate a prompt induction. The service has also established a monthly meeting with the Sister for the Children's Daycare Unit to ensure the unit is regularly updated about any children attending daycare for whom there may be current or ongoing safeguarding concerns.



7.2.2. MASH

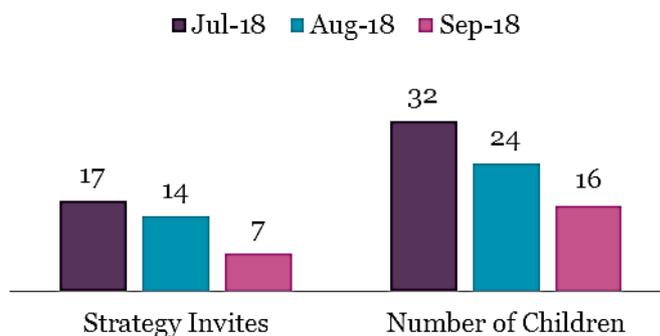
The Multi-Agency Safeguarding Hub (MASH) seeks to enable the sharing of information so risks to children can be identified at an early stage and is the ‘front door’ for all referrals with concerns for a child’s welfare. It is a link between universal services such as schools and general practice, community services and statutory services such as police and social care. The number of MASH information sharing requests to the Health Navigator by the local authority has decreased by 17% between Quarter One and Quarter Two. This will require monitoring and partnership scrutiny but may be attributable to the increased activity directing children and families to early help services. The number of referrals made to MASH by staff in community services has decreased by 45% between Quarter One and Quarter Two.



7.2.3. Strategy Meetings

Strategy meetings are multi agency meetings used to share available information to agree what action is required to safeguard and promote the welfare of a child. The safeguarding team attends all strategy meetings on behalf of the trust. The number of Strategy meeting invites has decreased by 12% between Quarter One and Quarter Two but it is worth noting there was a 40% decrease in invitations received between Quarter Four and Quarter One. The Named Nurse has raised this as a concern at the Local Safeguarding Children’s Board Quality and Assurance sub group and Assistant Director for children’s services. The Police Child Abuse Investigation Team have been unable to provide representation to the meetings for the month of September which has resulted in meetings not being quorate and may partially explain the decrease that has been noted.

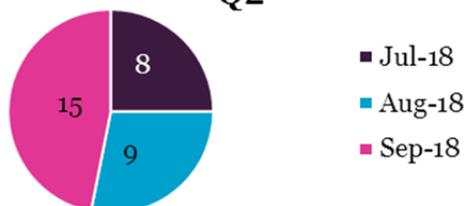
Strategy Invites Q2



7.2.4. Deliberate Self Harm (DSH)

The London Borough of Sutton has reviewed the frequency of these meeting which have been extended from fortnightly to every three weeks. These are partnership meetings to scrutinise the assessment and care pathway of all young people identified as at risk of self-harm/suicide. The data shows a 50% increase in identified cases of self-harm between Quarter One and Quarter Two. However, this is likely to be attributable to the cancellation of some meetings in Quarter One as the new Specialist Practitioner Lead for the London Borough of Sutton reviewed the current processes.

Deliberate Self Harm (DSH) Q2

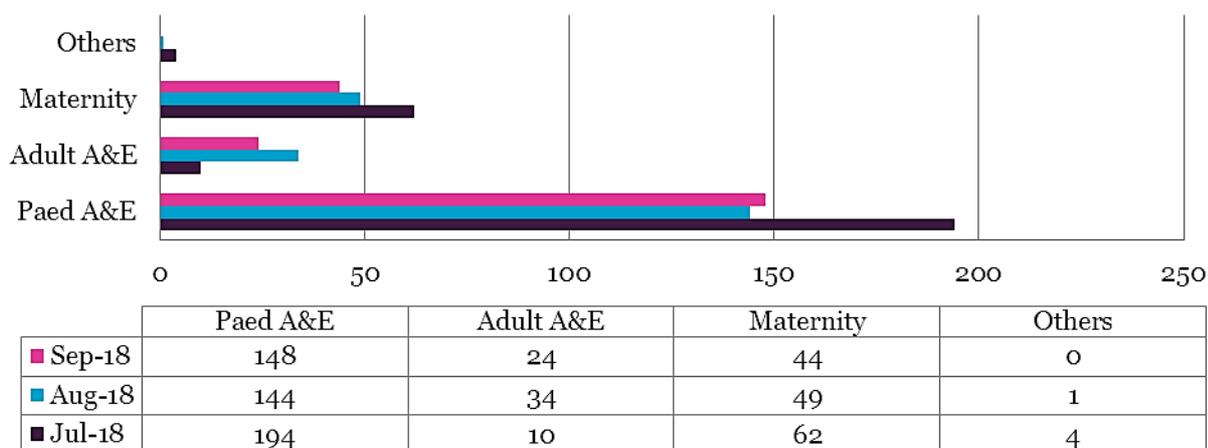


7.2.5. Community Liaison

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

Quarter Two has seen a 12% increase in children and young people attending the accident and emergency departments. Attendance for adults has seen an 8% decrease in attendance.

Safeguarding Liaison Q2



7.3. Pressure ulcers

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

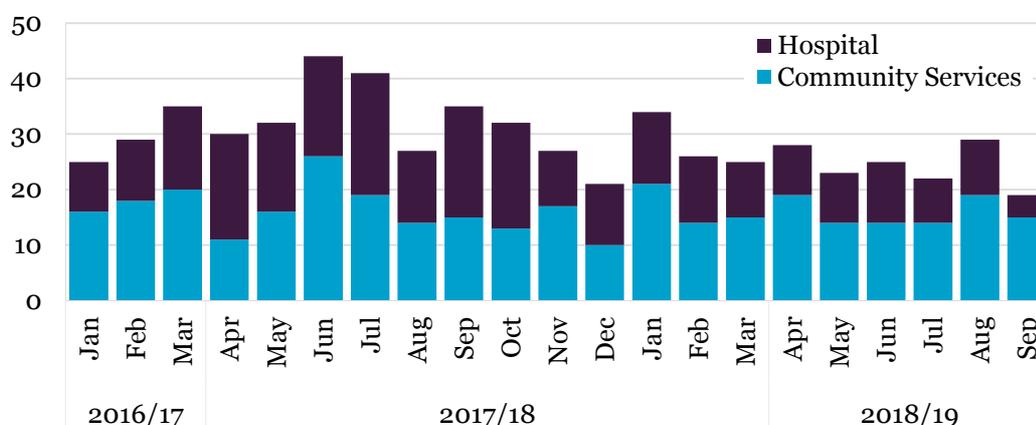
Category	Description
1	Non blanching redness of intact skin
2	Partial thickness skin loss or blister
3	Full thickness skin loss
4	Full thickness tissue loss
Unstageable	Depth unknown
Suspected deep tissue injury	Depth unknown

7.3.2. In Quarter Two, no patients developed a category 4 attributable pressure ulcer.

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

	July	August	September
Number of patients with pressure ulcers attributable to the Trust	23	29	26
Number of patients with pressure ulcers attributable to the hospital	9	10	11
Number of patients with pressure ulcers attributable to Community Services	14	19	15
Number of patients with attributable pressure ulcers Category 1	9	9	8
Number of patients with attributable pressure ulcers Category 2	10	11	15
Number of patients with attributable pressure ulcers Category 3	0	2	1
Number of patients with attributable pressure ulcers Category 4	0	0	0
Number of patients with attributable pressure ulcers Unstageable	3	5	0
Number of patients with attributable Suspected deep tissue injury	1	2	2

7.3.3. The chart shows the number of patients who developed pressure ulcers that are attributable to the Trust by month in all categories. April 2018/2019 data has been retrospectively updated.



8. Premises and equipment

8.1. Infection prevention and control

8.1.1. Mandatory surveillance

Indicator	Quarter 2 DCS* reportable	Quarter 2 attributable	YTD†	YTD attributable	Target	Variance from target	Forecast
MRSA‡ bacteriaemia	0	0	0	0	0	0	
<i>S. aureus</i> bacteriaemia	3	1	6	4	N/A	N/A	
<i>E. coli</i> bacteriaemia	20	9	38	21	N/A	N/A	
<i>Klebsiella sp</i> bacteriaemia	14	8	19	13	N/A	N/A	
<i>Pseudomonas aeruginosa</i> bacteriaemia	9	4	15	12	N/A	N/A	

	Quarter 2	Quarter 2 DCS attributable post 48 hours	YTD post 48 hours	CDT lapse in care YTD: total against target	Target	Variance from target	Forecast
<i>C. difficile</i> toxin	28	19	29	4	30	-29	

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

† YTD: year to date

‡ MRSA: meticillin-resistant *Staphylococcus aureus*

** N/A: not applicable

8.1.2. Healthcare-associated infections

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

	Chelsea	Sutton
MRSA bacteriaemia	0	0
MSSA bacteriaemia	0	2
<i>E. coli</i> bacteriaemia	7(2)	13(7)
<i>Klebsiella sp</i> bacteriaemia	9(5)	5(3)
<i>Pseudomonas aeruginosa</i> bacteriaemia	2(1)	7(3)
<i>Clostridium difficile</i> toxin detected (post 48 hour attributable)	13(11)	15(8)

8.1.3. Hand hygiene

The overall hand hygiene compliance score for the Trust in Quarter one is 96%. The Chelsea site compliance score is 94%, Sutton is 97% and Kingston 98%.

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



8.1.4. Mandatory surveillance

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

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

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

8.1.6. *Clostridium difficile* infection

All stool samples found to be *C. difficile* toxin (CDT) positive are reported to the HCAI DCS. Those cases which occur within 48 hours of admission are deemed to be community attributed. This is a change from the previous year which was cases within 72 hours. Cases which may have been preventable are deemed 'lapses in care' and recorded against *C. difficile* toxin objective target of 30. There was one lapse in Quarter One. There were three lapses of care in Quarter Two.

8.1.7. Carbapenemase-producing *Enterobacteriaceae* (CPE)

A number of patients continue to present with definite or probable CPE.

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

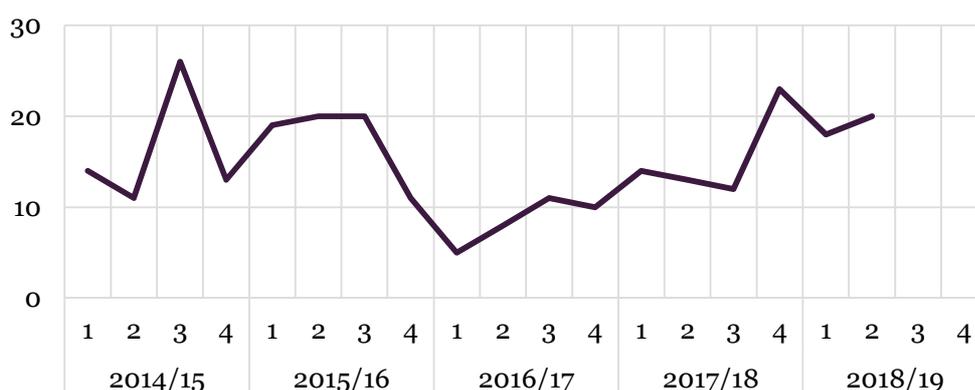
8.1.8. *Escherichia coli* bacteraemia

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

In Quarter Two there were 20 cases of *E.coli* bacteraemia.

All cases are subject to clinical review to determine likely cause. A major audit project is underway with The Christie NHS Foundation Trust and Clatterbridge Cancer Centre NHS Foundation Trust to evaluate the risk factors for *Escolar* in oncology patients.

The chart shows the number of *E.coli* infections for each quarter since 2014/15.



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

8.1.9. Flu

The 2018/19 flu campaign commenced in late September.

Peer vaccinators are playing a key role in vaccinating staff.

8.2. Sepsis

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

- 8.2.2. The leads are working on gap analysis to implement over 150 recommendations following National Institute for Health and Care Excellence (NICE) guideline 51 *Sepsis: recognition, diagnosis and early management* (published July 2016). An adult sepsis policy is due to be introduced incorporating NICE guidance, UK Sepsis Trust recommendations, NEWS 2 charts and an updated sepsis screening tool. Two senior nurses (with a combined 0.8 whole-time equivalent role) have been appointed to coordinate Trust efforts on sepsis and acute kidney injury.
- 8.2.3. The Sepsis Implementation Team meets regularly to promote awareness and early identification, escalation and management of sepsis and neutropenic sepsis.

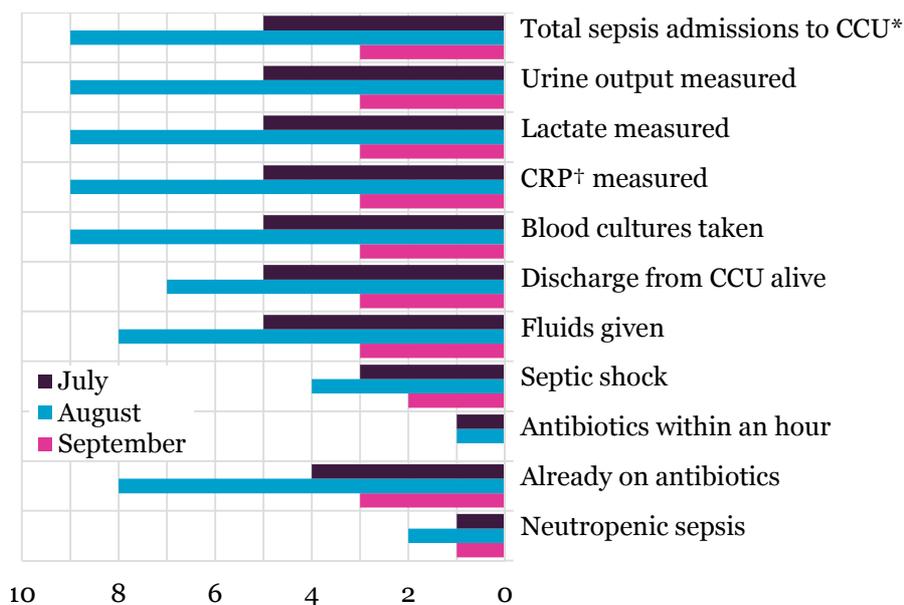
8.2.4. Data collection

The audit of all patients admitted to Critical Care Unit (CCU) with sepsis continued. Quarter two data shows strong compliance with the *Sepsis Six* bundle.

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

In addition to auditing CCU admissions, sepsis admissions to the Clinical Assessment Units are being monitored. A rollout of tools to screen for sepsis throughout all inpatient wards has begun as well as implementation of changes to the electronic record system to help utilise antimicrobials appropriately.

8.2.5. Sepsis admissions to CCU – July to September 2018



* CCU: Critical Care Unit
 † CRP: C-reactive protein

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 2 (NEWS 2 – an early predictor of deterioration) of 5 or above, or 3 in a single parameter with a suspected infection should be referred to CCU Outreach (24/7), a clinical site practitioner or an on-call junior doctor for immediate review. If sepsis is suspected it must be escalated to a senior clinician for immediate review.
- All patients referred to CCU Outreach teams continue to be assessed for signs of sepsis and the assessments are audited.
- All patients with neutropenic sepsis need a Multinational Association of Supportive Care in Cancer (MASCC) risk score to be recorded, and nurses need to complete a neutropenic sepsis audit which is sent to the Quality Assurance Team.
- The newly appointed sepsis/acute kidney injury nurses, CCU Outreach teams and the community practice education team continue to educate medical and nursing staff on implementation of the *Sepsis Six* bundle. Roadshows are conducted regularly at each Trust site. The NEWS 2 charts have been rolled out in the Trust in this quarter.
- The sepsis team are aiming to create a screensaver tool to highlight sepsis screening throughout the Trust.
- Work is underway to create Patient Group Directions (PGDs) that permit nursing staff to administer antibiotics rapidly in suspected cases of generalised sepsis. Such a PGD already exists for neutropenic sepsis.

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.*

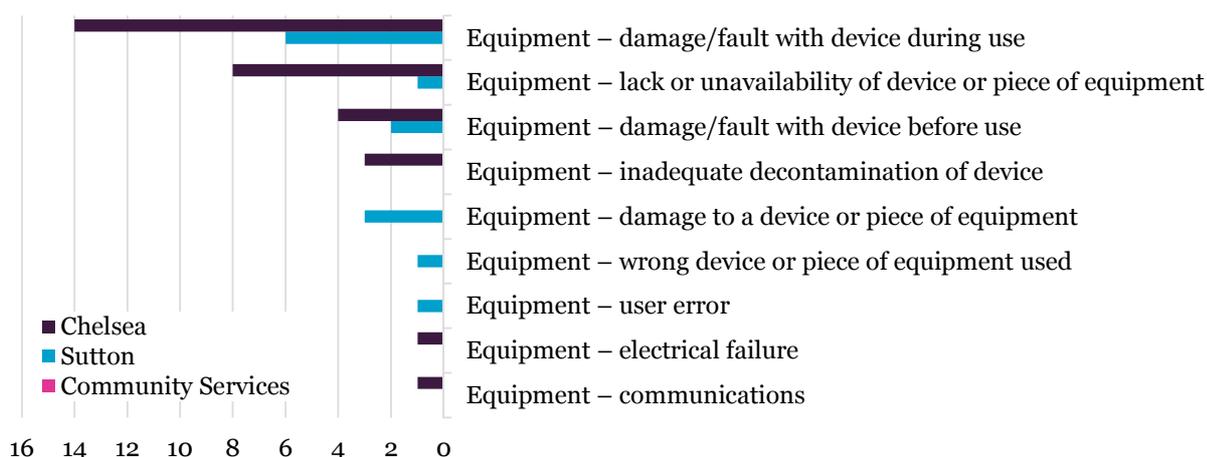
There were 45 patient safety incidents relating to medical devices reported this quarter (there were 57 in the previous quarter).

The main devices incidents included

- 17 involving various non-specified equipment
- 4 involving surgical equipment
- 4 involving therapy equipment
- 3 involving administration and giving sets
- 3 involving endoscopes.

No incidents were graded *moderate* or above. Sixteen were graded *low* and 29 *very low*.

8.3.2. Medical device incident category by site



8.3.3. Medical device incidents by category

There were 20 incidents relating to *Equipment – damage/fault with device during use* and six relating to *Equipment – damage/fault with device before use*.

The main devices included:

- 9 involving various non-specified devices
- 3 involving therapy equipment

8.3.4. Medical device incidents by type

Type of medical device	Total
Non-specified	17
Surgical instruments	4
Therapy Equipment	4
Administration and giving sets	3
Endoscopes	3
Computed tomography (CT)	2
Diathermy equipment and accessories	2
Intravenous therapy equipment (including needle, syringe, extension set)	2
Infusion pumps, syringe drivers	2
Dialysis equipment	1
Feeding tubes	1
Mattresses	1
Pathology equipment	1
Surgical power tools	1
Ultrasound equipment	1
Total	45*

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

8.3.5. Evaluation of new medical devices

The Medical Device Committee met twice this quarter and approved four proposals to evaluate or use new devices. Seven devices were approved for purchase (including approval to purchase following evaluations of devices from previous quarters).

Form A (low risk)	3
Form B (proposal to evaluate)	0
Form D (risk assessment - device not evaluated)	1
Approved for purchase	7
Total	11

8.4. Medicines optimisation

8.4.1. Medicines safety

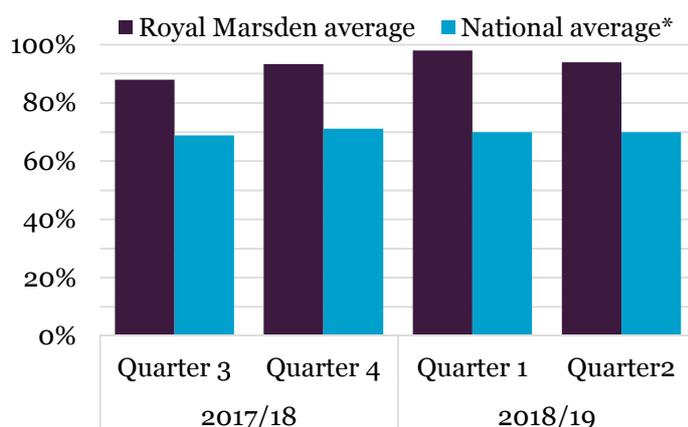
The Trust’s commitment to improve the safer use of medicines as part of the new *Harm free care* campaign continues to be the forefront of medicines governance.

8.4.2. Medication reconciliation

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

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

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

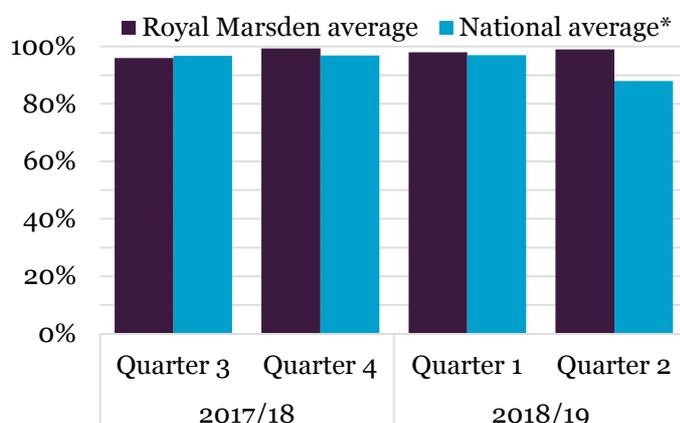


* National averages are calculated from the NHS Medication Safety Thermometer national dashboard.

8.4.3. Allergy documentation

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

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



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

8.4.4. Omission of critical medicines

In the second quarter 2018/19, there were 8 omissions in July, 14 omissions in Aug and 7 omissions in September. The majority of omissions were for valid clinical reasons, one patient refusal and one where the route was not available.

8.4.5. Electronic prescribing

The focus has been on pre-prescribing and 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 3 2017/18	Quarter 4 2017/18	Quarter 1 2017/18	Quarter 2 2018/19
eChemo prescriptions prescribed more than 5 days in advance	71%	71%	70%	67%
Available eChemo prescriptions screened more than 4 days in advance	91%	92%	85%	86%

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 75% of prescriptions were completed within 30 minutes. The average waiting times between April and June were 25 minutes (Sutton) and 22 minutes (Chelsea).

Outpatients Minutes	July		August		September	
	Sutton	Chelsea	Sutton	Chelsea	Sutton	Chelsea
0 to 30	70%	82%	68%	76 %	72%	81%
31 to 60	26%	17%	28%	23%	24%	18%
61 or more	4%	1%	4%	1%	4%	1%

Waiting times for prescriptions dispensed for discharge are shown in the table below. It shows that over 96% of discharges were completed within 60 minutes with 75% completed within 30 minutes. Average waiting times from April to June were 25 minutes (Sutton) and 20 minutes (Chelsea).

Discharges Minutes	July		August		September	
	Sutton	Chelsea	Sutton	Chelsea	Sutton	Chelsea
0 to 30	64%	78%	70%	77%	70%	92%
31 to 60	29%	18%	27%	20%	25%	7%
61 or more	7%	4%	3%	3%	5%	1%

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

- 8.5.1. The Patient Led Assessment of the Care Environment (PLACE) is an annual national assessment which examines various aspects of the patient environment.
- 8.5.2. The assessments, carried out in May, tested and scored patient environments on six factors:
- cleanliness
 - food
 - privacy, dignity and wellbeing
 - condition, appearance and maintenance
 - dementia
 - disability.

8.5.3. The Royal Marsden scored above the national average across all areas for both Chelsea and Sutton. The ‘disability’ and ‘dementia’ scores have improved significantly, and ‘food’ continues to score highly.

Criteria	National average score 2018	Chelsea 2017	Chelsea 2018	Sutton 2017	Sutton 2018
Cleanliness	98.47	99.85%	99.79	98.75%	99.79
Food*	90.17	96.49%	95.62	98.12%	95.27
Organisation food *	89.97	96.01%	97.50	96.01%	97.50
Ward food *	90.52	96.59%	95.30	98.85%	94.83
Privacy, dignity and wellbeing	84.16	94.86%	89.92	91.32%	91.49
Condition, appearance and maintenance	94.33	97.80%	97.43	94.59%	97.44
Dementia	78.89	76.20%	85.31	57.46%	83.94
Disability	84.19	88.35%	91.74	77.63%	91.06

* Note: The ‘Food’ score is the overall score and is a combination of the scores for the ‘Organisation Food’ and ‘Ward Food’ assessments.

8.6. Waste management

8.6.1. Total Waste Management contract

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

8.6.2. Offensive waste

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

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

8.6.3. Recycling hubs

Recycling is now in place at both sites and ‘bin hubs’ will shortly be introduced to communal and office areas to increase the volume of recyclable waste leaving The Royal Marsden. This will see the removal of ‘at desk’ bins and reduce plastic bag use.

8.6.4. Staff training

The Waste Management Team has delivered waste training to several wards at both sites and continues to offer this on demand. Mandatory training related to waste management is due for review and plans include the development of waste management intranet pages.

8.6.5. Carbon Trust

The Royal Marsden has applied to be reaccredited to the Carbon Trust’s Waste Standard; the world’s first and leading organisational waste reduction certification. The Standard will allow The Royal Marsden to quantify our waste footprint to a recognised international standard and identify real waste reduction opportunities.

8.7. Fire

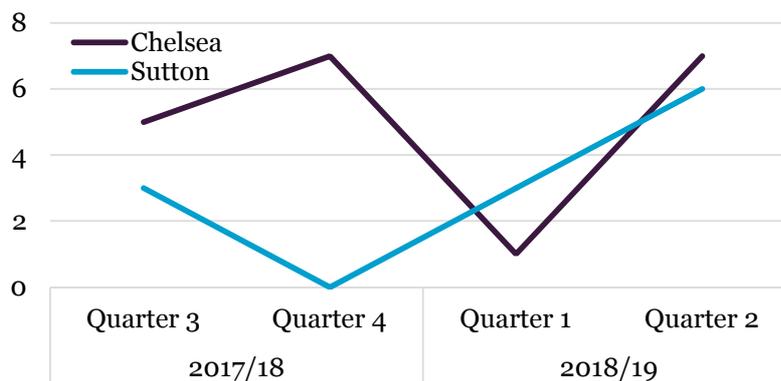
8.7.1. Number of fires

There were no actual fires in Quarter Two. (There had been two incidents relating to a single actual fire in the previous quarter.)

8.7.2. Fire-related incidents

The graph and table show the number of attributable fire related incidents throughout the Trust over the past four quarters. There has been an increase in reporting of fire related incidents since last quarter (from four to 13). This increase is due to improved reporting rates with the appointment of the new fire manager.

8.7.3. Fire-related incidents by site



8.7.4. Fire-related incidents by subcategory

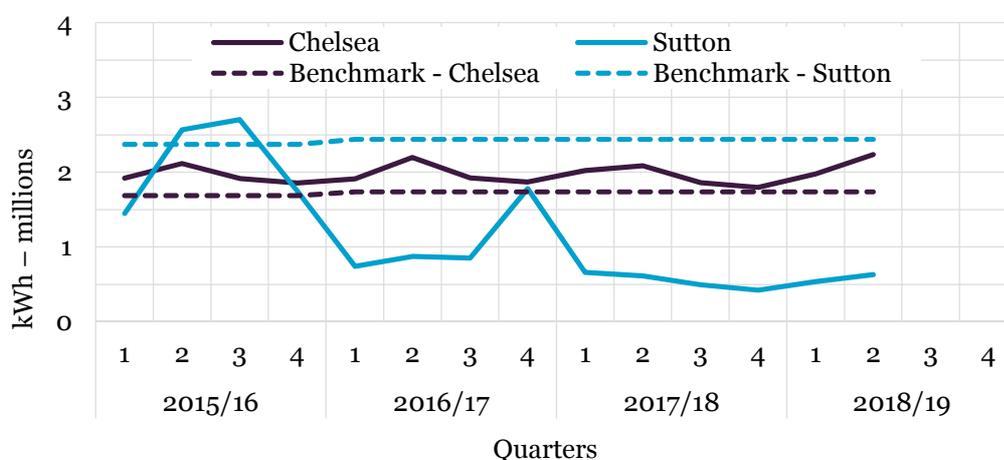
	Quarter 3 2017/18	Quarter 4 2017/18	Quarter 1 2018/19	Quarter 2 2018/19	Total
Detector activated – dust, smoke, building works	4	1	0	3	8
General fire issue	1	1	2	3	7
Detector activated – electrical equipment	0	2	0	3	5
Call point activated – accidentally operated	2	1	0	0	3
System fault – fault on fire alarm system	0	0	0	3	3
Actual fire	0	0	2	0	2
Fire safety deficiency	1	0	0	1	2
Detector activated – kitchens	0	1	0	0	1
Detector activated – overheating of area	0	1	0	0	1
Total	8	7	4	13	32

8.8. Energy use

8.8.1. Electricity consumption – Chelsea and Sutton

Electricity consumption in Quarter Two at Chelsea increased by 7 % on the same quarter last year and increased by 13% on previous quarter. The main contributor to the increased electricity is extra load of air conditioning systems due to hotter seasonal weather and heat wave conditions.

Electricity grid consumption in Quarter Two at Sutton increased by 2% on the same quarter last year and increased by 17% on previous quarter. CHP downtime, introduced new electricity loads and seasonal hot weather conditions are the main contributors for the increased consumption.

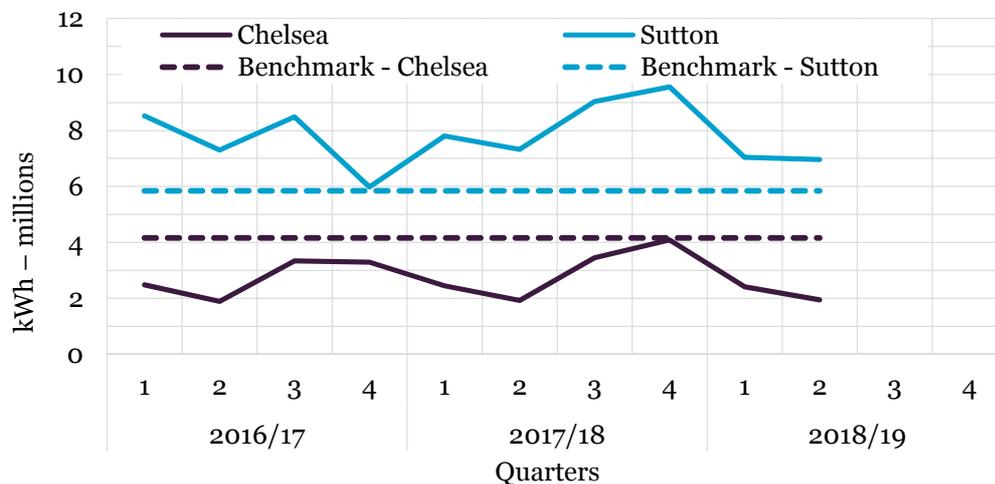


The benchmark used is a consumption average of five acute trusts in London. The Royal Marsden’s electricity consumption at the Chelsea site is slightly above the benchmark line but the consumption at Sutton is below the benchmark line. The Trust is preparing both a feasibility study for on-site generation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

8.8.2. Gas consumption – Chelsea and Sutton

Gas consumption in Quarter Two at Chelsea increased by 1% over the same quarter last year and reduced by 20% on previous quarter. The main reason for reduction is less heating demand due to warmer ambient temperature. The increase is due to the turning on of the heating system in mid-September, two weeks earlier than when the heating season usually starts.

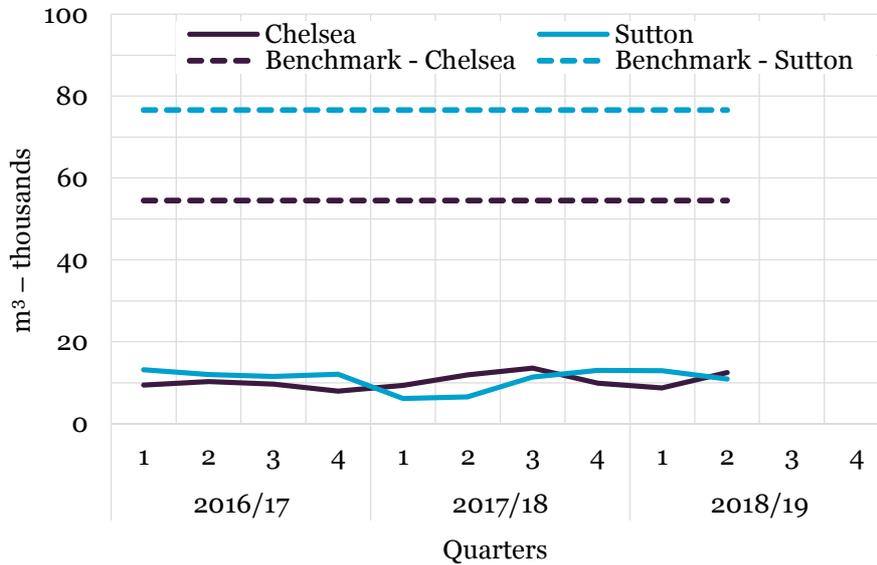
Gas consumption at Sutton was down 5% on the same quarter last year and reduced by 1% on previous quarter. The reduction is due to more efficient running of energy centre.



8.8.3. Water consumption – Chelsea and Sutton

Water consumption in Quarter Two at Chelsea was up 4% on the same quarter last year and 42% on previous quarter. Increased flushing water taps and water leaks are the main contributors.

Water consumption in Quarter Two at Sutton was up 66% on the same quarter last year and reduced by 15% on previous quarter. A faulty water meter was replaced in Quarter Three last year and as a result, more realistic water usage is reordered in Quarter Two this year compared to incorrect consumption recorded in last year Quarter Two.



8.9. Estate improvements – Chelsea

8.9.1. Positron emission tomography/computed tomography (PET/CT)



The new Siemens Biography Horizon PET/CT scanner was installed earlier this year on the Chelsea site, with the first patient being scanned in June 2018. The replacement of the PET/CT scanner with a high specification gives an increase in capacity of 30% allowing shorter waiting times for both NHS and private care patients and an improved patient experience with reduced scanning times.

8.10. Estate improvements – Sutton

8.10.1. Pharmacy expansion

Constructing a new extension to the front of the hospital to create a hub for the pharmacy, which provides sufficient storage and space to adequately manage new ready-made batch products and safely manage the preparation of aseptic products.

This also provided a delivery point where all the deliveries can be made direct rather than going through the main entrance and internal corridors.



8.10.2. Planning computed tomography (CT) scanner



The new Somatom Confidence RT Pro scanner was successfully installed in Sutton earlier this year and started seeing patients in September. This state of the art machine delivers quicker scanning times and higher quality images, which means patients have to spend less time on the machines and yet benefit from more precise radiotherapy planning.

As well as enhancing the treatment and care, the new scanner will support The Royal Marsden's world leading radiotherapy research. There are currently 47 open trials within radiotherapy research to develop new treatment techniques. This new machine will be vital to this work by providing high quality images and greater imaging capacity, helping to transform patient treatment more quickly.

The treatment room, control area and changing rooms were refurbished as part of the project, improving the workspace environment for both patients and staff.

9. Suitability of staffing

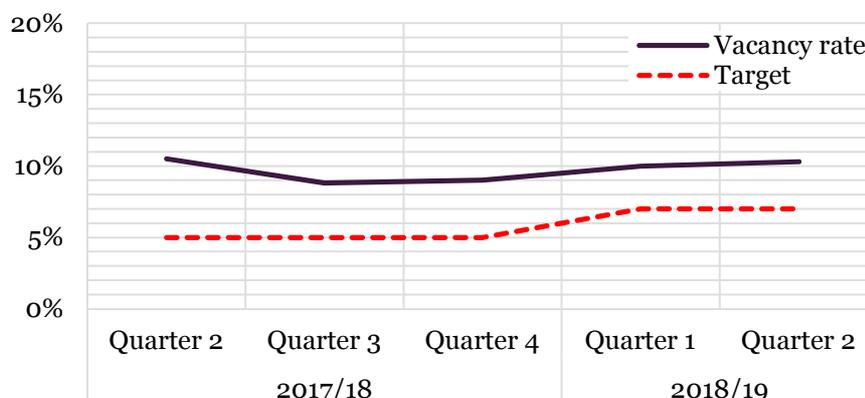
9.1. Human Resources

9.1.1. Performance indicators

	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	Quarter 1 2018/19	Quarter 2 2018/19
Vacancy rate (target 7.0%, raised from 5.0% from Quarter 1 2018/19)					
Trust total	10.5%	8.8%	9.0%	9.9%	10.3%
<i>Cancer Services</i>	7.2%	6.4%	7.7%	9.4%	9.3%
<i>Clinical Research</i>	3.4%	0.6%	-2.3%	-3.9%	1.0%
<i>Clinical Services</i>	12.2%	10.1%	9.8%	11.7%	11.8%
<i>Community Services</i>	16.6%	14.4%	14.7%	16.0%	17.0%
<i>Private Care</i>	17.2%	15.2%	15.4%	13.0%	9.3%
<i>Corporate</i>	7.7%	6.8%	8.6%	9.5%	10.1%
Voluntary turnover (target 12.0%)					
Trust total	15.5%	14.9%	15.2%	13.4%	12.8%
<i>Cancer Services</i>	13.9%	12.8%	12.4%	10.5%	11.2%
<i>Clinical Research</i>	13.5%	12.9%	13.0%	10.3%	8.2%
<i>Clinical Services</i>	14.0%	13.9%	14.2%	13.4%	13.1%
<i>Community Services</i>	21.5%	18.7%	18.5%	13.8%	12.5%
<i>Private Care</i>	20.7%	19.0%	20.2%	16.4%	12.9%
<i>Corporate</i>	15.1%	15.9%	16.9%	15.7%	15.5%
Sickness absence (target 3.0%)					
Trust total	2.6%	3.2%	3.6%	2.9%	3.4%
<i>Cancer Services</i>	2.7%	2.7%	3.3%	2.2%	2.9%
<i>Clinical Research</i>	2.1%	2.7%	2.6%	2.0%	1.5%
<i>Clinical Services</i>	2.2%	2.9%	3.4%	2.8%	3.8%
<i>Community Services</i>	3.0%	3.3%	4.5%	4.3%	4.7%
<i>Private Care</i>	3.2%	4.6%	5.2%	4.2%	4.4%
<i>Corporate</i>	2.9%	3.9%	4.2%	3.3%	3.3%
Appraisal rate (target 90.0%)					
Trust total	83.7%	82.6%	84.7%	88.6%	86.7%
<i>Cancer Services</i>	81.8%	77.0%	83.0%	89.4%	85.6%
<i>Clinical Research</i>	80.3%	72.9%	72.9%	85.5%	84.1%
<i>Clinical Services</i>	83.4%	83.5%	83.8%	91.1%	86.3%
<i>Community Services</i>	80.6%	86.3%	83.9%	89.7%	89.4%
<i>Private Care</i>	84.0%	84.0%	88.1%	86.7%	87.4%
<i>Corporate</i>	89.7%	89.7%	87.3%	87.8%	88.4%
Statutory and mandatory training (target 90.0%)					
Trust total	89.0%	89.2%	83.0%	91.1%	89.2%
<i>Cancer Services</i>	80.9%	80.6%	85.6%	87.1%	84.8%
<i>Clinical Research</i>	89.9%	88.4%	89.2%	89.5%	88.7%
<i>Clinical Services</i>	90.6%	91.6%	91.4%	93.4%	90.8%
<i>Community Services</i>	93.6%	93.6%	88.9%	90.1%	89.5%
<i>Private Care</i>	91.1%	92.2%	87.8%	92.2%	92.6%
<i>Corporate</i>	93.9%	94.1%	86.3%	94.8%	91.5%
Local induction (target 85.0%)					
Trust total	82.2%	84.0%	86.4%	89.1%	81.8%
<i>Cancer Services</i>	69.4%	76.6%	86.8%	89.8%	76.4%
<i>Clinical Research</i>	86.7%	84.6%	85.3%	90.8%	87.9%
<i>Clinical Services</i>	86.8%	87.2%	87.8%	90.7%	82.8%
<i>Community Services</i>	82.9%	85.7%	89.9%	92.6%	92.3%
<i>Private Care</i>	83.6%	82.9%	87.3%	82.8%	82.2%
<i>Corporate</i>	87.9%	89.3%	91.9%	86.2%	78.4%

9.1.2. Vacancy

The Trust vacancy rate has increased to 10.3% in Quarter Two 2018/19, which is above the trust target, but below the vacancy rate this time last year. The Vacancy rate target for the year 2018/19 has been set at 7%, which reflects the challenges for recruitment within London.



There continues to be a strong focus on nurse recruitment. We have recruited over half of the nurses needed to meet our recruitment target for this year. The trust was awarded the Nursing Times Employer of the Year Award, in recognition of the range of activities being undertaken within the trust to recruit, retain and develop our workforce.

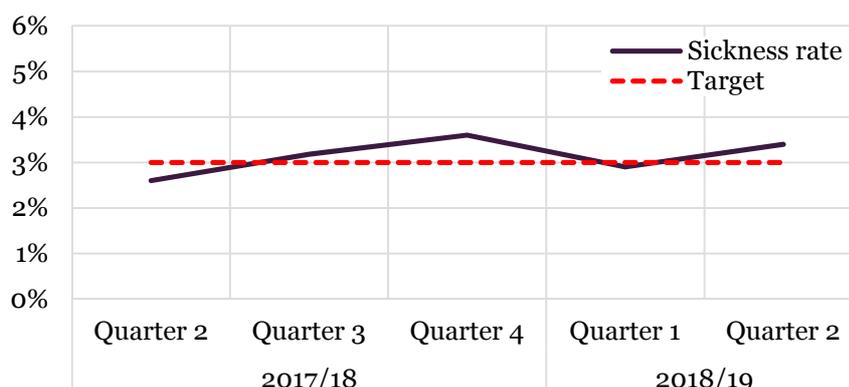
9.1.3. Voluntary turnover

Voluntary turnover reduced to 12.8% in Quarter Two but remains above the trust target of 12%. The Trust continues to pay careful attention to identifying and addressing the reasons staff give when they leave the trust.

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

9.1.4. Sickness

The Trust sickness rate this quarter has risen this quarter to 3.4%, with only two Divisions meeting the trust target. The seasonal flu vaccination programme has commenced, which aims to protect both our staff and patients over the winter season, with over 500 staff being vaccinated in the first couple of weeks. Long-term and short-term sickness absence is reviewed within the Divisions, and the Human Resources and Occupational Health teams provide targeted support to both management and staff members.



9.1.5. Appraisal

Appraisal compliance is lower than in Quarter One, at 86.7%, but still at a higher percentage than at this point of the appraisal cycle last year.

Appraisals are a key factor in motivating staff and supporting professional development, and work is underway as part of our Outstanding Culture programme, to integrate refreshed trust values into our appraisal format.

9.2. Mandatory training

- 9.2.1. Statutory and mandatory training forms part of the Trust's risk management strategy to minimise risk to patients, visitors and staff. In addition to the ongoing use of the WIRED mandatory training and appraisal compliance reporting system, progress against these topics are reported to divisions through the monthly scorecard.
- 9.2.2. The following table shows mandatory training compliance for the core topics for Quarter One. The figures for this quarter's overall compliance rate are shown against the red/amber/green (RAG) rating where
- red is less 60%
 - amber is 60% to target
 - green is at or above target.

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

Mandatory training topics	Update frequency requirement (in years)	Target	Hospital compliance rate	Community Services compliance rate	Overall Trust compliance rate Quarter 1 2018/19	Trend	Overall Trust compliance rate Quarter 2 2018/19
Adult basic life Support	1	90%	84%	90%	86%	↓	84%
Blood transfusion (generic update)	2	90%	89%	Not applicable	90%	↓	89%
Conflict resolution for frontline staff	3	80%	80%	86%	81%	↔	81%
Consent awareness (medical staff)	2	90%	85%	Not applicable	83%	↑	85%
Equality and diversity	3	90%	93%	95%	94%	↓	93%
Fire awareness	1 (clinical) 2 (other)	90%	88%	92%	91%	↓	89%
Infection prevention and control	1 (clinical) 3 (other)	90%	91%	89%	92%	↓	91%
Information governance	1	95%	89%	94%	94%	↓	89%
Medicines management (clinical staff)	1	90%	N/A	87%	85%	↑	87%
Manual handling – back care awareness (non-patient handling)	3	90%	91%	97%	93%	↓	92%
Manual handling (patient handling)	1	90%	87%	85%	86%	↑	87%
Paediatric basic life support	1	90%	82%	88%	86%	↓	84%
Risk management awareness	1 (managers) 3 (other)	90%	92%	96%	91%	↑	93%
Risk training for senior managers	1 (managers)	90%	83%	100%	86%	↓	83%

Mandatory training topics	Update frequency requirement (in years)	Target	Hospital compliance rate	Community Services compliance rate	Overall Trust compliance rate Quarter 1 2018/19	Trend	Overall Trust compliance rate Quarter 2 2018/19
Safeguarding vulnerable adults (level 1)	3	90%	92%	96%	92%	↔	92%
Safeguarding vulnerable adults (level 2)	3	90%	90%	93%	92%	↓	90%
Safeguarding vulnerable adults (level 3)	3	90%	89%	75%	88%	↓	82%
Safeguarding children (level 1)	3	90%	92%	94%	92%	↔	92%
Safeguarding children (level 2)	3	90%	89%	96%	92%	↓	90%
Safeguarding children (level 3)	3	90%	88%	88%	85%	↑	88%
WRAP (Prevent)	Once only	85%	91%	89%	89%	↑	90%
Venous thrombo-embolism and pressure ulcers (clinical staff)	1 (clinical)	90%	91%	61%	87%	↑	89%
Venous thrombo-embolism (medical staff)	Once only	90%	87%	N/A	94%	↓	87%

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

9.2.5. A compliance rate of 90% or above has been achieved in nine topic areas and a further fourteen topics achieved 80% or above. No topics reported less than 80% compliance.

9.2.6. This quarter has seen an increase in seven topics, a slight decrease in thirteen topics and three topics have remained static.

9.2.7. 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.

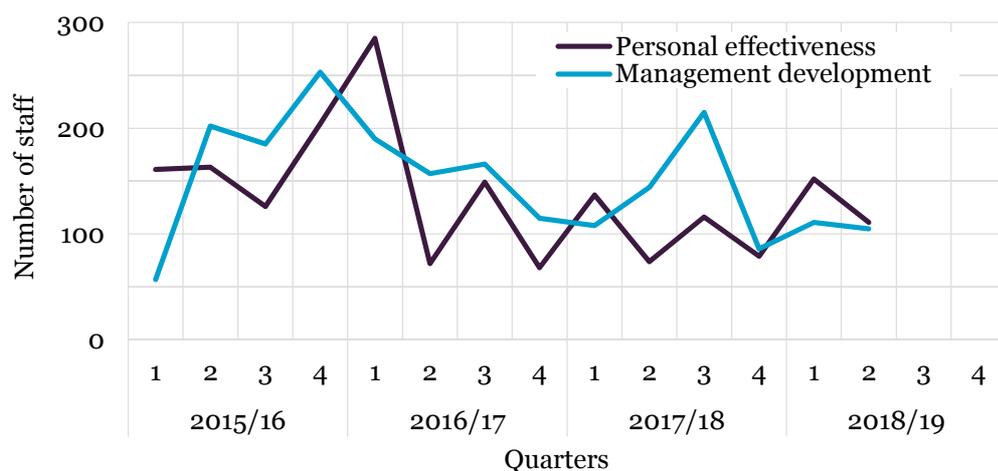
- 9.2.8. A review of the Training Needs Analysis was launched this quarter. This will ensure that mandatory training continues to be up to date with policy and legislative changes, follows best practice, refresher periods are appropriate and demand can be met.
- 9.2.9. A new version of WIRED was launched in this quarter which delivers enhanced reporting features and more accurate reporting.

9.3. Induction

- 9.3.1. For the third consecutive quarter the Trust continues to exceed the target of 85% set for induction, currently reported at 89%. This target was raised in April from 80%. Regular three-monthly targeted follow-up with line managers remains the key strategy for maintaining the local induction compliance rate, currently at 85% with monthly reminders to staff to complete the Month One on-boarding List and inform the Learning and Development Team. This will continue with monthly reminders targeted at those individuals who are not compliant to further increase compliance.
- 9.3.2. The Trust continues to exceed the target for attendance at Trust induction. This has decreased slightly to 89% from 92% since the last quarter due to increased recruitment. Additional Induction sessions have been scheduled wherever required to accommodate increases. Close monitoring, improved communication to delegates, and joint working with the Recruitment Team is ensuring that all new joiners attend Trust induction within two months of their start date. Auditing of new starters against attendance highlights where new joiners have not attended and follow-up continues to be a monthly task carried out by the Learning and Development team.

9.4. Non-clinical training and development

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



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

9.4.3. During Quarter Two the following workshops were delivered:

Personal Effectiveness:

- Medical Terminology course (AMSPAR)
- Communicating assertively
- Cultural Awareness
- Introduction to Supervisory Skills
- Information technology sessions in Microsoft Word, Excel and PowerPoint
- Meetings and minute taking
- Time Management
- Training and Presentation Skills:

Management Development:

- Finance sessions
- Honest conversations
- Learning to Lead
- Project management
- Preparing to Conduct HR investigations
- Managing poor work performance
- Managers Induction
- Recruitment and selection
- Resilience for leaders

Feedback from participants suggests that the trainers' approach to learning and expertise has enabled participants to put their learning into practice in the workplace.

- 9.4.4. During the quarter as well as continuing to offer Personal Effectiveness and Leadership skills programmes, the Learning & Development Team continued to support the Paired Learning Programme.
- 9.4.5. In this quarter, the Learning and Development Team continued to support the Career Development Mentoring Scheme for staff across bands 1 – 6. A further four mentees were matched with suitable mentors; the team have also recruited a further four mentors, which will enable a rolling programme to be offered in the future.
- 9.4.6. The Learning and Development Team support internal trainers and educators by offering a portfolio of training and presentation skills workshops. In quarter two, an innovative workshop on “lessons training can learn from mainstream media” gave participants the opportunity to develop and deliver training in a range of formats. .
- 9.4.7. The Learning and Development Team have also offered tailored expert coaching to trainers who wished to improve particular aspects of their practice. The Learning and Development Team also undertook observations and provided a consultancy service to individual trainers/managers who wish to develop and improve training practice in their area.

- 9.4.8. Through a systematic process of identifying learning needs at department and individual level, the Learning & Development Team have designed and delivered team-specific customer service training to address issues raised in patient surveys and improve the overall level of customer service. The final modules will be delivered and evaluated in quarter three.
- 9.4.9. The Learning and Development Team continues to support team development by identifying team development needs, designing and delivering bespoke team events/activities using a range of development tools including Belbin and Myers-Briggs Type Indicators (MBTI). They have also run skills-based sessions e.g. appraisal, time management, as part of team away-days.
- 9.4.10. Following a thorough learning needs analysis, the Learning and Development Team also designed a two day Leadership Development Programme for ward managers requested by the Matron. The programme comprises of team dynamics and leadership skills.
- 9.4.11. The Learning and Development Team have been involved in delivering wellbeing sessions on the Royal Marsden School's "Nurse Associate Programme". Feedback confirms that participants have appreciated the insights gained from these sessions and have commented on how the wellbeing techniques they learnt during the sessions have enhanced their clinical practice.
- 9.4.12. The Learning and Development Team continued to support the development and updating of an effective learning management system. The team has also supported the development of in-house e-learning programmes.

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. One national audit was registered in Quarter Two:
- Multinational retrospective audit of outcomes with a nuclear medicine scan in medullary thyroid cancer
- 10.1.3. Fifteen new clinical audit proposals and three re-audit proposals were approved by the committee in Quarter Two.
- 10.1.4. Four national audit reports were presented in Quarter Two:
- National Audit of Breast Cancer in Older Patients (NABCOP)
The report can be found here:
<https://www.nabcop.org.uk/reports/nabcop-2018-annual-report>
 - National Prostate Cancer Audit (NPCA)
The report can be found here:
<https://www.npca.org.uk/provider-results/trust/the-royal-marsden-nhs-foundation-trust>
 - National Oesophago-Gastric Cancer Audit (NOGCA) 2017 – Patient Report
The report can be found here:
<https://www.nogca.org.uk/reports/2017-patient-report>
 - National Bowel Cancer Audit (NBOCA): The feasibility of reporting patient reported outcome measures (PROMs) as part of the national colorectal cancer audit
The report can be found here:
<https://www.nboqa.org.uk/reports/proms-feasibility-study-2018>
- 10.1.5. Details of the 26 reports for local audits and quality improvement projects presented and approved by the Clinical Audit Committee in Quarter Two are shown in the following table.

10.1.6. Audits conducted at Chelsea and Sutton

Title	Action plan, learning and outcomes
Venous thrombosis-embolism (VTE) prescribing audit	Electronic recording of VTE risk assessment. Include the option of ‘no risk’ under thrombosis and bleeding risk on risk assessment. Ensure the dose banding is consistent on both the electronic patient record (EPR) and drug chart. Further training for prescribers on: <ul style="list-style-type: none"> • Documenting risk assessments correctly • Carrying out the risk reassessment for change in condition • Prescribing appropriate prophylaxis • Prescribe mechanical prophylaxis where indicated

Title	Action plan, learning and outcomes
Reducing unnecessary blood tests for inpatients at The Royal Marsden	<p>Redesign the request form to help reduce the number of blood tests ordered.</p> <p>Reorder the form so that glucose, urate, and gamma-glutamyl transferase (GGT) are removed from the common 'tick box' area.</p> <p>Lactate dehydrogenase (LDH) will be moved to the tumour markers section.</p>
Enhanced supportive care, access for advanced cancer patients	<p>Refined model of the integrated palliative care service care offered in lung and upper GI oncology clinics.</p> <p>Patient and staff feedback sought about the integrated palliative care service and its use and effectiveness.</p> <p>Business case developed in order to secure ongoing funding for the integrated palliative care service at The Royal Marsden.</p>
Understanding outstanding informational needs for outpatient visits to The Royal Marsden	<p>Further feedback sought from key stakeholders to modify the information.</p> <p>Glossy brochure will be available on request.</p> <p>Number of views monitored for six months.</p>
Re-audit on genetic assessment practice at The Royal Marsden for breast cancer patients	<p>Re-audit supported genetic input into the open access follow-up virtual multi-disciplinary team (OAFU VMDT) which is useful for identifying patients who will benefit from genetic referral prior to discharge.</p>
Breast cancer 1 (BRCA1) mutation rates in male breast cancer patients (2010-2017)	<p>Review list of patients who may be eligible for re-referral to discuss testing.</p> <p>Audit findings presented to clinical and academic team at The Royal Marsden and the Institute for Cancer Research for awareness and understanding.</p>
The Royal Marsden Breast implant bank: Current use and optimisation	<p>Audit findings presented to breast unit team to improve awareness and understanding.</p>
Pathology audit	<p>Completion of a scorecard that is suitable for quality and business purposes.</p> <p>Upgrade the electronic quality management software (Q-Pulse) to a web-based version for stem cell laboratory.</p> <p>Undertake quality and audit training and a competence assessment .</p> <p>Provide basic health and safety training for deputy training leads.</p>
Retrospective audit of terminal sedation in a tertiary referral cancer hospital	<p>Share results with the palliative care team across both sites to improve awareness and understanding.</p> <p>Teaching session arranged to refresh principles of care documentation.</p> <p>Share results with Horder Ward and discuss methods for ensuring nursing staff are involved in discussions and mandatory nursing training updates.</p> <p>Re-audit by September 2019.</p>

Title	Action plan, learning and outcomes
Strong opioid use in adult out-patients at The Royal Marsden	<p>Amend the controlled drug prescription form for outpatients.</p> <p>Include an advisory comment in the strong opioid patient information leaflet instructing patients to contact a health professional/Macmillan hotline if they use more than 4-6 doses/24 hours.</p> <p>Pharmacy will contact the prescriber of any initial strong opioid prescription that is greater than 30mg oral morphine/24 hours.</p> <p>Update the strong opioid patient information leaflet to include advice on signs of opioid toxicity and the current recommendations on driving and opioid use.</p>
Assessment and management of constipation in inpatients in The Royal Marsden	<p>Audit results presented as part of the quarterly palliative care departmental audit and research meeting to improve awareness and understanding.</p> <p>Undertake dedicated teaching to core medical trainees.</p> <p>Update constipation section of The Royal Marsden symptom control guidelines in line with current palliative care guidelines.</p> <p>Liaise with senior nursing staff regarding encouraging habitual use of bowel charts on all wards.</p>
Imaging referrers experience survey	<p>Appoint interventional radiology consultant.</p> <p>Utilise additional computerised tomography (CT) capacity on the Sutton site.</p> <p>Additional CT, magnetic resonance imaging (MRI) capacity available from August 2020 on Cavendish Square site.</p> <p>Implementation of CT extended days on Sutton site.</p> <p>There will be a business case for either a mobile or a re-locatable MRI unit on the Chelsea site.</p> <p>There will be additional ultrasound sessions from newly appointed consultants.</p> <p>Replacement of positron emission tomography (PET)/CT scanner on Chelsea site.</p> <p>There will be an appointment of a second radioisotope supplier to reduce failure risk.</p>
Audit of consent to examination or treatment – The Royal Marsden hospital	<p>Audit report forwarded to consultants whose patients were audited, with reference to the recording of copies of consent forms being accepted by patients.</p> <p>Audit report forwarded to the divisional directors and divisional nurse directors for wider dissemination.</p> <p>Clinicians encouraged to ensure all areas of a consent form are completed.</p> <p>Re-audit next year for surgical patients treated during March 2019.</p>

Title	Action plan, learning and outcomes
Clinical audit policy monitoring audit	<p>Clinical audit team reminded to use standards in the policy as a checklist for submitting clinical audit proposals at pre-clinical audit committee (CAC) meetings.</p> <p>Re-audit by March 2019.</p>
Audit of deaths in hospital at The Royal Marsden	<p>Inpatient deaths to be audited and reviewed at the quarterly meeting to determine if the death was either expected given the patient's overall clinical condition, or should have a clear identifiable irreversible reason for death that could not have been prevented by clinical intervention.</p> <p>Inpatient deaths audited and reviewed at the quarterly meeting to determine if patients who died in hospital with a documented preferred place of death that was not "hospital" have a clear, identifiable reason outside the control of The Royal Marsden as to why their preferred place of death was not achievable.</p> <p>The palliative care consultant, or their registrar, attends the multi-disciplinary team meetings for both the critical care unit (CCU) and haemato-oncology to be aware of patients whose condition is deteriorating.</p> <p>Additional medical staff members have been identified who will assist in completing the Structured Judgement Reviews (SJRs).</p> <p>Any deficiencies / lapses in care highlighted as learning points for dissemination to clinicians through a Trust-wide email bulletin.</p>

10.1.7. Audits conducted at Chelsea

Title	Action plan, learning and outcomes
Multidisciplinary quality improvement in altered airway care	<p>Dissemination of six months results at surgical audit and anaesthetic meeting to improve awareness and understanding.</p> <p>Continue weekly ward round and review.</p> <p>Critical care unit (CCU) staff nurse training.</p>
Audit of The Royal Marsden's compliance with the guidelines for melanoma treatment in the elderly	<p>Results presented to the dermatology department with emphasis on training and discussion of standards to improve awareness and understanding.</p> <p>Consider developing a multi-disciplinary team (MDT) referral form for other hospitals to use.</p> <p>Things to be included on the form:</p> <ul style="list-style-type: none"> • Stage and performance status • Whether or not the patient has been offered clinical trials/ surgery/ systemic treatment / lymph node dissection

Title	Action plan, learning and outcomes
The utility of fluorescence in situ hybridization (FISH) and reverse transcription polymerase chain reaction in formalin fixed, paraffin embedded tissues on the diagnosis of Ewing sarcoma region 1 (EWSR1) rearranged soft tissue sarcomas	FISH should be done in conjunction for tumours with EWSR1 gene rearrangements. FISH for gene rearrangement should be performed for EWSR1-negative tumours.
Patient evaluation of current breast radiotherapy information session	Liaise with lymphoedema services and physiotherapy to assess the feasibility of running morning and afternoon sessions. Patients informed about their pre-treatment radiotherapy session.

10.1.8. Audits conducted at Sutton

There were no reports in Quarter Two for audits that were conducted only at Sutton.

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

Title	Action plan, learning and outcomes
Safe transcribing of medicines/ medicines management – June 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit will be carried out for Quarter 3 2018/19.
High priority areas for pressure ulcer and leg ulcer bundle – June 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit will be carried out for Quarter 3 2018/19.
5 harms community documentation audit (adults services) – June 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit has been carried out for Quarter 1 2018/19.
Safe transcribing of medicines/ medicines management – August 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit will be carried out for Quarter 3 2018/19.

High priority areas for pressure ulcer and leg ulcer bundle – August 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit will be carried out for Quarter 3 2018/19.
5 harms community documentation audit (adults services) – July 2018	Results discussed at monthly senior community nurse meetings and local nursing team meetings. To continue monthly audit involving 10 records from Sutton and Cheam, 5 from Wallington and 5 from Carshalton. A full audit has been carried out for Quarter 1 2018/19.
Audit of consent to examination or treatment – SCHS	Audit report forwarded to clinicians and service managers whose patients were audited. Podiatry team reminded that patient information documents should be produced in accordance with the Trust policy and procedure and be published and archived accordingly.

10.2. Deaths following anti-cancer therapy

10.2.1. Purpose of monitoring

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

10.2.2. Aim

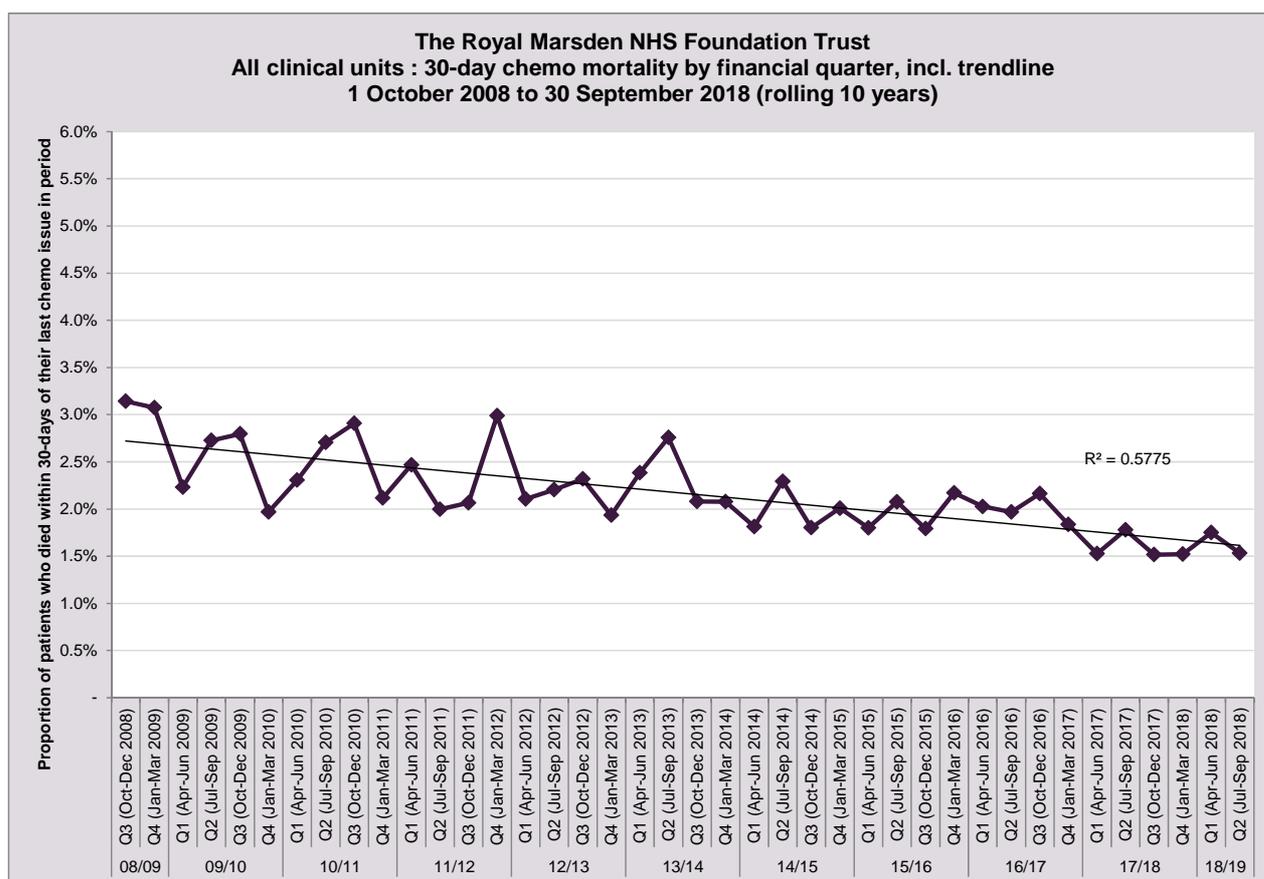
To track trends in the number of deaths within 30 days of receiving SACT at the Trust and deaths reported to the Trust from Quarter Two 2008/09 to Quarter Two 2018/19.

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

The last matching using data from the Office for National Statistics (ONS) was carried out on 31 October 2018.

10.2.3. Key points

- Quarterly graphic representation of trends for 30-day deaths.
- The overall trend has remained stable.
- In Quarter Two there were 67 deaths out of 4,374 patients (1.5%). (In Quarter One there were 76 deaths out of 4,348 patients (1.7%).)



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

10.3. 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.

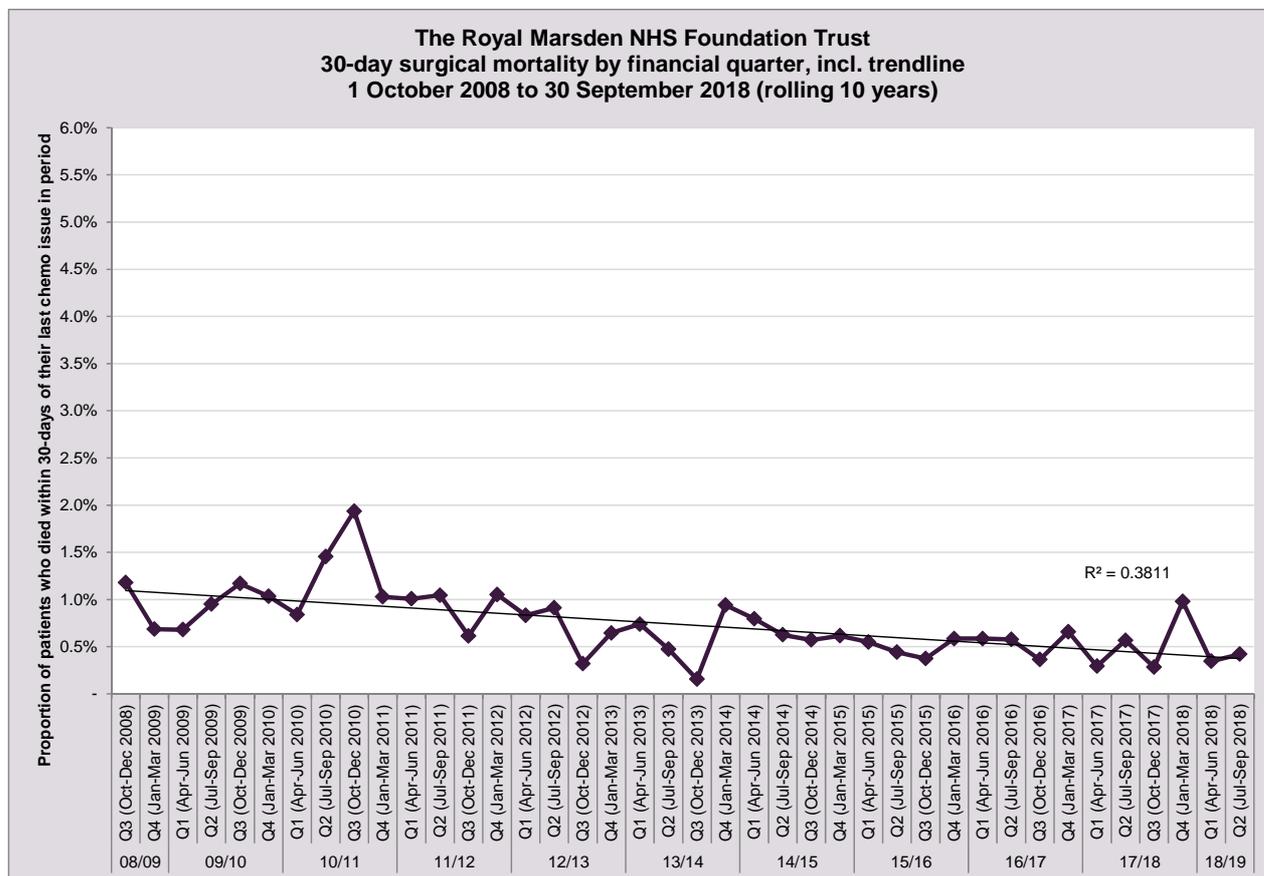
The last matching using data from the Office for National Statistics (ONS) was carried out on 31 October 2018.

10.3.3. Key points

- The overall trend has remained stable.
- 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.
- In Quarter Two there were 6 deaths out of 1,424 patients (0.4%). (In Quarter One there were 5 deaths out of 1,448 patients (0.3%).)

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



R² is a statistical measure that shows how closely the trend line fits the data. The value is between 0 and 1 – the higher the value the closer the fit.

10.4. Deaths following stem cell transplantation

10.4.1. Purpose

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

10.4.2. Aim

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

- 10.4.3. The number of transplants recorded in this quarter (July to September 2018) was 67 but to analyse 100-day mortality it is necessary to consider the transplants undertaken in the previous quarter (April to June 2018). This allows all patients to have reached 100 days post-transplant by the time this report is prepared. For example, a patient having a transplant on 30 June 2018 would reach 100 days on 8 October 2018.
- 10.4.4. The final number of recorded transplants carried out from April to June 2018 was 63 (54 adult and 9 paediatric patients).
- 10.4.5. The breakdown of transplant types, number of deaths within 100 days of transplant and the cause of death for April to June 2018 is given below:-

Adults

Transplant type	Number of transplants	Number of adult deaths at 100 days post-transplant	Overall TRM* percentage	Disease relapse or progression
Autologous†	36	0	0%	0%
Allogeneic‡ (all types)	18	2	6%	6%
– Allogeneic – unrelated donor	9	1	11%	0%
– Allogeneic – related donor	6	1	0%	17%
– Allogeneic – cord blood	3	0	0%	0

Paediatric

Transplant type	Number of transplants	Number of paediatric deaths at 100 days post-transplant	Overall TRM* percentage	Disease relapse or progression
Autologous†	3	0	0%	0
Allogeneic‡ (all types)	6	0	0%	0
– Allogeneic – unrelated donor	3	0	0%	0
– Allogeneic – related donor	3	0	0%	0
– Allogeneic – cord blood	0	0	0%	0

* TRM: Transplant related mortality

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

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

- 10.4.6. For the two adult patients who died within 100 days following the transplant
- one received an allogeneic blood transplant from a related donor for myelodysplastic syndrome but died at day 99 from relapsed disease
 - the other received an allogeneic blood transplant from a matched unrelated donor for acute myeloid leukaemia but died at day 32 from veno-occlusive disease and multi-organ failure (transplant-related).

There were no deaths recorded for paediatric patients receiving a Stem Cell Transplant during the April to June period.

10.4.7. 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.

10.4.8. 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. Information governance

10.5.1. Information Governance Committee

The Information Governance Committee considers information governance related incidents, policy approval, data quality, clinical records management, subject access requests, freedom of information requests, the Information Governance Toolkit, audits as well as other information governance related topics. There were two meetings of the committee in Quarter Two.

As part of the national Toolkit submission, the Trust is required to achieve a target of 95% for information governance training. The Trust's information governance training compliance as at 30 September 2018 is 89%; this position is considered an acceptable tolerance at this stage of the year with systems in place to monitor compliance.

10.5.2. Data Security and Protection Toolkit

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

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

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

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

- baseline and performance update (31 October 2018)
- final submission (end of March).

A baseline publication is not a full assessment but simply indicates that our self-assessment is underway. Details of the Trust's baseline assessment will not be publicly viewable, only that it has been completed.

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

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

CQC well led inspections will include data security but it has not yet been confirmed how this area will be inspected.

10.5.3. General Data Protection Regulation (GDPR) Project

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

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

In response to the GDPR, the Trust established a 'Task and Finish Group' that was chaired by the Caldicott Guardian (Chief Nurse) and attended by the Senior Information Risk Owner (Chief Operating Officer) and Data Protection Officer (Trust Secretary). A detailed action plan was produced to work towards GDPR compliance; progress against this action plan continues to be monitored by the Information Governance Committee. The Trust's Data Protection Officer has also reported to the Board of Directors on Trust compliance with GDPR and has added this to the Corporate Risk Register for further monitoring purposes.

10.5.4. Incident management and enforcement

The Information Commissioners Office has had the powers to fine organisations since 2010 and The Royal Marsden to date has not incurred any fines. Following the introduction of GDPR the maximum penalty has risen to £17,000,000 or 4% of gross national turnover. Under the new legislation, organisations are required to report breaches within 72 hour of the incidents discovery.

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

10.6. 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.

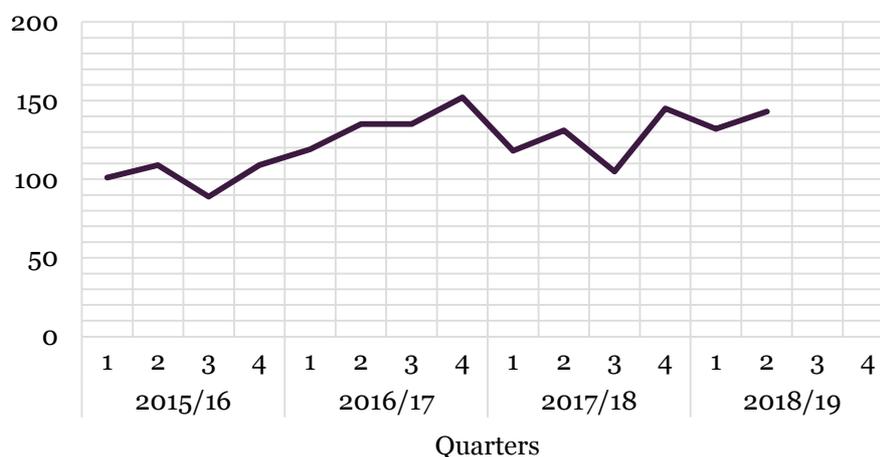
10.6.1. Requests received under the Freedom of Information Act 2000

The Trust received 143 requests during Quarter Two, compared to 131 in the second Quarter of the previous year. Of the 143 requests received in Quarter Two, 131 were answered within 20 working days (92%).

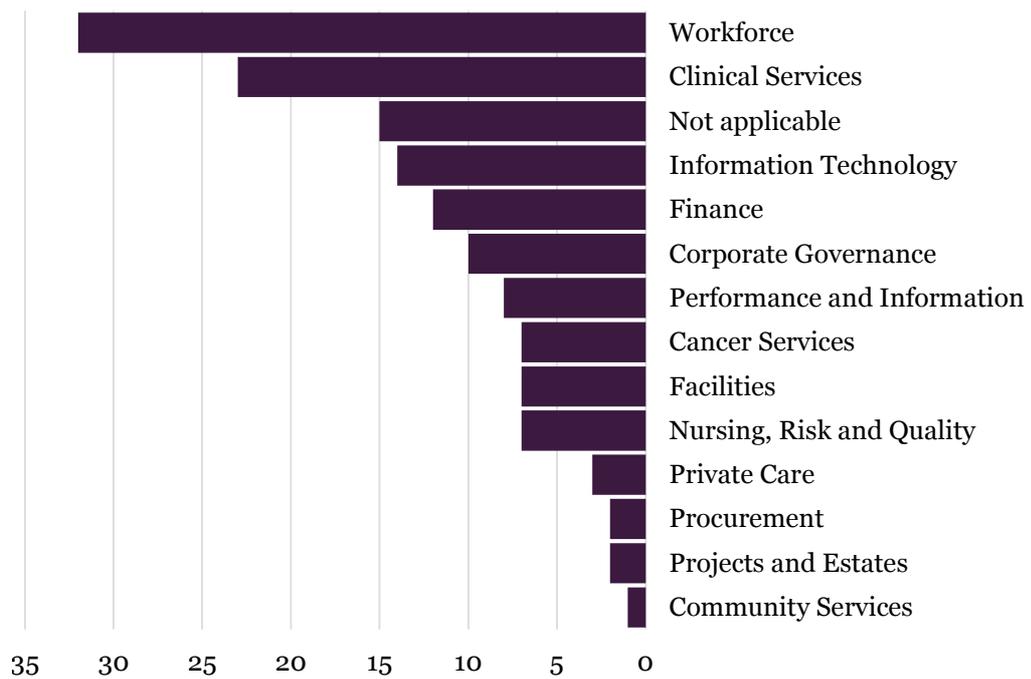
The requests in Quarter Two had the following outcomes:

Disclosed	90
Not applicable to The Royal Marsden	26
Partial	17
Information not held or clarification sought	2
Refused – exemption or too expensive to answer	8
Total	143

10.6.2. Number of requests received by quarter

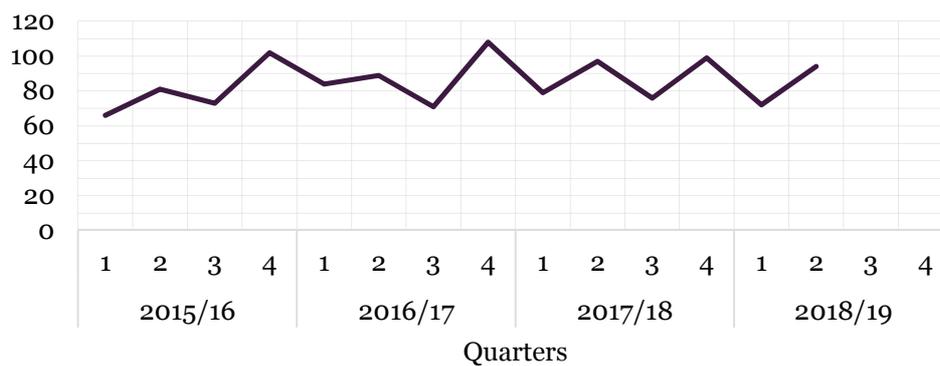


10.6.3. Number of requests by directorate and division



10.7. Access to patient records

- 10.7.1. The Data Protection Act 1998 requires that patients be given the right of access to and copies of their own medical records.
- 10.7.2. This quarter the Trust received 94 requests for personal disclosure of medical records for hospital patients. (This excludes notes required by other hospitals and those required for litigation purposes.)
- 10.7.3. The chart shows the number of requests received for hospital patients each quarter since 2015/16.



10.8. Radiotherapy

- 10.8.1. 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.
- 10.8.2. A two-day assessment took place in September at both sites. All areas of the Quality Management System (QMS) were inspected together with procedures for linear accelerator maintenance, computed tomography (CT) scanning, the mould room, and brachytherapy.

- 10.8.3. The report the this inspection was positive and confirms continued certification. No non-conformities were raised and 12 examples of best practice or improvements that have been implemented were noted. The inspector highlighted six opportunities for further improvement – the actions are not mandatory but will be addressed before the next inspection planned for March 2019.
- 10.8.4. Further internal audits were completed during the quarter bringing the number to seven for 2018/19. This included one more in depth report on compliance to the ISO clauses which had been proposed at the previous inspections. Reports from these audits were examined during the September inspection and were considered to meet all requirements. There have been 22 corrective actions raised for the year to date: all are closed with except one that relates to updating some of the clinical protocols.
- 10.8.5. The Radiotherapy Quality Management System consists of more than 1,100 documents. The documents are reviewed and updated after two years, or less if there is significant change. The number of documents under review or overdue is at its lowest for four years but work is continuing on Radiotherapy Clinical Protocols. The work is monitored by the Multiprofessional Team Quality Assurance (Radiotherapy) Committee (MPT QART) meeting and weekly Radiotherapy audit meetings.
- 10.8.6. Twenty-eight incidents were raised in the Trust's incident reporting system for the quarter (compared with 39 in the previous quarter). Incidents are coded using the *Towards Safer Radiotherapy* classification system, which allows comparable reporting across the industry. Three were graded as *low* severity and 24 as *very low*. One incident in September was graded *moderate* and judged to be a reportable radiation incident. Incidents were reviewed and discussed at the latest MPT QART meeting as part of root cause analysis and appropriate corrective actions were agreed.
- 10.8.7. No formal complaints relating to Radiotherapy were received. Fourteen letters or cards of praise for the service were recorded within the quarter.
- 10.8.8. Since April 2005, all Radiotherapy waiting times for both palliative and radical treatment have been within the 14 day and 28 day target (as set out in the Manual of Cancer Standards) respectively.

10.8.9. The table below shows the number of radiotherapy appointments for Quarters One and Two 2018/19.

		2018/19					
Appointments (number)		Apr	May	Jun	Jul	Aug	Sep
Chelsea	Palliative*	41	43	44	38	53	31
	Radical†	153	125	145	156	149	136
	Urgent‡	0	0	3	2	3	0
	Total	194	168	192	196	205	167
Sutton	Palliative	72	74	50	56	68	56
	Radical	212	190	210	215	179	200
	Urgent	5	4	2	3	1	4
	Total	289	268	262	274	248	260
Grand total		483	436	454	470	453	427

* 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.

10.8.10. The table below shows radiotherapy waiting times for Quarters One and Two 2018/19.

			2018/19					
Average waiting time (days)			Apr	May	Jun	Jul	Aug	Sep
Chelsea	Radical	All*	14.5	15.2	14.4	13.1	13.1	14.0
	Radical	No delay*	20.2	18.3	16.9	16.8	17.1	18.5
	Palliative	All	3.5	4.3	3.4	3.7	3.8	3.6
	Palliative	No delay	3.9	5.1	4.1	4.1	4.2	4.9
Sutton	Radical	All	15.8	15.2	17.8	15.5	13.8	15.2
	Radical	No delay	21.4	19.2	21.9	21.4	20.6	20.8
	Palliative	All	3.8	3.9	3.6	5.1	4.2	5.5
	Palliative	No delay	4.3	4.6	4.0	6.1	5.3	6.4

* **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).

10.9. Chemotherapy

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

The next inspection is due in October and will be a one-day visit at Sutton involving Robert Tiffany Ward (private care), the Bud Flanagan wards and Pharmacy. There are no outstanding actions from the previous inspection.

- 10.9.1. Internal auditing continued during the quarter with a further four audits completed including one covering compliance to ISO clauses. One resulting action remains to be closed that involves some updates to the Quality Manual.
- 10.9.2. Incidents are reported in accordance with Trust policy. In the quarter, 107 incidents relating to the multidisciplinary chemotherapy service were recorded compared to 125 in the previous quarter. Sixty-two were graded *very low* and 45 *low*. None was *moderate* or above.
- 10.9.3. Ninety-nine of the incidents related to medication issues. In accordance with Trust policy actions were agreed to ensure lessons are learned following an incident. The incidents will be reviewed at the next Quality Assurance in Chemotherapy Services Committee meeting.
- 10.9.4. No formal complaints were received in the quarter and 50 letters of praise and thanks from patients were logged.
- 10.9.5. Waiting times have been monitored for a number of years and discussed by the Quality Assurance in Chemotherapy Services Committee. Waiting times include the following steps which take place before administering chemotherapy:
 - taking blood and awaiting results
 - consultation with doctor
 - chemotherapy preparation by pharmacy.
- 10.9.6. Total waiting 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).
- 10.9.7. One stop patients wait longer as chemotherapy cannot be given until all preparation tasks are complete which typically takes 3 to 5 hours. Most patients prefer the one stop option, if geography allows, as this saves two separate visits to the hospital. Patients can be issued with a pager so allowing them to leave the site whilst preparation takes place.
- 10.9.8. Based on the table below tables below 15% of patients wait over 4 hours although individual units show some fluctuations.

10.9.9. The table below shows the number of chemotherapy appointments with waiting times longer than four hours for Quarters One and Two 2018/19.

Appointments	Total appointments	Appointment waits over 4 hours	Percentage waits over 4 hours
Granard House Day Unit	2,486	436	18%
Main Outpatients	186	2	1%
Medical Day Unit (Chelsea)	4,965	1,191	24%
Private Care Centre	385	69	18%
Wiltshaw Ward Consulting Room	3	0	0%
Ambulatory Inpatients (Bud Flanagan West)	106	27	25%
Bud Flanagan Ambulatory Care Unit	1,244	231	19%
Children's Day Unit	1,898	64	3%
IV Services (Sutton)	0	0	-
Kennaway Day Unit	571	35	6%
Medical Day Unit (Sutton)	4,613	123	3%
Minor Procedure Suite	128	32	25%
Mobile Chemotherapy Unit	269	0	0%
Oak Day Unit	349	219	63%
Robert Tiffany Day Unit	1,556	235	15%
Teenage Cancer Trust Unit	0	0	-
West Wing Day Unit	812	429	53%
Sir William Rous Unit	1,442	22	2%
Total	21,013	3,115	15%

10.9.10. The table below shows chemotherapy waiting times (from patient's arrival in clinic to start of treatment) for Quarters One and Two 2018/19.

Appointments	No waiting	1min-1hr	>1hr-2hrs	>2hrs-3hrs	>3hrs-4hrs	>4hrs-5hrs	>5hrs-6hrs	>6hrs-8hrs	Over 8hrs
Granard House Day Unit	93	606	479	460	412	249	131	53	3
Main Outpatients	18	117	39	6	4	1	1	0	0
Medical Day Unit (Chelsea)	399	2,083	509	279	504	593	407	177	14
Private Care Centre	17	88	69	72	70	37	22	10	0
Wiltshaw Ward Consulting Room	0	2	0	0	1	0	0	0	0
Ambulatory Inpatients (Bud Flanagan West)	4	63	5	3	4	2	11	12	2
Bud Flanagan Ambulatory Care Unit	100	384	266	141	122	109	88	32	2
Children's Day Unit	268	775	490	226	75	37	18	9	0
IV Services (Sutton)	0	0	0	0	0	0	0	0	0
Kennaway Day Unit	57	372	58	32	17	23	9	3	0
Medical Day Unit (Sutton)	1,742	2,317	82	152	197	69	40	13	1
Minor Procedure Suite	11	36	20	11	18	21	10	1	0
Mobile Chemotherapy Unit	105	160	3	1	0	0	0	0	0
Oak Day Unit	7	34	23	31	35	44	84	83	8
Robert Tiffany Day Unit	96	312	177	379	357	143	65	26	1
Teenage Cancer Trust Unit	0	0	0	0	0	0	0	0	0
West Wing Day Unit	23	201	72	46	41	108	177	140	4
Sir William Rous Unit	163	1,084	120	24	29	14	5	3	0
Total	3,103	8,634	2,412	1,863	1,886	1,450	1,068	562	35

10.10. JACIE accreditation

- 10.10.1. The Joint Accreditation Committee of the International Society for Cellular Therapy (ISCT) and the European Group for Blood and Marrow Transplantation (EBMT) (known as JACIE) promotes high-quality patient care and laboratory performance in haematopoietic stem cell collection, processing and transplantation centres through voluntary accreditation. The Royal Marsden service was first accredited in June 2009.
- 10.10.2. The full inspection of the Stem Cell Transplant service last November highlighted many areas of good practice but also some raised some points where improvement was needed. Over the quarter, further work was completed to address these improvement actions and these were submitted to the JACIE inspection team, as required, on 5th August.
- 10.10.3. The introduction of a new IT system capable of producing ISBT128 compliant labels and improved IT capabilities across the service has now been agreed. Contract agreement is now complete and the project plan for procurement, installation and commissioning can now proceed.

- 10.10.4. Plans to improve the Stem Cell Laboratory facilities have received approval by the Trust and work is scheduled to begin within the next three months. Plans have been submitted to the JACIE office as a response to inspection findings detailed in the report of February 2018.
- 10.10.5. A planned upgrade to the Q-Pulse document management system has begun with the provision of a new server. A new web-based version of Q-Pulse has now been released which will be rolled-out across the trust over the coming weeks.
- 10.10.6. JACIE has classified the Trust as “pending reaccreditation” until the accreditation committee have completed their assessment of the actions being taken. No response has yet been received but is expected within the next month.
- 10.10.7. Internal quality audits of processes are carried out regularly covering all areas of the transplantation service. A relatively quiet period in the quarter allowed seventeen further audits to be completed, within the Stem Cell Laboratory and Apheresis department with findings reviewed at Haematopoietic Stem Cell Transplant (HSCT) and Stem Cell User Group meetings.
- 10.10.8. The HSCT unit continued to identify, evaluate and report errors, accidents, and suspected reactions, which are reported through the Trust’s electronic incident reporting system (Datix) and discussed at the HSCT Committee and at the Haemato-oncology Risk Management Committee. During the quarter, 36 incidents attributable to transplant patients were raised, compared to 34 in the previous quarter. All the incidents were graded *very low* (21) or *low* (15). The largest category was medication incidents which accounted for 13 (36%) of the total.
- 10.10.9. Planned deviations from standard operating procedures are brought to the HSCT Committee for discussion and sign off. Within the period of this report, four planned deviations were recorded. It was agreed by the committee that unplanned deviations will in future be logged as incidents.
- 10.10.10. No transplant related formal complaints were received during this quarter.

10.11. Imaging Services Accreditation Scheme (ISAS)

- 10.11.1. The first annual ISAS reaccreditation document assessment was completed by the required date. The United Kingdom Accreditation Service’s (UKAS) web-based assessment tool was used to submit 1500 items of documentary evidence to demonstrate continued compliance to the ISAS standard. No physical inspection is required until September 2019.
- 10.11.2. The report from the inspection team was received on 5 October and confirmed that continued accreditation had been granted pending the closure of seven minor improvement actions. In addition, three recommendations were made that are not mandatory but will be included in the action plan. Evidence of completion of the seven mandatory actions is required by 5 November. Three of the seven actions were complete and the others were in progress. It was considered that the deadline could be achieved.

- 10.11.3. In September the ISAS Quality Manager and members of the imaging team attended the first ISAS London Regional Network Meeting at St Thomas' Hospital where details of the accreditation process at The Royal Marsden were presented to other organisations. This was very well received and has resulted in invitations to present at other meetings. It is hoped that the Regional Network will further develop to provide a forum at which to share best practice and experience and help form closer links to UKAS, the Royal College of Radiologists and other trusts.
- 10.11.4. The Quality Assurance in Diagnostic Imaging Services (QADIS) Meetings took place as planned on 21 August and 15 October. The ISAS web-based document submission, subsequent report and required improvement actions were discussed together with a number of other quality objectives. Minutes are available from the Quality Assurance Team.
- 10.11.5. Incidents are reported in accordance with Trust policy using the Datix Incident Reporting System, which is used to analyse incident details. In the quarter, 39 incidents relating to imaging services were recorded compared to 56 in the previous quarter. Twenty-four were graded *very low* and 15 *low*. No cases were recorded that were graded *moderate* or above but one case recorded short term harm to a patient and was discussed at a Discrepancy Meeting and the September meeting of the Trust's Integrated Governance and Risk Management Committee.
- 10.11.6. Over the quarter no formal complaints relating to imaging services were received. Seven letters of praise and thanks were logged.

10.12. Research governance

10.12.1. Research sponsor

Trust sponsorship was awarded to the following six projects:

Reference number	Title	Single or multiple centre
CCR4938	iSCORE: Immunotherapy Sequencing in Colon and Rectal Cancer	Single
CCR4964	Managing the experience of prostate biopsy: what are men's perceptions of their lived experience and support needs?	Multiple
CCR4892	IDOL: Magnetic Resonance Imaging Diagnosis of Uterine Leiomyosarcomas	Multiple
CCR4984	Molecular features of very late recurrence in ER+ breast cancer	Single
CCR4995	SWELL-G: Pilot Study Evaluation of the Clinical Implementation of SWELL-G: a Patient Reported Outcome Measure (PROM) for Sexual Difficulties in Women Treated by Pelvic Surgery and/or Radiotherapy for Cervical or Endometrial Cancer	Multiple
CCR4977	GOLF: Genetic signature for patients at risk of Lung cancer – a feasibility study	Multiple

10.12.2. Suspected unexpected serious adverse drug reactions

The following is a breakdown by study of the 23 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	3	3	0	0
CP8	1	1	0	0
DC4	1	1	0	0
DT4	2	2	0	0
DT5	1	1	0	0
JB58	2	2	0	0
JB59	1	1	0	0
JLo3	1	1	0	0
JLo4	3	3	0	0
MA2	1	1	0	0
MK2	4	4	0	0
NT2	1	1	0	0
UB15	1	1	0	0
UB19	1	1	0	0

* REC: Research ethics committee

10.13. Human Tissue Authority – human application licence

10.13.1. Compliance

The Stem Cell Transplant facility at Sutton 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 January 2019.

In July 2018 the licence was extended to cover the procurement of cells to be used as a starting point for the manufacture of cellular therapies such as CAR-T cells. There are plans to extend the licence further to cover other cell types and additionally to apply for a licence to cover procurement of tissues and cells at the Chelsea site.

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.

10.13.2. Quality improvement – audits

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

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

- *An audit of external facilities performing services for the Stem Cell Transplant Laboratory (SCTL)*

The six external suppliers that were audited performed well and no problems were identified. These companies provide critical services to the stem cell lab.

Critical process audits:

- *Re-audit of post-thaw CD3 viability*

This audit found that the viability of all tested samples met the target values.

- *Supplier audit – donor registry*

The donor registry met the expected level of service.

- *Donor consent for bone marrow donation*

All donors were consented but confirmation of consent was only met in 26% of cases. Staff have been reminded to record this. Audit to be repeated.

- *Audit of cleaning documentation associated with clean room processing*

Cleaning is being recorded correctly on individual patient worksheets but general cleaning log completion was 76%. A new procedure has been put in place to rectify this. To be re-audited.

- *Audit of sterility of cleaning agents used in the clean room*

No microbial growth was detected in cleaning agents over the life-span of their use within the clean room.

- *Audit of SCTL batch logging*

This has improved since the last audit but some transcription errors persist. This will be monitored.

- *Audit of overnight particle counting in clean room*

This audit showed that the clean room meets regulatory and local requirements in the at-rest state.

- *Re-audit of in-process particle counting*

No particles were detected when cell products were open to the environment. Results meet local and regulatory requirements.

10.13.3. 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 SCTL collates, evaluates and investigates errors, accidents and incidents according to Trust protocols and in order to comply with HTA regulations.

During this quarter three incidents were reported. Two involved the loss of a small quantity (<1% of product volume) of the cell product at the time of infusion. The third incident was the presence of a number of clots in the patient's harvest during the apheresis collection process.

10.14. Clinic waiting times

10.14.1. Standard

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

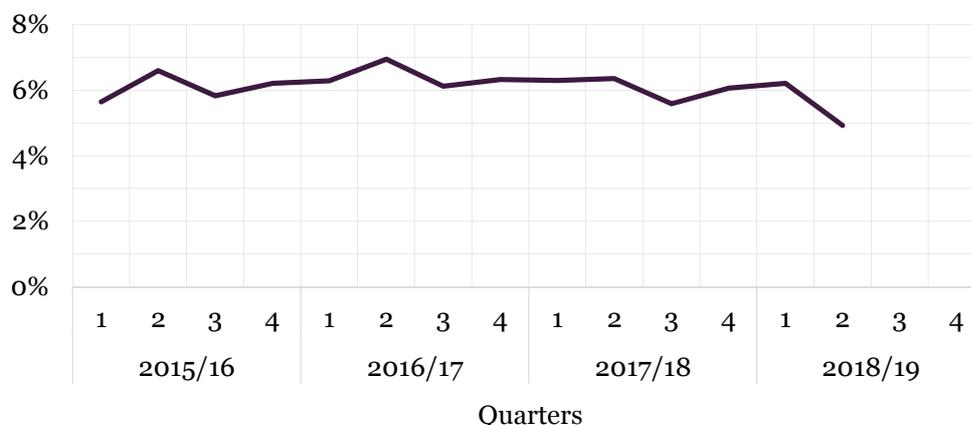
10.14.2. Waiting times

	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	Quarter 1 2018/19	Quarter 2 2018/19
Total (all patients seen in outpatient clinics)	42,487	42,940	43,756	44,421	44,145
Patients seen in 30 minutes or less	35,660 (83.9%)	37,491 (87.3%)	37,758 (86.3%)	39,064 (87.9%)	39,246 (88.9%)
Patients seen after 30 minutes and up to 1 hour	4,583 (10.8%)	3,597 (8.4%)	3,785 (8.7%)	3,398 (7.6%)	3,249 (7.4%)
Patients seen after 1 hour	2,244 (5.3%)	1,852 (4.3%)	2,213 (5.1%)	1,959 (4.4%)	1,650 (3.7%)

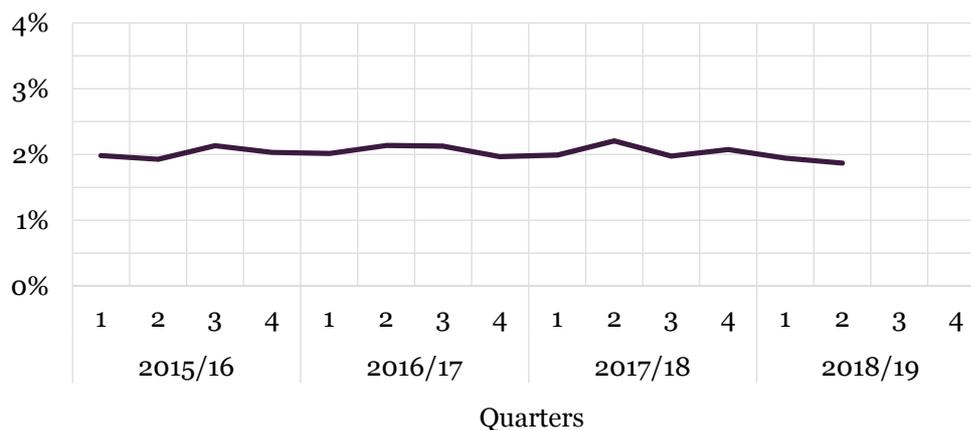
Monitoring sample: NHS patients included in the computerised booking system (excluding Bud Flanagan outpatients and invalid records) including the clinic types: consultant, nurse and professions allied to medicine e.g. physiotherapy.

10.15. Outpatient non-attendances

10.15.1. Non-attendance at first appointment

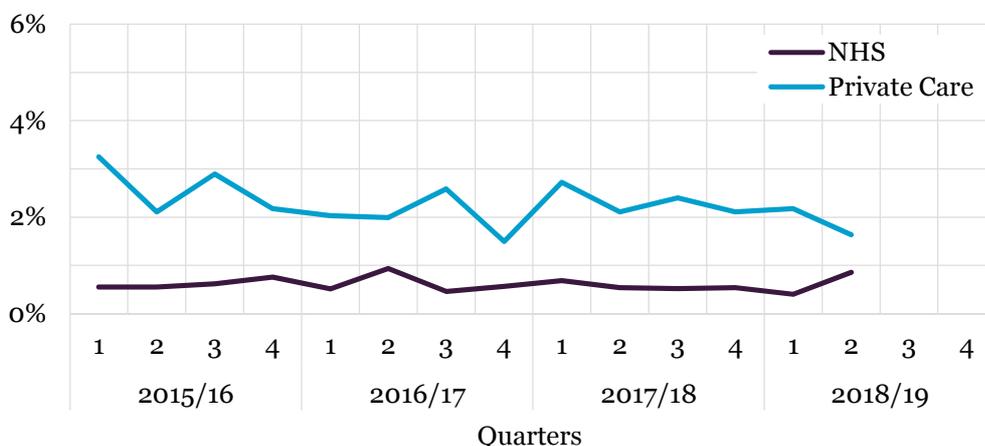


10.15.2. Non-attendance at subsequent appointment



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

10.16.1. In the quarter 0.85% of NHS clinics (44 out of 5,157) and 1.63% of private care clinics (36 out of 2,203) 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.



10.16.2. 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	26	110	26	61	52	171
Doctor attending meeting	8	37	6	15	14	52
Clinic day changed	7	30	1	2	8	32
Unexpected emergency	2	28	0	0	2	28
Doctor attending conference	0	0	2	3	2	3
Doctor on study leave	1	1	1	1	2	2
Total	44	206	36	82	80	288

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	61	40	5	106
Concerns relating to private care patients	9	0	Not applicable	9
Total	70	40	5	115

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

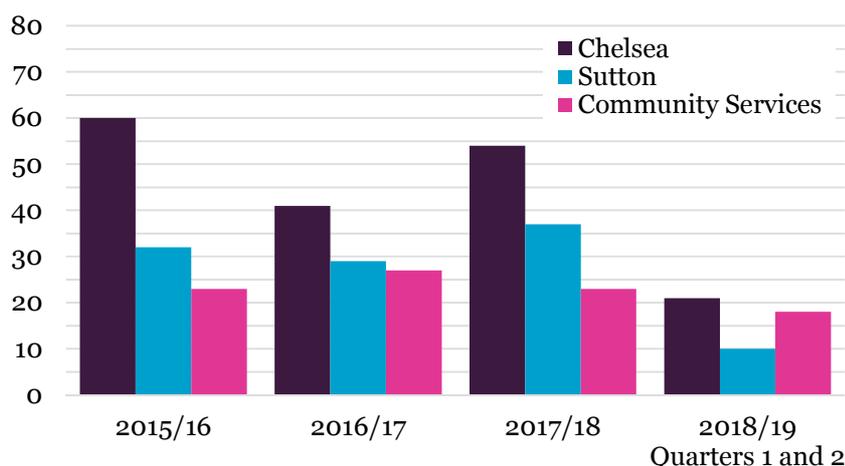
It is a Trust standard that all complainants receive

- 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	6	7	22
Complaints acknowledged within three working days	9 (100%)	5 (83%)	7 (100%)	21 (95%)

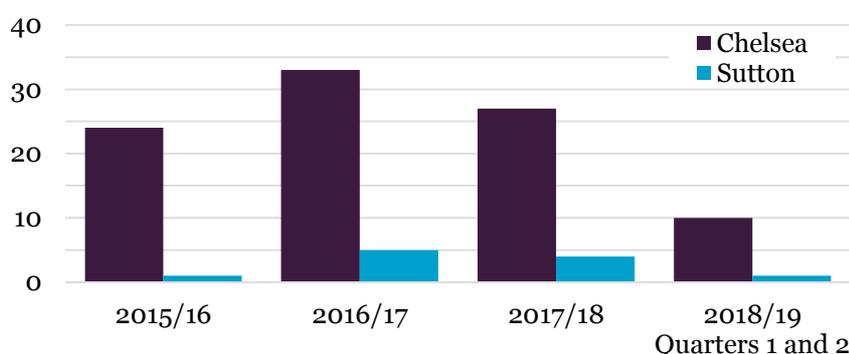
11.1.6. Number of complaints by financial year and site (NHS patients)



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

	Chelsea	Sutton	Total
Complaints received	8	1	9
Complaints acknowledged within three working days	8 (100%)	1 (100%)	9 (100%)

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

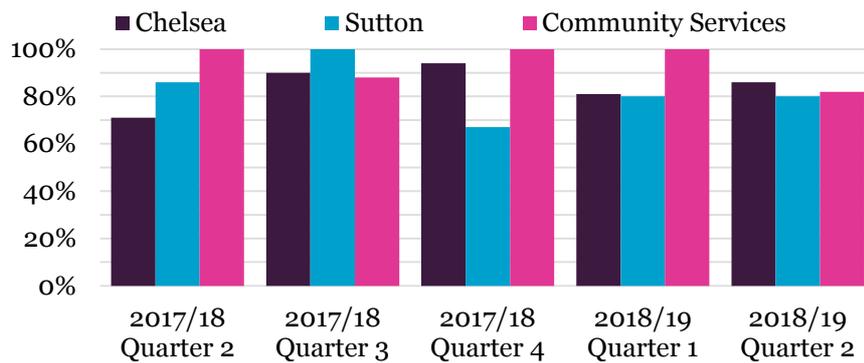


11.1.9. Number of complaints completed this quarter (NHS patients)

	Chelsea	Sutton	Community Services	Total
Complaints completed	12	5	11	28
Complainants receiving a response within agreed deadline	10 (83%)	4 (80%)	9 (82%)	23 (82%)

Complaints performance has been measured on complaints closed within the quarter to provide a definitive performance indicator. The breaches were due to length of investigation; awaiting a statement from a member of staff and awaiting final signature. Some investigations are more complex than others and although the Trust works to a 25 working day timescale for investigations, this is not always possible and will be agreed with the complainant.

11.1.10. Responses within agreed deadline (NHS patients)

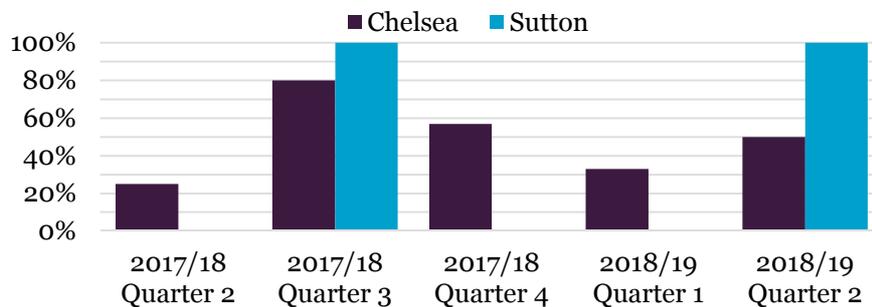


11.1.11. Number of complaints completed this quarter (private care patients)

	Chelsea	Sutton	Total
Complaints completed	4	1	5
Complainants receiving a response within agreed deadline	2 (50%)	0	2 (40%)

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

11.1.12. Responses within agreed deadline (private care patients)



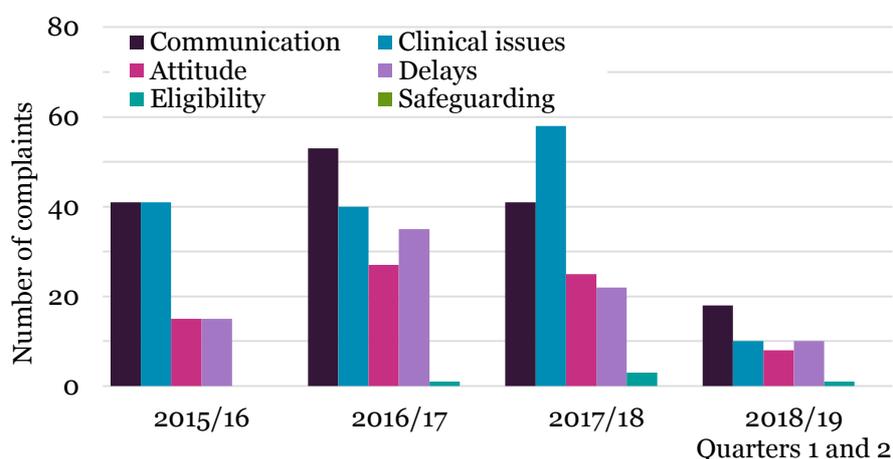
11.1.13. NHS complaints by patients' clinical commissioning groups (CCGs)

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

CCG	Number of complaints
NHS Bedfordshire	1
NHS Croydon	1
NHS Hammersmith and Fulham	3
NHS Havering	1
NHS Kingston	1
NHS Merton	1
NHS North West Surrey	1
NHS Richmond	2
NHS Surrey Downs	2
NHS Sutton	9
NHS West London	1
Total	22

11.1.14. Complaint subjects: main themes by financial year

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



11.1.15. Ethnicity of complainants for complaints received this quarter

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

Ethnic origin of complainant	Number of complaints
Asian Bangladeshi	0
Asian Indian	0
Asian Pakistani	0
Asian (other)	0
Black African	0
Black Caribbean	0
Black (other)	0
Chinese	0
Mixed White and Asian	1
Mixed White and Black African	0
Mixed White and Black Caribbean	0
Mixed (other)	0
White British	6
White Irish	0
White (other)	5
Other	1
Not disclosed	6
Awaiting confirmation	12
Total	31

11.1.16. Complaints completed this quarter – Chelsea

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Blood tests	Very low	Appointments	Difficulty in drawing patient's blood and attitude of nurse caused pain and upset	Staff reminded of process for accessing difficult veins. Apologies given.	Partly upheld
Breast	Very low	Access to treatment or drugs	Treatment and attitude of staff during inpatient stay	Staff reminded of the importance of clear communication.	Not upheld
Facilities	Very low	Communications	Attitude of receptionist	Manager discussed with member of staff and apologies given. Staff reflection.	Upheld
Gastro-intestinal	Low	Appointments	Poor organisation and administration resulting in regular delays	Review of service and pathways underway. Additional staff trained to support service and alleviate waiting times.	Upheld

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Gynaecology	Low	Access to treatment or drugs	Multiple delays in surgery	Explanation that surgery delays were unavoidable due to patient's poor health.	Partly upheld
Gynaecology	Very low	Access to treatment or drugs	Patient experienced side effects following chemotherapy	Reassurance given that patient was not given the medication that they did not want.	Partly upheld
Head and neck	Low	Admissions and discharges	Nursing care following surgery	Reiterated to staff the importance of escalating appropriately.	Partly upheld
Head and neck	Very low	Patient care	Family unhappy with behaviour of medical staff	Apology given for staff member's behaviour. They have reflected on their manner.	Upheld
Histo-pathology	Low	Patient care	Patient's second opinion showed carcinoma although thyroidectomy elsewhere showed no signs of malignancy	Reports are based on opinion and not always clear cut. Trust now carrying out doubt screening of patient samples.	Not upheld
Private patients	Very low	Appointments	Reoccurrence of scan delays Last minute cancellation of appointment	Apology for administration error in scan booking. Two consultant radiologists have been employed to help with service demands.	Upheld
Private patients	Low	Communications	No adequate explanation as to why report was never sent to patient's GP	Breakdown in communication as Histopathology Team was not informed of the patient. Actions set to improve communication.	Upheld
Private patients	Very low	Patient care	Unhappy with manner of medical team during endoscopy	Apology given. Staff member will undergo training.	Upheld
Private patients	Very low	Access to treatment or drugs	Delay in receiving NHS eligibility letter	Explanation given for not allowing patient transfer to NHS half way through treatment.	Partly upheld
Sarcoma	Low	Patient care	Computed tomography (CT) scan queries. Transport issues resulted in cancelled appointments	Explanations regarding why scan was not performed. Apologies for transport issues.	Partly upheld
Sarcoma	Low	Patient care	Poor communication resulted in unexpected biopsy performed in clinic. Lack of compassion and support	Apology for poor communication. Appointment letters will be reviewed to reflect the possibility of a biopsy on the day.	Upheld

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Urology	Very low	Communications	Incorrect diagnosis stated on discharge summary	Apologies given for administrative error. Staff training.	Upheld

11.1.17. Complaints completed this quarter – Sutton

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Breast	Very low	Communications	Poor behaviour of medical staff when examining patient	Apology and reassurance given that expectations of service have been reiterated to staff .	Upheld
Corporate services and private practice	Low	Privacy, dignity and wellbeing	Medical Day Unit does not have private rooms for patients that request them	Team looking to provide an area dedicated for patients requiring bloods. Private rooms and beds offered when necessary.	Upheld
Drug development unit	Low	Communications	Clinic letter has inaccuracy Conflicting information regarding clinical trial and surgery	Apology given that patient was not fully informed about the potential impact of the procedure.	Partly upheld
Head and neck	Very low	Communications	Unhappy with tone and lack of sympathy of clinic letter	Apology and reassurances given that Clinical Business Unit Manager is looking into this on a wider scale.	Partly upheld
Private patients	Very low	Waiting times	Poor IT system and failures Poorly designed Medical Day Unit lacks privacy	Trust is investing in new network infrastructure and looking at additional space for Medical Day Unit.	Partly upheld
Sarcoma	Low	Patient care	Recurrence of cancer was not identified and team did not respond adequately to new symptoms	Disease progressed despite chemotherapy. New symptoms addressed appropriately.	Not upheld

11.1.18. Complaints completed this quarter – Community Services

Service area	Risk grade	Subject	Concern	Action taken	Outcome
District nursing day	Low	Patient care	Delay in wound dressing being changed	Apology given for the lack of communication and information given to main carer regarding the change in the wound care.	Upheld
District nursing day	Very low	Patient care	Poor continuity of care provided by night nurses	Responsibilities of night visiting team explained.	Partly upheld

Service area	Risk grade	Subject	Concern	Action taken	Outcome
End of life care	Low	Patient care	Delay in palliative care being set up for patient	Staff involved will undergo additional training as referral was not appropriately managed.	Upheld
Health visiting	Very low	Values and behaviour (staff)	Several issues relating health visit	Apology for failures and experience .	Upheld
Musculo-skeletal service	Low	Patient care	Care, treatment and referral process of the Musculoskeletal Service	Appropriate guidance and escalation process was followed.	Partly upheld
Musculo-skeletal service	Very low	Access to treatment or drugs	Patient informed to go through physiotherapy to get scan which took one year	Patient's care was followed according to care plan.	Not upheld
Older people's assessment and rehabilitation service	Low	Patient care	Delay in referral for continuing care	Reassurance given that process was adhered to and apology for lack of response to call requests.	Partly upheld
Physiotherapy – outpatients	Very low	Appointments	Delay in initial physiotherapy appointment	Apology given for patient's incorrect address and delay caused as a result of this.	Partly upheld
Physiotherapy – outpatients	Very low	Appointments	Unhappy with wait for first physiotherapy appointment	Staff did not ask patient pre-set questions or did not record answers appropriately.	Upheld
Podiatry – community	Very low	Access to treatment or drugs	Toenail cutting service has been stopped	Confirmation that service has been stopped by clinical commissioning group.	Not upheld
Podiatry – diabetes	Very low	Access to treatment or drugs	Toenail cutting service has been stopped.	Confirmation that service has been stopped by clinical commissioning group.	Not upheld

11.1.19. NHS Digital data – benchmarking

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

The results for Quarter One 2018/19 (the latest available) are shown in the table below for selected service providers.

	Total brought forward	Total new	Total resolved	Number upheld	Number partially upheld	Total not upheld	Total carried forward
NHS England	21,715	29,706	28,330	9,460	8,661	10,209	23,091
NHS England London	3,436	5,204	5,065	1,701	1,668	1,696	3,575
The Royal Marsden	23	26	21	7	11	3	28
The Christie NHS Foundation Trust	4	21	13	2	5	6	12
University College London Hospitals NHS Foundation Trust	167	214	196	42	108	46	185
Chelsea and Westminster Hospital NHS Foundation Trust	164	218	288	122	94	72	94
St George's University Hospitals NHS Foundation Trust	272	260	304	304	-	-	228

From webpage digital.nhs.uk/data-and-information/publications/statistical/data-on-written-complaints-in-the-nhs/2018-19-quarter-1-experimental *Data on written complaints in the NHS – 2018-19 Quarter 1* on the NHS Digital website (published 6 September 2018; retrieved 31 October 2018).

11.1.20. Learning from complaints

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

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

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

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

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

Communication

Staff are reminded of the importance of clear introductions and communication with patients during clinic appointment to include discussing the process of physical examinations.

Staff are reminded that it is important to have clear and timely communication with patients when following up on their queries/concerns.

Delays

Administration teams have undergone additional training to ensure that appointments are made in a timely manner and adjusted if necessary.

Clinical issues

Clinical staff within outpatients have been reminded of the process for handling patients with difficult to access veins.

Attitude of staff

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

11.1.21. Parliamentary and Health Service Ombudsman referrals

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

The Trust currently has one complaint under investigation by the Ombudsman.

11.2. Letters of praise

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

11.2.2. In the quarter 162 letters of praise were received by the Head of Clinical Legal Services, Complaints and Patient Information. Some examples of the comments made in letters of praise follow.

11.2.3. Chelsea

General thanks

Thanks to the excellent treatment I received fifteen years ago, I am celebrating my 90th birthday next Saturday. God bless.

Burdett Coutts Ward

Thank you for all your support throughout this placement. You have all made me feel much more confident in my abilities.

Outpatients

Today I would like to say a big heartfelt thank you to everyone involved in my treatment here – you saved my life! You have been so supportive to both my wife and myself along this bumpy road. This is truly a fantastic example of just how good our precious NHS really is.

11.2.4. Sutton

Oak Ward

If there are any better than you I'm yet to experience them, so I thank you for being the best and treating me with kindness and respect.

Medical Day Unit

Thank you for all the support and understanding through my chemo. Always a kind word at hand.

Rapid Diagnostic Breast Clinic

I was pleased with the service I have received today. The staff were excellent, they were explaining clearly every step to me. Thank you all.

11.2.5. Community Services

Diabetes

I am deeply grateful to you for fitting me into your busy schedule recently. Your help was most invaluable in normalising my sugar levels which was deeply appreciated. My life is much better now.

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 16	Patient fall	Panel review 29 August 2018
Investigation 17	Pressure ulcers	Panel review 5 October 2018
Investigation 19	The Royal Marsden Macmillan Hotline	Panel review 22 October 2018
Investigation 20	Radiology	Discrepancy review 14 August 2018
Investigation 21	Pressure ulcer	Panel review 16 November 2018
Investigation 22	Patient fall	No panel required
Investigation 23	Equipment	No panel required
Investigation 24	Nasoendoscope	Panel review 15 November 2018
Investigation 25	Patient controlled analgesia	Panel review 30 October 2018
Investigation 26	The Royal Marsden Macmillan Hotline	Panel review 22 October 2018
Investigation 27	Pressure ulcer	Panel review 22 October 2018
Investigation 28	Missing documents	No panel required

Investigation number	Description	Investigation update/panel date
Investigation 29	Radiotherapy	Panel review 1 November 2018
Investigation 30	Paediatric multidisciplinary team	Panel date to be confirmed

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 34 (Yellow)	Radiologically Inserted Gastrostomy (RIG)	Complications following the procedure.	The Royal Marsden Macmillan Hotline RIG/triage flowchart advises that all potential RIG bleeds should be directed to the patient's local Emergency Department immediately
Investigation 59 (Yellow)	Delay in follow up	It was agreed that if the patient had been followed up three weeks later as planned the outcome would not have been different.	Discuss outcome of the investigation with the 14 secretarial teams to share lessons learnt specifically highlighting the importance of checking that appointments have been made.
Investigation 60 (SI)	Radiotherapy	The panel concluded that in this incident policy was followed when checking the pregnancy status prior to radiotherapy treatment and the risks of becoming pregnant were clearly highlighted to the patient.	Change the radiotherapy protocol to re-confirm pregnancy question at the patient's first treatment.

Investigation number and incident grade	Description	Outcome of investigation	Action taken following investigation include:
Investigation 5a (Orange)	Pressure ulcer	Following review of this incident the panel members were in agreement that this category 4 pressure ulcer was attributable to the Trust and avoidable due to the care and service delivery problems identified.	Training to all nursing staff to include the importance of completion of documentation.
Investigation 6 (SI)	Delay in diagnosis	It was the opinion of the panel that it is not possible to determine whether the outcome would have been different with earlier intervention.	A safeguard to be implemented in pharmacy to ensure that patients prescribed high dose steroids for four weeks or longer are flagged to a patient's consultant.
Investigation 7 (Green)	Lost equipment	The investigation was unable to establish the specific reason why the cystoscopes went missing due to security lapses within and outside the decontamination room and insufficient monitoring of the flexible endoscopes on a daily basis.	Closed circuit television (CCTV) outside the clean room to the decontamination room to be activated. The lift outside the back entrance to the decontamination room to be restricted to staff use only from the basement.
Investigation 9 (Green)	Controlled drug count	The <i>Controlled drugs: policy for safe management</i> was not followed – in particular the checking of controlled drugs prior to administration, controlled drug keys, recording of controlled drugs in the register and transfer of controlled drugs between theatres.	Standard operating procedure to be developed for theatres in relation to the storage, recording and administration of controlled drugs (to be added as an appendix to <i>Controlled drugs: policy for safe management</i>). This will include: that the latest point that controlled drugs should be signed for at the end of each case, not at the end of the list.

Investigation number and incident grade	Description	Outcome of investigation	Action taken following investigation include:
Investigation 14 (Green)	IT network issues	The active Royal Marsden VPLS British Telecom (BT) Link became non-responsive and was not releasing data packets to the WAN switch. This was due to a BT line failure and was reported to BT at approximately 11:30hrs on the day of the incident.	The Royal Marsden to formally contact BT in writing to request a copy of the report into this incident. BT to be advised of the consequences of this failure, and assurance to be sought that remedial action has been taken to prevent similar occurrences in the future.
Investigation 16 (SI)	Patient fall	The patient suffered an accidental fall that may have been related to uneven flooring levels.	Balcony to remain closed until it can be raised the same level as the day room (with non-slip decking).
Investigation 20 (Orange)	Radiological discrepancy	The consensus of the meeting was that the characteristics of the lesion were not the usual indications of a brain metastasis.	Reviewed and discussed at radiology discrepancy meeting.
Investigation 22 (Orange)	Patient fall	Situational circumstance that resulted in a fall. The immediate care provided to the patient was excellent and the falls documentation was good.	Provide additional training on completion of falls assessments and continue to raise awareness of the importance of identifying patients at risk of falls.

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

- 11.4.1. If an incident occurs that is graded moderate harm or above, a specific process needs to be followed to meet the requirements of the duty of candour.
- The patient or their family/carer must be informed that a suspected or actual patient safety incident has occurred within at most 10 working days of the incident being reported to local systems (Datix).
 - The initial notification must be verbal (face to face where possible). The verbal notification must be accompanied by an offer of written notification. The notification must be recorded in the electronic patient record for audit purposes.
 - An apology must be provided – a sincere expression of sorrow or regret for the harm caused both verbally and in writing.
 - A step-by-step explanation of what happened, in plain English, based on fact must be offered as soon as is practicable. This may constitute an initial view pending an investigation, but patients and families must be kept informed of the process.

- Any incident investigation reports must be shared with the patient/family within 10 working days of being signed off as complete and the incident closed by the relevant authority.
- If the requirements of the contractual Duty of Candour are not met the Commissioners can withhold the cost of an episode of care or implement a fine of £10,000 if the cost is not known.

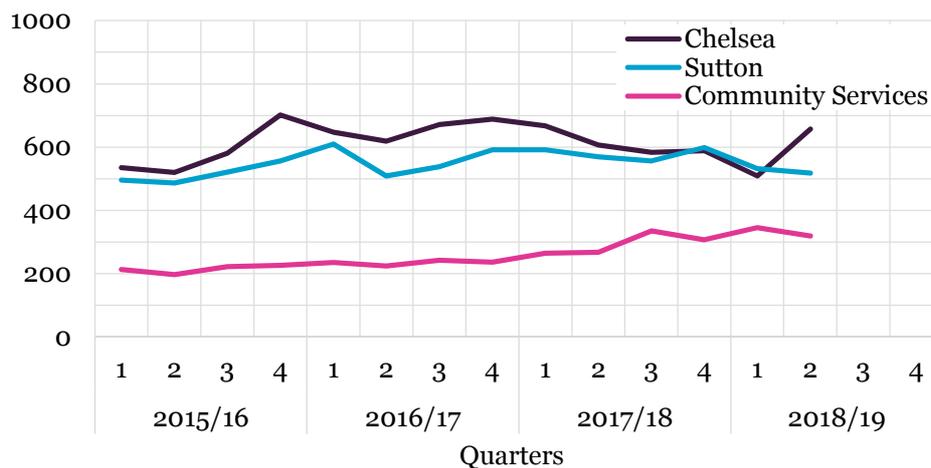
11.4.2. The *Being open and duty of candour policy* incorporates the requirement and the Risk Management team supports staff with this process to ensure compliance with the contractual requirement.

11.4.3. The Risk Management Team audits compliance against the requirements of the Duty of Candour six monthly. The next audit is due January 2019.

11.5. Incident statistics

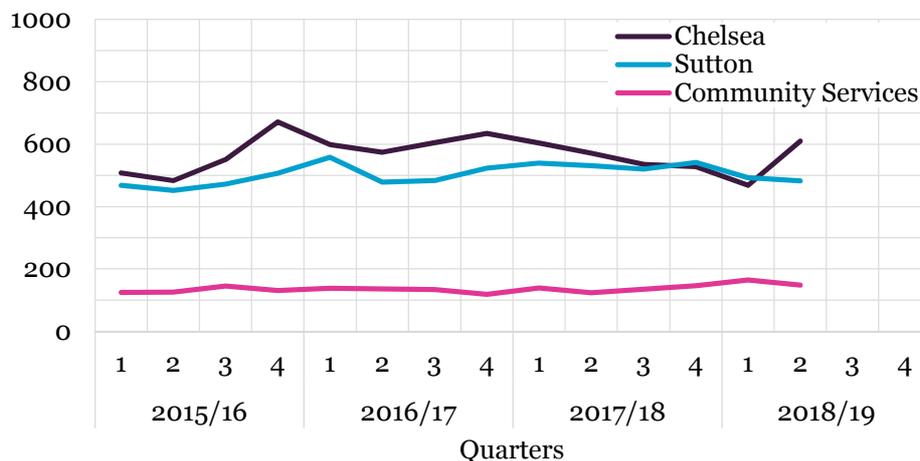
This section displays incident statistics for services which are currently run by The Royal Marsden NHS Foundation Trust. Historical data relating to services now commissioned by other healthcare providers have been excluded.

11.5.1. All reported incidents



11.5.2. All attributable incidents

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

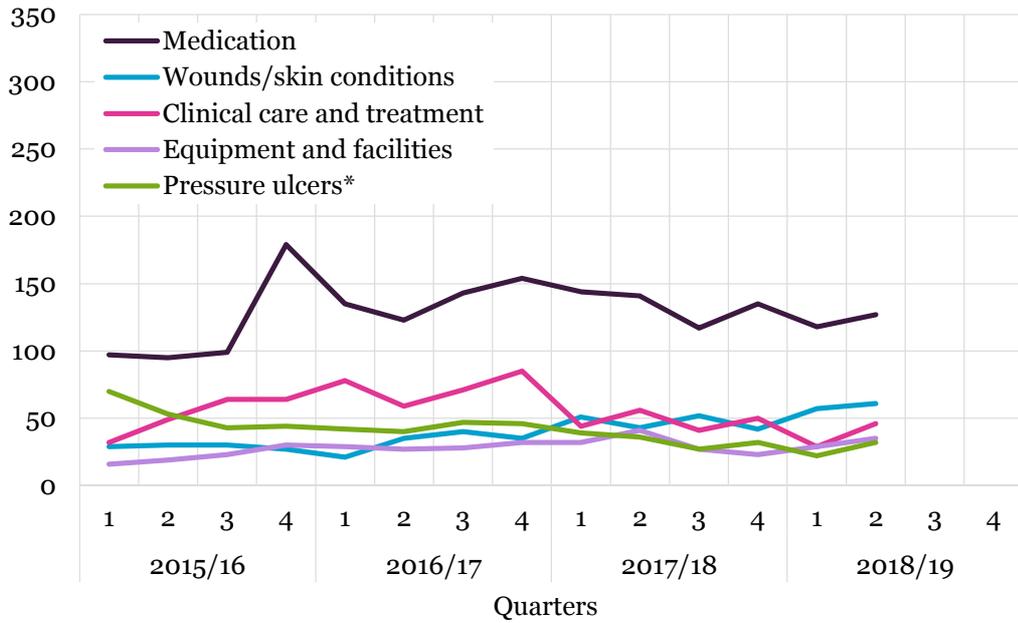


11.5.3. Patient safety incidents – top five categories

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

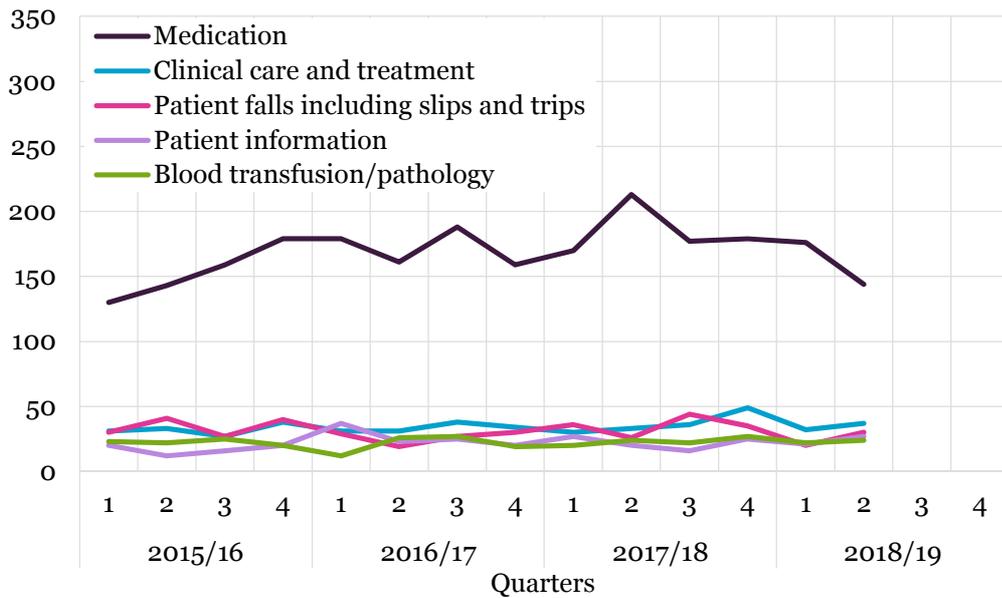
The charts show the five categories with the largest number of incidents in Quarter Two, and the number of incidents for these categories in previous quarters.

Chelsea

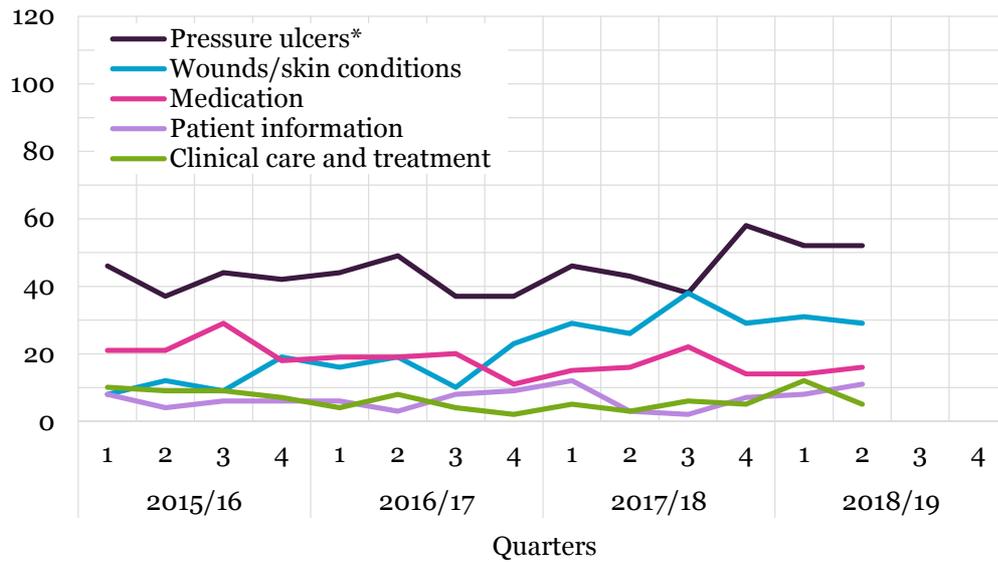


* One incident may represent more than one pressure ulcer.

Sutton



Community Services



* One incident may represent more than one pressure ulcer.

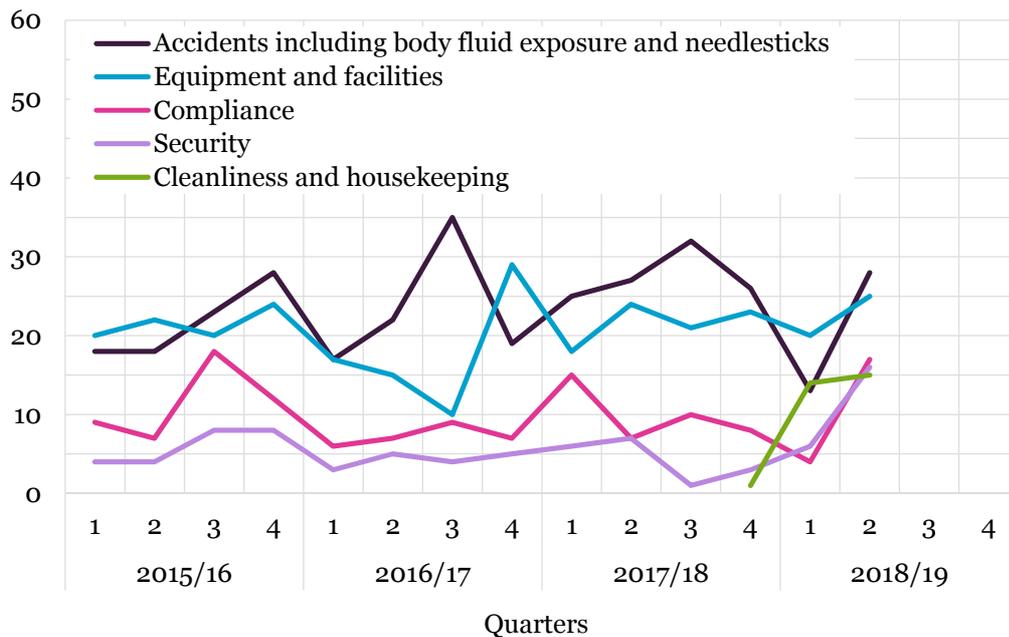
11.5.4. Non-patient safety incidents – top five categories

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

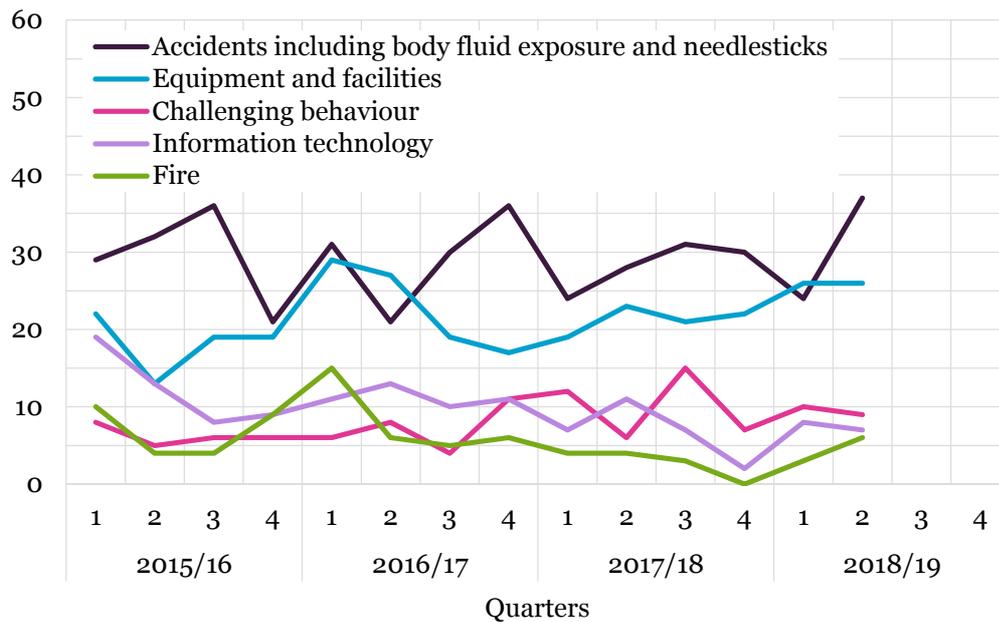
The charts show for the Chelsea and Sutton sites and for Community Services the five categories with the largest number of incidents in Quarter One, and the number of incidents for these categories in previous quarters.

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

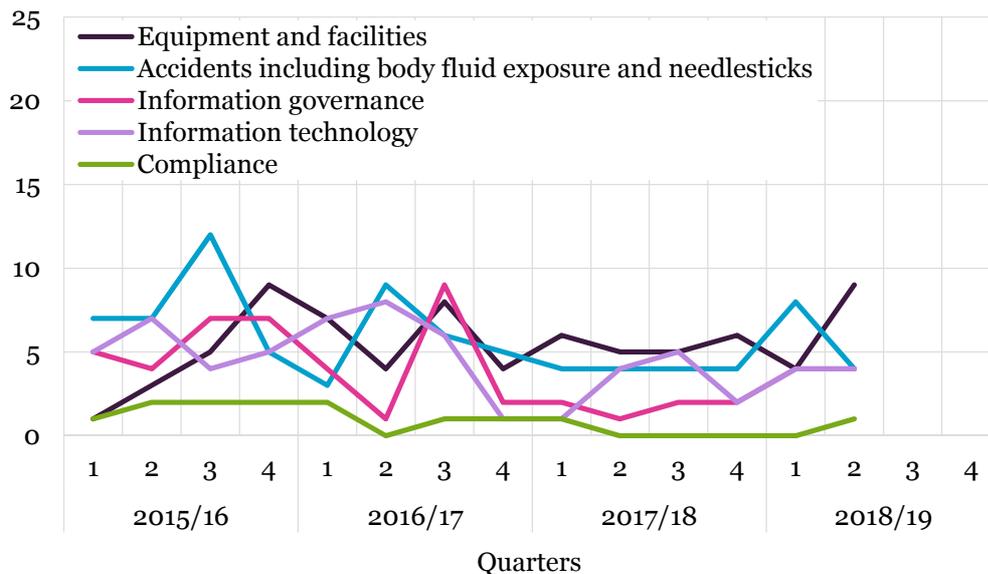
Chelsea



Sutton



Community Services



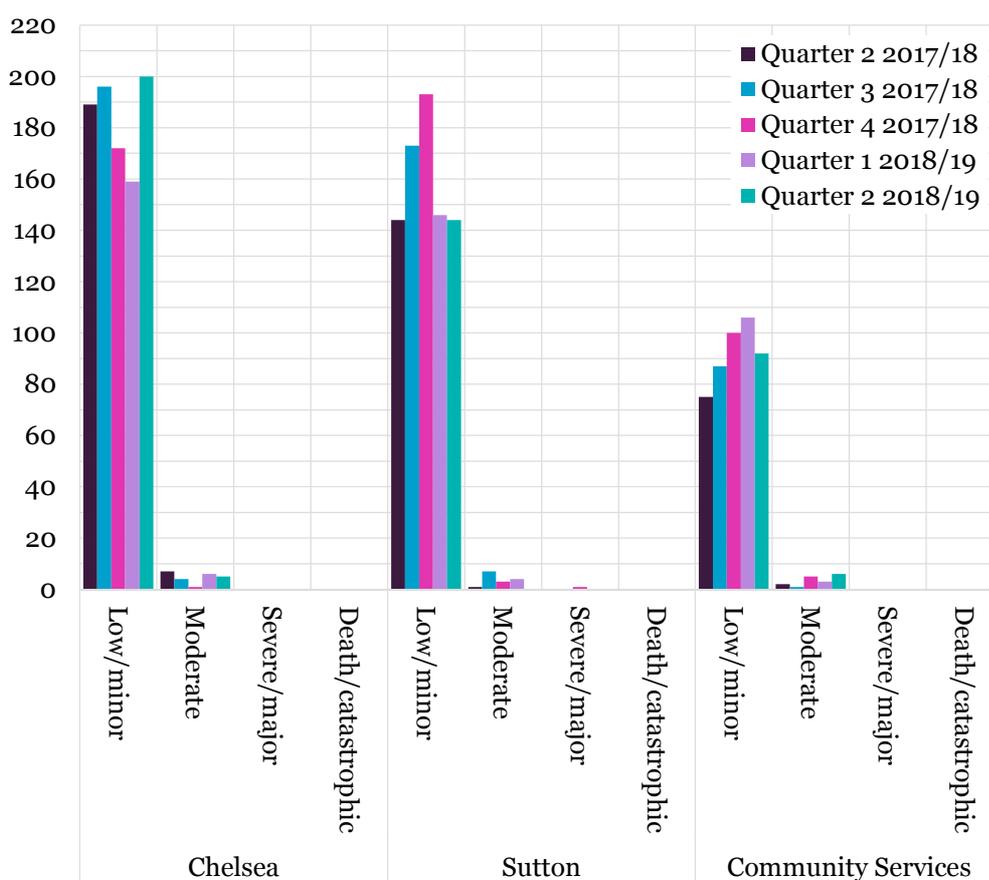
11.5.5. Severity

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

The categories are:

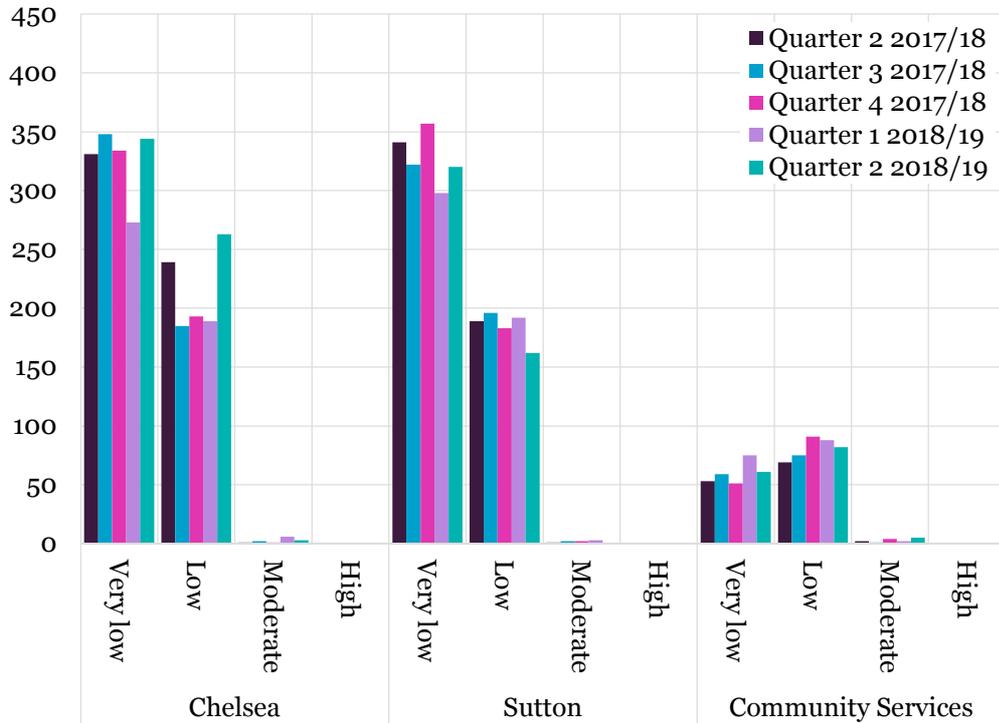
- No harm (listed in the table but not shown in the chart so that detail of the higher severity categories is clearer in the chart)
- Low/minor (minimal harm)
- Moderate (short term harm)
- Severe/major (permanent or long term harm)
- Death/catastrophic (caused by the incident).

		Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	Quarter 1 2018/19	Quarter 2 2018/19
Chelsea	No harm	375	335	355	303	405
	Low/minor	189	196	172	159	200
	Moderate	7	4	1	6	5
	Severe/major	0	0	0	0	0
	Death/catastrophic	0	0	0	0	0
Sutton	No harm	386	340	345	343	338
	Low/minor	144	173	193	146	144
	Moderate	1	7	3	4	0
	Severe/major	0	0	1	0	0
	Death/catastrophic	0	0	0	0	0
Community Services	No harm	47	47	41	56	50
	Low/minor	75	87	100	106	92
	Moderate	2	1	5	3	6
	Severe/major	0	0	0	0	0
	Death/catastrophic	0	0	0	0	0



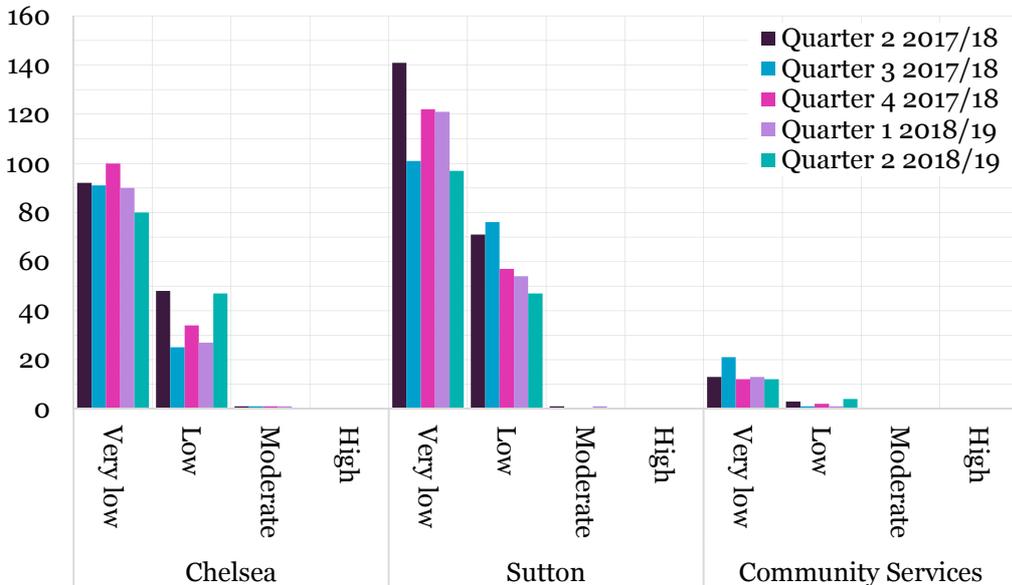
11.5.6. Risk grade

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



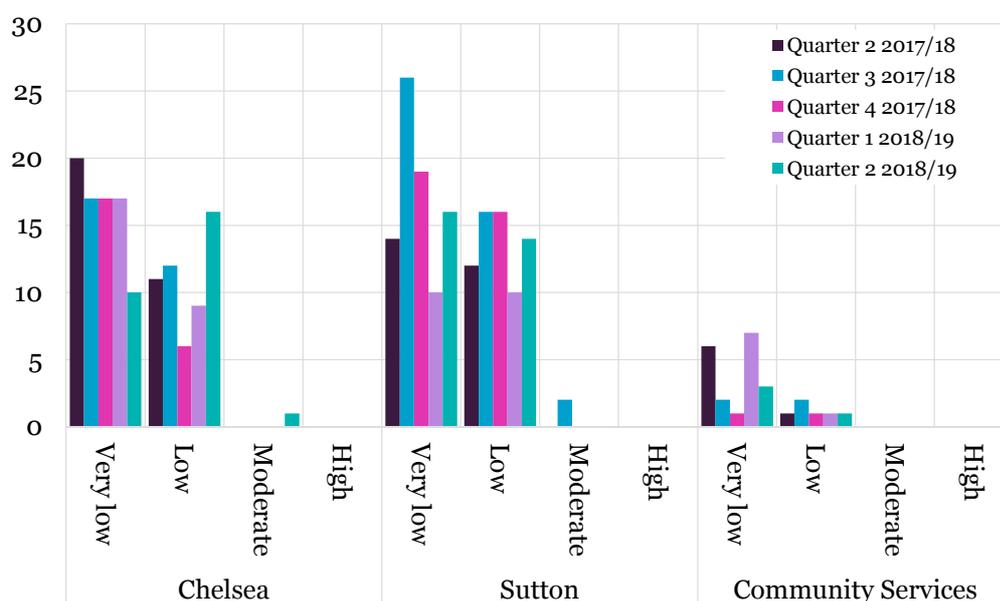
11.5.7. Medication incidents by risk grade

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



11.5.8. Patient fall incidents by risk grade

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



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

11.6.1. There was one incident involving a patient reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

- A patient sustained a fracture following a fall in the hospital. Full investigation was undertaken and a report submitted the Integrated Governance and Risk Management Committee (Investigation 16).

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.

12. Suitability of management

12.1. Reports to NHS Improvement and accounts

- 12.1.1. NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHS Improvement regulates foundation trusts to ensure they comply with the NHS provider licence. This is a detailed set of requirements covering how foundation trusts must operate.
- 12.1.2. In Quarter Two 2018/19 the Trust submitted the following finance and governance reports as part of the requirements:
- Month three 2018/19 In-Year Monitoring Workforce and Finance Returns and commentary sent on 9 July 2018
 - Month four 2018/19 In-Year Monitoring Workforce and Finance Returns and commentary sent on 7 August 2018
 - Month five 2018/19 In-Year Monitoring Workforce and Finance Returns and commentary sent on 6 September 2018
 - Updated annual plan to reflect change in Control Total and Provider Sustainability Fund income on 28 September 2018
 - Weekly agency returns sent to NHS Improvement on compliance with price caps and frameworks
- 12.1.3. In September 2016, NHS Improvement introduced a new Single Oversight Framework to align the approaches of the entities it consists of. One element of this, the Use of Resources Rating, replaced the previous Financial Sustainability Risk Rating. The Use of Resources Rating aligns providers into four segments: 1 (providers with maximum autonomy), 2 (providers offered targeted support), 3 (providers receiving mandated support) and 4 (providers in special measures).
- 12.1.4. At the end of Quarter Two 2018/19 The Royal Marsden had a Use of Resources Rating of 1. This means that the Trust is considered by NHS Improvement to be low risk in financial terms.

13. Glossary

AHP

Allied health professional.

Alfentanil

An opioid analgesic drug, used for anaesthesia in surgery.

ASD

Autism spectrum disorder.

bacteraemia

The presence of bacteria in the blood.

BacT/Alert

An automated microbial detection system.

brachytherapy

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

BRCA genes

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

care pathway

The route a person takes through healthcare services.

Care Quality Commission (CQC)

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

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

CCG

See *clinical commissioning group (CCG)*.

CDI

See *Clostridium difficile infection (CDI)*.

Cerebra

A charity for children with neurological conditions.

Channel

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

chemotherapy

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

ciprofloxacin

An antibiotic.

clinical commissioning group (CCG)

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

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

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

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

CNS

Clinical nurse specialist *or* Central nervous system.

commissioning

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

Commissioning for Quality and Innovation (CQUIN)

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

computed tomography (CT)

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

C-reactive protein (CRP)

A substance produced by the liver that increases in the presence of inflammation in the body. An elevated C-reactive protein level is identified by blood tests and can indicate inflammation which may be caused by a wide variety of conditions, from infection to cancer.

CQC

See *Care Quality Commission (CQC)*.

CQUIN

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

CT

See *Computed tomography (CT)*.

Customer Service Excellence standard

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

DAHNO

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

Data Security and Protection Toolkit (DSPT)

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

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

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

Datix

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

DNA

Patient non-attendance – 'did not attend'.

DSPT

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

eChemo

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

EPR

Electronic patient record.

Escherichia coli

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

ESMO

The European Society for Medical Oncology.

EudraLex

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

FCE

See *full consultant episode (FCE)*.

Five Senses Observation Study

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

full consultant episode (FCE)

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

GCP

See *Good Clinical Practice (GCP)*.

Good Clinical Practice (GCP)

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

haematopoietic stem cell (HSC)

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

In adults they are mostly found in bone marrow.

HCA

Healthcare assistant.

HCAI

See *Healthcare-associated infection*.

Healthcare-associated infection (HCAI)

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

Healthcare-associated infection Data Capture System (HCAI DCS)

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

holistic

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

holistic needs assessment

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

See *holistic*.

Hospital2Home

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

HPC

Haematopoietic progenitor cell.

HSC

See *haematopoietic stem cell (HSC)*

ICR

See *Institute of Cancer Research (ICR)*.

IGRM

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

Imaging Services Accreditation Scheme (ISAS)

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

Information Governance Toolkit

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

Institute of Cancer Research (ICR)

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

The partnership of The Royal Marsden and the ICR is the largest comprehensive cancer centre in Europe.

Integrated Palliative care Outcome Scale (IPOS)

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

See *Palliative care Outcome Scale (POS)*.

integrated governance

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

Integrated Governance and Risk Management Committee (IGRM)

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

Integrated Governance Monitoring Report

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

IPOS

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

ISAS

see *Imaging Services Accreditation Scheme (ISAS)*.

ISBT 128

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

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

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

JACIE

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

JAG

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

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

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

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

'LIBOR' funding

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

linac

Linear accelerator.

LocSSIPs

Local Safety Standards for Invasive Procedures.

magnetic resonance imaging (MRI)

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

medical devices

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

meticillin-resistant *Staphylococcus aureus* (MRSA)

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

mould room

A room where special masks are made of perforated thermoplastic to fit the faces of patients. (Radiotherapy applied to the head or neck requires the wearing of a special mask to prevent movement.)

MR Linac

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

MRSA

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

MRI

See *magnetic resonance imaging (MRI)*.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

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

National Early Warning Scores (NEWS)

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

National Institute for Health and Care Excellence (NICE)

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

NCEPOD

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

NEWS

See *National Early Warning Scores (NEWS)*.

NEWS 2

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

See *National Early Warning Scores (NEWS)*.

NHS Improvement

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

NHS Litigation Authority (NHS LA)

See *NHS Resolution*.

NHS Resolution

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

NHS standard contract

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

NICE

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

NMC

See *Nursing and Midwifery Council (NMC)*.

Nursing and Midwifery Council (NMC)

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

open access follow-up

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

Palliative care Outcome Scale (POS)

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

PALS

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

parotidectomy

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

Patient Advice and Liaison Service (PALS)

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

Patient and Carer Advisory Group (PCAG)

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

Patient Group Direction (PGD)

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

PCAG

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

perioperative

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

peripherally inserted central catheter (PICC) line

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

PET

See *Positron emission tomography (PET)*.

PGD

See *Patient Group Direction (PGD)*.

Pharmex

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

PICC line

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

pilot study

A small-scale trial run of a particular approach.

POS

See *Palliative care Outcome Scale (POS)*.

positron emission tomography (PET)

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

Prevent

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

Public Health England

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

QMS

See *Quality management system (QMS)*.

Q-Pulse

Proprietary quality management system software.

quality management system (QMS)

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

R²

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

radiotherapy

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

RAG rating

Red/amber/green rating.

RCN

The Royal College of Nursing.

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

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

RIDDOR

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

RIG

Radiologically-inserted gastroscopy.

RM Partners

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

SALT

Speech and language therapy.

Schwartz rounds

A forum for staff working in health organisations, from all backgrounds, to come together to talk about the emotional and social challenges of caring for patients. They are once a month usually at lunchtime (with lunch provided) for an hour.

sepsis

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

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

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

Sepsis Six

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

Sign up to Safety

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

SOP

Standard operating procedure.

sustainability and transformation plans (STPs)

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

Sutton Community Health Services

Part of The Royal Marsden Community Services (which also includes Sutton Children's Health Services) which has provided community healthcare services in Sutton since April 2016. The service is provided by The Royal Marsden's Community Services Division (and is referred to as *Community Services* in this report).

Triggers tool

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

TUPE

Transfer of Undertakings (Protection of Employment) Regulations 1981.

TYA

Teenage and young adult.

United Kingdom Accreditation Service (UKAS)

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

UKAS

See *United Kingdom Accreditation Service (UKAS)*.

venous thromboembolism (VTE)

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

VTE

See *venous thromboembolism (VTE)*.

Waste Issue Report and Enquiry (WIRE)

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

WHO

See *World Health Organization (WHO)*.

WIRE

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

WIRED

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

World Health Organization (WHO)

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

14. Care Quality Commission fundamental standards

From webpage www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards on the Care Quality Commission's website (webpage last updated 29 May 2017; retrieved 12 November 2018).

Person-centred care

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

Dignity and respect

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

This includes making sure:

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

Consent

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

Safety

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

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

Safeguarding from abuse

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

This includes:

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

Food and drink

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

Premises and equipment

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

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

Complaints

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

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

Good governance

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

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

Staffing

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

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

Fit and proper staff

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

Duty of candour

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

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

Display of ratings

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

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

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Life demands excellence



Radiotherapy and
Chemotherapy Services
FS38021 & FS38022

