
Integrated Governance Monitoring Report

April to June 2017

Quarter One 2017/18



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1. Introduction

- 1.1. Welcome to The Royal Marsden NHS Foundation Trust's Integrated Governance Monitoring Report.
- 1.2. The Integrated Governance Monitoring Report is a quarterly review of the governance of care, research and infrastructure provided at The Royal Marsden. Together with the monthly quality account, the six-monthly safer staffing report, the Board scorecard and the annual quality account (part of the Trust's annual report) it is part of The Royal Marsden's monitoring of safety and assurance of quality of service.
- 1.3. The Integrated Governance Monitoring Report is published on the Royal Marsden's website, www.royalmarsden.nhs.uk.
- 1.4. The Royal Marsden's Community Services Division delivered community services in Sutton and Merton until the end of March 2016. From April 2016 the Community Services Division provided services in Sutton as Sutton Community Health Services.
- 1.5. The Care Quality Commission's fundamental standards are intended to help providers of health and social care to comply with the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They are:
 - Person-centred care
 - Dignity and respect
 - Consent
 - Safety
 - Safeguarding from abuse
 - Food and drink
 - Premises and equipment
 - Complaints
 - Good governance
 - Staffing
 - Fit and proper staff
 - Duty of candour
 - Display of ratings.The fundamental standards are described in more detail on page 128.
- 1.6. The Care Quality Commission inspects and assesses organisations against the fundamental standards using five key questions:
 - *are they safe?*
 - *are they effective?*
 - *are they caring?*
 - *are they responsive to people's needs?*
 - *are they well led?*
- 1.7. Unless otherwise specified text, tables and charts refer to Quarter One 2017/18 (April to June 2017).

2. Executive summary

2.1. Is care safe?

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

2.1.1. Incident, complaints and claims investigations

Nine new incident investigations were declared in the quarter. Eighteen incident investigations were completed this quarter with remedial actions identified. (*Incident, complaints and claims investigations and serious incident reporting*, page 102.)

2.1.2. Clinical Legal Services

The Trust received nine requests for medical records intimating a claim against the Trust and three inquest notifications. (*Clinical Legal Services*, page 113.)

2.1.3. Infection prevention and control

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

There were two cases of *Staphylococcus aureus* bacteraemia in the quarter. There were 22 cases of *Clostridium difficile* toxin (CDT) in the quarter of which 13 were reportable to the Public Health England Mandatory Enhanced Surveillance Scheme (46 reportable cases 2016/17).

Four patients were infected with carbapenemase-producing organisms (CPOs) in the quarter. (*Infection prevention and control*, page 45.)

2.1.4. Fire

There were no actual fires in the quarter.

Nine fire incidents were attributable to the Trust. Nine fire incidents had been reported in the previous quarter. (*Fire*, page 54.)

2.1.5. Radiotherapy

In February BSI reviewed the Trust's progress in moving to the latest standard, ISO9001:2015. The review concluded that the service is well placed to make the transition once current work is completed.

There were 33 radiotherapy risk incidents, all risk-rated *low* and *very low* (46 the previous quarter). There were no complaints.

There were 1,315 appointments in the quarter (1,366 in the previous quarter). (*Radiotherapy*, page 78.)

2.1.6. Chemotherapy

Ninety-eight incidents were reported, all risk-rated *low* and *very low* (110 the previous quarter). Ninety-one of the incidents referred to medication issues (105 in Quarter Three). There were three complaints in the quarter. (*Chemotherapy*, page 80.)

2.2. Is care effective?

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

2.2.1. Commissioning for quality and innovation (CQUIN) goals

Quality improvement and innovation goals are agreed between The Royal Marsden, NHS England and Sutton Clinical Commissioning Group (CCG) through the Commissioning for Quality and Innovation (CQUIN) payment framework. NHS England and Sutton CCG have confirmed full payment for achieving the 2016/17 goals. Confirmation is awaited that the Royal Marsden has achieved the Quarter One milestones for this year's goals. (*Commissioning for quality and innovation (CQUIN)*, page 15.)

2.2.2. Symptom control and palliative care

The Symptom Control and Palliative Care Team has begun a pilot scheme for Lung Unit outpatients to support early advanced care planning and timely referral to specialist palliative care. (*Symptom control and palliative care*, page 26.)

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

NICE published 22 items of guidance which were presented to the Integrated Governance and Risk Management Committee in Quarter One. After the guidance was reviewed, six items were deemed relevant and six items were still under review at the time of reporting. Eight quality standards were presented to the committee of the five items deemed relevant, the Trust is fully compliant with three and partially compliant with two. Where relevant, action plans were drafted to modify services to comply with the guidance. (*National Institute for Health and Care Excellence (NICE)*, page 74.)

2.2.4. Sepsis

Fourteen patients were admitted to the Critical Care Unit with sepsis in the quarter. Data shows good compliance with the *Sepsis Six* bundle. (*Sepsis*, page 47.)

2.2.5. Medical devices

There were 61 incidents relating to medical devices this quarter (there were 60 in the previous quarter). The incidents were graded *low* (21) and *very low* (40).

The Clinical Product Review Committee approved 12 proposals to evaluate new equipment and approved three products for purchase. (*Medical devices*, page 49.)

2.2.6. Medicines optimisation

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

Waiting times for prescriptions dispensed for discharge: over 98% of prescriptions are completed within 60 minutes. Over two thirds are completed within 30 minutes. (*Medicines optimisation*, page 51.)

2.2.7. Deaths following stem cell transplantation

The Trust systematically collects data on deaths following treatment to monitor outcomes of people's care and treatment.

The figures relate to stem cell transplants in the previous quarter so that deaths in the following 100 days can be correctly identified. Forty-five stem cell transplants took place in Quarter Four 2016/17 (January to March 2017). (Seventy transplants took place in Quarter Four 2015/16.)

There were three deaths in the 100 days following transplant in Quarter Four. (No patients died in the corresponding quarter in 2015/16.)

The number of deaths in the period is low and similar to levels reported in the rest of Europe. (*Deaths following stem cell transplantation*, page 71.)

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 97 letters of praise. (*Letters of praise*, page 101.)

2.3.2. Safeguarding of adults at risk

Twenty-nine safeguarding incidents were raised in the quarter (there were 22 in Quarter Four; 10 in Quarter Three; 17 in Quarter Two; 14 in Quarter One 2016/17). Situations requiring safeguarding activity at The Royal Marsden remain few in number but have increased since Quarter Three of the last financial year.

Ten urgent applications were made under the Deprivation of Liberty safeguards.

There was one *Prevent*-related concern that was reported to the police. *Prevent* identifies vulnerable persons who are at risk of engaging in or supporting terrorism or terrorist activity. (*Safeguarding of adults at risk*, page 34.)

2.3.3. Friends and family test

In Quarter One 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.)
- 98% of Royal Marsden outpatients who responded would recommend the Trust. (Of NHS outpatients in England 94% of respondents would recommend their provider.)
- 97% of Royal Marsden community clients who responded would recommend the Trust. (Of NHS community clients in England 96% of respondents would recommend their provider.) (*Friends and Family Test*, page 19.)

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 30 new complaints relating to NHS patients and 10 new complaints relating to private patients in Quarter One. All were acknowledged in three days or less.

Thirty-two complaints relating to NHS patients and fourteen relating to private patients were completed in quarter One. Three complaints relating to NHS patients and three relating to private patients did not receive a response by the agreed deadline. (*Concerns and complaints*, page 88.)

2.4.2. Patient and Carer Advisory Group

The group discussed with staff the important role that porters have in making the experience of patients in the hospital positive. Members launched a programme of environmental surveys of patient areas as well as being part of the Patient-Led Assessments of the Care Environment (PLACE) inspection teams. Suggestions for improvement to the experience of patients in the outpatient departments were made. (*Patient and Carer Advisory Group*, page 18.)

2.4.3. Freedom of information

The Trust received 118 freedom of information requests during Quarter One, compared to 152 in the final Quarter of the previous year. Of the 118 requests, 115 were answered within 20 working days (97.5%). (*Freedom of information*, page 77.)

2.4.4. National inpatient survey 2016

Of 73 questions asking people who had been an inpatient at The Royal Marsden 63 results were better than most other trusts. For 10 questions, the Trust scored about the same as other trusts. For no question did the Trust score worse than most other trusts. (*National inpatient survey 2016*, page 18.)

2.4.5. Adult Psychological Support Service

Of 161 referrals that were accepted for outpatient support, 69 were received on the Chelsea site and 92 were received on the Sutton site (*Adult Psychological Support Service*, page 27.)

2.4.6. Paediatric and Teenage Psychological Support Service

The service received 76 new referrals and provided 405 therapeutic sessions in the quarter. (*Paediatric and Teenage Psychological Support Service*, page 30.)

2.4.7. Pressure ulcers

One patient developed a category 4 pressure ulcer attributable to the Trust. (*Pressure ulcers*, page 43.)

2.4.8. Clinic waiting times

There has been an increase in activity of 6.8% (2029) from 39,696 to 41,725 from Quarter One 2016/17 compared to Quarter One 2017/18. Over the same period the percentage of patients seen within 30 minutes or less of their appointment time has improved by 1.3% and those seen after one hour of their appointment time decreased by 0.7% (*Clinic waiting times*, page 85.)

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

In Quarter One 0.68% of NHS clinics (33 out of 4,820) and 2.73% of private care clinics (52 out of 1,908) were cancelled less than 15 days before the planned date. Cancellations for both NHS and private care clinics have increased since last quarter. (*Consultant clinics cancelled less than 15 days before planned date*, page 86.)

2.5. Are staff well led?

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

2.5.1. Reports to NHS Improvement and accounts

Clear leadership assures the sustainability of the Trust's financial position. NHS Improvement, the regulator of NHS foundation trusts, has given the Trust a Use of Resources Rating of 1, which means that the Trust is considered low risk in financial terms and is one of those producers with maximum autonomy. (*Reports to NHS Improvement and accounts*, page 115.)

2.5.2. Human resources

The vacancy rate has increased to 11.3% (against the target of 5%). This is partly due to a number of new posts added at the start of the year as part of the business planning process. The vacancy rate for hospital nursing is 11.3%. The community nursing vacancy rate is 25.9%.

The turnover rate is 15.1% and remains above the 12% target.

The sickness rate for the Trust has fallen from 3.5% to 2.7%, and is below the target of 3%.

The appraisal rate is 85.7%, below the target of 90%. (*Human resources*, page 59.)

2.5.3. Information governance

Information governance training compliance is 94.26%. (*Information governance*, page 76.)

2.5.4. Research governance

Ten projects were awarded Trust sponsorship. There were six suspected unexpected serious adverse drug reactions (SUSARs), none of which required further action. (*Research governance*, page 82.)

2.5.5. Staff Support Team

The staff support team held 508 one-to-one counselling sessions with staff.
(*Adult Psychological Support Service*, page 27.)

2.6. Conclusion

The Integrated Governance Monitoring Report demonstrates that The Royal Marsden promotes a culture in which safety concerns raised by staff and people who use its services are highly valued as integral to learning and improvement. Staff are open and fully committed to reporting incidents and near misses. The level and quality of incident reporting shows the levels of harm and near misses to ensure a robust picture of quality. There is ongoing, consistent progress towards safety goals reflected in a zero-harm culture.

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

3.1. Performance indicators

National Cancer Plan targets

Indicator	Target*	2017/18 (projected)†	2017/18 year to date	2016/17	2017/18 cumulative month
2 weeks					
% of patients seen within 2 weeks of urgent GP referral	93.0%	97.4%	97.4%	97.5%	Jun
% of patients seen within 2 weeks for breast symptoms	93.0%	93.6%	93.6%	95.5%	Jun
31 days					
First treatment – % treated within 31 days of decision to treat	96.0%	98.1%	98.1%	98.2%	Jun
Subsequent drugs – % treated within 31 days of decision to treat	98.0%	99.0%	99.0%	99.4%	Jun
Subsequent surgery – % treated within 31 days of decision to treat	94.0%	97.0%	97.0%	94.8%	Jun
Subsequent radiotherapy – % treated within 31 days of decision to treat	94.0%	94.6%	94.6%	97.6%	Jun
62 days					
All cancers – % treated within 62 days of urgent GP referral	85.0%	76.2%	76.2%	77.1%	Jun
All cancers – % treated within 62 days of urgent GP referral (post reallocation‡)	85.0%	85.6%	85.6%	84.9%	Jun
Referral from screening – % treated within 62 days of urgent GP referral	90.0%	89.1%	89.6%	90.0%	Jun
Referral from screening – % treated within 62 days of urgent GP referral (post reallocation‡)	90.0%	90.9%	91.3%	88.1%	Jun
Consultant upgrade – % treated within 62 days of urgent GP referral	N/A	62.5%	62.9%	76.8%	Jun

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

Activity data

Indicator	Target*	2017/18 (projected)†	2017/18 year to date	2016/17	2017/18 cumulative month
Number of NHS elective inpatient full consultant episodes	-	5,220	1,269	5,403	Jun
Number of NHS daycase full consultant episodes	-	11,682	2,840	11,295	Jun
Total NHS elective full consultant episodes	-	16,902	4,109	16,698	Jun
Number of NHS non-elective inpatient full consultant episodes	-	2,217	539	1,820	Jun
Number of NHS outpatient attendances	-	190,089	46,211	183,034	Jun

National access targets

Indicator	Target*	2017/18 (projected)†	2017/18 year to date	2016/17	2017/18 cumulative month
Cancelled operations					
Number of last minute cancelled operations for non-clinical reasons not admitted within 28 days**	0	0	0	0	Jun
Referral to treatment (RTT)					
RTT % incomplete pathways within 18 weeks	92.0%	95.7%	95.7%	94.6%	Jun
RTT number of patients on incomplete pathways waiting longer than 52 weeks	2	16	4	25	Jun

Other national indicators – data quality

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

Other national indicators – infection prevention and control

Indicator	Target*	2017/18 (projected)†	2017/18 year to date	2016/17	2017/18 cumulative month
Number of diagnoses of <i>Clostridium difficile</i> ††	-	53	13	46	Jun
Number of diagnoses of <i>Clostridium difficile</i> (lapses of care‡‡)	<= 31				
Number of diagnoses of meticillin-resistant <i>Staphylococcus aureus</i> (MRSA) bacteraemia	0	0	0	1	Jun

Other national indicators

Indicator	Target*	2017/18 (projected)†	2017/18 year to date	2016/17	2017/18 cumulative month
Number of occurrences of patients in breach of sleeping accommodation guidelines	0	0	0	0	Jun
Venous thromboembolism (VTE) risk assessment	95.0%	95.8%	95.8%	96.9%	Jun

* Target is based on Care Quality Commission targets where published

† 2017/18 figures show the year-to-date position seasonally projected to year-end.

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

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

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

‡‡ Lapses of care are determined in conjunction with Commissioners. The determination of what warrants a lapse in care can be several months after the diagnosis. Lapses of care will be reported from Quarter Two 2017/18.

3.2. Commissioning for Quality and Innovation (CQUIN)

3.2.1. A proportion of the Trust’s income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between NHS England and Sutton Clinical Commissioning Group (CCG) through the Commissioning for Quality and Innovation (CQUIN) payment framework.

3.2.2. CQUIN goals for 2017/18 were agreed with commissioners in the following subject areas for cancer specialist services and for community services:

3.2.3. Cancer specialist services

NHS England Acute CQUIN Schemes

- Enhanced supportive care access for advanced cancer patients
- Nationally standardised dose banding for adult intravenous systemic anti-cancer treatment
- Hospital Medicines Optimisation
- Stereotactic Radiotherapy (SRS/T) Services dataset
- Sustainability and Transformation Plan
- Clinical Utilisation Review (CUR) – please note the continuation of this scheme is under negotiation.

CCG CQUIN Schemes

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

3.2.4. Community Services

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

3.2.5. Details of the agreed CQUIN goals for Quarter One 2017/18 and the full 12-month period are outlined in the section below.

3.2.6. Acute NHS England CQUIN goals 2017/18

This table shows the Trust’s submitted position against each quarter’s milestones in the year 2017/18. Quarter One milestones were submitted to NHS England on 31 July 2017.

Scheme	Milestone	Quarter 1
Clinical Utilisation Review (CUR)	Scheme under negotiation. The Royal Marsden submitted Quarter 1 data.	Achieved

Scheme	Milestone	Quarter 1
Enhanced supportive care	Continuation of 2016/17 Enhanced Supportive Care programme in Renal and Medical Gynaecology patient groups. Based on 2016/17 performance, set action plan and trajectory for 2017/18.	Achieved
Dose banding	Collection of baseline data for range of dose banded drugs. Local drugs and therapeutics committee has agreed and approved principles of dose banding, and dose adjustments required. Agreement with commissioners of stretch target for improvement during course of the year.	Achieved
Hospital Medicines Optimisation	90% of new patients receiving best value generic/biologic product on 2017/18 Quarter 1 list. Approval of transition plan for increasing use of cost effective dispensing routes for outpatient medicines. Approval of transition plan including metrics to define 'fully and accurately populated submission'.	Achieved
Stereotactic Radiotherapy (SRS/T) dataset	Submission of agreed SRS/T dataset.	Achieved
Sustainability and Transformation Plan	No milestone in Quarter 1.	No milestone in Quarter 1

3.2.7. NHS England has confirmed full payment for the 2016/17 Acute schemes. Confirmation for Quarter One 2017/18 is awaited from the commissioners.

3.2.8. Acute CCG CQUIN goals 2017/18

The table shows the Trust's position against each quarter's milestones in the year 2017/18. Quarter One milestones were submitted to Sutton CCG on 31 July 2017.

Scheme	Milestone	Quarter 1
NHS staff health and wellbeing	Staff survey: submission of comprehensive action plan including plan for initiatives and evaluation criteria. Healthy food for NHS staff, visitors and patients: submission of a plan including target to shift to healthier product.	Achieved
Reducing the impact of serious infections (antimicrobial resistance and sepsis)	Timely identification of sepsis in Clinical Assessment Unit: set up audit process. Timely treatment for sepsis in Clinical Assessment Unit: set up audit process. Antibiotic Review: set up audit process.	Achieved

Scheme	Milestone	Quarter 1
e-Referrals	Develop plan to include definitive list of all services/clinics accepting first outpatient referrals (2-week rule) and details of the NHS e-Referral Services they are mapped to, identifying any gaps to be addressed. Set trajectory to reduce appointment slot issues in Quarters 2, 3 and 4.	Achieved
Sustainability and Transformation Plan	No milestone in Quarter 1.	No milestone in Quarter 1
Risk reserve	No milestone.	No milestone

3.2.9. Sutton CCG has confirmed 100% achievement for the Acute CCG schemes for 2016-17. Confirmation for Quarter One 2017/18 is awaited from the commissioners.

3.2.10. Community Services CCG CQUIN goals 2017/18

The table shows the Trust's position against each quarter's milestones in the year 2017/18. Confirmation for Quarter One 2017/18 is awaited from the commissioners.

Scheme	Milestone	Quarter 1
NHS staff health and wellbeing	Staff survey: submission of comprehensive action plan including plan for initiatives and evaluation criteria	Achieved
Improving the assessment of wounds	No milestone set in Quarter 1 2017/18 but update provided	No milestone
Personalised care and support planning	No milestone set in Quarter 1 2017/18 but updated provided	No milestone

3.2.11. The Trust has received confirmation from Sutton CCG of 100% achievement for 2016/17. The Trust has received confirmation of 100% achievement for Quarter One for community services.

4. Service users' needs and preferences

4.1. National inpatient survey 2016

- 4.1.1. The Trust was one of 149 acute and specialist trusts taking part in the national inpatient survey 2016. The survey has been run thirteen times. Questionnaires were sent to 1250 inpatients consecutively discharged from the Trust in July 2016. The response rate was 60%.
- 4.1.2. Of 73 questions asking people who had been an inpatient at The Royal Marsden 63 results were better than most other trusts. For 10 questions, the Trust scored about the same as other trusts. For no question did the Trust score worse than most other trusts
- 4.1.3. The score significantly improved compared to last year's survey for one question *Do you think the hospital staff did everything they could to help control your pain?*
- 4.1.4. In response to the findings of the survey, improvements will be made. Actions will be aimed at reducing noise at night and reducing discharge delays.

4.2. Patient and Carer Advisory Group

- 4.2.1. The Patient and Carer Advisory Group consists of current and former Royal Marsden patients and carers. The group elects one of its members as chairman and is given administrative support by a member of staff. The group works with the Trust on a variety of projects where the views of patients and carers can help make the hospital a better place for patients.
- 4.2.2. The manager of the porters described to the group the varied services the porters provide followed by questions from members. Members recognise the professional and caring service the porters provide and that it is essential to the good experience for patients during their stay in hospital.
- 4.2.3. Members began a programme of five-senses observational surveys of public areas of the Trust starting with the pharmacy area in Sutton. Members of the group observe an area and report their impressions based on what it looks like, how it smells, what they hear, what does the food, if relevant, taste like and how does it feel to the touch for example how clean is it.
- 4.2.4. Seven members spoke to pharmacy students at King's College to help them understand what it is like to be a patient.
- 4.2.5. Representatives of the group were part of the teams carrying out the Patient-Led Assessments of the Care Environment (PLACE). This annual assessment is reported nationally for all hospitals and looks at a range of environmental aspects that affect the quality of experience for patients. These include cleanliness of buildings, quality of food and signage.
- 4.2.6. Members suggested small changes that would improve the experience of patients in the outpatient departments to the service manager and Tissue Bank Manager. The comments focussed on improving feedback when delays are affecting clinics and how to improve the process of asking patients for their permission to use excess tissue taken for biopsies and in surgery for use in future research.

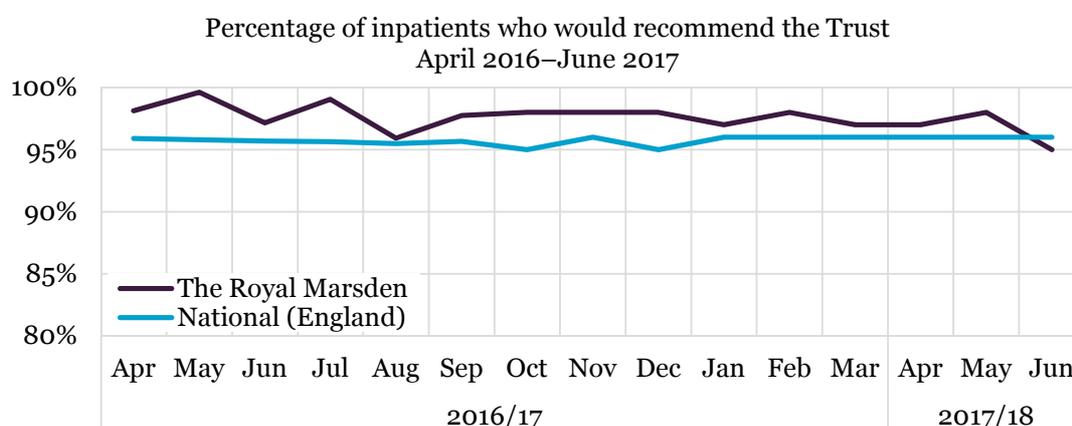
- 4.2.7. The results of the national inpatient survey 2016 were reviewed with issues suggested for action by the Trust. Further to noise at night and improved discharge information already identified by the Trust as requiring action members asked that encouraging patients to ask a friend or family member to attend when being discharged to help with remembering the discharge advice given by staff. Members also asked the Trust to consider whether bedside call bells could be responded to more quickly.
- 4.2.8. Members continued to represent the group on Trust committees and project groups including the Integrated Governance and Risk Management Committee, viewing room refurbishment and the soft facilities tender process.

4.3. Friends and Family Test

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

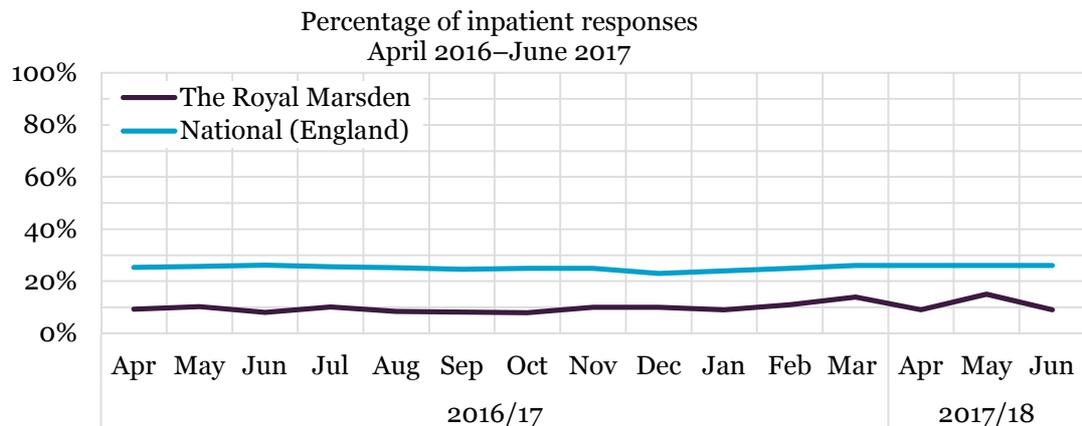
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?

- 4.3.2. 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.
- 4.3.3. 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.
- 4.3.4. In Quarter One 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.)
 - 98% of Royal Marsden outpatients who responded would recommend the Trust. (Of NHS outpatients in England 94% of respondents would recommend their provider.)
 - 97% of Royal Marsden community clients who responded would recommend the Trust. (Of NHS community clients in England 96% of respondents would recommend their provider.)
- 4.3.5. The results in the chart below show how the Trust compares against national scores for NHS **inpatients**.



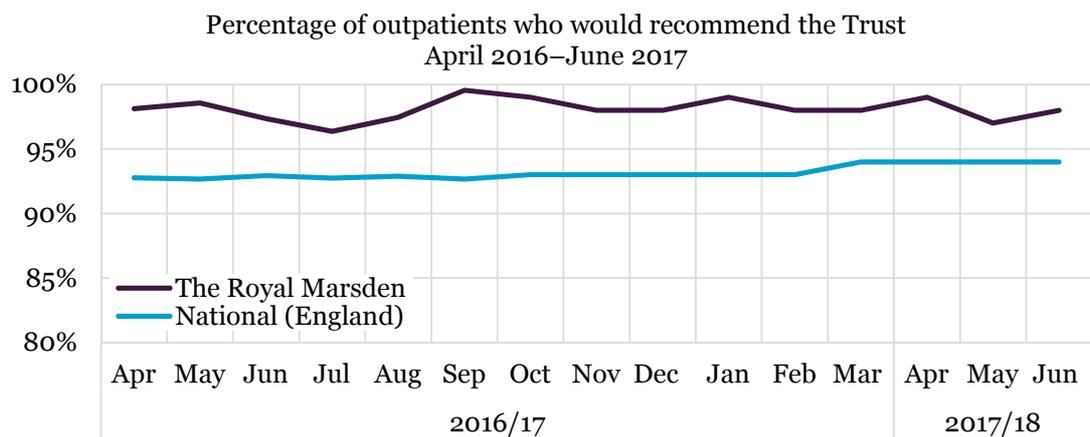
National data from www.england.nhs.uk.

4.3.6. In Quarter One 1,463 inpatients completed the test. The chart below shows the **inpatient response** rate of the Trust against the national response rate.



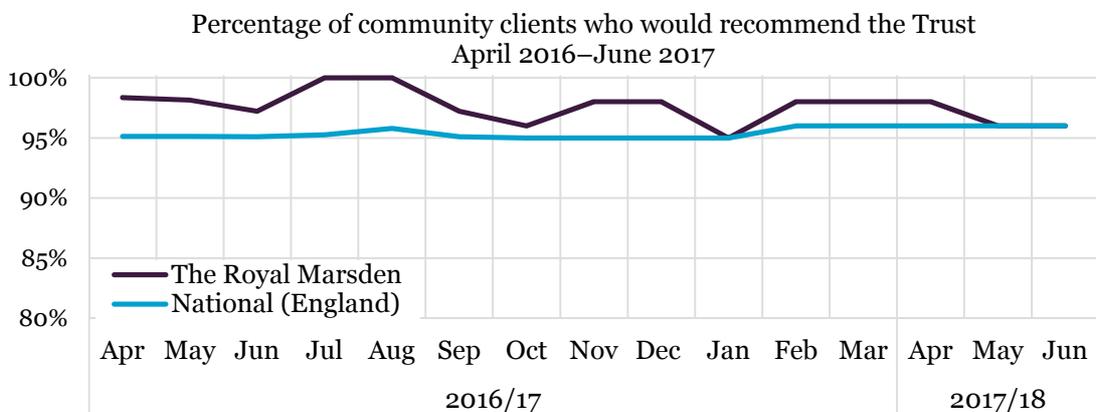
National data from www.england.nhs.uk.

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



National data from www.england.nhs.uk.

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



National data from www.england.nhs.uk.

- 4.3.9. Patients are encouraged to give their views, constructive suggestions, and feedback on their experiences. These comments are a valuable source of patient feedback and are analysed to help the Trust improve the experience of patients and their families, friends and carers.
- 4.3.10. The results are examined and reviewed by the Trust's Patient Experience and Quality Account Group which is jointly chaired by the Deputy Chief Nurse and a Trust governor. The group has a membership of Trust governors, Healthwatch representatives, Patient and Carer Advisory Group representatives, and representatives from the Trust's clinical staff.
- 4.3.11. The feedback can be attributed to an individual ward or department. Ward Sisters and Matrons review the data at minimum monthly, and it is also reviewed at the Clinical Business Units Monthly Performance Review meetings, attended by the Divisional Director, Clinical Lead and Divisional Nurse Director. Actions are taken each month to address any issues. The following are examples of areas that patients suggest require improvement.

4.3.12. Patient comments on areas where improvement could be made

Inpatients

It would have helped had the team been more proactive getting people to dim light and mute the TV at night. Telling people on admission would probably help.

Only problem was my TV didn't work and though reported on day 1 it didn't get fixed till 8th (last) day. So I couldn't use it till last day.

Sink in toilet/shower room partially blocked, does not drain well. Sometimes person going around ward taking blood pressure with machine would cleanse pads and wear gloves but sometimes not. Perhaps think through a procedure and make sure everyone adopts it.

We always receive such good care from the lovely nurses and staff here at the Marsden. We don't really have anything that can be improved apart from the car park cost not that is to do with the care.

Outpatients

I was given a contact number but my call always went through to an answering machine. I never got a call back after leaving a message, very frustrating.

I would like to receive more information in due course about the actual effects of the radiotherapy on the cancer and why my specific treatment regime was chosen.

Yet again another appointment where I have been waiting one hour and forty-five minutes past my allocated appointment time. This is every time I come for an appointment. Something needs to be changed to ensure sick patients do not have to endure these ridiculous waiting times.

Every time I attend clinic it is running at least 1 and a half hours behind which in my opinion is not acceptable, also being told that it is a 'busy clinic' is not a valid reason for the clinic to constantly be running this late.

Daycases

(Endoscopy) *Very good care. Sadly I had to wait 4 hours before a bed was ready. Perhaps a late arrival time should be issued to patients.*

Only complaint is waiting to be seen. Always at least an hour after appointment time. Do realize that the nurses are very busy. They are lovely when you are seen.

Excellent welcome by all staff. All staff in MDU giving chemotherapy are totally competent as well as very supportive. Difficult to suggest any improvement which might be made. At times the MDU are very stretched due to shortages of staff.

Whilst receiving chemotherapy, staff are thorough, pleasant and polite. The time spent waiting for medication at the hospital's pharmacy can be reduced as it is usually too long for cancer patient who does not have the energy to linger around the hospital for long. Also, prednisolone tablets containing low dosages which must be consumed in large quantities is not convenient for a cancer patient who is consuming numerous other drugs. The dose of each tablet should be higher. A and E for cancer patient at Royal Marsden should launch.

Improvement: Car parking space with price reductions. Very costly when treatment for all of hours. (Sutton)

I have a little gripe which is the blood waiting room is always too full because relatives and friends are in there rather than waiting in one of zones in outpatients.

Health visiting (Community Services)

Good staff knowledge and attention for the child. If the frequency of the service could be increased this would be very helpful.

Every aspect was good. The health visitor has information to hand. The communication between the hospital/NHS and the health visitor is lacking however. My baby has yet to receive his BCG.

I was listened to. I would however like to be seen in private as there are too many people in the room.

The health visitor was really friendly, smiling and willing to give advice. I would improve the waiting times as I waited over an hour.

4.3.13. Some positive comments from patients

Comments from those on inpatient wards

Amazing care – in fact when my elderly mum visited she said what a lovely hotel this is. I can't think of anything that can be improved on.

Friendly, kind efficient staff. Bright light and airy room. Nothing was ever a problem.

1. The outstanding experience was: at any point in a 24h period I was aware there were never less than four (4) members of staff actively on duty in the ward attending to the patients. 2. The food and meals provided were of the highest standard I have ever experienced in a hospital in the U.K. 3. No aspect of my stay do I consider was in need of improvement.

I received consistent care throughout my stay. All details were always efficiently handed over. I was treated very well and am extremely grateful to all that have looked after me.

The care has been exemplary every time I have come to the Royal Marsden. Every confidence was offered and received quite over and above any expectation. I felt in very safe hands all the time.

Comments from those attending as outpatients

It means a lot for me that my emotional well-being is taken as seriously as my physical health and all the people treating me here are sensitive and caring that I feel well supported each time I come here.

Very satisfied with my appointment. [The doctor] very helpful and informative and went to a lot of trouble to explain what she was doing and why. I wish all hospital appointments were as good as this.

Daycase

Everyone was so welcoming and friendly and they explained every step of the way. I do not believe that you could improve on this 1st class service.

I have been a patient here since 2011. You all have always been kind to me and helped me. I would like to say Thank you to you all.

Comments from those attending in community services

Children's services

From a child:

I feel extremely safe with my physiotherapist. She is amazing.

The wide range of advice and equipment to strengthen my body was great. I can't think of any improvements.

From a parent:

My daughter's dietitian is great, she is helping us a lot.

All aspects of my child's health/care plan was discussed and explained.

Service has been excellent with loads of good useful information. Health visitors are all kind and knowledgeable. They are always trying to help and give relevant advice.

School nursing

My child gets treated amazingly by all the staff here ... and I feel very comfortable coming here.

The nurses have been very supportive of my son's needs.

All aspects of my child's health/care plan was discussed and explained.

From a child: *I felt as if I was in good care and I had no worries.*

Health visiting

All excellent. Easy, simple, calm and no fuss.

Community nursing

Everything was explained and ongoing treatment.

Carer was extremely polite and chatty. Dispensed medication promptly and correctly.

The district nurse was kind, caring and gentle with a nice personality. I could not have wished for better treatment.

Therapy services

Great help. Very sensible staff.

Excellent communication about specific needs to maintain a balanced diet and exercise.

Good personal approach and manner. I found that the information I requested was given and I am able to take this further forward with my GP.

4.4. Patient Information Service

4.4.1. Activity for the quarter:

Type	New title/ new edition	Revision	Total
Booklets	1	4	5
Factsheets	3	26	29
Leaflets	3	12	15
Total	7	42	49

4.4.2. The new factsheets *Coeliac plexus block* and *Skype and telephone appointments* were produced this quarter.

4.4.3. Leaflets reviewed this quarter include *Guidance on care and nursing homes for patients and carers* and *Viewpoint: how to raise a concern or make a complaint*.

4.4.4. Booklets reviewed and updated this quarter include *Diet and breast cancer* and *Your health information, your confidentiality*.

4.4.5. The Patient Information team continues to ensure that the appropriate staff members are informed of updates to publications. This is done with emails to lead authors, group emails and Trust bulletins.

4.5. 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	14	0	14
Asian Indian	75	17	92
Asian Pakistani	36	5	41
Asian (other)	89	20	109
Black African	70	8	78
Black Caribbean	81	3	84
Black (other)	10	1	11
Chinese	32	9	41
Mixed White and Asian	16	0	16
Mixed White and Black African	4	1	5
Mixed White and Black Caribbean	11	1	12
Mixed (other)	23	4	27
White British	2,113	297	2,410
White Irish	56	9	65
White (other)	359	78	437
Other	83	114	197
Not disclosed	65	160	225
Total	3,137	727	3,864
Ethnic origin information completed*	3,072	567	3,639
Ethnic origin information completed (%)*	97.9%	78.0%	94.2%

*All values except *Not disclosed*

5. Personalised care, treatment and consent

5.1. Operating theatres

- 5.1.1. The Trust is continuing its international recruitment drive supported by its education strategy. The new nurses undertake the Objective Structured Clinical Examination (OSCE), which assesses the ability to competently apply professional skills and knowledge. There is also a drive to recruit qualified skilled theatre practitioners at bands 5 and 6 level.
- 5.1.2. An audit of non-pay consumables is underway to measure expenditure against activity. Costs are also being reviewed as part of an initiative to deliver cost-contained high-quality care for patients.
- 5.1.3. Workforce establishment and training requirements in the operating theatres are under review in line with the Trust's surgical strategy.
- 5.1.4. The weekly theatres scheduling planning meeting continues its work to improve operating theatres efficiency.
- 5.1.5. The new Trust-wide Local Safety Standards for Invasive Procedures (LocSSIPs) are reviewed at the monthly Operating Theatres Endoscopy Quality Safety Meeting.

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, will be implemented for patients referred to the Symptom Control and Palliative Care Team. This will allow the team to monitor interventions, and may in future act as a trigger for referral.

5.2.2. Hospital support

The Symptom Control and Palliative Care Team has begun a pilot scheme for Lung Unit outpatients to support early advanced care planning and timely referral to specialist palliative care using defined triggers. The project is supported by RM Partners, a cancer alliance across north west and south west London (part of the national cancer vanguard). Its aims are to improve integration between oncology and palliative care, to increase early referral to palliative care, and to increase the use of urgent care planning in patients with lung cancer who attend the outpatient department. These aims will be achieved by the introduction of a new triggers tool together with validated symptom assessment. Quarter One data will be available mid July to inform on-going progress of the project.

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.

5.2.4. Strategic developments

The Symptom Control and Palliative Care Team is progressing well with the national Commissioning for Quality and Innovation (CQUIN) for Enhanced Supportive Care. The Trust has met the quarterly CQUIN targets to date and the scheme has been extended to 2017/18. The team has attended two meetings of Enhanced Supportive Care leads to share best practice and has visited The Christie NHS Foundation Trust to view an outpatient clinic in action.

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

5.2.5. Supportive Care Home Team

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

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

5.3. Adult Psychological Support Service

The Trust provides a confidential psychological support service for patients who are treated at the hospital. The service offers support particularly in helping individuals and those close to them to adjust to the emotional impact of a cancer diagnosis.

5.3.1. Activity

During Quarter One, 166 referrals were made to the service (excluding psychosexual, family, BRCA group and to private patients). Of the referrals 161 were accepted for outpatient support, four were declined as they did not meet eligibility criteria, and one was redirected to Occupational Therapy for relaxation.

Of the 161 referrals that were accepted into the service, 69 were received on the Chelsea site and 92 on the Sutton site.

A new 'triage' system for screening and prioritising appointments was introduced in April. Patients whose referrals are accepted into the service are offered a telephone triage appointment. Some patients are discharged from the service at this point, while other patients are placed on the waiting list for therapy. The triage process has improved the management of the waiting list.

The table below illustrates the improving waiting times, from the acceptance of a referral to the first available face-to-face therapy appointment. This is shown in days for each site over the quarter based on the service’s availability.

Waiting time (days)	April	May	June
Chelsea	60	38	37
Sutton	55	51	36

The team of nurse counsellors and psychologists provided 265 outpatient therapy sessions in Chelsea and 346 sessions in Sutton.

5.3.2. Psychiatric Liaison Service

The Psychiatric Liaison Team – two Psychiatric Liaison Nurses, a Consultant Liaison Psychiatrist and Speciality Doctor – provide mental health assessment to inpatients with challenging psychological needs and arrange on-going support either through advice to the clinical team, direct care to the patient, or through onward referral to other services such as Psychological Support Service or community mental health teams. During the last quarter they assessed and provided support to 47 inpatients in Chelsea and 31 in Sutton.

5.3.3. Family support

Psychological support is available for cancer patients who are parents with children under eighteen years old. During the last quarter support has been provided to families both inpatient and outpatient setting.

	Chelsea	Sutton	Total
Inpatients	6	8	14
Outpatients	6	16	22
Total	12	24	36

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

5.3.4. Chaplaincy services

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

	Chelsea	Sutton	Total
Church of England	125	83	208
Roman Catholic	65	87	152
Christian Other	65	61	126
Muslim	77	21	98
Not Religious	42	43	85
Religion not known	18	11	29
Hindu	7	5	12
Buddhist	3	1	4
Jewish	3	1	4
Agnostic	1	0	1
Sikh	0	1	1
Atheist	0	1	1
Total number of patients	406	315	721
of which under palliative care	57	41	98
Funerals taken	0	1	1
Total number of visits	779	616	1,395

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

During Quarter One the chaplaincy team made 1,394 visits to 721 patients. Of these 779 visits were made on the Chelsea site and 616 visits were made on the Sutton site.

5.3.5. Staff Support Team

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

	One-to-one counselling	One-to-one supervision	Debriefing	Supervision groups
April	137	17	2	10
May	182	27	0	11
June	189	19	1	21
Total	508	63	3	42

Mindfulness sessions have continued on both sites.

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 76 new referrals and provided 405 therapeutic sessions in the quarter.
- 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 2017/18

Clinical supervision groups	10
Staff support groups	9
One-to-one supervision	74
Debriefs/complex case discussion	4

5.4.5. Patient groups

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

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

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

5.4.6. Other initiatives, innovations awards and research

The Paediatric and Teenage Psychological Support Service, together with the paediatric neuro-oncology clinical nurse specialist, is planning to put on an information and education day for patients’ schoolteachers. It is planned to repeat this event annually.

Research initiatives include the development of a short paediatric neuropsychological test battery. This will involve evaluating the developed test battery to determine if it is cost-effective, useful and effective to patients, parents and schools.

The service is also assessing the neurocognitive report format to make sure that it meets the needs of everyone involved and gives practical and applicable recommendations. This was approved as a service evaluation project and data collection continues. Specific information factsheets about cognitive problems and will be produced as an additional resource to add to the report. Charity funding was obtained to ensure continued funding for the project.

The research project investigating the development and validation of a paediatric and teenage distress and learning and memory thermometer (part of holistic needs assessment) is now in the analysis stage. An abstract has been accepted for oral presentation the Annual Congress of the International Society of Paediatric Oncology (SIOP 2017) in Washington DC in October. Operational guidelines about how to use the holistic needs thermometer will now be completed and put in place over the next six months.

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

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

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

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

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

6. Eating and drinking

6.1. Nutrition and catering patient surveys

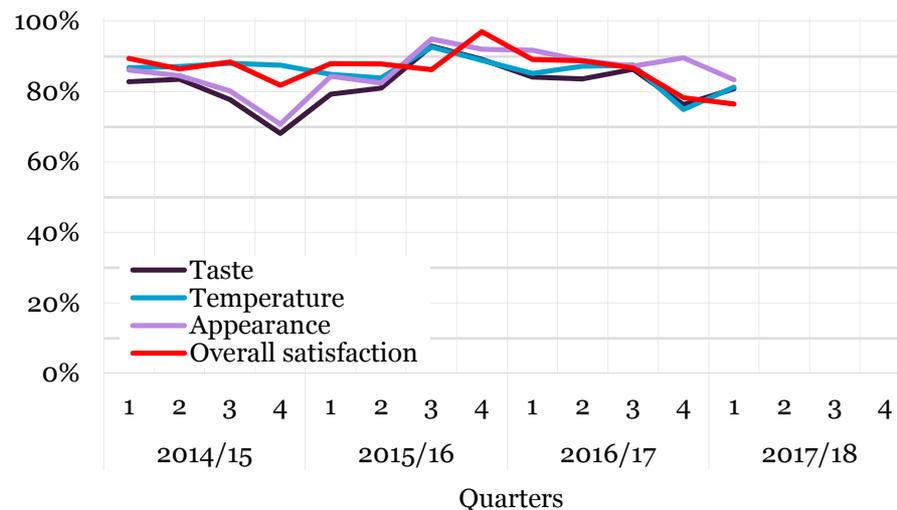
Patient surveys are undertaken at the Chelsea and Sutton sites. The patients' comments are regularly reviewed and particular points are actioned.

6.1.1. Patient survey results – Chelsea

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

- How would you rate the taste of your meal? (99 responses this quarter)
- How would you rate the temperature of the food? (91 responses this quarter)
- How would you rate the appearance of the meals? (84 responses this quarter)
- How would you rate your overall satisfaction with the catering service? (68 responses this quarter).

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

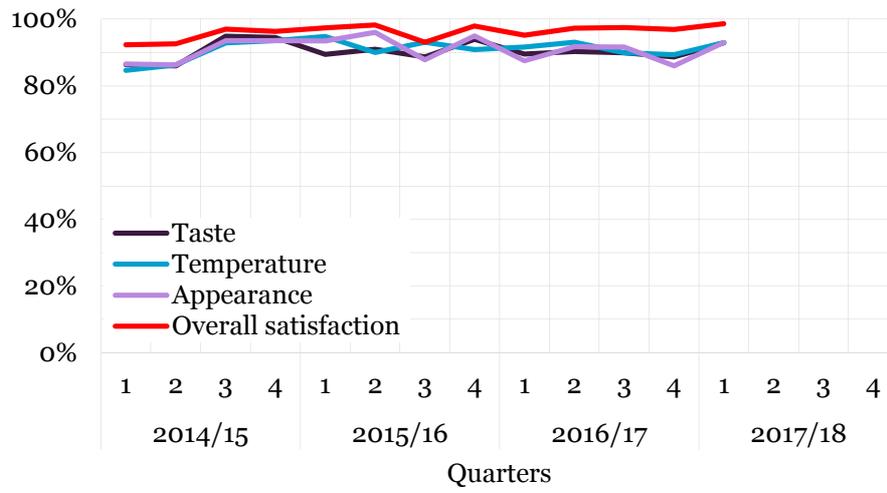


6.1.2. Patient survey results – Sutton

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? (141 responses this quarter)
- How would you rate the temperature of the food? (142 responses this quarter)
- How would you rate the appearance of the meals? (142 responses this quarter)
- How would you rate your overall satisfaction with the catering service? (147 responses this quarter).

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



7. Safeguarding and safety

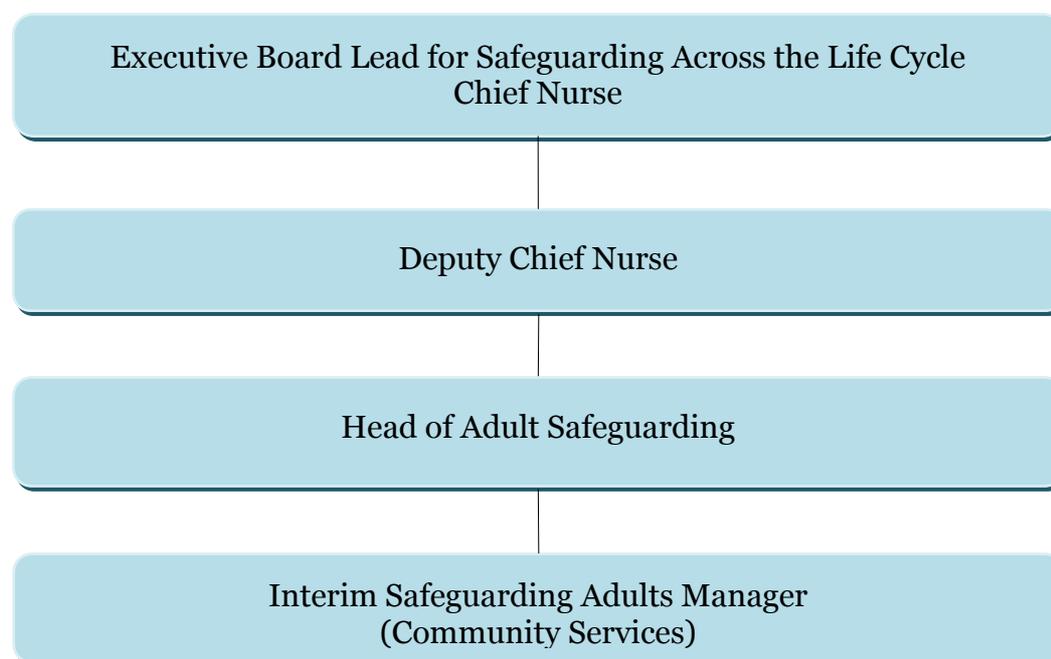
7.1. Safeguarding of adults at risk

Safeguarding adults at risk from abuse is everyone’s responsibility, safeguarding requires commitment from within the organisation and partnerships to ensure that there are safeguards against harm, abuse, neglect and poor practice. The safeguarding adults agenda is broad and far-reaching and requires leadership in the Mental Capacity Act and Deprivation of Liberty Safeguards, Prevent, Dementia, and Learning Disabilities.

The safeguarding adults agenda continues to be a priority for the Trust ensuring as far as possible that allegations of abuse are managed under the Care Act 2014 and Statutory Guidance as well as the *London Multi-agency safeguarding adults policy and procedures*. To safeguard adults from harm the Trust has systems, policies and processes, which are constantly reviewed to ensure that they comply with national and local guidance. Risks that are identified are managed and monitored by The Royal Marsden’s Safeguarding Children and Adults Board and there is a safeguarding adults at risk work plan in place to measure actions and progress against the agenda.

The Safeguarding Adults Team continues to support the Trust in implementing and measuring progress against the Care Quality Commission’s ‘must do’ actions. In practice, the actions focus on the application of the Mental Capacity Act 2005.

7.1.1. Adult safeguarding structure



The Trust continues its commitment to safeguarding adults working in partnership with the local authority safeguarding adults boards, commissioners and clinicians across the Trust.

The Chief Nurse is the executive lead for safeguarding across the life cycle and the Deputy Chief Nurse is the operational lead for safeguarding supported by the Head of Adult Safeguarding.

The Royal Marsden’s Safeguarding Children and Adults Board (chaired by the Chief Nurse/Deputy Chief Nurse) and Safeguarding Management Meeting group (chaired by Deputy Chief Nurse) review progress against the safeguarding work plan.

7.1.2. Key achievements against work plan

- Mental Capacity Act and Deprivation of Liberty Safeguards training delivered to staff within community services as a part of the Care Quality Commission action plan.
- Increased support to ensure ‘learning in action’ in the application of the Mental Capacity Act/Deprivation of Liberty safeguards across the Trust.
- Continued Trust presence and commitment to both partnership and internal safeguarding boards and subgroups to share, report and review safeguarding practice in the Trust.
- Learning disabilities friend study day held and learning disabilities friend role re-launched. There is a strong commitment from staff across a range of services to support service users who have a learning disability.
- Strengthened adult safeguarding leadership in Community Services.
- Trust wide safeguarding adults risk register in place monitored by the Trust is safeguarding board.

7.1.3. Safeguarding adults activity

During Quarter One, concerns raised 29 safeguarding adults across the Trust. This is an increase from Quarter Four 2016/17 when 22 safeguarding concerns were raised across the Trust. A Trust-wide risk has been identified that not all reported concerns are being captured and reported in line with Trust policy; ongoing work to improve this is a part of safeguarding adults training and the work plan.

There were two safeguarding enquiries relating to care provided by Community Services reported during this period.

The Trust has also been involved in one Safeguarding Adults Review during this period.

Hospitals	Quarter 4 2016/17	Quarter 1 2017/18	Increase
Number of referrals to local authority	3	4	34%
Number of concerns but not meeting safeguarding adults threshold	N/A	9	N/A

In Quarter One there were four safeguarding concerns raised from the Trust's Chelsea and Sutton sites, an increase of 34% since Quarter Four 2016/17.

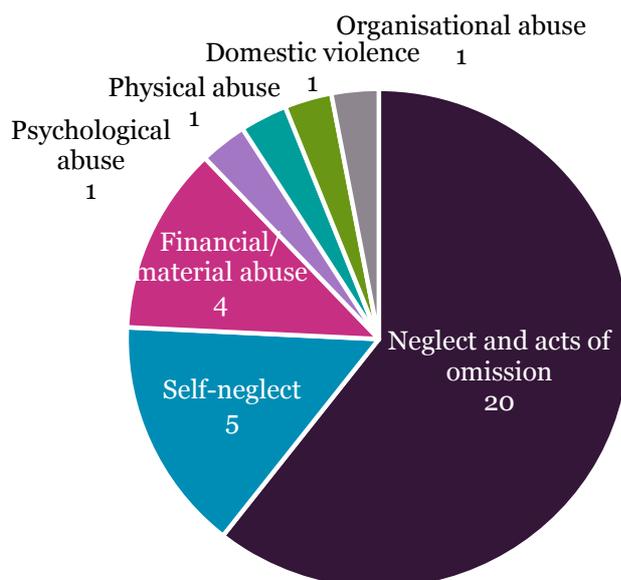
Nine safeguarding incidents were reported on The Datix incident reporting system (Datix) that did not meet the safeguarding adults threshold for formal referral raised from the Chelsea and Sutton sites.

Community Services	Quarter 4 2016/17	Quarter 1 2017/18	Increase
Number of referrals to local authority	19	25	32%
Number of concerns but not meeting safeguarding adults threshold	N/A	4	N/A

In Quarter One there were 25 safeguarding concerns raised by Community Services, an increase of 32% since Quarter Four 2016/17. Community nursing teams continue to raise the most safeguarding concerns within the Trust, having raised 25 of the 29 referrals this quarter.

7.1.4. Alerts by category of abuse

A safeguarding concern may have more than one category of abuse recorded therefore more than one type of abuse may be reported for a single safeguarding incident. *Neglect and acts of omission* and *Self-neglect* continue to be the highest reported categories with 20 and five concerns respectively. The number of *neglect and acts of omission* concerns raised has increased by 50% compared to Quarter Four. Four concerns were raised in regards to *financial/material abuse* and one concern each was raised for *organisational abuse, domestic violence, physical abuse* and *psychological abuse*.



7.1.5. Pressure ulcer incidents

During Quarter One there were 28 attributable and non-attributable incidents reported within the Trust relating to category 3 and 4 pressure ulcers. Five of these were attributable acquired pressure ulcers.

All multiple grade 2, grade 3 and grade 4 pressure ulcers are screened using the Safeguarding Pressure Ulcer Protocol and four of these, all from Community Services, were reported to the local authority under the safeguarding adult procedures.

The Trust Pressure Ulcer Panel reviews all root cause analysis investigations in regards to category 3 and 4 pressure ulcers identified within the Trust. These cases can often include safeguarding adults concerns, such as concerns around informal carer, concerns about formal care provisions provided by adult social care or the clinical commissioning group, and poor discharge from general hospitals. A member of the Safeguarding Adults Team attends the Pressure Ulcer Panel.

7.1.6. Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

The Trust Safeguarding Adults Team lead on the Mental Capacity Act and Deprivation of Liberty safeguards agenda for the Trust. Additional study sessions were delivered to staff working in community services as well as sessions for nursing staff working on the Critical Care Unit at recent study days.

Mental capacity is covered in safeguarding adults level 2 mandatory training which is delivered at induction to all new starters in the Trust. A key finding from the Care Quality Commission inspection highlighted that improvements are required in relation to the application of the Mental Capacity Act and Deprivation of Liberty Safeguards.

In Quarter One 78 community staff attended bespoke Mental Capacity Act and Deprivation of Liberty Safeguards training and 26 staff are booked onto the next two training sessions, which is a part of the Care Quality Commission action plan. Level 2 safeguarding adults training also includes training on the Mental Capacity Act and Deprivation of Liberty safeguards and community services compliance was 96% at the end of this quarter.

7.1.7. Deprivation of Liberty Safeguards referrals

Applications are made when the team caring for the patient consider the patient lacks the capacity to consent to care and treatment and meet the acid test (i.e. is not free to leave, and is subject to constant supervision).

Ten urgent applications were made for Deprivation of Liberty Safeguards in Quarter One. This is an increase from Quarter Four where six urgent applications were made.

	Urgent applications	Number assessed for Standard Authorisation	Standard Authorisation Granted	Increase in urgent referrals from Quarter 4 2016/17
Quarter 1 2017/18	10	1	0	67%

7.1.8. 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) is to help identify vulnerable persons who are at risk of engaging in or supporting terrorism or terrorist activity. Awareness training is provided in two levels: basic awareness and the *Workshop to Raise Awareness of Prevent (WRAP)*.

The Chief Operating Officer is the organisational *Prevent* Lead and the Head of Adult Safeguarding is the *Prevent* lead and leads on the strategic work for the agenda as well as ensuring training is provided as well as representing the Trust within NHS *Prevent* Forums and networks.

During this quarter, there has been one *Prevent*-related concern that was reported to the police. There have been no other enquiries to the *Prevent* lead in the quarter and no referrals made to Channel Panel.

Basic *Prevent* awareness is provided within safeguarding adults and children training and WRAP training is provided as an additional bespoke session. There were no WRAP sessions held during this quarter.

7.1.9. *Prevent* training compliance

Training	Number of staff completed Quarter 1	Number of compliant staff
Basic Awareness	430	3,493
Workshop to raise awareness of <i>Prevent</i> (WRAP)	0	364

7.1.10. Dementia

The Trust's Dementia Champions network aims to meet quarterly and works to support the improvements of patient pathways and environments for patients with dementia.

During this period, the group has supported with Diversity and Dementia Week and providing Dementia friends training to Trust staff. Members have been involved in Trust delirium pathway improvements under the frailty project.

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

7.1.11. Dementia awareness training

Training	Number of staff completed within the Trust to date
Tier 1	1,207
Tier 2	51

7.1.12. Learning disabilities

During this quarter nursing staff from the Trust's hospital sites have received disability awareness training as a part of mandatory training. These sessions have been well received and there is a plan to roll the sessions out to community teams. This training aims to help raise awareness of the challenges faced by people with learning disabilities and how they can support these people to get the best from their treatment by making reasonable adjustments to support them. The session also raises awareness of the Trust's drive to recruit learning disability buddies who will champion the agenda, raise awareness within their own teams, and deliver training to others.

The learning disabilities buddies network was re-launched and, culminating in a study day for staff buddies, 17 staff received buddy training. This was delivered by internal and external agencies, the day was well evaluated and will be repeated to train additional staff.

During this quarter the Trust formally notified NHS England of the Learning Disabilities Mortality Review (LeDeR) Programme lead. There have been no referrals to LeDeR during this period.

7.1.13. Training

Safeguarding adults Level 1 training

Level 1 training covers basic safeguarding recognition and awareness, and is part of the Trust induction (delivered jointly face-to-face with Safeguarding Children) and mandatory training through e-learning. Staff need to refresh at this level every three years. The level 1 training also includes basic *Prevent* awareness training. The Trust internally aims for compliance target of 90%.

Safeguarding adults level 1 training compliance at the end of Quarter One was 93% which has increased slightly from 92% compliance in Quarter Four.

Safeguarding Adults Level 1

Division/directorate	Number of staff	Number of compliant staff	Number of non-compliant staff	Compliance rate
Cancer Services Division	182	152	30	84%
Capital Projects Directorate	4	4	0	100%
Chief Executive's Office	11	10	1	N/A
Chief Nurse Directorate	38	37	1	97%
Chief Operating Officer – management	11	10	1	91%
Clinical Research and Development	179	170	9	95%
Clinical Services Division	507	482	25	95%
Community Services Division	60	56	4	93%
Estates Directorate	58	57	1	98%
Facilities Directorate	223	202	21	91%
Finance Directorate	48	44	4	92%
Information Technology	44	44	0	100%
Marketing, Communications and Fundraising Division	22	22	0	100%
Other Corporate	21	21	0	100%
Performance and Strategy Implementation	53	49	4	92%
Private Care Division	94	88	6	94%
The Royal Marsden Cancer Charity	34	34	0	100%
Workforce Division	69	67	2	97%
Total	1,658	1,549	109	93%

7.1.14. Safeguarding adults level 2 training

Level 2 training is for all clinical staff and includes training around the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, as well as basic Prevent awareness. The training is delivered either through face-to-face training or via e-learning. Staff need to refresh at this level every three years. The trust internally aims for a compliance target of 90%.

Safeguarding adults level 2 training compliance at the end of Quarter One was 86% which has increased from 82% compliance in Quarter Four.

Safeguarding Adults Level 2

Division/Directorate	Number of staff	Number of compliant staff	Number of non-compliant staff	Compliance
Cancer Services Division	652	516	136	79%
Chief Executive's Office	2	2	0	100%
Chief Nurse Directorate	21	20	1	95%
Clinical Research and Development	184	161	23	88%
Clinical Services Division	805	699	106	87%
Community Services Division	320	306	14	96%
Information Technology	1	1	0	100%
Private Care Division	185	165	20	89%
Royal Marsden Cancer Charity	1	1	0	100%
Workforce Division	23	21	2	91%
Total	2,194	1,892	302	86%

The Trust facilitates a level 3 safeguarding programme for identified senior members of staff. Additional training sessions and bespoke e-learning packages and workbooks are being developed and reviewed to continue to improve compliance, and to improve understanding and confidence in this area.

7.1.15. Key priorities for Quarter Two

- Recruit to Specialist Safeguarding Adults advisor post.
- Continue to raise awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards across the Trust and feed back to interested parties on progress against the CQC action plan.
- Ensure key safeguarding adults policies are reviewed, robust and up to date.
- Undertake a training needs analysis to include the best practice guidance for safeguarding adults, Mental Capacity Act and *Prevent* training and develop a safeguarding training strategy (across the lifecycle).
- Ensure the Trust has a plan to imbed requirements of LeDeR.
- Ensure consideration of safeguarding is robust for incidents (including serious incidents) and complaints, including reviewing recording of safeguarding within Datix.
- Ensure that safeguarding adults reporting both internally and externally is robust, identifying achievements, risks and key objectives.

7.2. Protection and identification of vulnerable children and young adults

7.2.1. Number of child protection plans on last day of reporting period, broken down by geographical area and by reason for putting plan in place

Reason	Area	April	May	June
Total each month (permanent and temporary)	Sutton	228	241	257
	Hospital	5	4	4
Physical	Sutton	18	17	16
	Hospital	0	0	0
Emotional	Sutton	99	89	93
	Hospital	1	1	1
Neglect	Sutton	106	128	141
	Hospital	3	2	2
Sexual	Sutton	5	7	7
	Hospital	1	1	1

7.2.2. Number of child protection case conference invitations received

Quarter 1 Initial invitations	Health Visitor	School Nurse	Quarter 1 Review invitations	Health Visitor	School Nurse
Invitations received	38	54	Invitations received	40	77
Attended	36	46	Attended	31	24
Non-attendance: non- quorate by borough	2	3	Non-attendance: non- quorate by borough	2	7
Non-attendance: no health needs of child	0	1	Non-attendance: no health needs of child	0	35
Other non-attendance by healthcare professional and reasons	0	4 OOB	Other non-attendance by healthcare professional and reasons	4 LAC 2 Transfer out 1 Mother and baby unit	7 OOB 4 LAC

Transfer out: relates to children subject to Child Protection Plan who have transferred to another area prior to the scheduled review Child Protection Case Conference.

OOB: out of borough – relates to children who are resident in the London Borough of Sutton but do not attend a Sutton school.

LAC: relates to children subject to Child Protection Plan who have recently been accommodated as a Looked after Child.

The figures show the number of children for whom the service received an invitation to a case conference. Each child discussed at conference has an individual conference report by the health practitioner. Health visiting staff attend conferences for children aged less than five years and the school nursing service attends for children of school age. The difference between the number of invitations received and conferences attended is attributable to a range of factors that includes conference cancelled, inappropriate invitation (for example the child has moved to another area) or no identified health needs for a school-aged child/children.

7.2.3. Number of multi-agency risk assessment conference (MARAC) cases with children

	April	May	June
Sutton	11	28	14
Hospital	0	0	0

7.2.4. Level of safeguarding supervision

	April	May	June
Health Visitors	28%	86%	93%
School Nurses	33%	66%	92%

7.3. Pressure ulcers

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

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

Category	Description
1	Non blanching redness of intact skin
2	Partial thickness skin loss or blister
3	Full thickness skin loss (fat visible)
4	Full thickness tissue loss (muscle/bone visible)

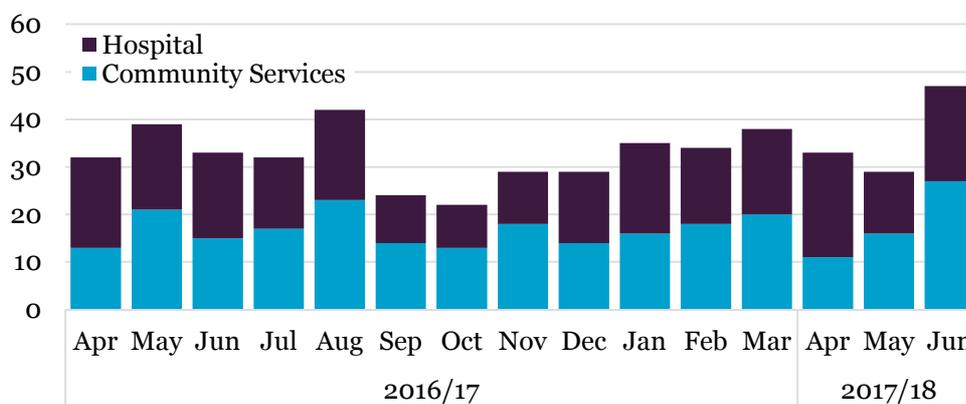
7.3.3. Since June 2015, category 4 pressure ulcers that cause severe harm to the patient and are attributable to the Trust have required reporting under the national serious incident reporting system.

7.3.4. In Quarter One, one patient in hospital and no community services patients developed a category 4 pressure ulcer that was attributable to the Trust. From 1 April 2016 community services data only contains pressure ulcers reported from Sutton Community Health Services.

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

	April	May	June
Number of patients with pressure ulcers attributable to the Trust	33	29	47
Number of patients with pressure ulcers attributable to the hospital	22	13	20
Number of patients with pressure ulcers attributable to Community Services	11	16	27
Number of patients with attributable pressure ulcers Category 1	8	9	9
Number of patients with attributable pressure ulcers Category 2	23	19	34
Number of patients with attributable pressure ulcers Category 3	2	1	3
Number of patients with attributable pressure ulcers Category 4	0	0	1

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



8. Premises and equipment

8.1. Infection prevention and control

8.1.1. Mandatory surveillance

Indicator	Quarter 1 DCS* reportable	Quarter 1 DCS attributable	YTD†	YTD attributable	Target	Variance from target	Forecast
MRSA‡ Bacteraemia	0	0	0	0	0	0	
<i>S. aureus</i> Bacteraemia	2	N/A**	2	N/A	N/A	N/A	
<i>E. coli</i> bacteraemia	14	6	14	6	42	-36	
VRE bacteraemia	1	1	1	1	N/A	N/A	
<i>Klebsiella</i> sp. bacteraemia	9	4	9	4	29		
<i>Pseudomonas aeruginosa</i> bacteraemia	1	0	1	0	16		

	Quarter 1	Quarter 1 DCS attributable post 72 hours	YTD post 72 hours	CDT lapse in care YTD: total against target	Target	Variance from target	Forecast
<i>C. difficile</i> toxin	22	14	14	N/A	31	-31	

*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. Hand hygiene

The overall hand hygiene compliance score for the Trust in Quarter One is 92%. The Chelsea site compliance score is 89%, Sutton is 96% and Kingston 92%.

8.1.3. *Staphylococcus aureus* bacteraemia

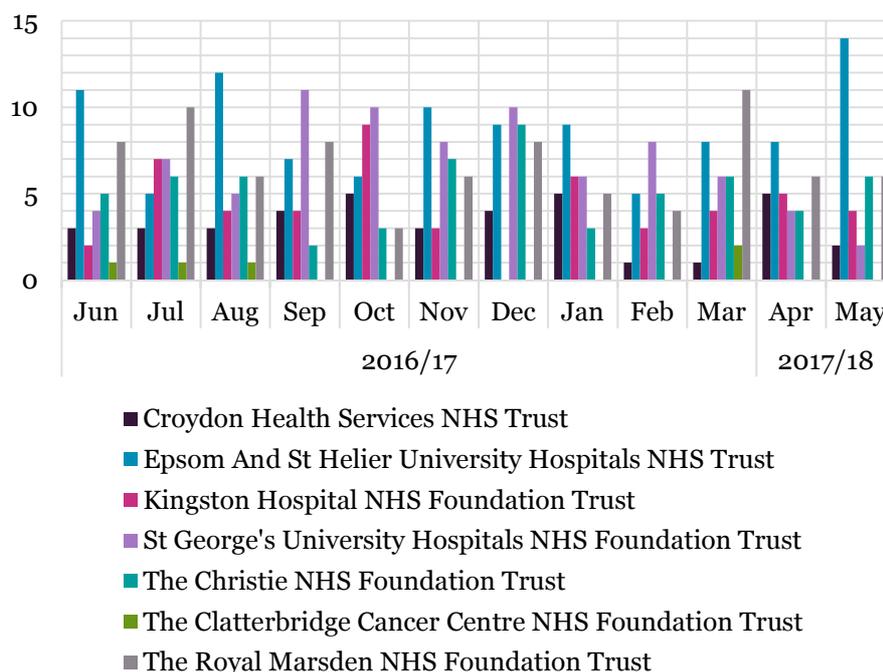
There were two cases of *Staphylococcus aureus* bacteraemia in the quarter which were related to an infected peripherally inserted central catheter (PICC) line. The policy has been amended to introduce pre procedure skin decolonisation.

8.1.4. *Clostridium difficile* infection

All stool samples found to be *Clostridium difficile* toxin (CDT) positive are reported to the HCAI DCS. Those cases which occur within 72 hours of admission are deemed as community attributed. Cases which may have been preventable are deemed 'lapse in care' and recorded against *C. difficile* toxin objective target of 31.

There were 22 cases of CDT in Quarter One, of these 13 were DCS reportable as post 72 hours.

The trajectory remains at no more than 31 lapses in care for 2017/18. Cases have not yet been assessed with the commissioner for any lapses.



8.1.5. Carbapenemase-producing Enterobacteriaceae (CPE)

There were four patients with CPE in Quarter One (three confirmed and one suspected). Two patients were from Kuwait, one from Malta and one was referred from another hospital in England

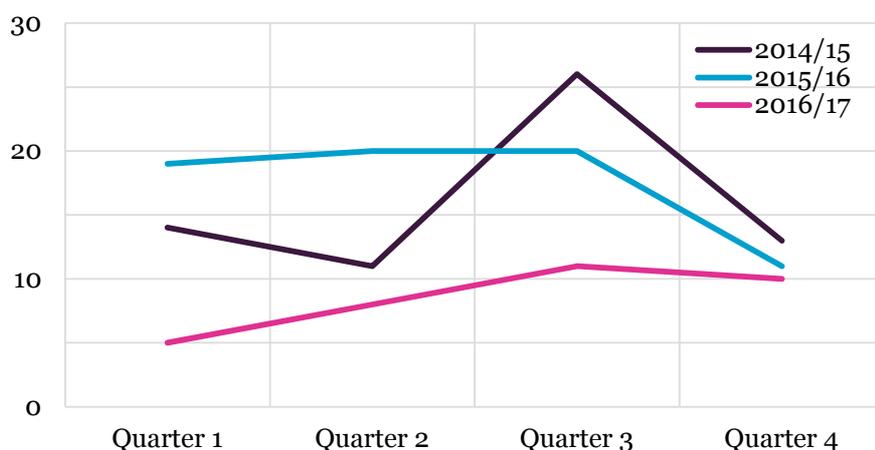
8.1.6. *E.coli* bacteraemia

There is now a new requirement for reporting of *E.coli*, *Klebsiella* sp. and *Pseudomonas aeruginosa* bacteraemia onto the HCAI DCS. These are all gram-negative bacteria and numbers of cases have been rising across the UK for some years. These infections are often associated with urinary tract infection, urinary 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 through NHS Improvement has issued an ambition to see a 50% reduction in these gram-negative blood stream infections by March 2021, starting with a 10% reduction of *E.coli* bacteraemia in this financial year.

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

Preliminary analysis of the data indicates approximately a third of cases in the last quarter are associated with the urinary tract and another third were diarrhoea associated along with mucositis/chemotherapy. These patients all have complex co-morbidities.

The Infection Prevention and Control Team is arranging to meet with the urology nursing team to look at actions for future reduction.



8.1.7. Contract review meetings and audit

The joint tender (with two neighbouring healthcare partners) for the facilities contract is underway. Monthly contract review meetings attended by matrons monitor concerns and ensure that actions are followed through. Operational audits are carried out weekly to validate cleaning scores submitted by the contractor's supervisors.

8.1.8. Enteric pathogens

Three patients were admitted with Norovirus in the quarter, three patients with *Salmonella*, three with *Campylobacter* and two with Rotavirus. There was no associated cross infection to others and no ward closures.

Interestingly two patients were seen with *Listeria monocytogenes*. Both had recent travel history. The cases were typed and there was no link to each other or to The Royal Marsden. There has been a recent recall of sandwiches from a national supplier due to *Listeria*.

8.1.9. Flu

Planning for the 2017 flu season begins with a meeting scheduled for the 24 July.

8.2. Sepsis

- 8.2.1. The Royal Marsden joined the *Sign up to Safety* campaign in November 2014. Along with a reduction in medication incidents and pressure ulcers, the aim of the campaign is to reduce the number of avoidable deaths from severe sepsis and septic shock in the Trust by 100% over three years. The Consultant in Critical Care and Anaesthesia is the medical lead for sepsis and the Matron for Critical Care and Outreach is the nursing lead.

- 8.2.2. The leads are working on gap analysis to implement over 150 recommendations following National Institute for Health and Care Excellence (NICE) guideline 51 *Sepsis: recognition, diagnosis and early management* (published July 2016). Furthermore, there is work underway to incorporate potential new definitions of sepsis, new recommendations from the Surviving Sepsis Campaign and combine guidance on generalised and neutropenic sepsis. Additionally, a senior nurse is due to be appointed to coordinate Trust efforts on sepsis and acute kidney injury.
- 8.2.3. The Sepsis Implementation Team meets regularly to promote awareness and early identification, escalation and management of sepsis and neutropenic sepsis.

8.2.4. Data collection

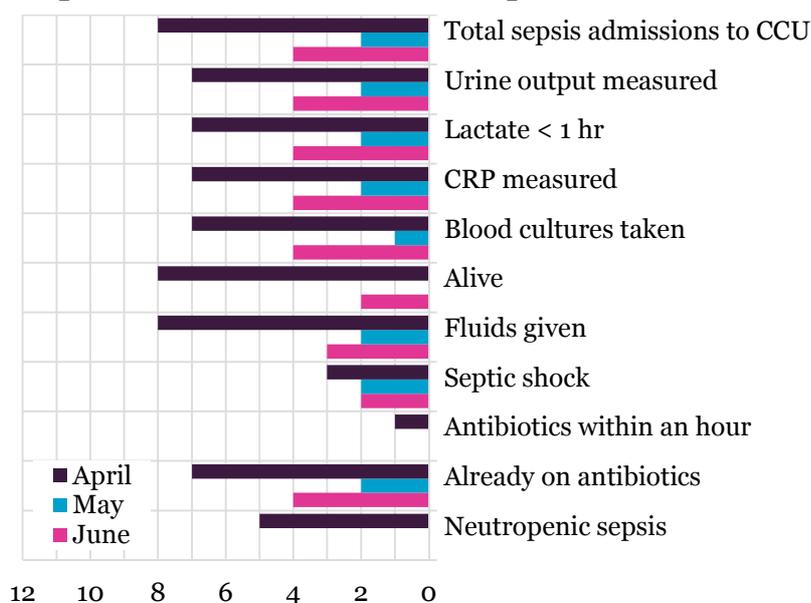
The audit of all patients admitted to Critical Care Unit (CCU) with sepsis continued. Quarter One data shows good compliance with the *Sepsis Six* bundle.

Fourteen patients were admitted to CCU with sepsis in the quarter, with four patients dying in critical care. Approximately one third of the patients (five) admitted had neutropenic sepsis. All but one patient had urine output measured, lactate monitored and C-reactive protein (CRP) measured. The lactate monitoring (92%) is similar to the first quarter last year (93%) and reflects the measurement in all bar one patient.

All fourteen patients were already receiving antibiotics or received antibiotics within the first hour of presenting with sepsis. This continues the high rates seen since the commencement of the *Sign up to Safety* initiative.

The neutropenic sepsis audit was completed by the Acute Oncology Service (AOS) team.

8.2.5. Sepsis admissions to CCU – April to June 2017



8.2.6. Implementation of action plan

- Gap analysis of NICE guideline 51 for adults and paediatrics is in progress to ensure that the Trust is compliant with recommendations.
- All patients with a national early warning score (NEWS – an early predictor of deterioration) of 4 or above with a suspected infection should be referred to CCU Outreach (24/7), a clinical site practitioner or an on-call junior doctor for immediate review. If sepsis is suspected it must be escalated to a senior clinician for immediate review.
- All patients referred to CCU Outreach teams continue to be assessed for signs of sepsis and the assessments are audited.
- All patients with neutropenic sepsis need a Multinational Association of Supportive Care in Cancer (MASCC) risk score to be recorded, and nurses need to complete a neutropenic sepsis audit which is sent to the Quality Assurance Team.
- CCU Outreach teams and the community practice education team continue to educate medical and nursing staff on implementation of the *Sepsis Six* bundle.
- Appointment of a senior nurse to spearhead the prevention, assessment and management of sepsis and acute kidney injury.

8.3. Medical devices

8.3.1. Medical device incidents

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

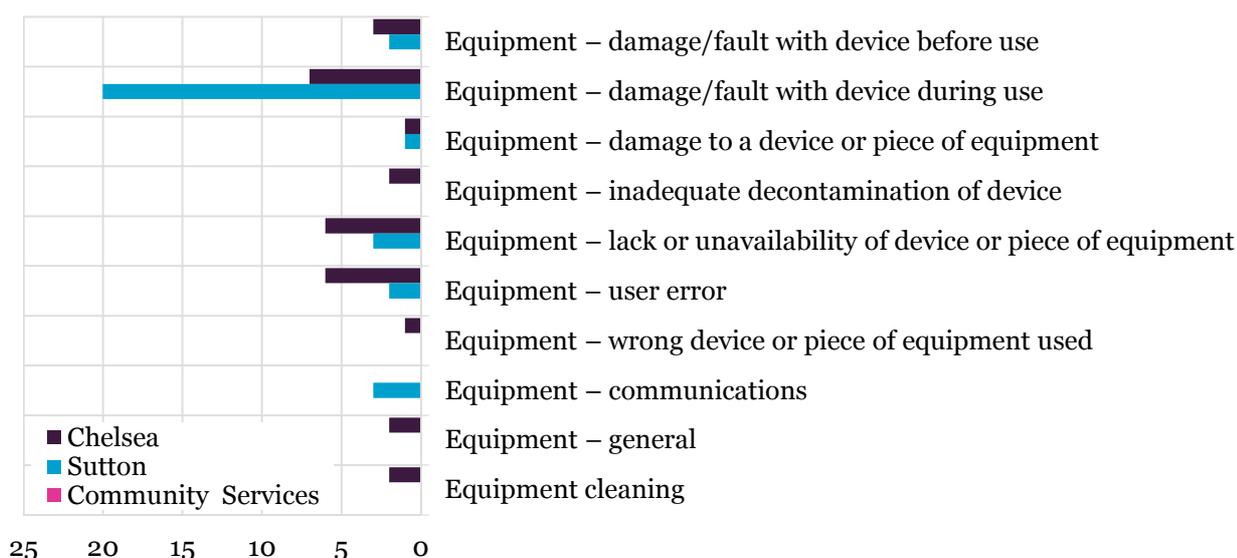
There were 61 incidents relating to medical devices this quarter (there were 60 in the previous quarter).

The main devices incidents included:

- 19 involving various non-specified equipment
- five involving beds and mattresses
- five involving intravenous (IV) equipment
- five involving pathology equipment.

No incidents were graded *moderate*, 21 were *low* and 40 were *very low*.

8.3.2. Medical device incident category by site



8.3.3. Medical device incidents by type

Type of medical device	Total
Various non-specified equipment	19
Bed (including mattress)	5
Pathology equipment	5
Intravenous equipment (e.g. needle, syringe, extension set)	5
Endoscopes	4
Administration and giving sets	4
Anaesthetic machine/equipment	3
Feeding tubes	3
Pump/syringe driver	3
Surgical instruments	2
Fridge/freezer	2
Facilities (other)	1
Monitor screens	1
Resuscitators	1
Radiotherapy equipment (e.g. simulator, MRI)	1
Staples and staple guns	1
Thermometers	1
Wound drains	1
Total	62

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

8.3.4. Evaluation of new medical devices

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

8.3.5. Clinical Product Review Committee medical device proposals

Form A (low risk)	2
Form B (proposal to evaluate)	12
Form D (risk assessment - device not evaluated)	2
Approved for purchase	3
Total	19

8.4. Medicines optimisation

8.4.1. Medicines safety

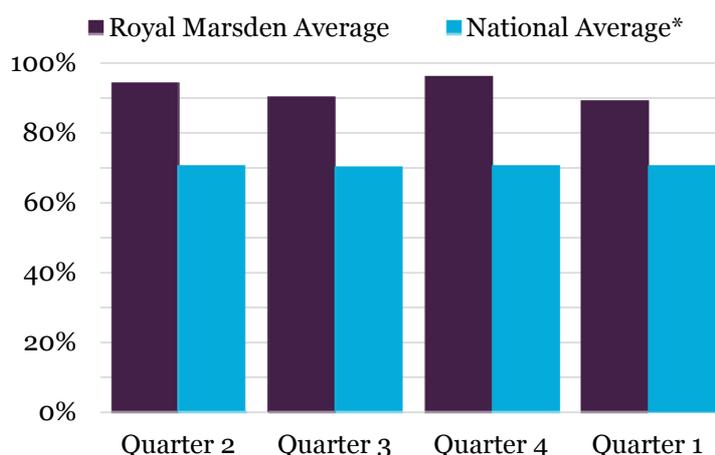
The Trust's commitment to improve the safer use of medicines as part of the *Sign up to Safety* campaign continues to be at the forefront of medicines governance.

8.4.2. Medication reconciliation

Results of the medication safety thermometer for the first quarter have 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 each quarter in 2016/17 through to the first quarter of 2017/18.

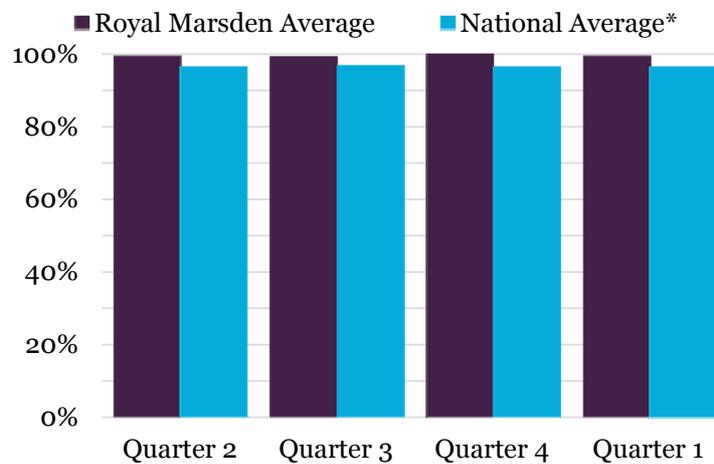


* National averages are calculated from the NHS Medication Safety Thermometer national dashboard.

8.4.3. Allergy documentation

Allergy documentation on the inpatient drug chart was demonstrated to be high and the Trust aims for 100% compliance.

The chart shows the percentage of allergy status documented for each quarter in 2016/17 through to the first quarter of 2017/18.

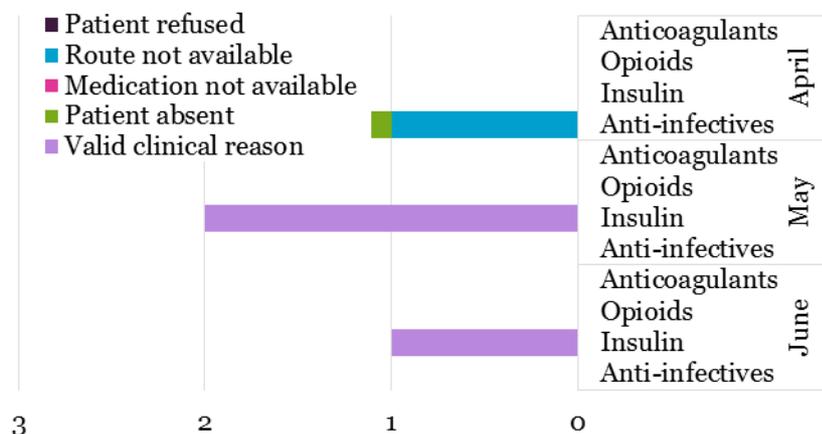


* National averages are calculated from the NHS Medication Safety Thermometer national dashboard.

8.4.4. Omission of critical medicines

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

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



8.4.5. Electronic prescribing

From April 2016 all adult clinical units were using the electronic chemotherapy prescribing system (eChemo) and its introduction to paediatrics is well underway.

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

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

The table shows the eChemo system prescribing metrics.

	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17	Quarter 1 2017/18
eChemo prescriptions prescribed more than 5 days in advance	78%	77%	75%	74%
Available eChemo prescriptions screened more than 4 days in advance	94%	93%	92%	93%

8.4.6. Medication supply partnership

Ongoing quality improvement meetings between Boots UK and Royal Marsden staff has enabled the teams to jointly review prescription pathways to improve the patient experience and expectations.

Outpatient waiting time data in the table below shows that 87% of prescriptions are completed within 30 minutes. The average waiting times between April to June were 20 minutes (Sutton) and 17 minutes (Chelsea).

Outpatients Minutes	April		May		June	
	Sutton	Chelsea	Sutton	Chelsea	Sutton	Chelsea
0 to 30	84%	92%	81%	86 %	84%	96%
31 to 60	15%	7%	18%	12%	14%	4%
61 or more	1%	1%	1%	2%	2%	0%

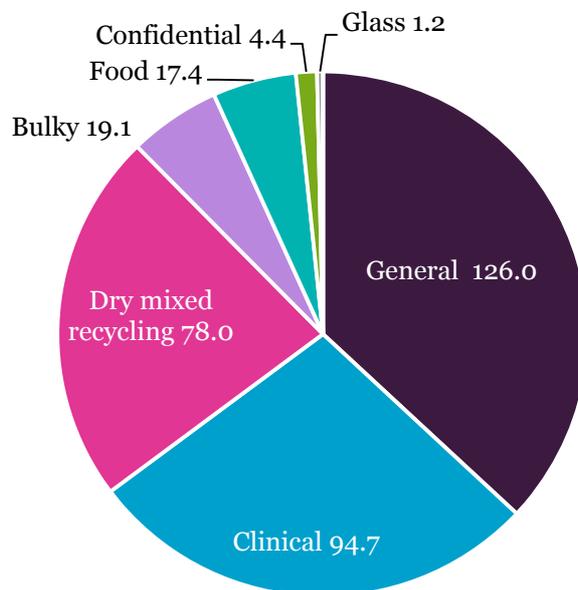
Waiting times for prescriptions dispensed for discharge are shown in the table below. It shows that over 98% of discharges were completed within 60 minutes with over two thirds completed within 30 minutes. Average waiting times from April to June were 20 minutes (Sutton) and 16 minutes (Chelsea).

Discharges Minutes	April		May		June	
	Sutton	Chelsea	Sutton	Chelsea	Sutton	Chelsea
0 to 30	76%	94%	77%	94%	78%	95%
31 to 60	22%	5%	20%	5%	20%	5%
61 or more	2%	1%	3%	1%	2%	0%

8.5. Waste management

8.5.1. Domestic and clinical waste

The chart shows the quarterly waste by category with values in tonnes.



The combined total amount of waste produced by Chelsea and Sutton for Quarter One was 340.84 tonnes.

The annual 2017/18 Pre-Acceptance audits for Chelsea and Sutton sites were completed in May. The annual 2017/18 Dangerous Goods audits for Chelsea and Sutton were completed in June 2017.

8.6. Fire

8.6.1. Statutory compliance

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

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

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

The Trust has no unresolved enforcement actions to implement.

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

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

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

8.6.2. Fire risk assessments

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

8.6.3. Fire preparedness

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

8.6.4. Planned evacuation procedures

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

8.6.5. Simulated evacuations

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

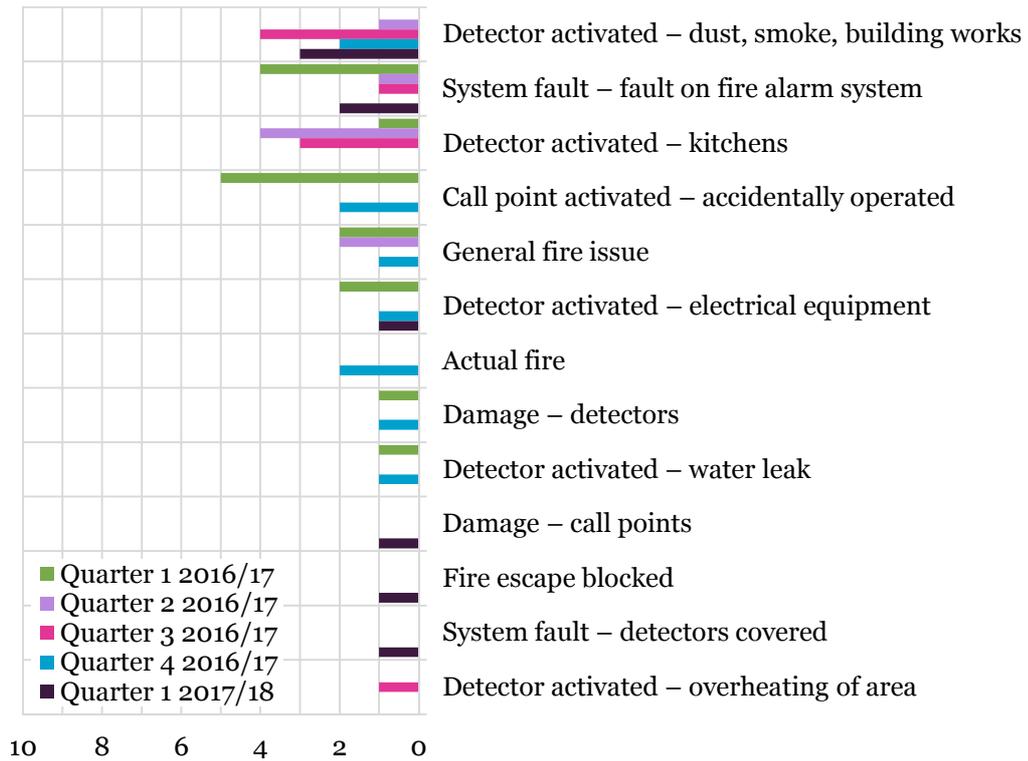
8.6.6. Fire incidents this quarter

There were no actual fires this quarter.

There were nine fire incidents attributable to the Trust. (Ten fire incidents were reported in Quarter Four 2016/18).

Incident category	Number of incidents
Detector activated – dust, smoke, building works	3
System fault – fault on fire alarm system	2
Detector activated – electrical equipment	1
Damage – call points	1
Fire escape blocked	1
System fault – detectors covered	1
Total	9

8.6.7. Fire incidents in the last five quarters

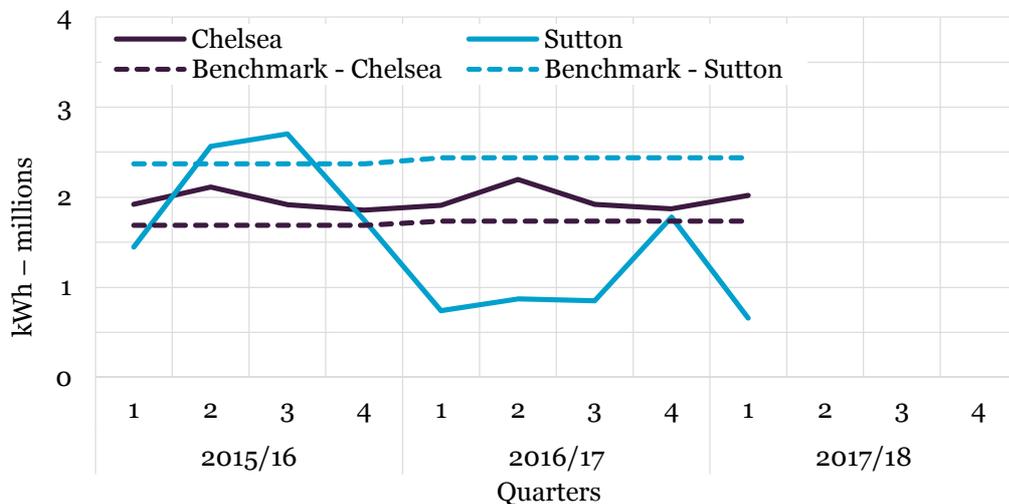


8.7. Energy use

8.7.1. Electricity consumption – Chelsea and Sutton

Electricity consumption in Quarter One at Chelsea increased by 6% on the same quarter last year and increased by 8% on previous quarter (Quarter Four 2016/17). The main contributor to the increased electricity is extra load of the new Stewart House building and additional load of air conditioning systems due to hotter seasonal weather.

Electricity grid consumption in Quarter One at Sutton reduced by 11% on the same quarter last year and 63% on Quarter Four in 2016/17. The generation of electricity from the on-site combined heat and power plant (CHP) has reduced the amount of electricity imported from national grid to the site.

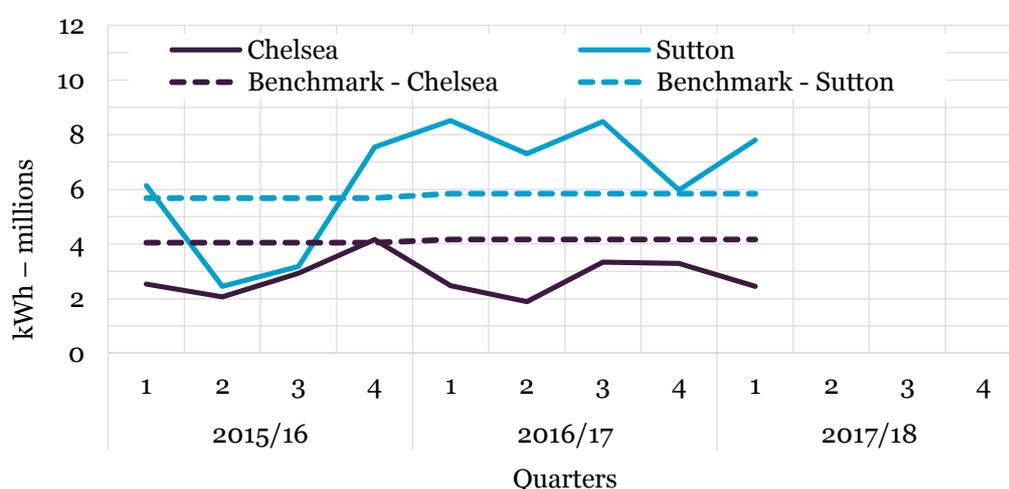


The benchmark used is an average of consumption of five acute trusts in London. The Royal Marsden’s electricity consumption at the Chelsea site is slightly above the benchmark line but the consumption at Sutton is below the benchmark line. The Trust is preparing a feasibility study for on-site generation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

8.7.2. Gas consumption – Chelsea and Sutton

Gas consumption in Quarter One at Chelsea reduced 1% over the same quarter last year and 25% on Quarter Four in 2016/17. The main reason for reduction is less heating demand due to warmer ambient temperature.

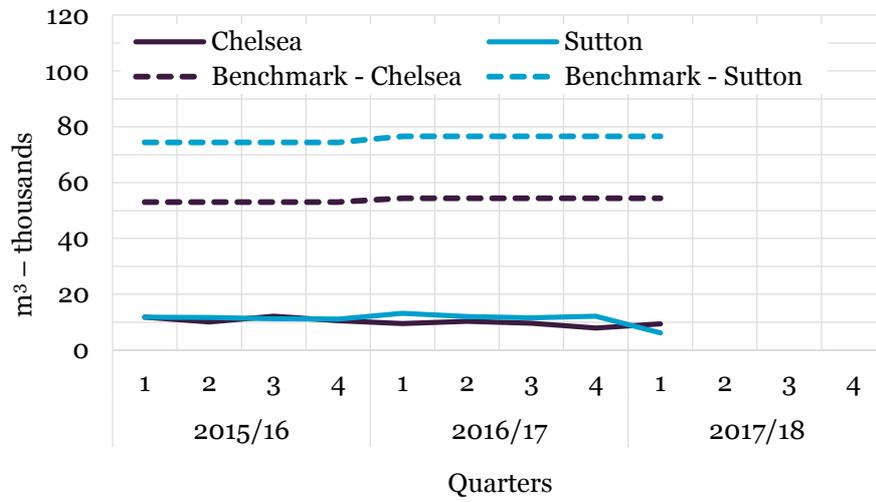
Gas consumption at Sutton was down 8% on the same quarter last year and increased by 30% on Quarter Four in 2016/17. The reduction is due to more efficient running of the energy centre and the increase is due to the CHP system unviability in Quarter Four last year, which has resulted in less gas consumption.



8.7.3. Water consumption – Chelsea and Sutton

Water consumption in Quarter One at Chelsea was down 1% on the same quarter last year and increased 18% on Quarter Four 2016/17. A faulty water meter was replaced in Quarter One and as a result, more realistic water usage was reordered compared to incorrect consumption recorded in previous quarter.

Water consumption in Quarter One at Sutton was reduced 53% on the same quarter last year and 49% on Quarter Four in 2016/17. A faulty water meter is the main reason for not registering actual usage.



9. Suitability of staffing

9.1. Human Resources

9.1.1. Performance indicators

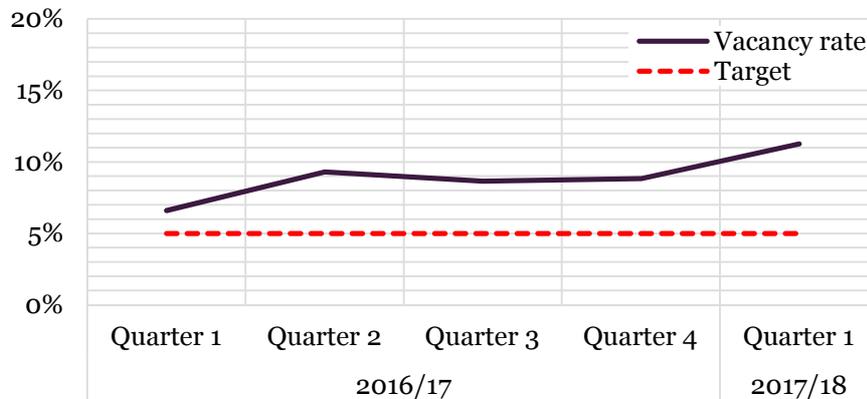
	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17	Quarter 1 2017/18
Vacancy rate (target 5.0%)					
Trust total	6.6%	9.3%	8.6%	8.8%	11.3%
<i>Cancer Services</i>	4.2%	6.4%	5.8%	6.3%	7.2%
<i>Clinical Research*</i>					13.0%
<i>Clinical Services</i>	7.8%	9.0%	7.8%	6.9%	11.3%
<i>Community Services</i>	11.7%	15.4%	14.6%	15.7%	17.8%
<i>Private Care†</i>					18.0%
<i>Corporate†</i>	6.8%	12.7%	11.8%	10.7%	8.0%
Turnover (target 12.0%)					
Trust total	15.1%	14.6%	15.1%	15.2%	15.1%
<i>Cancer Services</i>	11.8%	12.8%	12.1%	12.6%	13.6%
<i>Clinical Research*</i>					13.0%
<i>Clinical Services</i>	16.8%	15.6%	15.1%	14.2%	13.3%
<i>Community Services</i>	15.7%	19.7%	22.1%	23.0%	21.0%
<i>Private Care†</i>					20.9%
<i>Corporate†</i>	14.7%	14.3%	14.9%	14.9%	14.5%
Sickness absence (target 3.0%)					
Trust total	2.9%	2.6%	2.8%	3.5%	2.7%
<i>Cancer Services</i>	2.8%	2.9%	2.4%	3.1%	2.3%
<i>Clinical Research*</i>					2.3%
<i>Clinical Services</i>	3.0%	2.2%	2.7%	3.6%	2.6%
<i>Community Services</i>	3.0%	3.2%	3.7%	3.6%	2.1%
<i>Private Care†</i>					4.8%
<i>Corporate†</i>	3.3%	3.2%	3.3%	4.4%	3.1%
Appraisal rate (target 90%, raised from 85% from Quarter 1 2016/17)					
Trust Total	82.4%	80.5%	83.5%	86.9%	85.7%
<i>Cancer Services</i>	80.1%	72.3%	79.0%	86.5%	87.2%
<i>Clinical Research*</i>					85.0%
<i>Clinical Services</i>	84.0%	85.3%	85.9%	86.8%	85.5%
<i>Community Services</i>	80.0%	76.6%	84.6%	89.0%	85.8%
<i>Private Care†</i>					81.3%
<i>Corporate†</i>	83.5%	84.1%	84.8%	85.4%	86.6%
Statutory and mandatory training (target 90.0%)					
Trust total	90.4%	91.2%	86.4%	87.8%	89.0%
<i>Cancer Services</i>	84.9%	81.2%	79.4%	81.6%	81.7%
<i>Clinical Research*</i>					90.3%
<i>Clinical Services</i>	92.4%	82.6%	88.5%	88.9%	90.4%
<i>Community Services</i>	91.5%	87.7%	88.4%	91.1%	93.3%
<i>Private Care†</i>					90.4%
<i>Corporate†</i>	93.7%	92.8%	90.6%	89.2%	93.1%
Local induction (target 80.0%, raised from 70.0% from Quarter 1 2016/17)					
Trust total	84.5%	76.0%	72.3%	80.8%	84.2%
<i>Cancer Services</i>	81.3%	74.8%	67.4%	79.6%	82.1%
<i>Clinical Research*</i>					86.9%
<i>Clinical Services</i>	89.3%	76.3%	75.2%	84.5%	88.8%
<i>Community Services</i>	75.0%	70.7%	71.3%	78.5%	81.3%
<i>Private Care†</i>					75.0%
<i>Corporate†</i>	83.7%	78.1%	71.6%	77.6%	82.3%

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

† Private Care data and Corporate data is reported separately from Quarter 1 2017/18

9.1.2. Vacancy

The Trust vacancy rate has increased to 11.3% in Quarter One, above the Trust target of 5.0%. This includes a number of posts added at the start of the year as part of the business planning process.



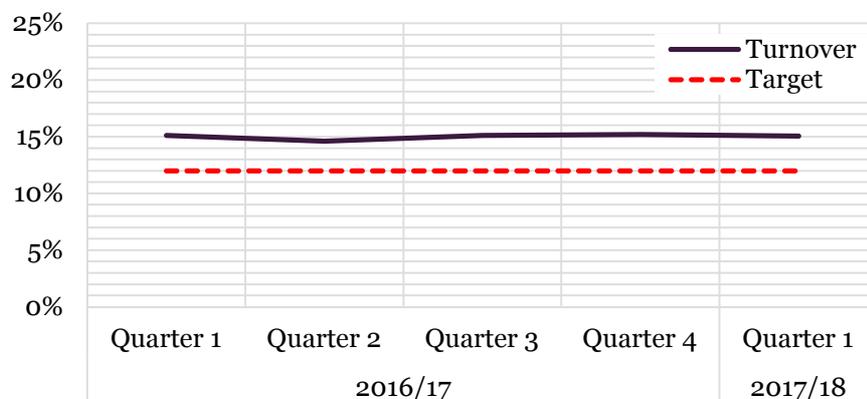
Trust Recruitment Open Days continue to take place every month, with additional events for individual specialties or staff groups where needed. The trust has set its nursing recruitment target for the next 12 months, and a strong pipeline of candidates has already been established. The international recruitment campaign has commenced, with members of the senior nurse team having travelled to the Philippines, where they made offers to 31 experienced nurses.

Attrition continues to be a challenge, particularly in Community Services, but this situation is expected to improve with the number of candidates under offer increasing, strengthening of induction processes, and the establishing of local incentive schemes.

The overall nurse vacancy rate for the Trust at the end of Quarter One was 13.3%, the hospital vacancy rate being 11.3% and the Community Services vacancy rate being 25.9%.

9.1.3. Turnover

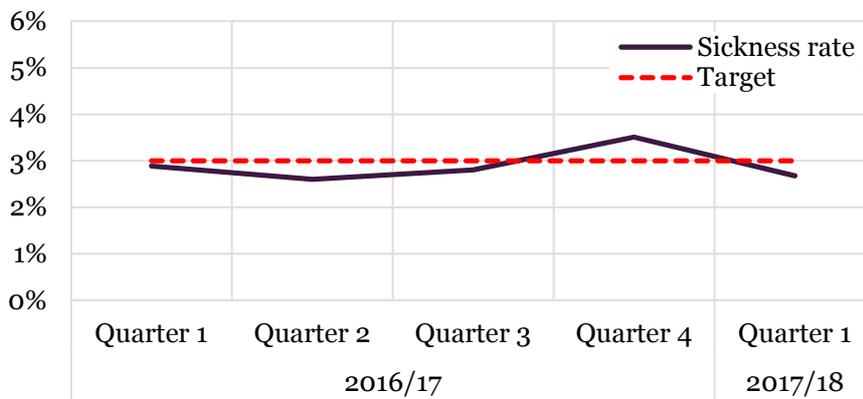
The turnover rate has decreased slightly in Quarter One, to 15.1% and remains above the Trust target.



The Trust continues to utilise survey and other data from both new starters and leavers to identify reasons for staff joining and leaving the Trust. Managers use the Trust’s staff recognition schemes to reward good performing teams and individuals. Promotion of health and wellbeing events and initiatives continues to be a priority, and invitations to the Trust Annual Staff Awards ceremony have been sent out.

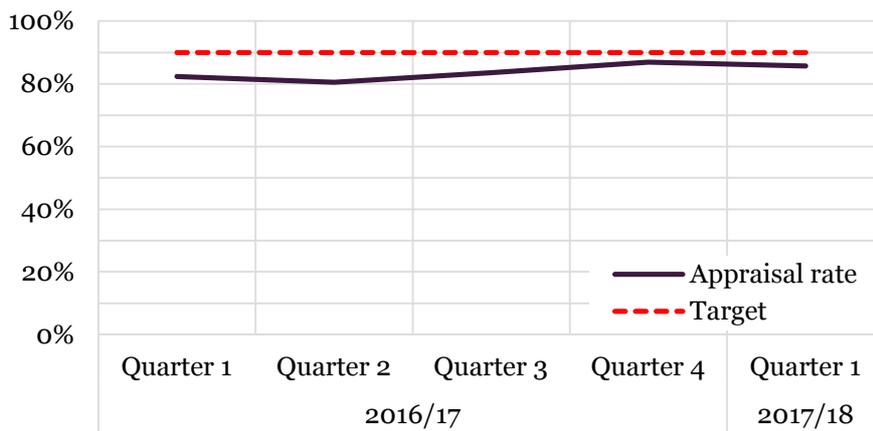
9.1.4. Sickness

The sickness rate has fallen this quarter to 2.7%, lower than trust target, and following seasonal trends. Absence rates for all divisions showed improvement at the end of the quarter. The Human Resources team provide sickness absence data, and support management of long-term sickness and frequent short-term absences. Sickness absence data is reviewed by reason for absence to ensure appropriate provision of occupational health and other support services.



9.1.5. Appraisal

Quarter One compliance is 85.7%. Close monitoring will continue to ensure progress towards the 90% target by the end of the year. A new streamlined reporting system, which allows managers to self-report on completed appraisals, is due for roll out later this year.



9.2. Mandatory training

9.2.1. Part of the strategy to improve mandatory training compliance has focused on seven core topics: *Adult basic life support, Fire awareness, Safeguarding vulnerable adults, Safeguarding children, Information governance, Paediatric basic life support* and *Infection prevention and control*. In addition to the ongoing use of the WIRED mandatory training and appraisal reporting system, progress against these topics is reported to divisions through the monthly scorecard.

9.2.2. The following table shows mandatory training compliance for the core topics for Quarter One.

Mandatory training topics	Update frequency requirement (in years)	Target	Cancer specialist compliance rate	Community Services compliance rate	Overall Trust compliance rate Quarter 4 2016/17	Overall Trust compliance rate Quarter 1 2017/18	Trend
Adult basic life support	1	90%	82%	88%	81%	83%	▲
Blood transfusion (generic update)	2	90%	93%	Not applicable	94%	93%	▼
Conflict resolution for frontline staff	3	80%	77%	85%	79%	79%	■
Consent awareness (medical staff)	2	90%	81%	Not applicable	84%	81%	▼
Equality and diversity	3	90%	91%	93%	90%	91%	▲
Fire awareness	1 (clinical) 2 (other)	90%	86%	92%	84%	88%	▲
Infection prevention and control	1 (clinical) 3 (other)	90%	88%	88%	87%	88%	▲
Information governance	1	95%	94%	98%	96%	94%	▼
Medicines management (clinical staff)	1	90%	87%	81%	85%	86%	▲
Medicines management (medical staff)*	3	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	
Manual handling – back care awareness (non-patient handling)	3	90%	88%	93%	89%	89%	■

Mandatory training topics	Update frequency requirement (in years)	Target	Cancer specialist compliance rate	Community Services compliance rate	Overall Trust compliance rate Quarter 4 2016/17	Overall Trust compliance rate Quarter 1 2017/18	Trend
Manual handling (patient handling)	1	90%	84%	86%	80%	84%	▲
Paediatric basic life support	1	90%	82%	85%	80%	83%	▲
Risk management awareness	1 (managers) 3 (other)	90%	91%	95%	90%	90%	■
Risk Training for Senior Managers	1 (managers)	90%	70%	50%	61%	70%	▲
Safeguarding vulnerable adults (level 1)	3	90%	92%	97%	92%	93%	▲
Safeguarding vulnerable adults (level 2)	3	90%	85%	96%	83%	87%	▲
Safeguarding children (level 1)	3	90%	82%	98%	91%	92%	▲
Safeguarding children (level 2)	3	90%	88%	98%	90%	90%	■
Safeguarding children (level 3)	3	90%	86%	95%	90%	89%	▼
Venous thrombo-embolism and pressure ulcers (clinical staff)	1 (clinical)	90%	67%	87%	83%	86%	▲
Venous thrombo-embolism (medical staff)	Once only	90%	66%	Not applicable	70%	66%	▼

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

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

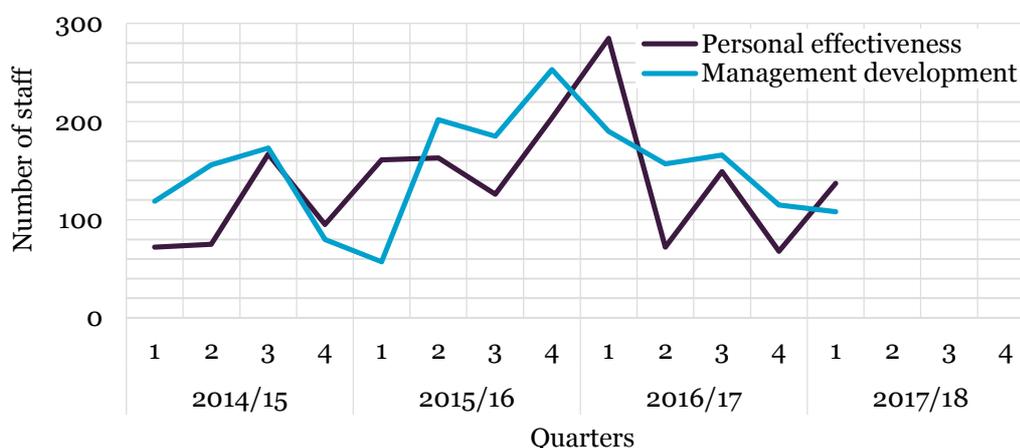
- 9.2.4. The training compliance targets are agreed locally in line with national guidance. Typically, 90% is the target for mandatory training topics, benchmarked against London Trusts (as referenced in the pan-London streamlining project February 2016). Ninety-five per cent is the national requirement for Information Governance training, 80% has been locally agreed for Conflict Resolution and Local Induction.
- 9.2.5. A compliance rate of 90% or above has been achieved in seven topics areas and 80% or above in the remaining topics areas with the exception of three topics.
- 9.2.6. Overall compliance rates have remained stable with a number of increases.
- 9.2.7. *Resuscitation* training remains a focus area for increasing compliance. Additional sessions continue to be scheduled since Quarters Three and Four 2016/17. These have helped to increase compliance in *Paediatric basic life support* (83%) and *Adult basic life support* training (83%).
- 9.2.8. The additional sessions have increased compliance and further work to increase capacity continues. An example of this is the recent launch of the video-based *Basic life support* module for medical staff designed to increase quicker accessibility. A positive impact is expected in Quarter Two. Work with matrons and other professional leads to analyse the reasons for noncompliance and promote additional training sessions continues. An enhanced system of electronic prompts and reminders have been developed for individuals and managers. This is anticipated to raise compliance further in the coming quarter.
- 9.2.9. *Safeguarding vulnerable adults level 1 and 2* training compliance has increased slightly following a targeted non-compliance reminder to staff conducted in the last quarter.
- 9.2.10. Five topics have decreased slightly since Quarter Four:
- *Blood transfusion* by one percentage point
 - *Consent for medical staff* by three percentage points
 - *Information governance* by two percentage points
 - *Safeguarding children level 3* by one percentage point
 - *Venous thromboembolism (medical staff)* by two percentage points.
- 9.2.11. In areas where a decrease in compliance has been identified diagnostics are carried out and improvement plans are put in place. Targeted reminders of non-compliance are being sent by the Learning and Development team on a regular basis of topics that are decreasing or not meeting targets in order to improve compliance. This will continue to be the strategy over the next quarter.

9.3. Induction

- 9.3.1. The compliance rate for local induction (86%) has continued to exceed the target of 80%. Regular targeted follow-up with line managers remains the key strategy for maintaining the local induction compliance rate. This will continue quarterly with monthly reminders targeted at those individuals who are not compliant.
- 9.3.2. The compliance rate for attendance at Trust Induction has remained stable with a slight increase to 93%, since the last quarter. Close monitoring, improved communication to delegates and links with Recruitment ensure that all new joiners attend Trust Induction appropriately within two months of their booked start date. Auditing of new starters against attendance highlights non-attendance and allows these cases to be followed up.

9.4. Non-clinical training and development

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



- 9.4.2. The number of learning activities scheduled continues to be dependent on need. The fluctuation in numbers completing training each quarter is dependent on scheduling patterns and focus on particular topics at different times during the year.
- 9.4.3. During Quarter One the following workshops were delivered:
- *Communicating assertively*
 - information technology sessions in *Microsoft Word, Excel and PowerPoint*
 - *Meetings and minute taking*
 - *Time management*
 - *Performance appraisal*
 - *Project management*
 - *Introduction to supervisory skills*
 - *Managing sickness absence*
 - *Resilience for leaders.*

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

- 9.4.4. The Learning and Development Team supports internal trainers and educators by offering a portfolio of training and presentation skills workshops. In Quarter One two workshops were delivered for trainers/educators across the Trust to develop their understanding of diverse learning needs/styles and impactful personal presence. In addition a two-day bespoke workshop for trainers in Community Services was delivered covering how to deal with difficult behaviours in training.
- 9.4.5. The *Learning to lead* programme continues to be well attended and 16 managers completed the first cohort this financial year. The programme continues the Trust's commitment to developing line managers.
- 9.4.6. The Learning and Development Team supports team development through effective diagnostic processes to identify team issues and goals and innovative design of bespoke programmes to promote positive change. In this quarter, specialist facilitators within the department designed and facilitated two successful team events which strengthened each group's collective identity and goals, as well as enhancing individuals' sense of value and purpose.

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

10.1. Annual quality account

- 10.1.1. As part of a drive to be open and honest all NHS hospitals and foundation trusts have to publish annual financial accounts and a quality account.
- 10.1.2. Quality accounts are useful for the Trust Board, which is responsible for the quality of services. The Board can use the quality account in its role of assessing and leading the Trust. Frontline staff are encouraged to use quality accounts to compare their performance with other trusts and to help improve their service.
- 10.1.3. For patients, carers and the public, the quality account should be easy to read and understand, and highlight important areas of safety and effective care provided in a caring and compassionate way. It should also show how the Trust concentrates on any improvements that can be made to care or experience.
- 10.1.4. The Patient Experience and Quality Account Committee met and reviewed the final draft of the annual quality account with submissions against Quarter Four data. The committee commented on the layout and formatting of the document.
- 10.1.5. In May 2017 after successful external scrutiny from the trust's auditors and final approval from the Finance Audit committee, the quality account was published as part of the Trust's annual report. The quality account includes the quality priorities for 2017/18, which were agreed by the board.
- 10.1.6. In June 2017 in order to comply with requirements, the annual quality account was published as a separate document on NHS Choices website and the Trust's website.
- 10.1.7. The Patient Experience and Quality Account committee will continue to monitor the progress of the annual account during 2017/18.

10.2. Clinical audit

- 10.2.1. The Clinical Audit Committee coordinates, evaluates and reviews all clinical audits in the Trust.
- 10.2.2. Twenty new clinical audit proposals were presented to the committee for review in Quarter One.
- 10.2.3. One national audit was registered:
Paediatric Antifungal Stewardship: Optimising Antifungal Prescription in Children (PASOAP).
- 10.2.4. There were no national audit reports published in Quarter One.

10.2.5. Audits conducted at Chelsea and Sutton

Title	Action plan, learning and outcomes
Does prescribing of diclofenac for palliative care inpatients at The Royal Marsden Hospital comply with national guidance on the safe use of diclofenac?	<p>Undertake informal hospital teaching across wards to raise awareness about the use of diclofenac as well as the importance of accurate review and documentation.</p> <p>Undertake formal teaching within the Core Medical Training rota.</p> <p>Presentation of the audit results in the pain team and palliative care multi-disciplinary team (MDT) meeting.</p>
Re-audit of the process and outcome of getting compression garments for the management of lymphoedema on prescription	<p>Patients reminded that the prescription request letter should be delivered within a week to the general practitioner (GP) if it is not sent electronically.</p> <p>Lead nurse to inform representatives from Surrey Downs Clinical Commissioning Group (CCG) and Croydon CCG of the results of the audit.</p>
Snapshot audit of what is the impact on staffing of staff being called away from the outpatients department (OPD) to assist colleagues elsewhere?	<p>Matrons and Divisional Clinical Nurse Director responsible for OPD to review the audit tool prior to commencement of the next audit.</p>
Cervical cancer soft-tissue image guided radiotherapy verification: development of a training programme to facilitate radiographer review	<p>Workbook version 2 revised.</p> <p>Further training organised.</p> <p>Practice moved from offline review to online review of guidelines.</p>
Impact of advance practice in a well-established radiologically inserted gastrostomy (RIG) service	<p>Develop a factsheet for community services and general practitioners.</p> <p>Develop a triage flowchart in gastrostomies complications that can be used by the acute oncology service (AOS) or out-of-hour's service.</p> <p>Carry out the audit for another year to see if the complication rate will further decrease, more specifically on the displacement category.</p> <p>Continue with the measures and strategies already in place and review every six months.</p>
The use of low molecular weight heparin (LMWH) for treatment of venous thromboembolism in the Sarcoma unit	<p>The audit presented at sarcoma team meeting to raise awareness of current guidelines and audit findings.</p> <p>Findings discussed with computing department and department responsible for the electronic patient record (EPR).</p> <p>Re-audit following education action.</p>

10.2.6. Audits conducted at Chelsea

Title	Action plan, learning and outcomes
Re-audit of do we now achieve full artificial feeding on the critical care unit (CCU) over 22hrs?	<p>Practice reviewed.</p> <p>Re-audit planned.</p>

Title	Action plan, learning and outcomes
Incidence of catheter-associated urinary tract infection after gynaecological laparotomy: can we reduce it?	Best practice confirmed.
Re-assessment of time taken from decision to treat patients within the sarcoma unit with intravenous chemotherapy and treatment start date	The audit findings presented at sarcoma meeting. The audit findings disseminated to local faculty via email report. Medical Day Unit (MDU) booking system reviewed. Re-audit in March 2019.
Cytology rates of pleural effusions in ovarian cancer patients undergoing primary debulking surgery	The audit findings discussed at the multidisciplinary gynaecology meeting. Re-audit planned for June 2018.
Mortality rates following radical (90 day mortality) and palliative (30 day mortality) radiotherapy in soft tissue sarcoma patients treated at The Royal Marsden	Where appropriate, stricter selection criteria for patients with Eastern Cooperative Oncology Group (ECOG) grade ≥ 3 . Performance status to be documented on radiotherapy request forms. Reason for delivering radiation to be clearly documented on the request forms.

10.2.7. Audits conducted at Sutton

Title	Action plan, learning and outcomes
Audit on staff exposure when administering Radium 223 Dichloride Therapy	Update on the risk assessment in terms of dose rate from syringe at 50cm. The Frequency and Severity Risk rating would be maintained as 4 and 1 respectively giving it a colour rating of Yellow.
Review of the number of breast cancer surgery patients seen by the physiotherapist in Assessment and Pre-admission Unit (APU), Sutton	Liaised with pre-assessment nursing team, provided further education and updated new staff on the role of physiotherapy for patients undergoing certain types of breast surgery. Redefined and updated appropriate breast surgery referral criteria for pre-assessment nursing staff – partly through education and laminated flow chart. Regularly update pre-assessment nursing and administrative staff on named physiotherapists who are covering pre-assessment clinics, including contact details.
Rolling audit of transfer of paediatric oncology patients to paediatric intensive care unit (PICU)	Best practice confirmed.
Nasopharyngeal cancer in children and adolescents at The Royal Marsden	Toxicities documented and managed more proactively. Radiologically inserted gastrostomy (RIG) or percutaneous endoscopic gastrostomy (PEG) considered early in the treatment pathway. Better post-treatment recovery package laid out, outlining treatment summary, radiation dose to critical structure and potential late toxicities or side effect.

10.2.8. Audits conducted in Sutton Community Health Services

Title	Action plan, learning and outcomes
Audit of the implementation of health recommendations from Review Health Assessments (RHA) for Looked After Children (LAC)	<p>The audit findings to be disseminated and shared with staff in community services and audit completion confirmed with Sutton Local safeguarding Children Board (LSCB) and Clinical Commissioning Group (CCG).</p> <p>Meeting between the LAC specialist nurses to discuss follow up of health recommendations and how they should be recorded on the RHA paperwork.</p> <p>Data monitoring and tracking spread sheet implemented in LAC service to track implementation of all health recommendations with particular emphasis on those allocated to LAC specialist nurse and out of borough professionals. This will be reviewed monthly as a standing agenda item in the LAC service team meeting.</p>

10.3. Deaths following anti-cancer therapy

10.3.1. Purpose of monitoring

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

10.3.2. Aim

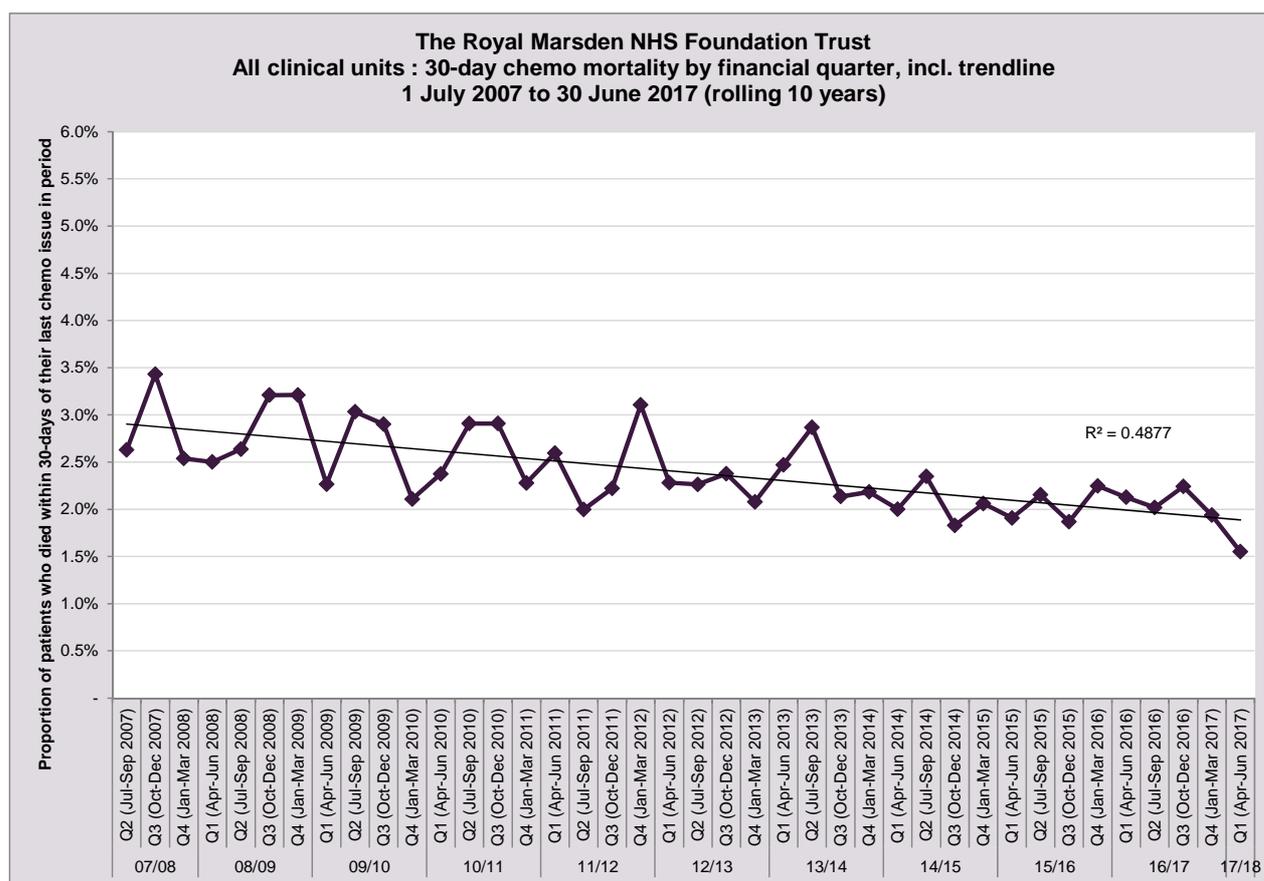
To track trends in the number of deaths within 30 days of receiving SACT at the Trust and deaths reported to the Trust from Quarter Two 2007/08 to Quarter One 2017/18.

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

The last matching using data from the Office for National Statistics (ONS) was carried out on 2 August 2017

Key points from 30-day deaths trend analysis

- Quarterly graphic representation of trends for 30-day deaths.
- The overall trend has remained stable.
- In Quarter Four there were 77 deaths out of 3,974 patients (1.9%) analysed, and in Quarter One there were 63 deaths out of 4,063 patients (1.6%) analysed.



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 (April to June 2017) was 64 but to analyse 100-day mortality it is necessary to consider the transplants undertaken in the previous quarter (January to March 2017). This allows all patients to have reached 100 days post-transplant by the time this report is prepared. For example, a patient having a transplant on 31st March 2017 would reach 100 days on 9th July 2017.
- 10.4.4. The final number of recorded transplants carried out from January to March 2017 was 45 (40 adult and 5 paediatric patients).
- 10.4.5. The breakdown of transplant types, number of deaths within 100 days of transplant and the cause of death for January to March 2017 is given below.

Adults

Transplant type	Number of transplants	Number of adult deaths at 100 days post-transplant	Overall TRM* percentage	Disease relapse or progression
Autologous [†]	29	2	3.5%	1 (3.5%)
Allogeneic [‡] (all types)	11	0	0%	0
– Allogeneic – unrelated donor	7	1	14%	0
– Allogeneic – related donor	2	0	0%	0
– Allogeneic – cord blood	2	0	0%	0

Paediatric

Transplant type	Number of transplants	Number of paediatric deaths at 100 days post-transplant	Overall TRM* percentage	Disease relapse or progression
Autologous [†]	2	0	0%	0
Allogeneic [‡] (all types)	3	0	0%	0
– Allogeneic – unrelated donor	0	0	0%	0
– Allogeneic – related donor	1	0	0%	0
– Allogeneic – cord blood	2	0	0%	0

* TRM: Transplant related mortality

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

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

10.4.6. For the three adult patients who died within 100 days following the transplant, one received an allogeneic transplant from an unrelated donor whilst the other two received autologous transplants. Further details are shown below:

- One patient received an autologous transplant for multiple myeloma but died at day 98 from non-transplant related-disease progression.
- The second patient received an autologous transplant for non-Hodgkin lymphoma but died at day 5 from transplant related necrotising colitis.
- The third patient received an allogeneic transplant from a matched unrelated donor but died at day 93 from transplant-related central nervous system toxicity.
- There were no deaths recorded for paediatric patients receiving a stem cell transplant during Quarter Four.

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. Deaths following surgery and anaesthesia

10.5.1. Purpose

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

10.5.2. Aim

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

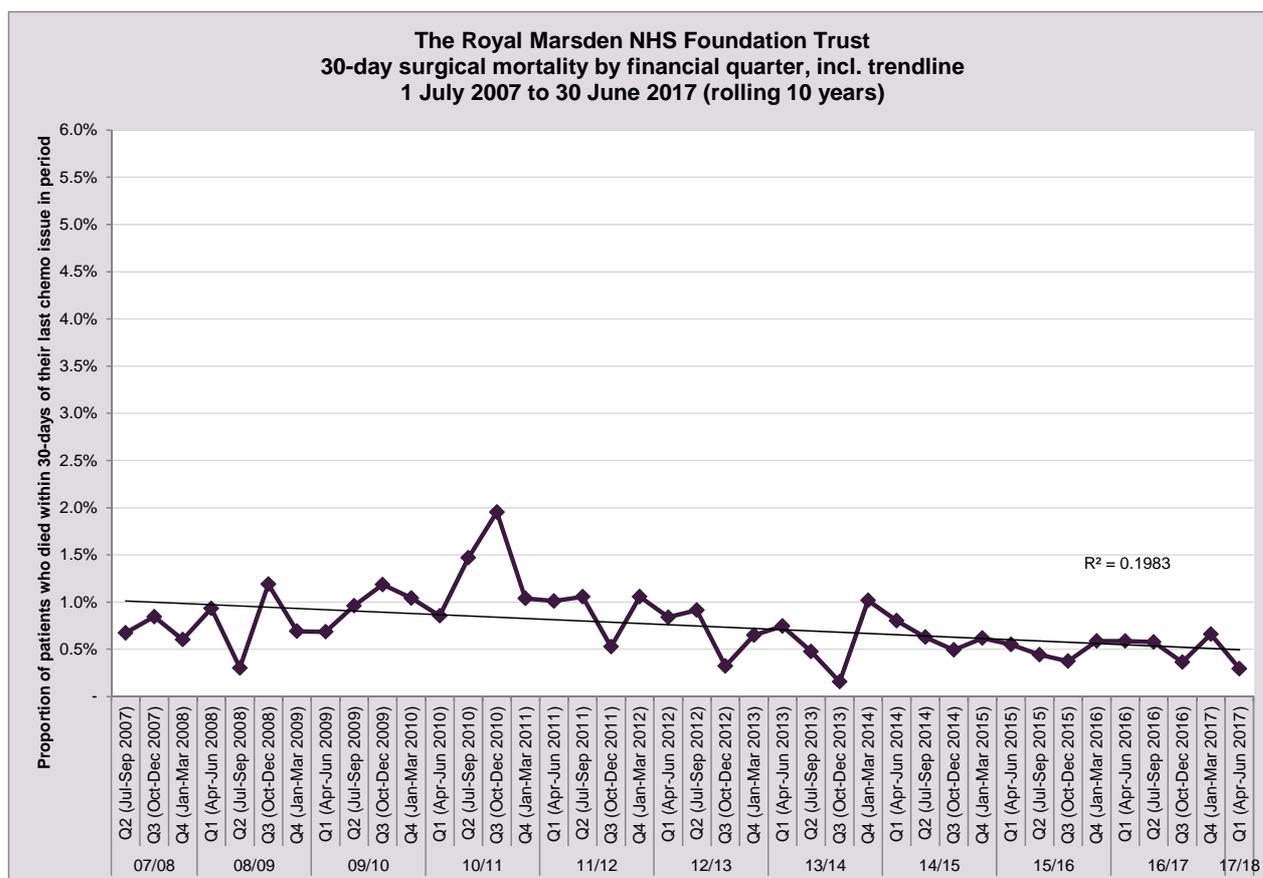
10.5.3. Key points from 30-day deaths trend analysis

- Data are presented quarterly from Quarter Two 2007/08 to Quarter One 2017/18.
- The overall 30 days death rate has been stable.
- There was no observed trend.
- In Quarter One 2017/18 there were four deaths out of 1,359 patients (0.3%).

10.5.4. Actions

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

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



Source: raw data from Trust Information Department. The last matching using data from the Office for National Statistics (ONS) was carried out on 2 August 2017.

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

- 10.6.1. The National Institute for Health and Care Excellence (NICE) provides guidance, sets quality standards and manages a national database to improve people’s health and prevent and treat ill health. Further details about NICE and its work programmes are available at the NICE website www.nice.org.uk.
- 10.6.2. NICE standards assist the Trust in reviewing current practice against the latest standards and ensuring is safe, effective and responsive to people’s needs.

10.6.3. NICE published 22 items of guidance which were presented to the Integrated Governance and Risk Management Committee (IGRM) in Quarter One. After the guidance was reviewed, six items were deemed relevant and six items were still under review at the time of reporting.

Type of guidance	Seen at IGRM	Under review	Reviewed and deemed not relevant	Reviewed and deemed relevant	Fully compliant*	Partially compliant*
Clinical	9	2	2	5	3	2
Diagnostics	1	1	0	0	0	0
Medical technologies	2	1	1	0	0	0
NICE	5	1	3	1	1	0
Interventional procedures	5	1	4	0	0	0
Total	22	6	10	6	4	2

* For items deemed relevant

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

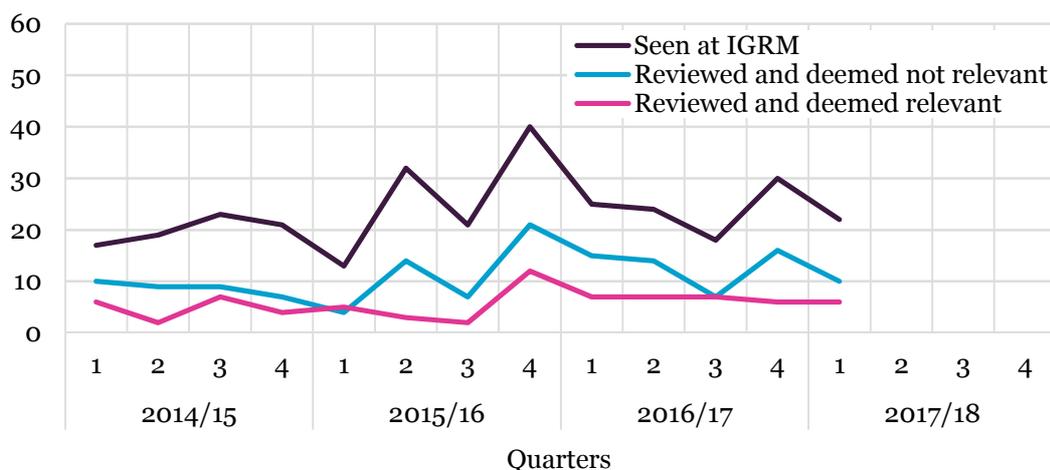
Type of guidance	Seen at IGRM	Under review	Reviewed and deemed not relevant	Reviewed and deemed relevant	Fully compliant*	Partially compliant*
Quality standards	8	3	0	5	3	2

* For items deemed relevant

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

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

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



10.7. Information governance

10.7.1. Information Governance Committee

The Trust Information Governance training compliance is currently 94.26%, which is within acceptable tolerance at this stage of the year. Systems are in place to monitor compliance.

The Information Governance Committee meets regularly to discuss incidents, policy approval, data quality, clinical records management, subject access requests, freedom of information requests, the Information Governance Toolkit, audits and other topics. There were two meetings of the committee in Quarter One.

10.7.2. Information Governance Toolkit

The Information Governance Toolkit is an assessment tool that NHS Digital requires NHS organisations to submit annually in order to measure compliance against information governance standards. This year’s submission consists of two stages throughout the financial year:

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

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

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

10.7.3. Incident management and enforcement

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

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

The ICO has powers to issue undertakings, which commit an organisation to a particular course of action in order to improve its compliance and enforcements notices. Enforcement notices are also issued by the ICO 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 had any enforcement notices or undertakings and there have been no major information governance incidents.

10.8. Freedom of information

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

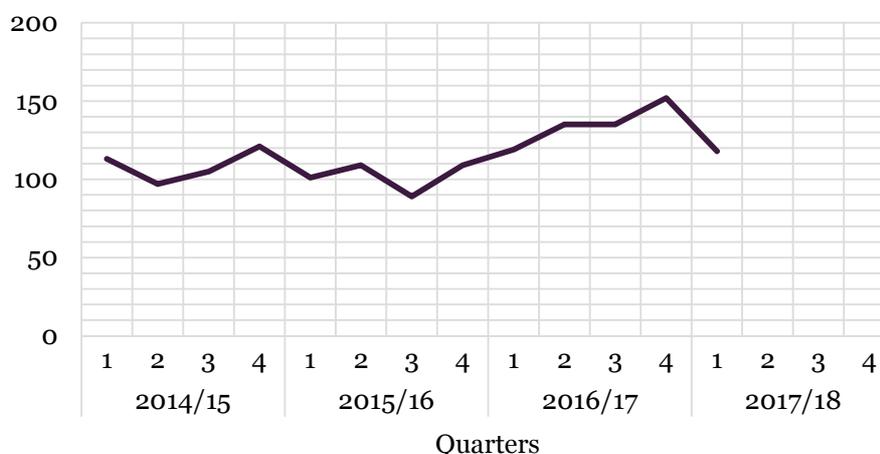
10.8.2. Requests received under the Freedom of Information Act 2000

10.8.3. The Trust received 118 requests during Quarter One, compared to 152 in the final Quarter of the previous year. Of the 118 requests received in Quarter One, 115 were answered within 20 working days (97.5%).

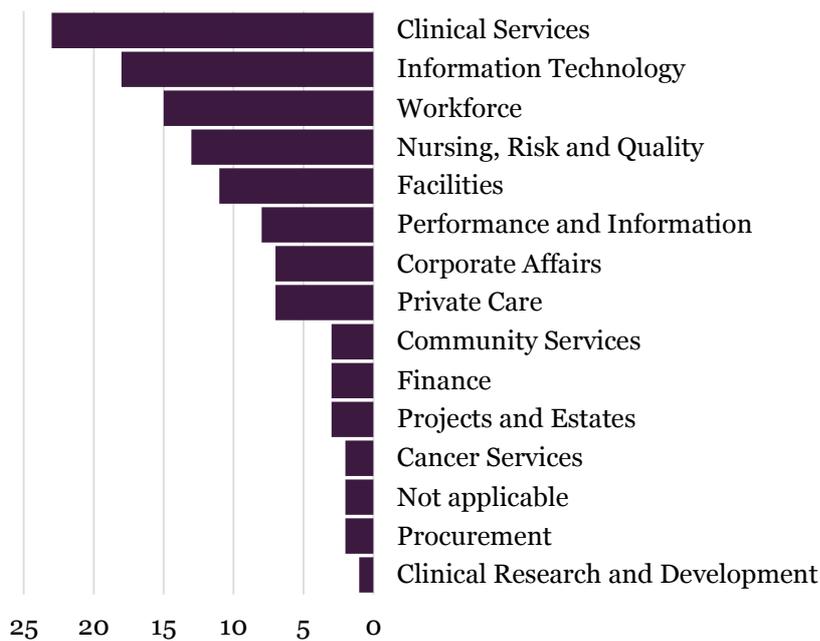
10.8.4. The requests in Quarter One had the following outcomes:

Disclosed	86
Not applicable to The Royal Marsden	18
Partial	9
Refused – exemption or too expensive to answer	2
Information not held or clarification sought	3
Total	118

10.8.5. Number of requests received by quarter

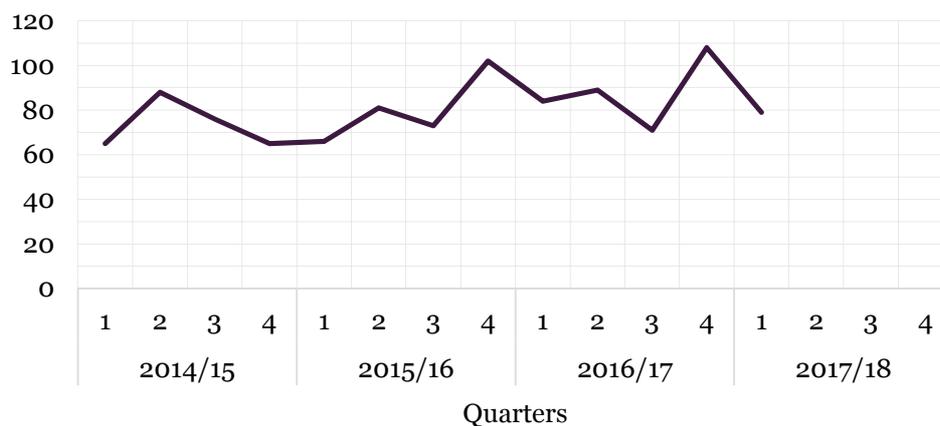


10.8.6. Number of requests by directorate and division



10.9. Access to patient records

- 10.9.1. The Data Protection Act 1998 requires that patients be given the right of access to and copies of their own medical records.
- 10.9.2. This quarter the Trust received 79 requests for personal disclosure of medical records for hospital patients. (This excludes notes required by other hospitals and those required for litigation purposes.)
- 10.9.3. Requests required for litigation purposes are described in the *Clinical legal services* section on page 113.
- 10.9.4. The chart shows the number of requests received for hospital patients each quarter since 2014/15.



10.10. Radiotherapy

- 10.10.1. The Radiotherapy Service is certified to the ISO9001:2008 quality standard by the British Standards Institute (BSI) and is assessed by an external auditor twice a year.

- 10.10.2. Since the ‘readiness review’ audit was conducted last February, work has continued to convert the current quality management system to complete the transition to ISO9001:2015. This work has addressed all the observations made at review and has included, revision of all quality management documents to form a single unified Quality Manual covering the entire scope of certification, changes to the audit reporting and management reporting.
- 10.10.3. The next assessment will take place in September and the new version of the standard. If successful the transition to ISO9001:2015 will be complete and a new certificate will be issued.
- 10.10.4. Internal auditing continued covering selected patient pathways and two new audits addressing the requirement of ISO9001:2015 were carried out. Only four minor non-conformities were raised which have all since been closed.
- 10.10.5. Thirty-three incidents were raised in the Trust’s incident reporting system (Datix) for the quarter (compared with 46 in the previous quarter). Incidents are coded using the *Towards Safer Radiotherapy* classification system, which allows comparable reporting across the industry. Eleven were graded *low* and twenty-two *very low* severity. These were reviewed and discussed at the Multiprofessional Team Quality Assurance (Radiotherapy) Committee (MPT QART) as part of root cause analysis and agreement reached on any appropriate corrective actions required.
- 10.10.6. No complaints relating to Radiotherapy were received but numerous letters or cards of praise for the service were recorded in the quarter.
- 10.10.7. 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.
- 10.10.8. The table below shows the number of radiotherapy appointments for Quarter One 2017/18.

		2017/18		
Appointments (number)		Apr	May	Jun
Chelsea	Palliative*	49	29	37
	Radical†	126	126	106
	Urgent‡	5	2	1
	Total	180	157	144
Sutton	Palliative	65	71	76
	Radical	180	204	221
	Urgent	2	9	6
	Total	247	284	303
Grand total		427	441	447

* Palliative: treatment intended for alleviation of symptoms

† Radical: treatment intended to cure or eradicate underlying disease

‡ Urgent: treatment given where a beneficial clinical effect can be achieved for a short period of time. The only common example is radiotherapy given within 24 hours for patients with metastatic cord compression.

10.10.9. The table below shows radiotherapy waiting times for Quarter One 2017/18.

			2017/18		
Average waiting time (days)			Apr	May	Jun
Chelsea	Radical	All*	14.1	15.4	15.2
	Radical	No delay*	18.3	18.5	18.7
	Palliative	All	4.4	3.8	4.3
	Palliative	No delay	4.9	4.3	5.3
Sutton	Radical	All	17.9	17.5	15.9
	Radical	No delay	23.7	24.1	22.5
	Palliative	All	4.7	5.3	5.2
	Palliative	No delay	5.3	6.7	5.7

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

- firstly, those patients who receive radiotherapy as part of a range of other treatments (such as surgery or chemotherapy). The radiotherapy is scheduled to fit in with the whole package of treatments.
- secondly **No delay:** those patients for whom radiotherapy is the first definitive treatment and who are only waiting for radiotherapy (i.e. not delayed by other treatments).

10.11. Chemotherapy

- 10.11.1. The Chemotherapy service is certified to the ISO9001:2008 quality standard and is assessed by an external auditor from the British Standards Institute (BSI) twice a year.
- 10.11.2. Changes to the quality documentation, auditing method and agenda of the ISO Chemotherapy Committee meetings have been introduced. This was in response to a recommendation from BSI following the ‘readiness review’ audit conducted in February 2017 to assess compliance to the latest ISO9001:2015 standard.
- 10.11.3. The next assessment has been scheduled for September and will be a one-day visit that will assess both compliance to ISO9001:2008 and readiness for transition to ISO9001:2015. If successful, the transition will be complete and a new certificate will be issued.
- 10.11.4. Internal auditing was carried out during the quarter covering the Bud Flanagan Ambulatory Care Area using the new audit method required by ISO9001:2015. This resulted in the identification of a single minor non-conformance, which has since been closed.
- 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, 98 incidents relating to the multidisciplinary chemotherapy service were recorded compared to 110 in the previous quarter. Fifty-five were graded *very low* and 43 as *low*.
- 10.11.6. Ninety-one incidents related to medication issues. In accordance with Trust policy actions were agreed to ensure lessons are learned following any incident. The incidents will be reviewed at the next ISO Chemotherapy Committee meeting.

- 10.11.7. Three complaints were received in the quarter but letters of praise and thanks from patients were also logged. The complaints were related to delayed delivery of chemotherapy medication in one incidence and staff attitude in the other two. All have been addressed and resolved by the Complaints Team.
- 10.11.8. Waiting times have been monitored for a number of years and discussed at the ISO Chemotherapy Committee. Waiting times include a number of steps which take place before administering chemotherapy:
- taking blood and awaiting results
 - consultation with doctor
 - chemotherapy preparation by pharmacy.
- 10.11.9. The length of 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').
- 10.11.10. Patients choosing one-stop wait longer as chemotherapy cannot be given until all preparation tasks are complete which typically takes three to five hours. Most patients prefer the one-stop option if geography allows as this saves two separate visits to the hospital. Patients can be issued with a pager, allowing them to leave the site whilst preparation takes place.
- 10.11.11. The number of chemotherapy appointments is rising across all sites. The overall target of no more than five per cent of patients waiting more than four hours for treatment was missed at seven per cent as shown in the tables below, although individual units show some fluctuations.
- 10.11.12. The table below shows the number of chemotherapy appointments with waiting times longer than four hours for Quarter One 2017/18.

Appointments	Total appointments	Appointment waits over 4 hours	Percentage waits over 4 hours
Medical Day Unit (Chelsea)	3011	422	14%
Granard House Day Unit	1881	176	9%
Homecare	17	0	0%
Private Care Centre	41	5	12%
Wiltshaw Ward Consulting Room	2	0	0%
Ambulatory Inpatients (Bud Flanagan West)	49	17	35%
Children's Day Unit	1201	34	3%
Bud Flanagan Ambulatory Care Unit	732	83	11%
Kennaway Day Unit	607	4	1%
Medical Day Unit (Sutton)	3120	5	<1%
Robert Tiffany Day Unit	954	3	<1%
West Wing Day Unit	493	2	<1%
Oak Day Unit	141	84	60%
Mobile Chemotherapy Unit	77	0	0%
IV Services (Sutton)	0	0	-
Teenage Cancer Trust Unit	0	0	-
Sir William Rous Unit	1046	2	<1%
Total	13372	837	6%

10.11.13. The table below shows chemotherapy waiting times (from patient’s arrival in clinic to start of treatment) for Quarter One 2017/18.

Appointments	No waiting	1min-1hr	>1hr-2hrs	>2hrs-3hrs	>3hrs-4hrs	>4hrs-5hrs	>5hrs-6hrs	>6hrs-8hrs	Over 8hrs
Medical Day Unit (Chelsea)	334	1,471	340	186	258	260	123	37	2
Granard House Day Unit	85	466	443	455	256	120	41	14	1
Homecare	0	17	0	0	0	0	0	0	0
Private Care Centre	0	7	10	10	9	3	2	0	0
Wiltshaw Ward Consulting Room	1	1	0	0	0	0	0	0	0
Ambulatory Inpatients (Bud Flanagan West)	5	22	3	1	1	3	12	2	0
Children’s Day Unit	222	430	316	147	52	17	12	5	0
Bud Flanagan Ambulatory Care Unit	100	257	163	75	54	52	21	10	0
Kennaway Day Unit	64	460	58	17	4	4	0	0	0
Medical Day Unit (Sutton)	173	2,650	263	20	9	2	1	2	0
Robert Tiffany Day Unit	182	615	115	33	6	0	2	1	0
West Wing Day Unit	18	356	99	14	4	1	0	1	0
Oak Day Unit	7	14	5	14	17	34	32	17	1
Mobile Chemotherapy Unit	10	65	2	0	0	0	0	0	0
IV Services (Sutton)	0	0	0	0	0	0	0	0	0
Teenage Cancer Trust Unit	0	0	0	0	0	0	0	0	0
Sir William Rous Unit	87	845	104	8	0	1	1	0	0
Total	1,288	7,676	1,921	980	670	497	247	89	4

10.12. Research governance

10.12.1. Research sponsor

Trust sponsorship was awarded to the following 10 projects:

Reference number	Title	Single or multiple centre
CCR4639	PADDLE: PATient Derived Xenografts - mouse models (Avatars) of Lung cancer	Single
CCR4590	PRIMING: Pembrolizumab and hypofractionated stereotactic radiotherapy in metastatic Non-small-cell lung cancer patients	Single
CCR4738	The MIRABELLE Project: MR-guided Radiotherapy to Breast with dose Escalation to regional Lymph Nodes	Single
CCR4644	STILE: STereotactic body radiotherapy with Immunotherapy: feasibility and Lung Effects	Multiple
CCR4735	Does a grading system based on proliferation markers predict prognosis in Medullary Thyroid Cancer?	Single

CCR4737	Breast-Q questionnaire for women in the general population: A study to provide a comparison for our research on women with breast cancer	Single
CCR4729	The PERTH study: Patient, carer and clinician experience of routine blood testing during cancer therapy	Single
CCR4622	A randomised study to investigate the effectiveness of acupuncture for the treatment of anxiety in patients with advanced cancer	Single
CCR4750	Assessing pain following Vacuum-Assisted Resection of Breast Tissue Procedures	Single
CCR4753	PAC-MAN: A Prospective Translational Tissue Collection Study in Early and Advanced Pancreatic Ductal Adenocarcinoma (PDAC) to Enable Further Disease Characterisation and Development of Potential Predictive and Prognostic Biomarkers	Multiple

10.12.2. Suspected unexpected serious adverse drug reactions

The following is a breakdown by study of the six 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
JB55	1	1	0	0
KH4	4	4	0	0
OB12	1	1	0	0

10.13. Human Tissue Authority – human application licence

10.13.1. Compliance

The Stem Cell Transplant facility is licensed by the Human Tissue Authority (HTA) for the use of stem cells in human application. The last inspection took place in September 2016 resulting in renewal of the licence. The next inspection will take place in 2018.

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

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

The department is involved in the procurement of a specialist stem cell transplant IT system that will meet the requirements of UK law concerning the labelling of stem cell products. This will also ensure that the transplant programme is able to meet JACIE standards.

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.

Audits carried out during the quarter:

– *Re-audit of standard operating procedures and policy*

All staff are required to read current versions of departmental policies and procedures and to record that this has been done as part of their competency records. A previous audit highlighted failure to sign records to show that SOP reading had taken place but the re-audit did not show any significant improvement. This is attributable in part to a significant turnover of staff since the previous audit. Importance of standard operating procedure (SOP) and policy reading has been stressed and the audit will be performed again in six months.

– *Critical process audit of the issue of fresh haematopoietic progenitor cells (HPCs) to the ward*

Critical process audits are performed regularly to confirm that procedures are being followed according to the SOP. The audit showed full compliance with the SOP.

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

Environmental particle counting of viable and non-viable particles takes place during open processing of stem cells to monitor possible levels of contamination. The presence of particles may indicate failure of air filters or cleaning regimens. The results of the audit showed that no particles were detected when open processing was taking place.

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 Stem Cell Transplant Laboratory collates, evaluates and investigates errors, accidents and incidents according to Trust protocols and to comply with HTA regulations. During the quarter no incidents occurred that required reporting to the HTA.

10.14. 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

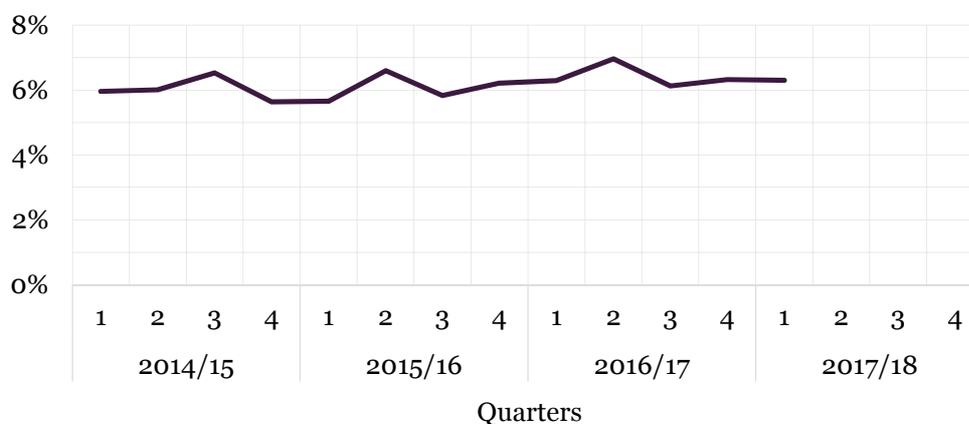
	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2017/18	Quarter 1 2017/18
Total (all patients seen in outpatient clinics)	39,696	41,352	40,643	42,933	41,725
Patients seen in 30 minutes or less	32,637 (82.2%)	34,256 (82.8%)	34,146 (84.0%)	36,433 (84.9%)	34,856 (83.5%)
Patients seen after 30 minutes and up to 1 hour	4,721 (11.9%)	4,515 (10.9%)	4,215 (10.4%)	4,404 (10.3%)	4,693 (11.2%)
Patients seen after 1 hour	2,338 (5.9%)	2,581 (6.2%)	2,282 (5.6%)	2,096 (4.9%)	2,176 (5.2%)

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.

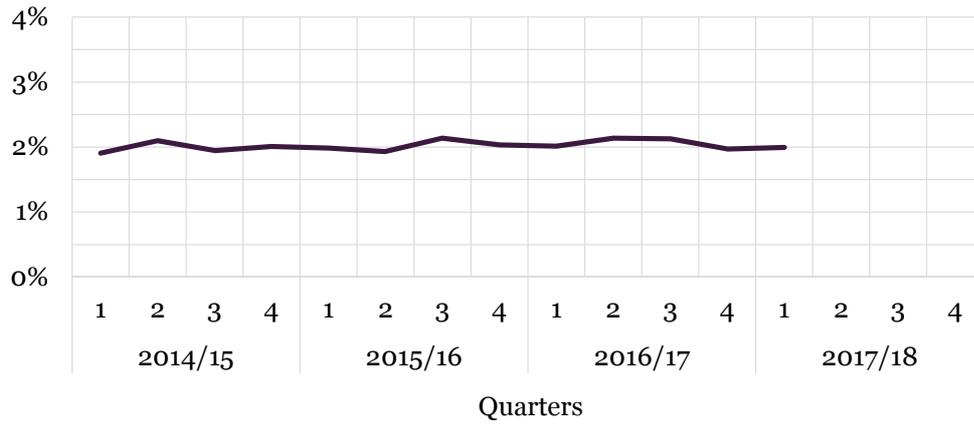
- 10.14.3. There has been an increase in activity of 6.8% (2029) from 39,696 to 41,725 from Quarter One 2016/17 compared to Quarter One 2017/18. Over the same period the percentage of patients seen within 30 minutes or less of their appointment time has improved by 1.3% and those seen after 1 hour of their appointment time decreased by 0.7%.
- 10.14.4. Between Quarter Four 2016/17 and Quarter One 2017/18 there has been an increase in activity of 724 attendances, improvement in those seen within 30 minutes of their appointment time by 1.1% and a decrease in those seen after an hour of their appointment time by 0.7%.

10.15. Outpatient non-attendances

10.15.1. Non-attendance at first appointment

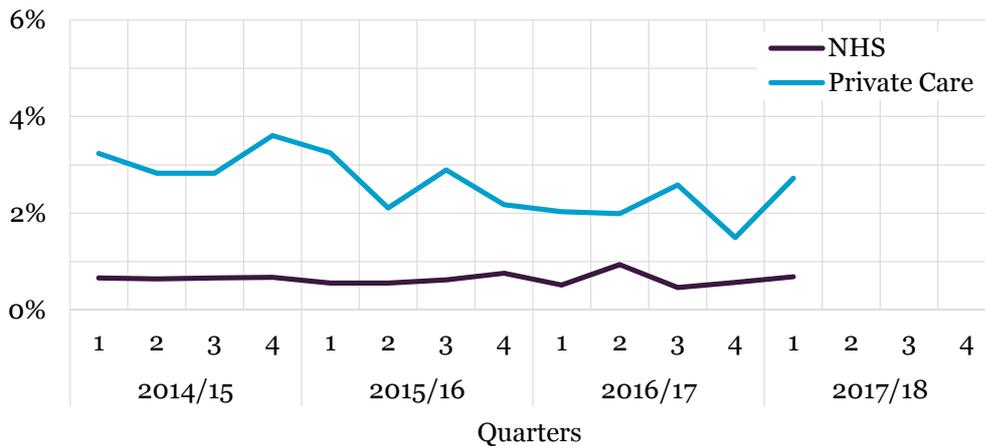


10.15.2. Non-attendance at subsequent appointment



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

10.16.1. In Quarter One 0.68% of NHS clinics (33 out of 4,820) and 2.73% of private care clinics (52 out of 1,908) were cancelled less than 15 days before the planned date. The percentage for both NHS and private care clinics has increased since last quarter.



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	22	133	41	130	63	263
Doctor attending conference	2	10	2	8	4	18
Clinic day changed	3	15	0	0	3	15
Doctor attending meeting	4	22	7	26	11	48
Doctor on study leave	0	0	1	6	1	6
Staff sick leave	1	15	0	0	1	15
Unexpected emergency	1	9	1	3	2	12
Total	33	204	52	173	85	377

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	53	38	9	100
Concerns relating to private care patients	5	0	Not applicable	5
Total	58	38	9	105

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

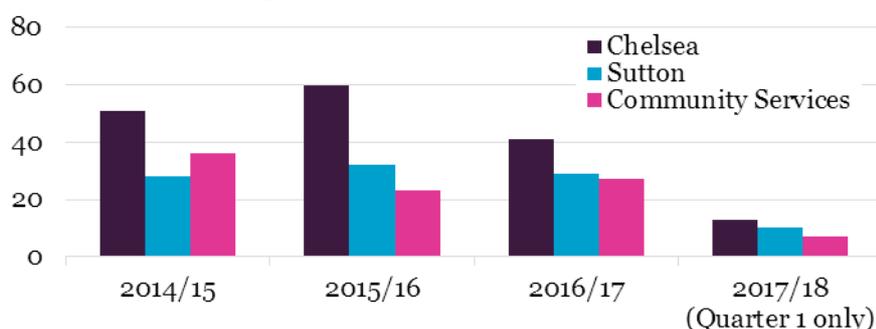
It is a Trust standard that all complainants receive

- 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	13	10	7	30
Complaints acknowledged within three working days	13 (100%)	10 (100%)	7 (100%)	30 (100%)

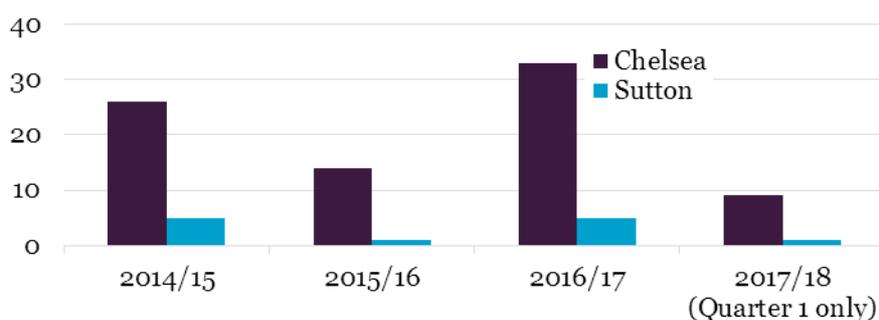
11.1.6. Number of complaints by financial year and site (NHS patients)



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

	Chelsea	Sutton	Total
Complaints received	9	1	10
Complaints acknowledged within three working days	9 (100%)	1 (100%)	10 (100%)

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

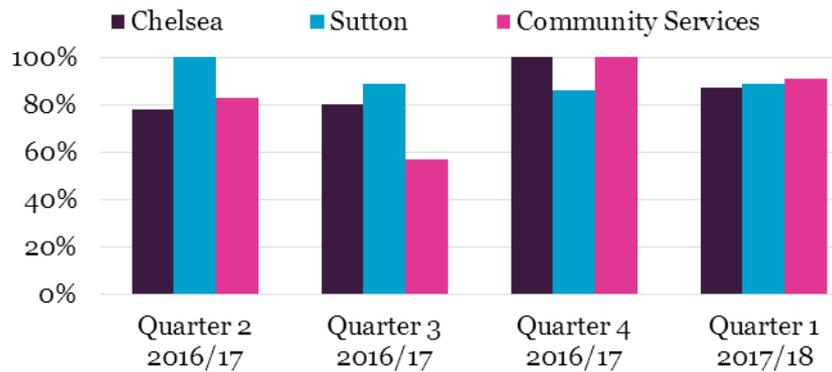


11.1.9. Number of complaints completed this quarter (NHS patients)

	Chelsea	Sutton	Community Services	Total
Complaints completed	15	9	8	32
Complainants receiving a response within agreed deadline	13 (87%)	8 (89%)	8 (100%)	29 (91%)

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.

11.1.10. Responses within agreed deadline (NHS patients)

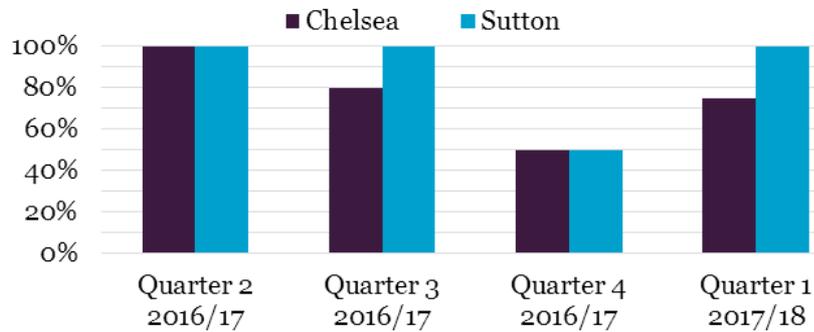


11.1.11. Number of complaints completed this quarter (private care patients)

	Chelsea	Sutton	Total
Complaints completed	12	2	14
Complainants receiving a response within agreed deadline	9 (75%)	2 (100%)	11 (79%)

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 Coastal West Sussex	1
NHS Croydon	2
NHS Ealing	1
NHS Guildford and Waverley	1
NHS Hillingdon	1
NHS Lambeth	2
NHS Merton	1
NHS North Hampshire	1
NHS North West Surrey	1
NHS Redbridge	1
NHS Southend	1
NHS Southwark	1
NHS Surrey Downs	1
NHS Surrey Heath	1
NHS Sutton	12
NHS West Kent	1
NHS North West London	1
Total	30

11.1.14. Risk rating

The overall risk rating is identified using the following risk matrix:

Likelihood		Actual severity consequence				
		None/ Insignificant	Low/ Minor	Moderate	Severe/ Major	Death/ Catastrophic
		1	2	3	4	5
Almost certain	5	Yellow	Yellow	Orange	Red	Red
Likely	4	Yellow	Yellow	Orange	Red	Red
Possible	3	Green	Yellow	Orange	Red	Red
Unlikely	2	Green	Green	Yellow	Orange	Red
Rare	1	Green	Green	Yellow	Orange	Red

The risk grade in the tables of complaints is defined as:

Very low	Green
Low	Yellow
Moderate	Orange
High	Red

11.1.15. Complaints completed this quarter by risk grade – NHS patients

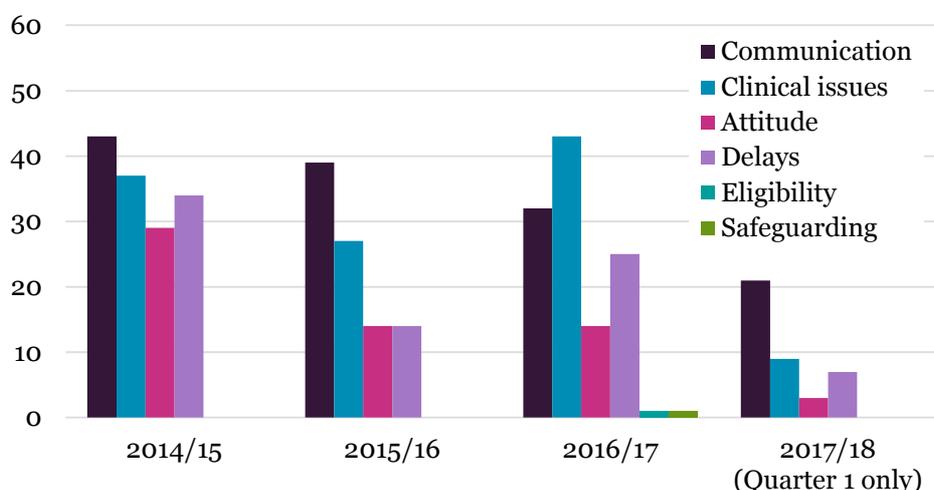
Risk grade	Chelsea	Sutton	Community Services	Total
Very low	10	4	5	19
Low	5	4	3	12
Moderate	0	1	0	1
High	0	0	0	0
Total	15	9	8	32

11.1.16. Complaints completed this quarter by risk grade – private care patients

Risk grade	Chelsea	Sutton	Total
Very low	8	2	10
Low	4	0	4
Moderate	0	0	0
High	0	0	0
Total	12	2	14

11.1.17. Complaint subject: 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.



11.1.18. Ethnicity of complainants for complaints received this quarter

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

Ethnic origin of complainant	Number of complaints
Asian Bangladeshi	0
Asian Indian	0
Asian Pakistani	0
Asian (other)	0
Black African	0
Black Caribbean	0
Black (other)	0
Chinese	1
Mixed White and Asian	0
Mixed White and Black African	0
Mixed White and Black Caribbean	0
Mixed (other)	0
White British	2
White Irish	0
White (other)	0
Other	0
Not disclosed	37
Awaiting confirmation	0
Total	40

11.1.19. Complaints completed this quarter – Chelsea

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Breast	Very low	Communication	Appointment cancelled without notification	Future letters regarding change of appointments will be scanned and an audit trail maintained to avoid it happening again.	Partly upheld Closed 11 May.
Breast	Low	Communication	Late cancellation of appointment that was not re-scheduled	In future, will ensure that all patients are advised of delays.	Partly upheld Closed 20 April.

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Breast	Low	Eligibility	Access to treatment for a new diagnosis	Staff across the Trust will be educated that appointments should not be delayed whilst awaiting confirmation of eligibility.	Partly upheld Closed 6 April.
Central Referrals	Very low	Communication	CRO and appointment changed at last minute and patient was given incorrect new appointment date	Lack of awareness of customer services policy discovered – more clarity between teams is required.	Partly upheld (Status confusion) Closed 18 May.
Corporate	Very low	Communication	Dissatisfied with staff attitude and manner	Doctor involved apologised for any misunderstanding.	Not upheld Closed 6 June.
Corporate	Very low	Communication	Seen as a private patient after transferring to the NHS	Apology made and fees were waived. Confusion of status has been resolved.	Upheld Closed 31 May.
Corporate	Very low	Diagnosis	Blood results were lost and this was not communicated to patient prior to appointment	Staff have been reminded of correct checking procedures. Any message regarding problems with blood samples will be relayed to member of the clinical team.	Partly upheld Closed 15 June.
Gastro-intestinal	Very low	Delays	Referral rejected despite previous history with hospital	Explanation given as to why referral was not accepted.	Partly upheld (Appointment cancelled) Closed 23 May.
Gastro-intestinal	Very low	Referral	End of life care	Clinical team will be mindful of language used in communicating with patients and their families.	Not upheld Closed 11 April.
Gastro-intestinal	Very low	Referral	Rejection of referral for second opinion	Policy outlined and explained.	Partly upheld (More mindful communication) Closed 16 June.
Gynaecology	Very low	Communication	Communication on prognosis. Queried why natural treatment methods were not discussed	Apologies given for any miscommunication.	Not upheld Closed 19 May.

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Gynaecology	Very low	Communication	Blood tests follow up not booked or communicated	Clinician reminded to respond to queries in timely manner and of escalation process.	Partly upheld Closed 26 June.
Gynaecology	Very low	Diagnosis	Delay in providing results	Apologies and explanation given.	Not upheld. Closed 18 May.
Private Care	Low	Communication	Dissatisfied with consultation and care and treatment options provided	Apologised about misunderstanding, complimentary appointment offered.	Upheld Closed 23 June.
Private Care	Very low	Communication	Attitude of nurse and length of wait for change of dressing	Review of staffing levels underway.	Partly upheld Closed 11 May.
Private Care	Very low	Communication	Attitude of team and misunderstanding over payment	Member of staff reminded of Trust values and clear communication.	Partly upheld (Staffing review to take place) Closed 10 May.
Private Care	Very Low	Communication	Issues relating to charges and staff attitudes	Charges were accurate.	Not upheld Closed 26 June.
Private Care	Very low	Communication	Patient scheduled for radiotherapy but advised not well enough to begin treatment	Review of escalation procedure for delays to clinic consultations and review of time in which patients are informed of costs of treatment prior to treatment dates.	Not upheld Closed 5 May.
Private Care	Low	Communication	Request for information needed to apply for visa not forthcoming	Clinicians reminded of importance of timely communication.	Partly upheld (Team error, training to take place) Closed 26 June.
Private Care	Low	Delays	Long wait for scan and accounts issues	£50 offered as goodwill gesture.	Not upheld Closed 5 May.
Private Care	Low	Food	Allergies not taken into account for catering	Review of allergen policy, risk assessment carried out on bathrooms and audit to take place.	Partly upheld (Service review) Closed 13 June.
Private Care	Very low	Transport	Request for transport rejected	Staff reminded on how to appropriately engage with patients and reminded of escalation policy. (Re-opened)	Partly upheld (Review undertaken) Closed 13 June.

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Radiology	Very low	Delays	Length of wait for X-ray	Emphasised to staff clear communication.	Not upheld Closed 14 June.
Sarcoma	Low	Communication	Summary of appointment sent to several people including former employer	Inadequacy in system highlighted, process of adding and removing individuals from recipient list will be added to secretary's handbook.	Upheld (Review of handbook) Closed 7 April.
Sarcoma	Low	Communication	Poor staff attitude and lack of communication around diagnosis	Staff to reflect on conduct during clinic appointments. (Re-opened)	Not upheld Closed 13 June.
Sarcoma	Very low	Transport	Unhappy with attitude of transport advisor	Implemented clearer guidelines and communication for patients travelling from outside catchment area.	Partly upheld (Clearer communication) Closed 12 April.

11.1.20. Complaints completed this quarter – Sutton

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Breast	Very low	Communication	Dressing appointment cancelled and no contingency in place	Appointments to be rescheduled and communicated by telephone and in writing.	Partly upheld (Review of practice) Closed 19 May.
Gastro-intestinal	Low	Communication	Dissatisfied with care management	Clinical staff will confirm at outset of phone conversation that patient is happy to receive information in this way and will confirm appropriate days and times for calls.	Partly upheld (Clearer communication) Closed 18 April.
Gastro-intestinal	Moderate	Communication	Lack of communication: positron emission tomography (PET) scan was not reported on which delayed treatment	Importance of checking results highlighted with surgical team as well as timely follow up. (Re-opened).	Upheld (Reiteration of process) Closed 5 April.

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Head and Neck	Very low	Clinical care	Family unhappy with end of life care provided to their mother including privacy and dignity	Actions include reiteration of central venous access device (CVAD) and medical records policies. Independent report underway regarding cancer progression.	Partly upheld (Reiteration of policy) Closed 30 June.
Paediatrics	Low	Clinical care	Difficulties experienced by staff in changing catheter	Standard operating procedure being developed around cross cover on sites. Patient information under review.	Party upheld (Service and policy review) Closed 21 June.
Paediatrics	Very low	Communication	Copy of life insurance claim sent to patient's mother without consent	Agreed all documents should be shared with both parents.	Not upheld (Advice given appropriate) Closed 25 April.
Paediatrics	Low	Safeguarding	Concerns regarding discharge of patient	Appropriate assessments and reviews undertaken.	Not upheld Closed 6 June.
Private Care	Very low	Diagnosis	End of life care	Apologies were given, as at present the Trust is unable to offer formal psychological support to relatives and friends of patients. (Re-opened)	Not upheld Closed 16 June.
Private Care	Very low	Environment	Dissatisfaction with facilities and service	Patient entertainment services will be retendered, any entertainment issues will be escalated to front of house.	Upheld (Review and processes reiterated) Closed 8 June.
Urology	Low	Communication	Dissatisfied with communication and lack of collaboration between services. Unhappy that biopsy sample could not be used	Explanation of why biopsy sample could not be used and apologies for delay.	Not upheld Closed 7 April.

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Urology	Very low	Diagnosis	Patient called and told of cancer recurrence and had to wait 2 days to speak to consultant	Communication not appropriate, clinical staff reminded to confirm patient is still happy to conduct appointment in this way at outset.	Partly upheld (Reflection on clear communication) Closed 10 May.

11.1.21. Complaints completed this quarter – Community Services

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Children's Services	Low	Communication	Patient discharged from chiropodist service	Departmental decision, patient was only referred for six appointments.	Not upheld Closed 19 June.
Children's Services	Very low	Communication	Advice for restricting diet due to fructose intolerance, blood later found in stool	Correct information and advice given based on information contained in referral.	Not upheld Closed 20 June.
Children's Services	Very low	Communication	Referral to consultant paediatrician not completed	Staff to be supported with time management.	Upheld (Reflection and support in time management) Closed 8 May.
Musculo-skeletal	Low	Communication	Unable to make appointment	Disruption due to service redesign.	Partly upheld (Reflection on clear communication) Closed 23 May .
Musculo-skeletal	Very Low	Communication	Reporting of X-ray results and late cancellation of clinic appointment	Reviewing collaborative services and information provided to patients regarding additional scans. Implemented administration strategy to ensure cancelled appointments are rebooked.	Upheld (Service review undertaken) Closed 20 June.
Occupational Therapy – Children's Services	Low	Communication	Patient experiencing difficulties and wishes to access services however advised not eligible	Relevant information on restrictions and commissioning explained.	Not upheld Closed 12 April.

Podiatry	Very low	Clinical care	Podiatrist removed excess skin from foot. Patient later admitted to hospital with infection	Service will ensure that all referrals to Community Services establish if there are any known disabilities which could affect timely access and engagement in treatment decisions.	Not upheld Closed 6 June.
Speech and Language Therapy - Children	Very low	Delays	No Speech and Language Therapy clinics in borough as staff on leave	Service restricted due to staffing levels, additional clinics will be held in the next month as a result.	Partly upheld (Service review undertaken) Closed 24 May.

11.1.22. NHS Digital data - benchmarking

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

The results for Quarter Four 2016/17 (the latest available) are shown in the table below for selected service providers. On its website NHS Digital describes the data as ‘provisional and experimental and ... care should be taken when interpreting the results’.

Trust	Total brought forward	Total new	Total resolved	Number upheld	Number partially upheld	Total not upheld	Total carried forward
NHS England	18,775	30,324	28,112	10,569	7,967	9,846	20,987
NHS England London	3,072	5,573	4,545	1,665	1,324	1,556	4,100
The Royal Marsden	7	41	33	4	15	14	15
The Christie NHS Foundation Trust	5	16	16	10	3	3	5
University College London Hospitals NHS Foundation Trust	115	227	205	63	91	51	137
Chelsea and Westminster Hospital NHS Foundation Trust	150	169	167	91	37	39	152
St George’s University Hospitals NHS Foundation Trust	98	236	250	250	0	0	84

11.1.23. 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 monthly.

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

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

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

Communication

It is important to ensure that when there are last minute cancellations this should be communicated to the patient by telephone where possible and not just in writing.

Attitude of staff

Clinical staff need to remain empathetic and courteous at all times whilst reiterating information as not all patients will understand their diagnosis or care plan in the first instance.

Clinical issues

Staff need to be more pro-active in seeking assistance from other staff and working collaboratively with colleagues from other sites.

Delays

Staff need to proactively escalate any concerns regarding delays to senior members of staff.

11.1.24. Complaints handling survey 2016/17

A complaints handling survey is sent out to complainants each month, for complaints closed two months previously and this is ongoing. The completed returned surveys for 2016/17 was assessed by a Clinical Auditor and reported on in the previous quarter.

11.1.25. Parliamentary and Health Service Ombudsman referrals

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

The Trust currently has five complaints under investigation by the Ombudsman. One final report was received in the quarter. This related to a complaint, which was not upheld and was closed with the Ombudsman.

11.2. Letters of praise

- 11.2.1. Staff are encouraged to send any letter of praise they receive to the Head of Clinical Legal Services, Complaints and Patient Information for noting in this report and to help identify any members of staff who should receive personal thanks for their work from the Chief Executive.
- 11.2.2. In the quarter, 97 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

Diagnostic radiology

I wanted to send you my love and appreciation for your kindness and support that you gave me when I came for my early mammogram. You really are a light and a gift to humankind. I am most humble and grateful for your helping hand and heart.

Radiotherapy

You are all exceptional and your bright personalities made my daily visit over the five weeks go quickly.

11.2.4. Sutton

Kennaway Ward

Thank you for all your support, compassion and honesty, it has really helped the whole family come to terms with what has happened. It became a daily conversation between the family as to which nurse was looking after Dad for the day and the night shift and we can honestly say it didn't matter who it was as every single one of you are so fantastic as what you do and showed so much compassion.

Lymphoedema

Thank you so much you have no idea how much your very special kindness, humour, warmth, knowledge and care helped me.

11.2.5. Community Services

Podiatry

The podiatrist has at all times been focused on achieving the best possible outcome for my presenting condition. He has always been attentive and listened to my feedback on treatment. His history taking was exemplary and he constantly referred to his notes during each consultation to ensure he gave the best possible advice.

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 1	Delay in follow up	Awaiting confirmation if a panel review is required
Investigation 2	Patient fall	Panel 15 July 2017
Investigation 4	Standard of care	Awaiting confirmation if a panel review is required
Investigation 6	Crematorium forms	Panel 13 July 2017
Investigation 7	Communication issues	No panel required
Investigation 9	Lost to follow up	Awaiting confirmation if a panel review is required
Investigations 3, 5 and 8	Pressure ulcers	Reviewed at the monthly pressure ulcer panel

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 50 Yellow	Medication incident	The panel agreed that this incident was attributable to the Trust and avoidable. However, there also needed to be feedback to the partner service provider regarding the poor discharge of this patient and the incorrectly written medication document.	Authorisation to administer medication document to be reviewed in conjunction with community pharmacy lead from the partner service provider.

Investigation number and incident grade	Description	Outcome of investigation	Action taken following investigation include:
Investigation 63 Serious Incident	Community burn – contact with radiator	The hospital bed was positioned next to the radiator in the patient’s room. It was agreed that if equipment is to be provided to a patient, a member of the nursing team must make contact in order to carry out a home visit and undertake a risk assessment.	Audit the provision of equipment to ensure that the revised process is being adhered to and that the holistic means assessment is being completed appropriately.
Investigation 66 Green	Delay in follow up	Systems and process issues caused a 2-month delay between the first multidisciplinary team meeting and the commencement of chemotherapy.	Revision of the <i>Access Policy</i> and <i>Internal Referrals Standard Operating Procedure</i> to incorporate: – Timeframe of internal referral process – Outline the process and who is responsible for ensuring internal referrals are completed.
Investigations 73a and 73b Orange	Acute kidney injury (AKI)	Both incidents identified that blood tests were requested and the results were available that same day, but not reviewed by the requester or the clinician who reviewed the patient.	Feedback to IGRM regarding AKI. The Director of IT to present to IGRM a paper outlining an interim measure to improve the process for being notified of test results before the introduction of order communications (an integrated system for electronically ordering tests and posting results on the patient record).
Investigation 75 Green/ unconfirmed	Medication incidents	Patients should not be expected to collect their medications from more than one dispensary/location and that one dispensary should take ownership of all the patients’ medications.	Review of the medication supply pathway that currently requires patients to attend different dispensaries/locations to identify if one pharmacy can take ownership of dispensing all medications.
Investigations 76 and 81 Orange	Patient falls	The documentation was not completed in full and there were some delays in referral to the allied health professionals.	All ward areas to undertake regular audit of at risk and post falls care plans.

Investigation number and incident grade	Description	Outcome of investigation	Action taken following investigation include:
Investigation 77 Yellow	Lost pathology	The histopathology sample was not returned to off-site storage and subsequently lost.	To review if a bar coded tracking system should be used for histopathology samples
Investigation 80 Green	Medication incident	Lack of link between 'Nurse Administration' and the 'eChemo' electronic prescribing system. This means that the act of administration does not 'lock down' that element of the prescription to further edit.	Software Development: integration of Nurse administration system and Day function on eChemo.
Investigation 86 Unconfirmed	Triage	The investigation found the Royal Marsden Macmillan Hotline (RMMH) nurse did not contact the clinical site practitioner (CSP) to confirm bed status at the time of the call and there was a miscommunication between the RMMH staff and the CSP based at Sutton.	To reinforce to RMMH triage staff that if a CSP is being contacted for advice it should be made clear if the call is regarding bed capacity or whether advice is being sought in regards to a patient's symptoms.
Investigation 87 Yellow	Fine needle aspiration	The World Health Organization (WHO) surgical checklist is not currently in use for these procedures; however, it is intended that as part of the program of work to meet the requirements of the National Safety Standards for Invasive Procedures that a Local Safety Standard will be developed with a shortened checklist.	Use the modified WHO checklist prior to all interventional procedures performed in the Radiology Department.
Investigation 92 Green	Clinical care and treatment	This complex case had a full review. Care and service delivery problems were identified but they were not felt to have contributed to the outcome.	A review of the Trust's Ascitic Drain Insertion and Management Policy to incorporate: Management of patient with malignant ascites. Intravenous fluid management pre and during paracentesis of patients with complex comorbidities.

Investigation number and incident grade	Description	Outcome of investigation	Action taken following investigation include:
Investigation 2a Serious incident	Patient fall	It was the opinion of the panel that the patient's fall was unavoidable as the documentation of the care provided was completed to the expected standards and highlighted evidence of collaborative team working.	Explore what fall prevention strategies are in place at other major acute centres.
Investigation 2b Orange	Patient fall	The patient's fall took place at approximately 06:00 hrs. The timing of patient falls is monitored by the Falls Steering Group and it was agreed this should be discussed on a monthly basis to identify any patterns regarding the timing of patient falls.	Timing of falls to be monitored monthly at the Falls Steering Group. Explore the availability of purchasing anti-slip thromboembolic stockings.
Investigations 71b, 74c and 88a Serious incidents	Category four pressure ulcers	Community acquired pressure ulcers that were found to be attributable and avoidable.	Ongoing plan of action to address and reduce the likelihood of avoidable pressure ulcers.

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

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

- If the requirements of the contractual Duty of Candour are not met the Commissioners can withhold the cost of an episode of care or implement a fine of £10,000 if the cost is not known.

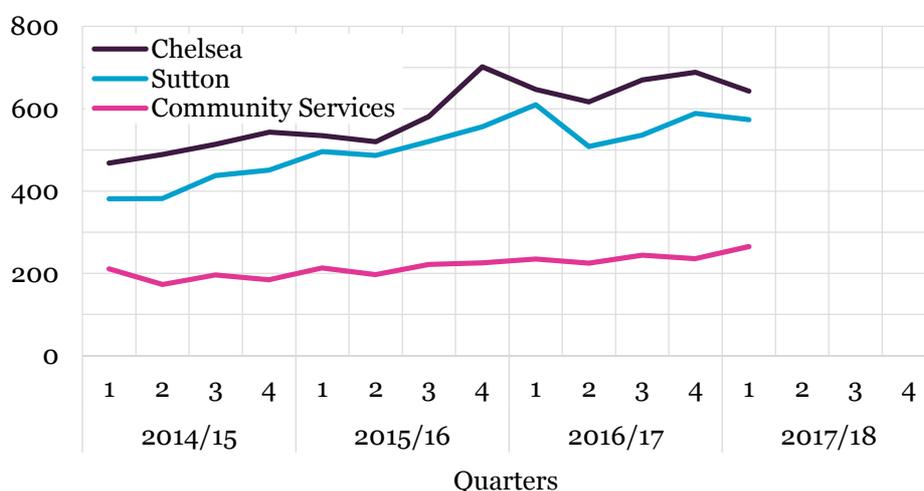
11.4.2. The *Being Open and Duty of Candour Policy* incorporates the requirement and the Risk Management team supports staff with this process to ensure compliance with the contractual requirement.

11.4.3. The Risk Management Team audit compliance against the requirements of the Duty of Candour six monthly. The next audit will be undertaken July 2017.

11.5. Incident statistics

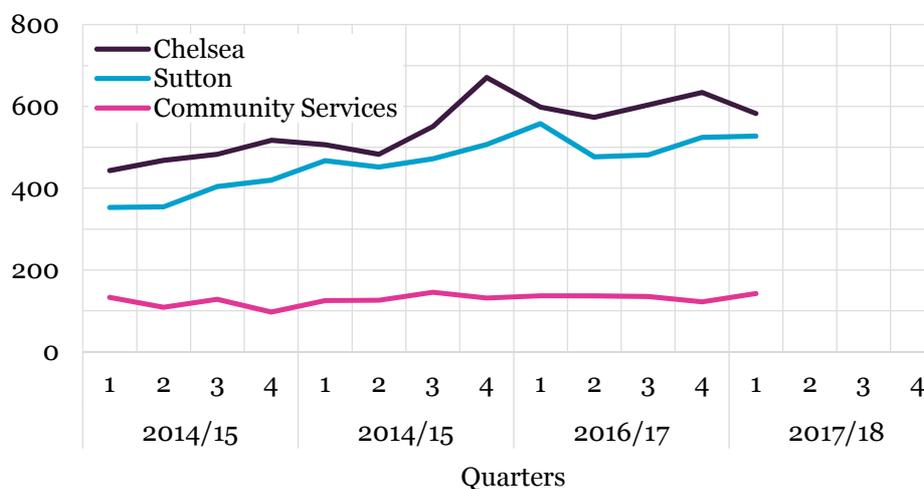
This section displays incident statistics for services which are currently run by The Royal Marsden NHS Foundation Trust. Historical data relating to services now commissioned by other healthcare providers have been excluded.

11.5.1. All reported incidents



11.5.2. All attributable incidents

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

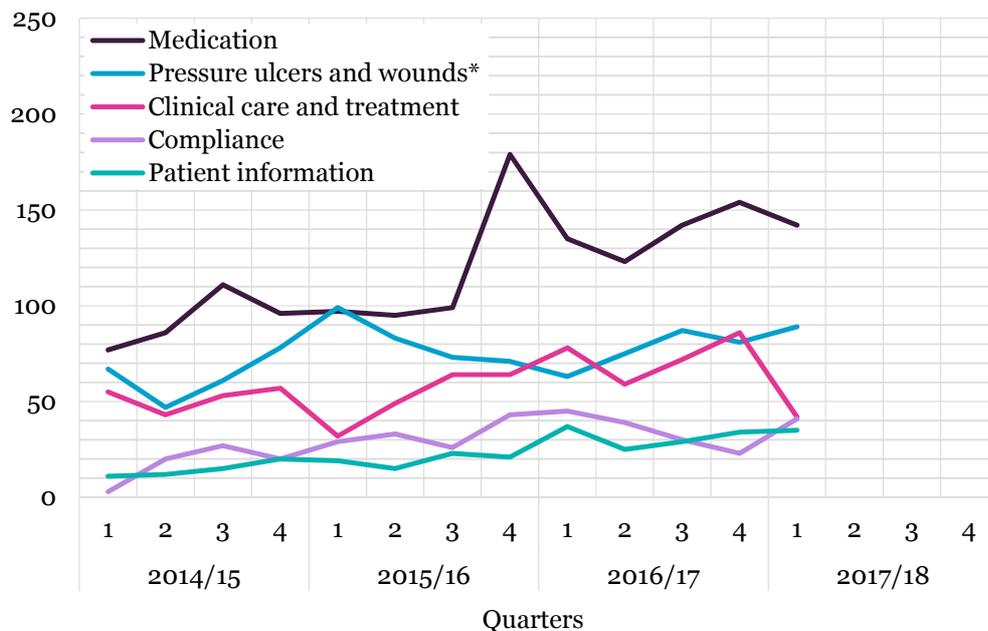


11.5.3. Patient safety incidents – top five categories

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

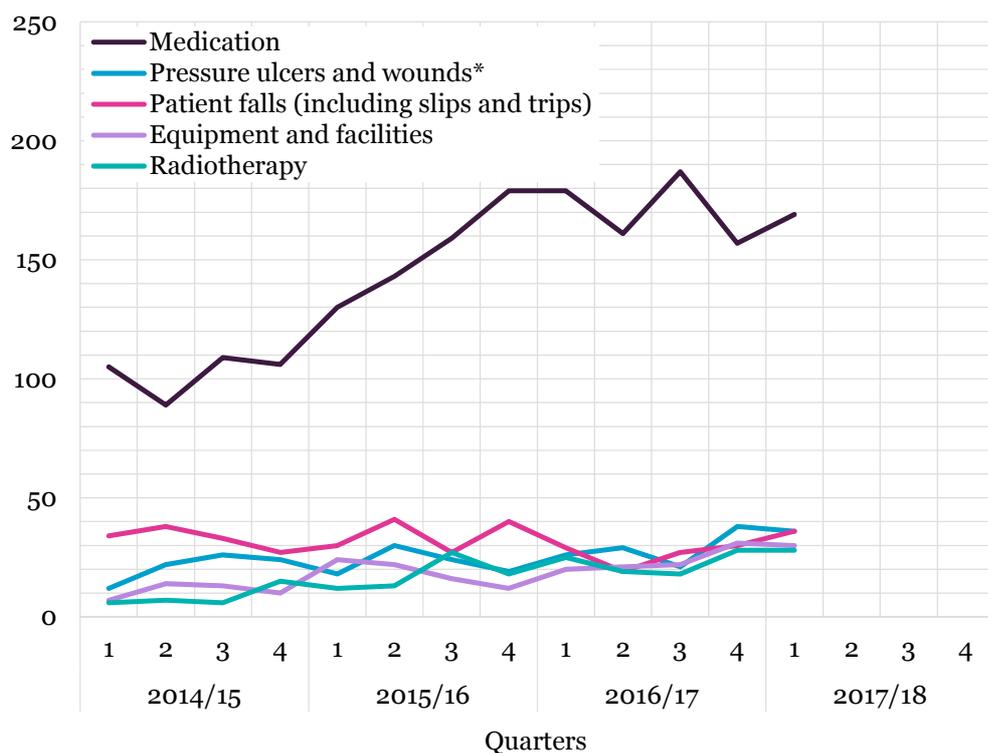
The charts show the five categories with the largest number of incidents in Quarter One, and the number of incidents for these categories in previous quarters.

Chelsea



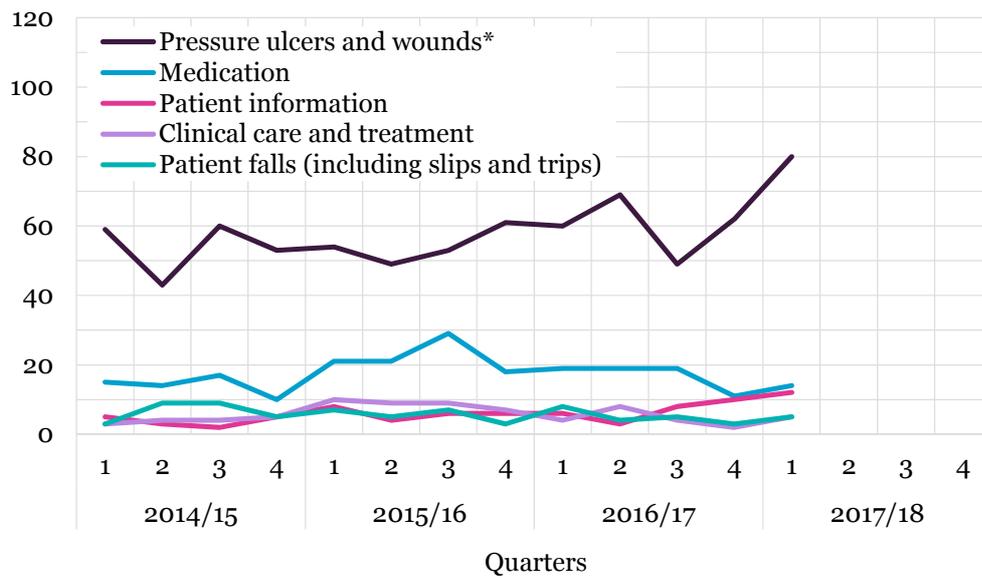
* One incident may represent more than one pressure ulcer.

Sutton



* One incident may represent more than one pressure ulcer.

Community Services



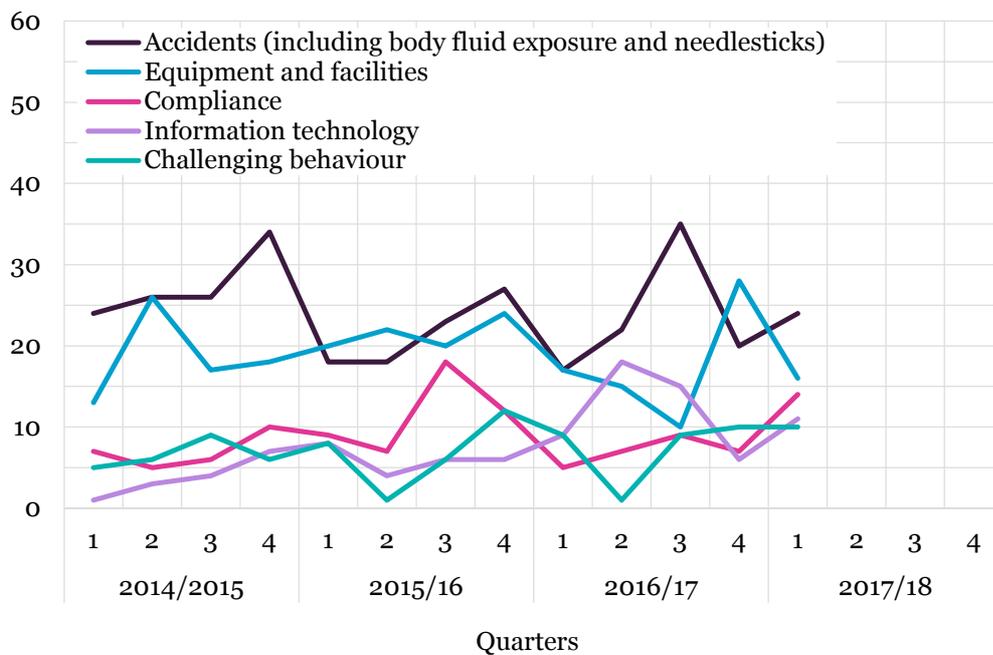
* One incident may represent more than one pressure ulcer.

11.5.4. Non-patient safety incidents – top five categories

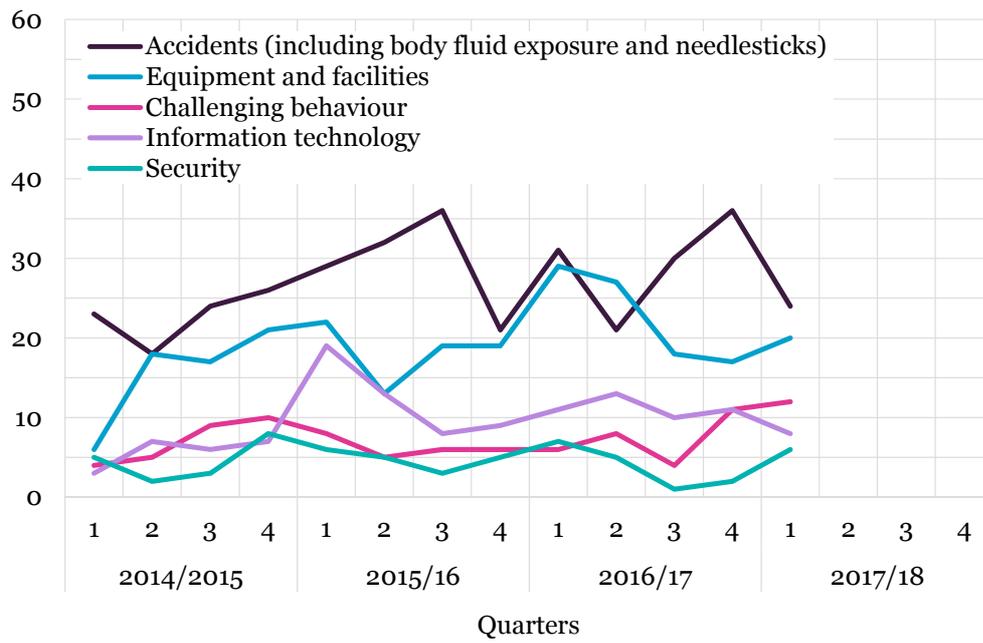
Non-patient safety incidents are those incidents that do not directly involve a patient.

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.

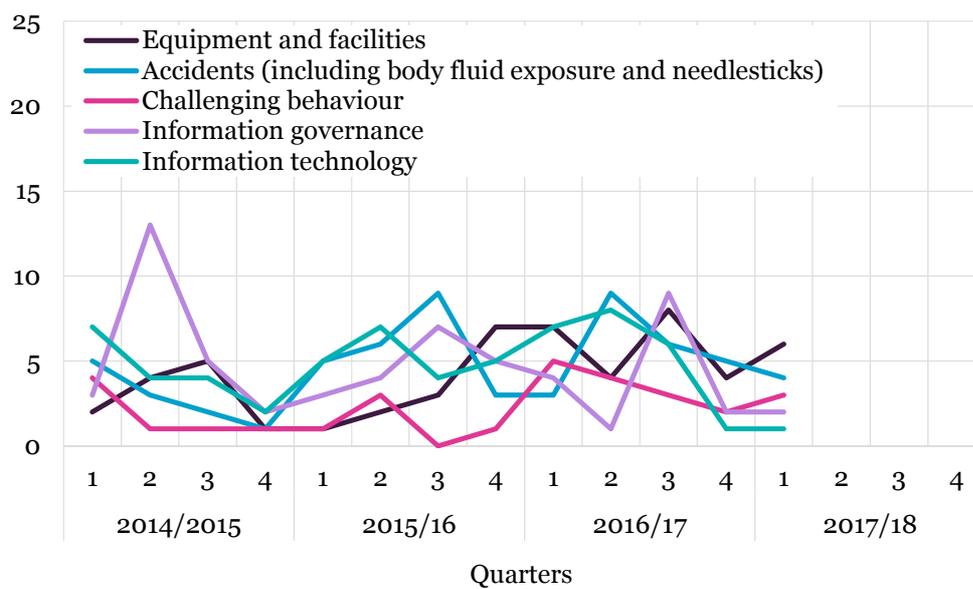
Chelsea



Sutton

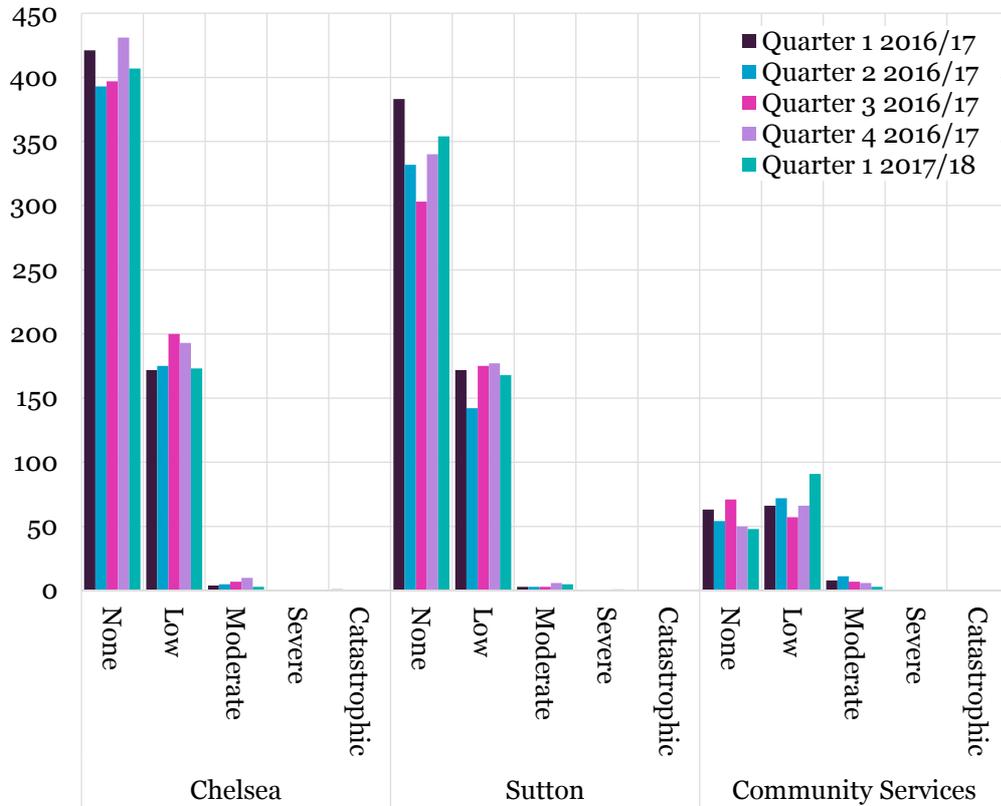


Community Services



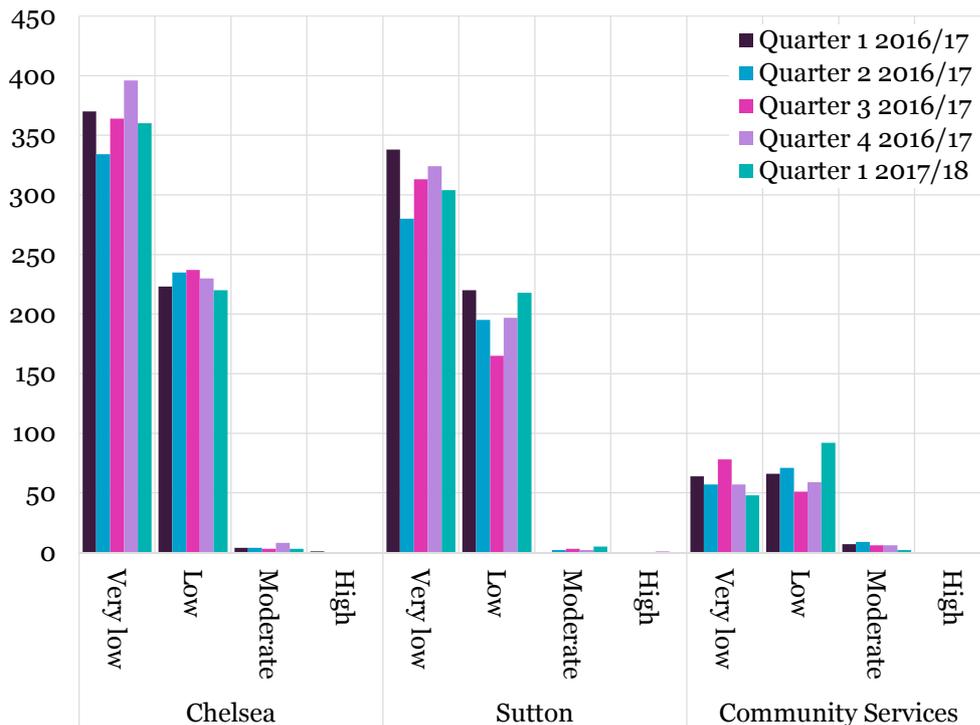
11.5.5. Severity

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



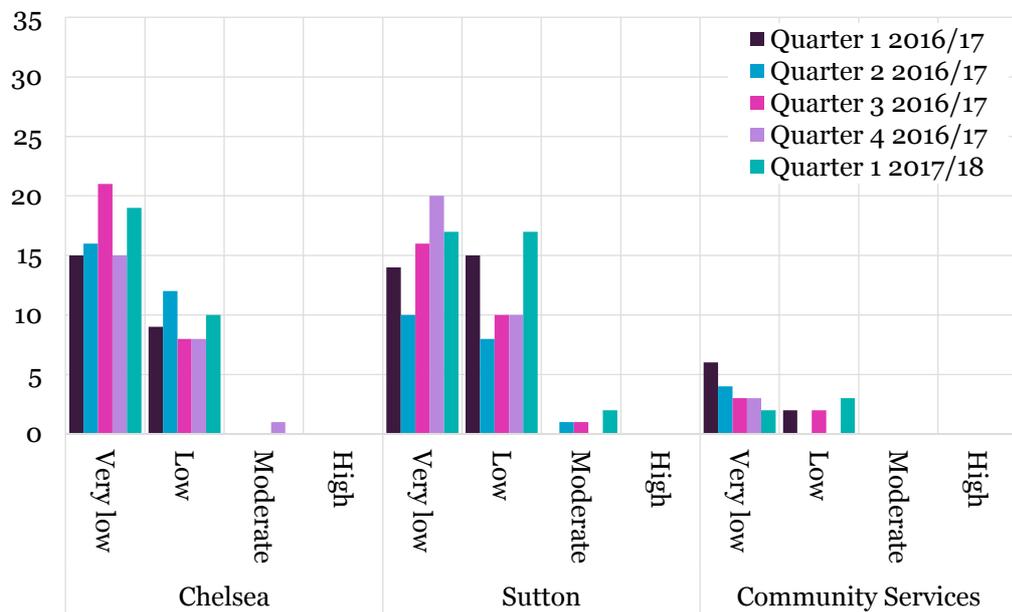
11.5.6. Risk grade

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



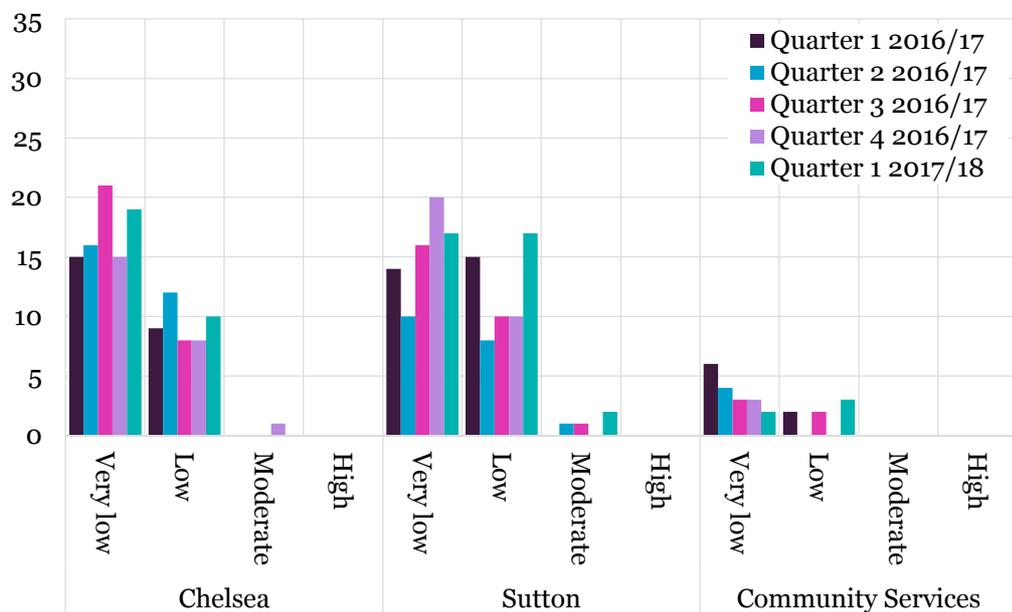
11.5.7. Medication incidents by risk grade

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



11.5.8. Patient fall incidents by risk grade

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



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

11.6.1. There were no incidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

11.7. Risk assessments – the Trust risk register

- 11.7.1. The Trust risk register contains risks that score a risk rating above 12. The register continues to be reviewed and updated each quarter. All risks that score 9 and above remain on the divisional registers and those whose scores have been reduced through preventative action are downgraded.
- 11.7.2. The Trust risk register is reviewed quarterly at the Integrated Governance and Risk Management Committee and the Quality, Assurance and Risk Committee.
- 11.7.3. Departmental risk assessments, incident reports, targets and other areas that identify significant risks are added as new risks at the time that they are identified.
- 11.7.4. The register is held electronically which means that the registers are more accessible for the nominated leads in the divisions. If high graded risks are reported these are escalated immediately to appropriate members of the executive team.

11.8. Clinical Legal Services

11.8.1. Claims received in Quarter One

The Trust received nine requests for medical records intimating a claim against the Trust and three inquest notifications in Quarter One.

11.8.2. Open claims in Quarter One

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

Stage	Sub-stage	Total	Description of sub-stage
Pre-action			
	Request for medical records	25	Request where claim intimated against the Trust
	Letter before action/claim/ notification of claim	3	Pre-action letter detailing allegations likely to be subject to court proceedings
	Letter of Claim	1	Response to the allegations as set out in the Letter of Claim
	Letter of response	7	Response to the allegations as set out in the letter before action/claim
	Negotiating settlement	2	Attempts to reach settlement without recourse to the court
Issued claims			
	Claim form served	0	Formal court proceedings sent to the Trust
	Particulars of claim served	0	Formal allegations sent to the Trust and court
	Defence served	1	Trust provides formal response to allegations denying all or some of the allegations made
	Negotiating Settlement	1	Attempts to reach settlement without recourse to the court
	Structured payment	1	Claim settled and annual payments made to Claimant
	Discontinued	0	Claimant withdrew claim. Legal costs to be confirmed
Total		41	

11.8.3. Closed claims in Quarter One

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

The claim withdrawn involved NHS and Private Care and although it was withdrawn against the Trust, it continues against the consultant in their private capacity.

Open files by category

Of the 41 claims, 39 relate to Clinical Negligence Scheme for Trusts (CNST) and two claims relates to employer liability (EL).

11.8.4. Inquests received in Quarter One

The Trust received notification of three new inquests in Quarter One and an inquest is listed for August 2017. However, the Coroner has not called Trust staff to give evidence.

Stage	Chelsea	Sutton	Community Services	Kingston
Request for documents	2	0	0	0
Inquests listed for hearing	1	0	0	0

11.8.5. Inquests concluded Quarter One

One inquest concluded in the quarter. The conclusion was an acute traumatic extradural haemorrhage.

The inquest that was reported in Quarter Four 2016/17, to which a Regulation 28 order* was attached, has been closed following the Trust's response to the Coroner's Prevention of Future Death report. It has not yet been made public by the Coroner. The Coroner raised a concern about the procedure that the Trust had for providing inpatients a copy of their discharge summary. Subsequently, the Trust reviewed the protocol for discharging patients and the following actions have been instigated; A generic discharge summary template that all clinicians can complete, this includes discharge summaries for patients who wish to take a copy with them on the day of discharge and patients who opt out of receiving correspondence receive a printed copy of their completed discharge summary following discharge.

* Coroner's (Investigations) Regulations 2013: a report raised by the Coroner at any time during the progress of an inquest investigation where the Coroner has concerns action may need to be taken to prevent future deaths occurring.

12. Suitability of management

12.1. Reports to NHS Improvement and accounts

- 12.1.1. NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHS Improvement regulates foundation trusts to ensure they comply with the NHS provider licence. This is a detailed set of requirements covering how foundation trusts must operate.
- 12.1.2. In Quarter One 2017/18 the Trust submitted the following finance and governance reports as part of the requirements:
- 2016/17 Foundation Trust Consolidation Return, unaudited, sent to NHS Improvement on 25 April 2017
 - 2016/17 Foundation Trust Consolidation Return, unaudited, with updated agreement of balances information, sent to NHS Improvement on 10 May
 - 2016/17 Foundation Trust Consolidation Return, audited, sent to NHS Improvement on 30 May
 - Chief Executive Officer's and Chief Financial Officer's certificate on the 2016/17 Foundation Trust Consolidation Return sent to NHS Improvement on 30 May
 - Independent Auditor's report on the 2016/17 Foundation Trust Consolidation Return sent to NHS Improvement on 30 May
 - 2016/17 Annual Accounts, unaudited, sent to NHS Improvement on 25 April
 - 2016/17 Annual Accounts audited, sent to NHS Improvement on 30 May
 - 2016/17 Annual Report sent to NHS Improvement on 30 May
 - Independent Auditors Report on the 2016/17 Annual Report and Accounts sent to NHS Improvement on 30 May
 - Independent Assurance Report on the 2016/17 Quality Report sent to NHS Improvement on 30 May
 - Independent Auditors ISA (UK & I) 260 Report sent to NHS Improvement on 30 May
 - Chief Executive Officer's Statement of Assurance on Events After the Reporting Period sent to NHS Improvement on 22 June
 - Month Twelve 2017/18 Foundation Trust Key Data return sent to NHS Improvement on 19 April
 - Month Twelve 2017/18 Foundation Trust Consolidation return and Commentary sent to NHS Improvement on 28 April
 - Month One in Year Key Financial Data return sent to NHS Improvement on 16 May
 - Month Two 2017/18 Foundation Trust Consolidation return and Commentary sent to NHS Improvement on 15 June
 - Month Two 2017/18 Workforce return sent to NHS Improvement on 16 June
 - Weekly agency returns sent to NHS Improvement on compliance with price caps and frameworks.

- 12.1.3. In September 2016 NHS Improvement introduced a new Single Oversight Framework to align the approaches of the entities it consists of. One element of this, the Use of Resources Rating, replaced the previous Financial Sustainability Risk Rating. The Use of Resources Rating aligns providers into four segments: 1 (providers with maximum autonomy), 2 (providers offered targeted support), 3 (providers receiving mandated support) and 4 (providers in special measures).
- 12.1.4. At the end of Quarter One 2017/18 The Royal Marsden had a Use of Resources Rating of 1. This means that the Trust is considered by NHS Improvement to be low risk in financial terms.

13. Glossary

AHP

Allied health professional.

Alfentanil

An opioid analgesic drug, used for anaesthesia in surgery.

ASD

Autism spectrum disorder.

bacteraemia

The presence of bacteria in the blood.

brachytherapy

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

BRCA genes

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

care pathway

The route a person takes through healthcare services.

Care Quality Commission (CQC)

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

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

CCG

See *clinical commissioning group (CCG)*.

CDI

See *Clostridium difficile infection (CDI)*.

Cerebra

A charity for children with neurological conditions.

chemotherapy

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

ciprofloxacin

An antibiotic.

clinical commissioning group (CCG)

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

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

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

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

CNS

Clinical nurse specialist *or* Central nervous system.

commissioning

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

Commissioning for Quality and Innovation (CQUIN)

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

computed tomography (CT)

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

C-reactive protein (CRP)

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

CQC

See *Care Quality Commission (CQC)*.

CQUIN

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

CT

See *Computed tomography (CT)*.

Customer Service Excellence standard

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

DAHNO

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

Datix

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

eChemo

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

EPR

Electronic patient record.

Escherichia coli

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

ESMO

The European Society for Medical Oncology.

EudraLex

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

FCE

See *full consultant episode (FCE)*.

Five Senses Observation Study

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

FTC

See *Foundation Trust Consolidation (FTC) files*.

full consultant episode (FCE)

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

GCP

See *Good Clinical Practice (GCP)*.

Good Clinical Practice (GCP)

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

haematopoietic stem cell (HSC)

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

In adults, they mainly reside in the bone marrow.

HCA

Healthcare assistant.

holistic

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

holistic needs assessment

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

See *holistic*.

Hospital2Home

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

HSC

See *haematopoietic stem cell (HSC)*

ICR

See *Institute of Cancer Research (ICR)*.

IGRM

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

Information Governance Toolkit

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

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

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

Institute of Cancer Research (ICR)

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

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

integrated governance

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

Integrated Governance and Risk Management Committee (IGRM)

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

Integrated Governance Monitoring Report

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

JACIE

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

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'.

magnetic resonance imaging (MRI)

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

medical devices

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

meticillin-resistant *Staphylococcus aureus* (MRSA)

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

MR Linac

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

MRSA

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

MRI

See *magnetic resonance imaging (MRI)*.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

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

National Early Warning Scores (NEWS)

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

National Institute for Health and Care Excellence (NICE)

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

NCEPOD

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

NEWS

See *National Early Warning Scores (NEWS)*.

NHS Improvement

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

NHS Litigation Authority (NHS LA)

See *NHS Resolution*.

NHS Resolution

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

NHS standard contract

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

NICE

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

open access follow-up

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

PALS

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

parotidectomy

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

Patient Advice and Liaison Service (PALS)

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

Patient and Carer Advisory Group (PCAG)

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

Patient Group Direction (PGD)

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

PCAG

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

perioperative

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

peripherally inserted central catheter (PICC) line

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

PET

See *Positron emission tomography (PET)*.

PGD

See *Patient Group Direction (PGD)*.

PICC line

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

pilot study

A small-scale trial run of a particular approach.

positron emission tomography (PET)

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

Public Health England

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

radiotherapy

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

RCN

The Royal College of Nursing.

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

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

RIDDOR

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

RM Partners

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

Schwartz rounds

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

sepsis

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

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

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

Sepsis Six

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

Sign up to Safety

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

SOP

Standard operating procedure.

sustainability and transformation plans (STPs)

The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care. These proposals, called sustainability and transformation plans (STPs), are place-based and built around the needs of the local population.

Sutton Community Health Services

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

TUPE

Transfer of Undertakings (Protection of Employment) Regulations 1981.

TYA

Teenage and young adult.

venous thromboembolism (VTE)

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

VTE

See *venous thromboembolism (VTE)*.

Waste Issue Report and Enquiry (WIRE)

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

WHO

See *World Health Organization (WHO)*.

WIRE

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

WIRED

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

World Health Organization (WHO)

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

14. Care Quality Commission fundamental standards

From webpage www.cqc.org.uk/content/fundamental-standards on the Care Quality Commission's website (webpage last updated 29 May 2017; retrieved 8 September 2017).

Person-centred care

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

Dignity and respect

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

This includes making sure:

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

Consent

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

Safety

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

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

Safeguarding from abuse

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

This includes:

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

Food and drink

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

Premises and equipment

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

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

Complaints

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

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

Good governance

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

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

Staffing

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

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

Fit and proper staff

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

Duty of candour

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

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

Display of ratings

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

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

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Life demands excellence



Radiotherapy and
Chemotherapy Services
F538021 & F538022

