The ROYAL MARSDEN
NHS Foundation Trust

Quality Account 2016/17

Front cover photo
Filipe Carvalho, Advanced Nurse Practitioner
in Colorectal cancer.

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What is a quality account?

All NHS hospitals or trusts have to publish their annual financial accounts. Since 2009, as part of the drive across the NHS to be open and honest about the quality of services provided to the public, all NHS hospitals have had to publish a quality account.

You can also find information on the quality of services across NHS organisations by viewing the quality accounts on the NHS Choices website at www.nhs.uk.

The purpose of this quality account is to:

1. summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2016/17; and
2. set out our quality priorities and objectives for 2017/18.

To begin with, we will give details of how we performed in 2016/17 against the quality priorities and objectives we set ourselves under the categories of:

Safe care

Effective care

Patient experience

Where we have not met the priorities and objectives we set ourselves, we will explain why, and set out the plans we have to make sure improvements are made in the future.

Secondly, we will set out our quality priorities and objectives for 2017/18, under these same categories. We will explain how we decided upon these priorities and objectives, and how we will aim to achieve these and measure performance.

Quality accounts are useful for our board, who are responsible for the quality of our services, as they can use them in their role of assessing and leading the trust. We encourage frontline staff to use quality accounts both to compare their performance with other trusts and also to help improve their own service.

For patients, carers and the public, this quality account should be easy to read and understand. It should highlight important areas of safety and effective care being provided in a caring and compassionate way, and also show how we are concentrating on improvements we can make to patient care and experience.

It is important to remember that some aspects of this quality account are compulsory. They are about significant areas, and are usually presented as numbers in a table. If there are any areas of the quality account that are difficult to read or understand, or you have any questions, please contact us through the Patient Advice and Liaison Service (PALS) by phoning 0800 783 7176, or visit our website at www.royalmarsden.nhs.uk.

This quality account is divided into three sections.

Part 1	Introduction to The Royal Marsden NHS Foundation Trust and a statement on quality from the Chief Executive (CE)
Part 2	Performance against 2016/17 quality priorities and our quality priorities for 2017/18
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Part 1

Introduction to The Royal Marsden NHS Foundation Trust and a statement on quality from the Chief Executive

The quality of care patients and their families receive, and their experiences, are central to all that we do. The Royal Marsden is the largest cancer centre in Europe and, in association with The Institute of Cancer Research (ICR), is responsible for the largest cancer research programme in the UK.

This year has been another outstanding year for us as we have continued to achieve high ratings from our two major regulators – NHS Improvement and the Care Quality Commission (CQC). We welcomed the CQC in April when they inspected our services and saw the excellent standards we deliver to our patients. Our commitment to meeting the challenges of continuing to provide quality care and experience within a cost-effective framework underpins the following four corporate objectives for 2016/17.

1. 'Improve patient safety and clinical effectiveness'
2. 'Improve patient experience'
3. 'Deliver excellence in teaching and research'
4. 'Ensure financial and environmental sustainability'

Our commitment to improving quality is demonstrated by the following achievements in the year from 1 April 2016 to 31 March 2017.

Care Quality Commission (CQC) Inspection

The CQC carried out a routine inspection in April 2016. The final report from this inspection was published in January 2017. The CQC currently awards ratings across all service areas. Our cancer-care services and community services have been rated 'Good'. The Royal Marsden's services have been rated 'Outstanding' for the Chelsea site, and for radiotherapy, critical care, and chemotherapy on the Sutton site. We have also been rated 'Outstanding' for the quality of our caring environment. And The Royal Marsden has been rated 'Good' for services for children and young people, haematology, the treatment of adult solid tumours, and outpatients (Chelsea site).

In 2011 The Royal Marsden accepted responsibility for Community Services in Sutton to trial new ways of working to give care to local people. Sutton Community Healthcare Services was inspected by the CQC and rated 'Good' for children and young people and end-of-life care, with adult community services requiring improvement, mainly in documentation and staffing levels.

Customer Service Excellence Standard

In March, The Royal Marsden's cancer care services were once again successfully assessed against the Customer Service Excellence Standard. The standard recognises public services that are 'efficient, effective, excellent, equitable and empowering – with the citizen always and everywhere at the heart of public services provision'. The Royal Marsden has now held the standard for eight years, and is one of only a few hospitals to do so.

Equality and Diversity

At The Royal Marsden, equality, diversity, inclusion and human rights are central to the way we provide healthcare services to our patients and support our staff. We want to be known as an organisation that promotes equality, values and celebrates diversity, and has created an inclusive environment for receiving care and maintaining employment.

The Care Quality Commission (CQC) report published in January 2017 rated our caring as 'Outstanding', and referred specifically to our efforts to promote equality and inclusion for our patients and staff. They noted the improvements made in the diversity of our workforce, the way that we monitor our success in meeting our Workforce Race Equality Standard.

The CQC's report also highlighted that staff demonstrated an awareness and understanding of equality issues relating to patients, and that people were "treated with kindness, dignity, respect and compassion while they received care and treatment from staff." This is a tremendous achievement.

During 2016/17, we were highly commended at the 2016 BMA Patient Information Awards for our resource on supporting children with cancer in school. We also trained 253 staff as dementia friends, supported an event for people with diabetes from different faiths who fast as part of their religion, and 89% of staff completed equality and diversity training.

The Royal Marsden School

The Royal Marsden School (the School) continues to promote excellence. Student numbers have held up well, despite the cuts in education funding. The academic partnership with the University of East Anglia (UEA) is in its second year and progressing successfully. UEA continues to monitor the School's quality, and expects high standards of academic performance. For the sixth year in a row, the School met 100% of its quality-performance and contract-monitoring measures, as assessed by Health Education England North West London (HENWL). In summarising the assessment of the School's performance against these quality indicators, the Senior Commissioning Manager at HENWL wrote the following.

"I would like to take this opportunity to reiterate how impressed I am with the quality of the information and supporting evidence submitted to HEE from The Royal Marsden School. It is clear that you and your team approach the Workforce Development Contract and Quality requirements with a real dedication to ensuring robust internal processes, strong relationship management and collaboration with commissioning partners from NHS Trusts and smaller providers alike and to developing innovative programmes to meet the changing needs of the NHS workforce."

In 2016/17, 52 modules were attended by 929 students, 30% of whom were staff at The Royal Marsden. In October 2016 we held a graduation ceremony to give academic awards from St George's University of London to 80 students, the largest number of students to date, after they had successfully completed their education in the school.

The number of school staff travelling to provide education and training for other organisations and NHS trusts has increased significantly this year. Training in communication skills training, end-of-life care, acute oncology and chemotherapy is in great demand by NHS trusts in London and across the UK.

Improving patient experience – Always Events

In January 2016, we became one of ten NHS trusts delivering the 'Always Events' programme supported by NHS England. As part of this programme, we are focusing on improving patient experience of Bud Flanagan Ambulatory Care Unit at Sutton. The Always Event – 'Patients will always be informed about key information for their outpatients visit' – was co-designed by the staff and patients on the unit. The patients and carers have produced a video explaining their experience of care and what improvements could be made to improve their experience. The ward sisters were invited to speak at a national conference in November 2016 to share their experience of co-designing an Always Event. The programme will continue to be delivered on the unit and will then be rolled out across the trust.

Food and drink

An external evaluation of the food we provide to patients found that the catering service at The Royal Marsden has achieved consistently high PLACE (Patient-Led Assessment of the Care Environment) scores. The 2016 PLACE scores put The Royal Marsden among the highest-scoring NHS trusts in England. The scores achieved were 97.32% and 95.78% for food provided on the ward at Sutton and Chelsea respectively, and 96.18% and 95.78% on 'the delivery of food and drinks' at Sutton and Chelsea respectively.

Customer satisfaction scores for the food provided to patients are gathered each month, and reported every three months in the Integrated Governance Monitoring Report. The food is rated on areas including taste, temperature, appearance, and overall satisfaction with the catering service. Survey scores show a consistent result of above 85% (Chelsea) and 90% (Sutton) of patients rating the service as 'excellent' or 'good'.

Research Excellence

The Applied Health Research programme at The Royal Marsden is designed to provide support to people who have cancer, or have had cancer. We have a range of over 50 studies and service evaluations that deal with rehabilitation needs and support for cancer patients. Some of the highlights of our current studies include the following.

'People's ability to maintain their physical activity levels during chemotherapy treatment for soft tissue sarcoma.'

'Presence and impact of swallow difficulties for people with advanced lung cancer.'

'Art Therapy for Chronic Pain.'

'Aromatherapy massage to enhance Sleep in critical care (CCR 4308)'

'A CBT training intervention for women with psychosexual difficulties post-gynaecological cancer treatment.'

'Developing an on-line emotional support resource for men affected by prostate cancer.'

'Sing with Us London, Tenovus Cancer Choir study to explore the benefits of singing for those affected by cancer.'

'PREDICT: Predicting patients at risk of developing gastrointestinal symptoms after treatment with pelvic radiotherapy.'

'The impact of targeted therapies on the cognitive function for patients in Phase I trials and those undergoing (chemo)radiation with intensity modulated radiotherapy (IMRT) for Head and Neck Cancer (HNC).'

Sign up to Safety

In June 2016 we celebrated the first year of the Sign up to Safety campaign. Over 60 delegates, including student nurses, governors, clinical and managerial staff, and patient and carer representatives, attended the event. We showcased the significant work we have achieved in reducing harm to patients in three areas – reducing harm from sepsis, reducing medication errors, and reducing harm from pressure sores. We will continue to focus in these three areas over the next two years of our safety improvement plan.

We and our board have tried to take all reasonable steps to make sure the information in this quality account is accurate. On behalf of the Board of The Royal Marsden NHS Foundation Trust (the Trust) I can confirm that, as far as I know and believe, the information in this quality account is accurate.

Cally Palmer CBE
Chief Executive
26 May 2017

Part 2

Performance against 2016/17 quality priorities and our quality priorities for 2017/18

Introduction

The quality priorities and targets for 2016/17 are shown in the table below. The priorities and targets in blue were mandatory in 2016/17 (that is, we had to include them) and the priorities and targets in red are the ones we have set ourselves. Our performance against the targets is summarised in the table below. The table also shows which quality priorities we have set ourselves for 2017/18.

Table 1: Quality priorities and targets for 2016/17 and 2017/18

Category		Quality priority	Target for 2016/17	Performance for the year from April 2016 to March 2017	Target set for 2017/18
Safe care	1	To reduce the number of cases of healthcare-related infections (MRSA and clostridium difficile infections). Applies to hospital inpatient beds at The Royal Marsden and patients of Sutton Community Healthcare Services.	For there to be less than one case of MRSA infection per year.	Not achieved.	For there to be less than one case of MRSA infection per year. For there to be fewer than 31 cases of clostridium difficile infection due to a 'lapse in care'.
			For there to be fewer than 31 cases of clostridium difficile infection per 100,000 bed days. (A bed day is when a patient is in hospital overnight. It is measured in a large number to spot trends.)	Achieved (Information provided by the trust.)	
Safe care	2	To maintain or increase the number of patient-safety incidents and near misses that are reported, reducing the percentage of incidents that have resulted in severe harm or death (A 'near miss' is when an event had the potential to harm the patient and the staff prevented it from happening). (A patient-safety incident is an incident which could have harmed or did harm a patient.) Applies to hospital inpatient beds at The Royal Marsden and Sutton Community Healthcare Services.	For the rate of reported patient-safety incidents that have caused severe harm or death to be below 0.089 per 1000 bed days. (In 2015/16 the rate of severe harm or death from incidents per 1000 bed days was 0.033 for hospital and 0.0 for community.)	Achieved (Information provided by the trust.)	For the rate of reported patient-safety incidents that have caused severe harm or death to be below 0.06 per 1000 bed days.

Category		Quality priority	Target for 2016/17	Performance for the year from April 2016 to March 2017	Target set for 2017/18
Safe care	3	To maintain the percentage of admitted patients assessed for the risk of venous thromboembolism (getting a blood clot in a vein).	For the percentage of patients who have been assessed to stay above 95%.	Achieved (Information provided by the trust.)	For the percentage of patients who have been assessed to stay above 95%. Of those patients assessed as high risk, appropriate treatment is started. Reassess 70% of patients within 24 hours.
			Of those patients assessed as high risk, appropriate treatment is started.	Achieved (Information provided by the trust.)	
			Reassess 70% of patients within 24 hours.	Partially achieved (Information provided by the trust.)	
Effective care	4	To reduce the incidence of emergency readmissions to hospital within 28 days of patients being discharged.	For the number of avoidable readmissions to be below 0.2%.	Achieved (Information provided by the trust.)	For the number of avoidable readmissions to be below 0.2%.
Effective care	5	To reduce the incidence of category-3 pressure sores (full-thickness skin loss) and category-4 pressure sores (full-thickness tissue loss) developing in patients while they are receiving community care. 2016/17 – applies to Sutton Community Healthcare Services. 2017/18 – applies to Sutton Community Healthcare Services, and The Royal Marsden inpatients.	For the percentage of category-3 and category-4 pressure sores arising in patients receiving community care to be less than 0.2%.	Achieved (Information provided by the trust.)	For the percentage of category-3 and category-4 pressure sores arising in patients receiving community care and hospital care to be less than 0.15%. For 90% of category-3 and category-4 pressure sores, both already existing and developing while receiving community care or hospital care, to have healed or improved to category 1 (redness of intact skin, which does not fade when pressed) or category 2 (partial-thickness skin loss or blister) within three months.
			For 90% of category-3 and category-4 pressure sores, both already existing and developing while receiving community care, to have healed or improved to category 1 (redness of intact skin, which does not fade when pressed) or category 2 (partial-thickness skin loss or blister) within three months.	Achieved (Information provided by the trust.)	
Effective care	6	For patients to be given information about the side effects of medicines to take after being discharged.	For 75% of patients to receive information about side effects of medicines before they are discharged home.	Achieved (Information provided by the trust.)	Will not apply in 2017/18.

Category		Quality priority	Target for 2016/17	Performance for the year from April 2016 to March 2017	Target set for 2017/18
Effective care (New for 2017-2018)	6	Reducing harm from sepsis: a. To increase the number of patients screened for sepsis. b. To give antibiotics within one hour of patients being diagnosed with sepsis Applies to hospital inpatients and patients going to the Clinical Assessment Unit.	Did not apply in 2016/17.	Did not apply in 2016/17.	a. For more than 90% of patients who meet the local criteria for suspecting sepsis to be screened for sepsis. b. For more than 90% of patients given antibiotics within one hour of sepsis being diagnosed.
Patient experience	7	a. To make sure that we are responding to inpatients' personal needs. b. To continue using the 'Friends and Family Test' question for patients receiving community care. (The Friends and Family Test question asks people who use NHS services whether they would recommend the services to others.)	a. For our results in the Friends and Family Test for hospital inpatients to still be higher than the national average.	Achieved (Information was gathered from a patient survey and published nationally by NHS England.)	a. For our Friends and Family Test score for hospital inpatients to be more than 95%. b. For our Friends and Family Test score for community services to be more than 95%.
			b. For the Friends and Family Test results to be above 90% and to increase patient satisfaction, using the CARE Measure tool, to over 90% for community services.	Achieved (Information was gathered from a patient survey and published nationally by NHS England.)	
Patient experience	8	To increase the percentage of staff who would recommend The Royal Marsden to friends or family needing care.	For more than 95% of surveyed staff to say that they would recommend The Royal Marsden.	Achieved (Information was gathered from a staff survey and published nationally by NHS England.)	For more than 95.5% of surveyed staff to say that they would recommend The Royal Marsden.
Patient experience	9	a. To reduce waiting times at chemotherapy appointments and improve patients' experiences relating to waiting times. b. To reduce waiting times in outpatient clinics and improve patient experiences relating to waiting times	a. For 80% of patients to be satisfied with the length of time they had to wait to start their treatment. b. For no more than 8% of patients to have to wait more than one hour.	Achieved (Information provided by the trust.)	a. For 80% of patients attending chemotherapy appointments to wait no longer than one hour to start their treatment. b. For no more than 6% of patients to have to wait more than one hour.

Category	Quality priority		Target for 2016/17	Performance for the year from April 2016 to March 2017	Target set for 2017/18
Adult services (community services)	**10a**	To increase the number of relevant community-services patients who have a falls-risk assessment.	For the Adult Services team to develop a falls-risk assessment. For at least 65% of patients who are identified as being at risk of a fall to have a falls-risk assessment.	Achieved (Information provided by the trust.)	Will not apply in 2017/18.
Adult services (community services)	**10b**	To reduce the number of medication errors causing moderate or low harm to patients under the care of community services to less than four a year.	For a medicine review (reconciliation) to take place during the first assessment of a patient after being discharged from hospital or after a hospital outpatient appointment.	Achieved (Information provided by the trust.)	Will not apply in 2017/18.
Children's services (community services) (New for 2017/18.)	**10a**	To increase the number of looked-after children having health assessments completed within the statutory timescale. To increase the number of looked-after children receiving a leaving-care summary by the time they leave care. (Children who have been in local-authority care must leave that care before their 18th birthday. A leaving-care summary is provided before they leave.) Applies to children's community services	Did not apply for 2016/17.	Did not apply in 2016/17.	For 100% of all looked-after children to have a health assessment completed by a nurse or a health visitor every year for children over five; and every six months for children aged two to five. For 100% of all looked-after children receiving a leaving-care summary to have it completed by a nurse before they leave care (on or before their 18th birthday).

Category		Quality priority	Target for 2016/17	Performance for the year from April 2016 to March 2017	Target set for 2017/18
Adult services (community services) (New for 2017-2018)	**10b**	To reduce waiting times for musculo-skeletal patients and improve waiting times. Applies to community services	Did not apply in 2016/17.	Did not apply in 2016/17.	For 80% of patients to be satisfied with the time they wait for a first appointment at the Assess and Treat clinic.

The next section gives more details of the quality priorities, the progress we made in meeting the targets set for 2016/17, how we will improve our performance, and how our performance will be monitored and measured.

Performance against priorities for Quality improvement 2016/17

Priority 1

To reduce the number of cases of healthcare-related infections – MRSA infection and clostridium difficile infection.

This applies to patients at The Royal Marsden and patients of Sutton Community Healthcare Services.

Targets

1. For there to be less than one case of meticillin-resistant staphylococcus aureus (MRSA) infection per year.
2. For there to be fewer than 31 cases of clostridium difficile infection caused by a failure in care per 100,000 bed days. (A bed day is when a patient is in hospital overnight. It is measured in a large number to spot trends.)

"Ensuring patients come to no harm is one of the pillars of care at The Royal Marsden. Infection prevention and control is a fundamental aspect of caring for patients with cancer."

Sarah Whitney
Matron, Infection Prevention and Control

Because of their reduced immunity, patients with cancer are more vulnerable to infection, even from germs that would normally be harmless. This makes preventing infection an important priority for patient safety.

What we did in 2016/17 – MRSA

– We renewed our focus on staff training covering the collection of blood cultures.

– We increased our focus on hand hygiene.

– We refocused the matrons' audits and the ward checklist.

What we did in 2016/17 – clostridium difficile (C.diff)

– We focused on antimicrobial management during the weekly ward round and using review stickers for antimicrobial medicines.

– We promoted antimicrobial stewardship (closely monitoring the correct use of antibiotics) through weekly antibiotic ward rounds, regular audits, education sessions, and promoting the European Antimicrobial Awareness Week. We rolled out a red review sticker across the Trust ahead of a CQUIN (Commissioning for Quality and Innovation) inspection focused on antimicrobial use.

– The Infection Prevention and Control team (IPCT) and housekeeping teams, along with the matrons, carried out weekly audits of the patient environment to monitor standards and identify any areas for improvement.

– We introduced ultraviolet technology, which is being successfully used in Sutton as a quick but effective way of disinfecting rooms if it is not possible to use hydrogen peroxide vapour.

– We introduced online training to cover the basics of preventing infection, so face-to-face training for clinical staff can focus on topical areas of concern.

How we performed in 2016/17

– There were 46 cases of C.diff arising more than three days after admission. Those cases have been reviewed to check for any 'lapse in care'. Only five cases so far have been identified as being caused by a failure in care.

– We are on target for there to be fewer than 31 cases of C. diff infection arising from lapses in care.

– There was one case of MRSA. The patient was not an inpatient at the time of the blood culture test, and it was unclear whether it was a genuine infection or a contaminated sample. The Clinical Commissioning Group (CCG) concluded that it was a contaminated sample.

– Lead Nurse Pat Cattini won the British Journal of Nursing's 'Infection Prevention Nurse of the Year' Award.

Actions to improve our performance

- Continuing to follow the process of 'universal decolonisation' of patients having surgery. The aim of this is to minimise the risk of pneumonia and infection at the site of the surgery.
- Performing monthly audits to make sure MRSA and Carbapenemase-producing Enterobacteriaceae (CPE) screening is carried out where necessary.
- Continuing to use high-level disinfection with hydrogen peroxide vapour (HPV) after patients who had healthcare-related infections are discharged, to minimise the risk to new patients.
- Regularly reviewing policies and publishing them on our intranet.

How improvements will be measured and monitored

- The Infection Prevention and Control team will carry out audits of premises used by Sutton Community Healthcare Services.
- Ward staff will carry out audits for hand hygiene.
- Further work will be carried out to review and improve the way we monitor hand hygiene.
- Clinical departments will be audited. These audits will focus on isolating patients, taking care of devices inserted under the skin and the patient environment. Feedback will be given to the relevant department to improve practice.
- Audits of MRSA and CPE screening will be carried out each month.
- All C.diff infection that is identified in specimens will be reviewed with the clinical team, before being passed the Care Quality Commission.
- We will carry out 'root-cause analysis' for MRSA or any infections where there is concern. (This means that we will review the notes of patients with infections to uncover ways to improve care for future patients. Root-cause analysis is based on the idea that several factors (roots) can contribute to a problem (infection) developing.)

Priority 2

To maintain or increase the number of reported patient-safety incidents and near misses, while reducing the rate and percentage of patient-safety incidents resulting in severe harm or death.

A patient-safety incident is an incident which could have harmed or did harm a patient. This applies to patients at The Royal Marsden and patients of Sutton Community Healthcare Services.

Target

For the rate of reported patient-safety incidents that have caused severe harm or death to be below 0.089 per 1000 bed days. (In 2015/16 the rate of severe harm or death from incidents per 1000 bed days was 0.033 for hospital and 0.0 for community.)

"Incident reporting continues to be a patient-safety priority. We strive to increase the number of near-miss and no-harm incidents reported by increasing the feedback that individual staff receive when they report an incident, and also the trust-wide dissemination of learning from investigations."

Chris Lafferty
Head of Patient Safety and Analytics/Deputy Head of Risk Management

What we did in 2016/17

– All staff who reported an incident received individual feedback.

– Incident reports on significant events were passed to the Integrated Governance and Risk Management (IGRM) Committee and then used widely across the Trust to help with learning.

– Examples of incidents were shared during training.

– We reported all patient-safety incidents that we were responsible for to the National Reporting and Learning Service (NRLS). Before NRLS produced their six-monthly reports, we gave details of all actions taken as a result of investigations. (Please note, these changes may not have been reported by the NRLS, so our information may not be the same as that which has been reported by the NRLS.)

How we performed in 2016/17

– Tables 2, 3 and 4 separate out the information for the acute hospital sites in Chelsea and Sutton (combined), and for Sutton Community Healthcare Services. In 2016/17 we have seen an increase in reported incidents. This is due to an increased awareness of reporting patient-safety incidents.

Table 2 below shows that, at the Chelsea and Sutton sites, the rate of reported incidents that caused severe harm or death in 2016/17 was two, as in the previous two years.

Table 2: Chelsea and Sutton patient safety incidents

Measure	2014/15	2015/16	1st quarter of 2016/17	2nd quarter of 2016/17	3rd quarter of 2016/17	4th quarter of 2016/17	**Overall for 2016/17**
Number of bed days	63598	60443	14,905	14,781	15,246	15,139	**60,071**
Rate of reported patient-safety incidents (severe harm or death) per 1000 bed days	0.031	0.033	0.07	0	0	0.07	**0.033**
Number of patient-safety incidents (severe harm or death)	2	2	1	0	0	1	**2**
Total patient-safety incidents	2780	3233	939	859	884	955	**3637**
Patient-safety incidents (severe harm or death) as a percentage of all patient-safety incidents	0.07%	0.06%	0.11%	0%	0%	0.11%	**0.06%**

Note: the figures for the first three quarters have been updated to reflect the most recent information available.

Table 3 below shows that for community services, in 2016/17 there were no patient-safety incidents resulting in severe harm or death.

Table 3: Sutton Community Healthcare Services patient safety incidents

Measure	2014/15	2015/16	1st quarter of 2016/17	2nd quarter of 2016/17	3rd quarter of 2016/17	4th quarter of 2016/17	**Overall for 2016/17**
Number of contacts (appointments attended)	513,707	677,293	91,331	79,114	80,897	80473	**331815**
Rate of reported patient-safety incidents (severe harm or death), per number of contacts	0	0	0	0	0	0	**0**
Number of patient-safety incidents (severe harm or death)	0	0	0	0	0	0	**0**
Total patient-safety incidents	1034	768	109	109	97	98	**413**
Patient-safety incidents (severe harm or death) as a percentage of all patient-safety incidents	0%	0%	0%	0%	0%	0%	**0%**

Note: the figures for the first three quarters have been updated to reflect the most recent information available.

Comparison with national figures

The National Reporting and Learning System (NRLS) reports that for the period from April 2016 to September 2016, the proportion of incidents resulting in severe harm or death was less than 1% of all incidents reported, which is consistent with national figures. This was the latest information available when this document was produced.

Recognising and reporting an incident resulting in severe harm or death is an indicator of an organisation's culture of accurately reporting incidents. The NRLS's reports show that The Royal Marsden is within the middle 50% of reporting organisations.

Actions to improve our performance

Keeping to Regulation 20 – The Duty of Candour

This is a regulation to make sure that we are open and honest about care and treatment. Under regulation 20, if there is a patient-safety incident that is graded moderate harm or above, we must follow a set process. You can find full details on the website at www.cqc.org.uk/content/regulation-20-duty-candour

Our Being Open and Duty of Candour Policy incorporates the requirements of the Duty of Candour. To make sure that we are open and honest about incidents that fall under regulation 20, the Risk Management team review every reported incident that is graded moderate harm and above. The review starts on either the day that the incident is reported, or the next working day. If the incident is confirmed as being correctly graded as moderate harm or above, the Risk Management team works with the relevant clinical staff to make sure the patient is told about the incident, and that an appropriate apology is given within 10 days of the incident being reported on the incident reporting system.

The patient is kept informed of our investigation. If a report is being produced, the patient is asked if they would like to receive a copy of it. The Risk Management team follow up to make sure that the report is sent to the patient along with an offer to meet them to go through the findings.

The Duty of Candour process is monitored every six months by an audit, and the results are given to the Integrated Governance and Risk Management (IGRM) Committee, the Quality, Assurance and Risk (QAR) Committee, and the Trust Board Committee.

Priority 3

To maintain the percentage of admitted patients assessed for the risk of venous thromboembolism (getting a blood clot in a vein).

Targets

1. For the percentage of patients who have been assessed to remain above 95%. Of those patients assessed as high risk, appropriate treatment is started.
2. Reassess 70% of patients within 24 hours.

"It is vital that we maintain the focus on VTE within the Trust, our patients are at a higher risk and we have a duty to inform them."

Ann Duncan
Matron

Venous thromboembolism (VTE) is a single term for both deep-vein thrombosis (DVT) and pulmonary embolism (PE). A deep-vein thrombosis is a blood clot that forms in a deep vein (usually in the leg). If a clot breaks off and travels to the arteries of the lung, it causes a pulmonary embolism, which can be life-threatening. VTE can be avoided by giving preventative treatment (for example, prophylaxis) to patients at risk. Patients with cancer are at greater risk of developing VTE, therefore this continues to be a safety priority for us.

Our VTE Steering Board is now well established, and VTE risk assessments are carried out for all appropriate patients. All planned inpatients are sent information leaflets before their appointment to tell them what they can do to help prevent clots forming, how to recognise the signs and symptoms of clots, and what to do if they develop any of these signs and symptoms. There are also posters and information leaflets available throughout the hospital, and from our Patient Advice and Liaison Service (PALS).

The VTE risk assessment may be carried out using either the patient's drug chart or by using the electronic clinical documentation system.

What we did in 2016/17

- We had patient representatives on the VTE Steering Board.
- We completed an audit called 'Snap-shot survey of verbal and written information on blood clot prevention'.
- We reduced the size of the 'Blood Clot Alert – Recognise the Signs and Reduce the Risks' leaflet after receiving feedback suggesting that it is wallet-sized.
- We switched to using anti-embolic stockings (AES) as a result of an up-to-date review.
- We trialled a new AES product.
- We developed a new VTE Care Plan for patients to sign off.

How we performed in 2016/17

- We achieved the target of 95% success in making sure all of our patients are appropriately assessed for the risk of developing VTE.
- 94% of patients who were assessed as high risk started on appropriate treatment.
- We could not fully meet the target of 70% of patients being reassessed within 24 hours. We reassessed 64% of patients.

See table 4 for more information.

Table 4: Percentage of patients who have had a risk assessment completed

	Percentage of patients who have had a risk assessment completed	Those identified as high risk (percentage or number)	Appropriate treatment started (percentage or number)	Number of patients reassessed within 24 hours
2012/13	96.5%	-	-	-
2013/14	96.75%	-	-	-
2014/15	97.1%	-	-	-
2015/16	96.1%	-	-	-
2016/17				
1st quarter of 2016/17	96.9%	100%	100%	76.1 %
2nd quarter of 2016/17	96.7%	100%	89.2 %	64.7 %
3rd quarter of 2016/17	96.7%	100%	96%	71.8 %
4th quarter of 2016/17	96.2%	100%	89.3%	41.7 %

Actions to improve our performance

- Making sure there are VTE posters in all clinical areas.
- Developing the use of handheld tablets in the Medical Day Unit to show the patient-safety film 'Blood Clots and You'.
- Auditing the delivery and understanding of information surrounding VTE checks, and monitoring VTE care plans on all wards, as well as incorporating care plans into the admission booklet.
- Making sure there is training for Harm Free Care Champions, as well as for staff on mandatory training.
- Taking part in World Thrombosis day on 13 October 2017.
- Working with leading VTE charities to make sure that VTE risks are clear, consistent, and available to people with cancer.
- Making sure VTE risk is part of the chemotherapy care bundle (a set of measures that, when carried out together, reduces the risk of a patient developing a blood clot).

How improvements will be measured and monitored

- The VTE Steering Board will continue to monitor VTE incidents, assessments and prevention procedures. Performance will also be monitored at the Trust's Steering Board and through the monthly board scorecard. The scorecard is reviewed at each trust board meeting and contains, among other items, the number of patients assessed for risks associated with VTE.
- We have reached our targets, but this will continue to be included as a priority for 2017/18 as this remains an important indicator of our improvement in protecting patients from avoidable harm.
- We will improve our methods of collecting and analysing data.
- We will continue to monitor our performance in raising awareness of VTE and VTE care plans.

Priority 4

To reduce the incidence of emergency readmissions to hospital within 28 days of patients being discharged.

Target

For the number of avoidable readmissions to be below 0.2%.

'The Acute Oncology Service and Clinical Assessment Unit have been developed to improve patient pathways and outcomes for patients requiring emergency assessment and treatment for the management of symptoms caused by their disease or cancer treatment. The Clinical Assessment Unit has been established to provide a point of care for patients requiring urgent assessment and treatment for acute oncology issues. These services work together to prevent hospital admission and ensure that the patient is cared for in the best environment and support early discharge from hospital as appropriate.'

Ali Hodge
Advanced Nurse Practitioner Acute Oncology and Clinical Assessment Unit

Since 2012/13, quality accounts should show the percentage of patients of all ages and sexes who were readmitted within 28 days of being discharged, and the national average. It is important to note that some readmissions will include patients who are admitted because of the side effects of treatment, so it may be difficult to explain any differences between us and other NHS trusts.

How we performed in 2016/17

Graph 1 shows the percentage of patients who were readmitted within 28 days from April 2013 to March 2017. Readmissions have stayed below 0.4% of all admissions since April 2012. Some emergency readmissions are an unavoidable consequence of the original treatment. However, some could be avoided by making sure that patients receive:

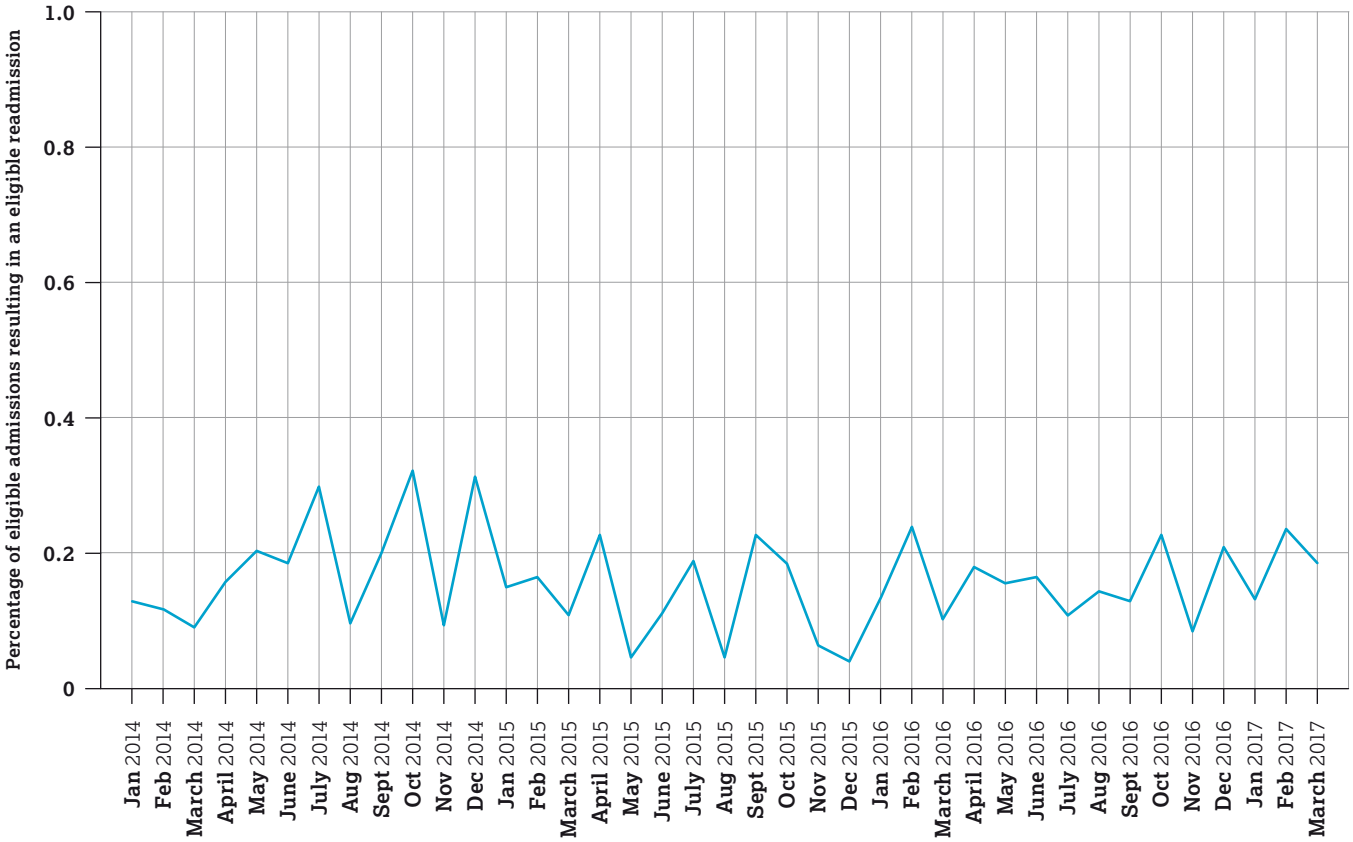
– the best possible treatment according to their needs; and

– careful planning and support for caring for themselves when they leave hospital

Table 5: Number of patients who were readmitted within 28 days from 1 April 2016 to 31 March 2017

Month	Number of patients readmitted within 28 days
April 2016	8
May 2016	7
June 2016	8
July 2016	5
August 2016	7
September 2016	6
October 2016	10
November 2016	4
December 2016	9
January 2017	6
February 2017	10
March 2017	6
Total	**86**

Graph 1: Percentage of emergency readmissions of patients within 28 days



Actions to improve our performance

- Continuously reviewing and evaluating medical care using the Enhanced Recovery Programme (ERP).
- Developing an Enhanced Recovery Programme for after liver surgery.
- Developing closer links with community services.
- Developing short-stay surgical procedures.
- 10% of readmissions being reviewed and common themes explored.
- Introducing the acute oncology out-of-hours admission prioritisation guide, and updating the access policy. This guide has a specific 'triage' sheet to help staff prioritise care. This is then recorded on the patient's electronic record.
  - Putting telephone triage into practice to reduce patient anxiety.
  - Communicating better with the Acute Oncology Service (AOS) at other hospitals.
  - Reviewing non-elective patients and the Acute Oncology Service team.
  - The Acute Oncology Service team discussing, at monthly meetings, patients who have been readmitted within 28 days.

Priority 5

To reduce the incidence of category-3 pressure sores (full-thickness skin loss) and category-4 pressure sores (full-thickness tissue loss) developing in patients while they are receiving community care.

Applies to patients of Sutton Community Healthcare Services.

Targets

1. For the percentage of category-3 and category-4 pressure sores arising in patients receiving community care to be less than 0.2%.
2. For 90% of category-3 and category-4 pressure sores, both already existing and developing while receiving community care, to have healed or improved to category 1 (redness of intact skin, which does not fade when pressed) or category 2 (partial-thickness skin loss or blister) within three months.

"It remains a high priority area for our service to focus on prevention, early identification and management of patients with pressure ulcers and patients at risk of developing pressure ulcers to enable the appropriate care delivery to be implemented in a timely manner."

Nanette Garner
Senior Sister, Sutton and Cheam Integrated Locality Team

This remains a challenging but important priority for community services, and we have continued to focus upon the prevention and management of pressure sores for the benefit of patients.

What we did in 2016/17

- Community nursing staff continued to meet the requirement to carry out a pressure-sore risk assessment during the first face-to-face contact with the patient.
- We improved the reporting of patients being admitted to the community-services caseload.
- A working group was set up to develop a pressure-sore care bundle (a set of measures that, when carried out together, reduces the risk of pressure sores) based on best practice. This makes sure there is a standardised approach to managing pressure sores across community services.

How we performed in 2016/17

- We met our first target of having less than 0.2% of patients developing category-3 and category-4 pressure sores that were attributed to us while under the care of community services. See table 6 for more details.
- 0.11% of patients developed category-3 and category-4 pressure sores that were attributed to us while under the care of community services.
- 92% of patients referred to community nursing received a pressure-sore risk assessment at their first appointment.
- 100% of category-3 and category-4 pressure sores improved to at least category 2 within three months of being diagnosed.

Table 6: Number of category-3 and category-4 pressure sores developed while receiving care from community services.

	Number of patients with a category-3 or category-4 pressure sore developing while under the care of Sutton Healthcare Services	Percentage each month	**Percentage over quarter**
April 2016	Category 3 = 4 Category 4 = 0	0.2%	**Quarter 1 (1 April to 30 June):** **0.17%**
May 2016	Category 3 = 6 Category 4 = 0	0.3%	
June 2016	Category 3= 1 Category 4 = 0	0.04%	
July 2016	Category 3 = 3 Category 4 = 0	0.12%	**Quarter 2 (1 July to 30 September):** **0.10%**
August 2016	Category 3 = 3 Category 4 = 1	0.15%	
September 2016	Category 3 = 0 Category 4 = 1	0.04%	
October 2016	Category 3 = 1 Category 4 = 0	0.04%	**Quarter 3 (1 October to 31 December):** **0.09%**
November 2016	Category 3 = 2 Category 4 = 0	0.09%	
December 2016	Category 3 = 3 Category 4 = 0	0.14%	
January 2017	Category 3 = 2 Category 4 = 0	0.09%	**Quarter 4 (1 January to 31 March):** **0.09%**
February 2017	Category 3 = 1 Category 4 = 1	0.09%	
March 2017	Category 3 = 2 Category 4 = 0	0.09%	

Actions to improve our performance

– Community services continuing with the agreed programme of service improvement. This programme includes strategies for preventing, identifying and managing pressure sores, either while the patient is under our care or when the patient is admitted into our community services.

– Introducing a pressure-sore care bundle to provide a standardised approach to managing pressure sores across community services.

How improvements will be measured and monitored

All diagnoses of category-3 and category-4 pressure sores will be investigated through a root-cause analysis and the findings will be presented at planned two-weekly pressure-sore panel meetings. This will identify root causes and guide improvements that need to be made.

We will carry out an audit to review the performance of the pressure-sore care bundle in terms of completion of the paperwork and the accuracy of recordings. The audit will take place before the end of July 2017.

Priority 6

For patients to be given information about the side effects of medicines to take after being discharged.

Target

For 75% of patients to receive information about side effects of medicines before they are discharged home.

"We know that providing patients with a better understanding of their medication can help to prepare patients to cope with unwanted side effects. During the patient journey many healthcare professionals will discuss medications but it is important for us to know if this information is provided in a way the patient perceives as useful, and to ensure it covers useful information such as 'side effects to look out for'. Pharmacy staff are skilled in providing this information and emphasis on patient facing roles is required to improve this provision of key medicines information"

Fleur Harvey
Associate Chief Pharmacist

The outcome of care depends on patients taking their treatment correctly. We aim to help patients understand the purpose of their medication as well as the potential side effects, as this information will help them take the recommended treatment correctly.

Information about medication is provided at various stages of the patients' treatment – prescribing and reviewing medication.

Comparison with national figures

The Care Quality Commission's Patient Survey, which was carried out between August 2015 and January 2016, found that in comparison with other organisations, The Royal Marsden rated 'better', scoring 7.8 out of 10, when asked if patients were told about the side effects to watch out for when taking medication.

The pharmacy department are working to increase the number of patients that a member of the pharmacy team will discuss medication with before they are discharged.

What we did in 2016/17

- We changed the way the pharmacy works (the workflow) so members of the pharmacy team can talk to patients about their medicines when they are discharged (known as medication counselling).
- We carried out an audit to identify the increase in medication counselling.
- We carried out an audit to find out whether the level of information patients receive on the Medical Day Unit is considered to be satisfactory, and how patients prefer to receive information. This audit compared departments where pharmacy staff provide medication counselling against departments that do not currently provide it.

How we performed in 2016/17

Table 7 shows a significant increase during the year in the number of patients receiving medication counselling when they are discharged. All patients now receive counselling about their medicines.

Table 7: Number of patients receiving medication counselling from the Medical Day Unit's pharmacy

Month	Number of patients needing to be discharged with eChemo medicines	Average percentage of patients receiving medication counselling
March 2016	290	14%
April 2016	299	75%
May 2016 (up to 20 May 2016)	295	84%
May 2016 to March 2017: all patients (100%) discharged from the Medical Day Unit receive medication counselling.		

Pharmacy staff on Medical Day Units now give all patients medication counselling when they are discharged.

National figures show that patients' satisfaction with the information they receive from The Royal Marsden about side effects was already higher than average.

We carried out a further audit to find out whether medication counselling at the point of discharge would have a positive effect on this patient-satisfaction rating. The audit involved two day units at the Sutton site – the Medical Day Unit and the BUD Flanagan Ambulatory Care Unit. A total of 52 patients were reviewed.

Of patients from the BUD Flanagan Ambulatory Care Unit, 83% were satisfied with the information they had received from pharmacy staff.

Overall a slightly higher satisfaction level was achieved from patients in the Medical Day Unit, with 96% of patients being satisfied with the medication counselling they received.

This audit showed that medication counselling at the point of discharge has a positive effect on patients' experience.

The audit also looked closely at whether the patients believed they had received satisfactory levels of information on the side effects of medication. 100% of the patients on their first cycle had received information about their medication. Of those, 89% had received information specifically about the side effects of their medication.

Actions to improve our performance

- Evaluating feedback from patients to better understand how we could improve the practice of providing information.
- Evaluating the possibility of increasing the availability of pharmacy staff in all day units and inpatient areas.

How improvements will be measured and monitored

- Monthly review of progress will be monitored through pharmacy department scorecards to cover all day unit areas.
- We will regularly monitor patient satisfaction with the levels of information they receive on medication (including side effects).

Priority 7a

To make sure that we are responding to inpatients' personal needs.

Target

For our results in the Friends and Family Test for hospital inpatients to remain higher than the national average.

"We have used the friends and family feedback to develop patient forums to get a dialogue between the haematology unit and the patients. We have also improved our patient information following feedback from patients and are just about to install patient information TVs in our waiting area for health promotion, and to help patients understand delays."

Samantha Wigfall
Matron

The 'Friends and Family Test' was introduced by the Prime Minister on 25 May 2012. Under this test, all NHS patients are asked whether they would recommend a particular A&E department or ward to their friends and family. The results of this test are used to improve the experience of patients, and to highlight priority areas for action.

The question asked is:

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

The patients then choose their answer from the following.

– Extremely likely
– Likely
– Neither likely nor unlikely
– Unlikely
– Extremely unlikely
– Don't know

We then ask:

'What was good about your care and what could be improved?'

Patients answer this question freely. Comments are reviewed by the matrons and ward and, where appropriate, action is taken.

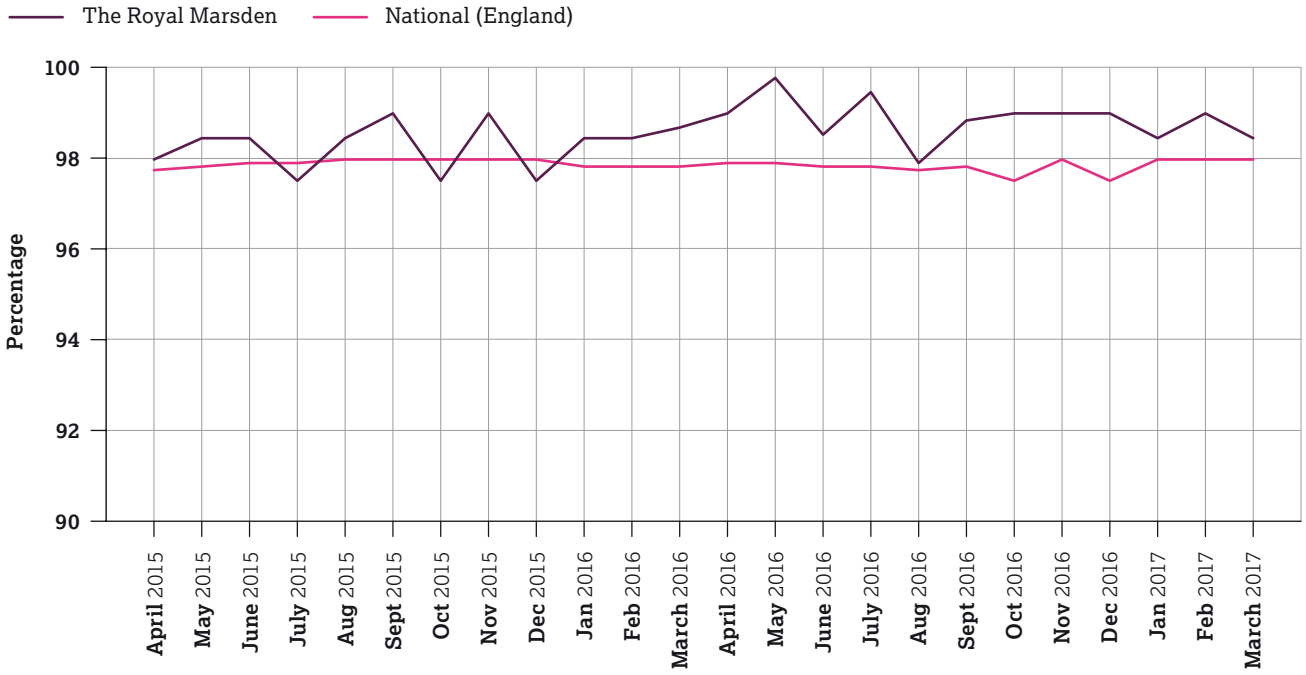
What we did in 2016/17

– Posters about the Friends and Family Test are displayed around the Trust buildings, and there are collection boxes for responses outside all wards and in outpatient and day-care areas.
– We ask all patients to fill in the Friends and Family Test form and put it into a collection box. Once a week the forms are collected, and an external company processes the feedback and returns this to us.
– We have introduced extra questions to allow patients to rate our services in terms of dignity, involvement, information, cleanliness and staff.
– We set up a new Patient Experience Steering Group, chaired by the Deputy Chief Nurse, to review the Friends and Family Test responses alongside results from national surveys on patient experience.

How we performed in 2016/17

– We achieved our target with an average across the year of 98% of inpatients saying that they would recommend us. This is higher than the national average of 96%.

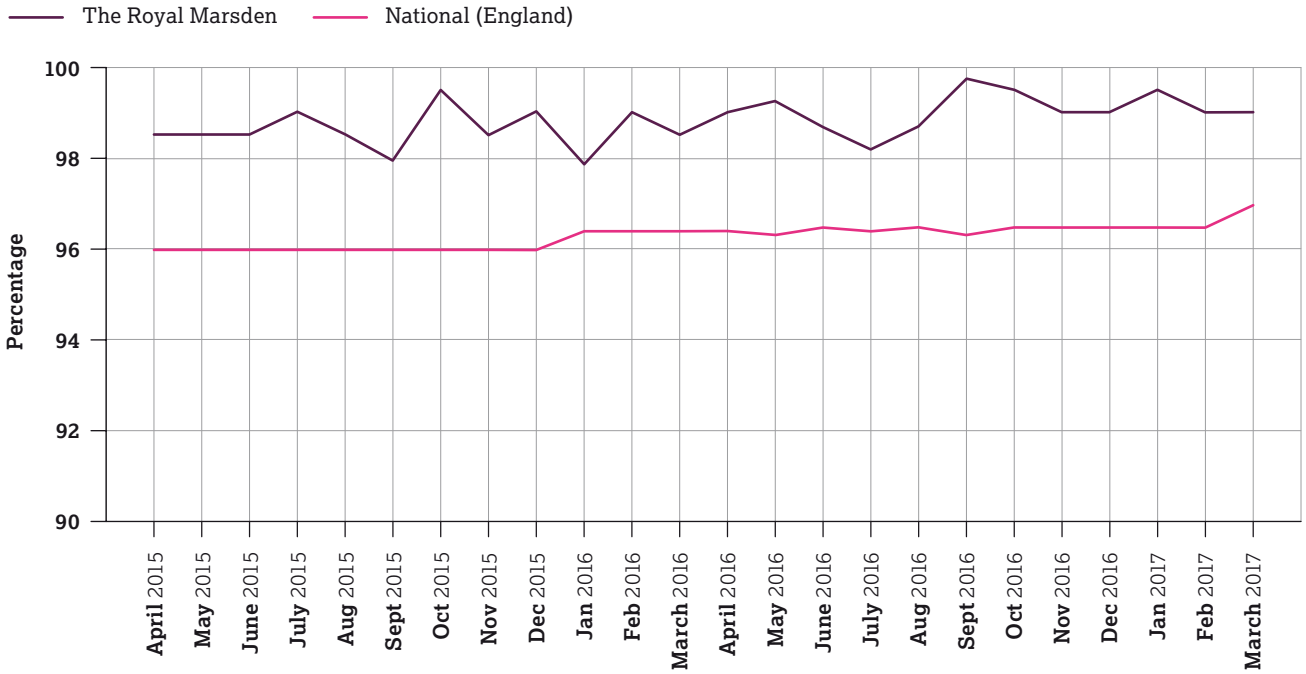
Graph 2: Percentage of inpatients who would recommend us



NHS England displays the information that has been collected each month for 170 providers of NHS-funded services for inpatients and independent-sector providers for inpatients, outpatients, community services, dental, ambulance, accident and emergency (A&E), maternity, mental-health and GP services. There is information about the Friends and Family Test on the website at www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

– We have achieved our target with an average across the year of 98% of outpatients saying that they would recommend us. This is higher than the national average of 93%.

Graph 3: Percentage of outpatients who would recommend us



Actions to improve our performance

- Continuing to use the Friends and Family Test question to get feedback from patients on how we can improve our services.
- Continuing to work with staff who are in contact with patients to increase the response rate for the Friends and Family Test.
- Continuing to communicate results to trust staff, patients, relatives and carers at meetings, and publicly displaying results on wards' notice boards and our website.
- Analysing the comments received to identify key areas for improvement.
- Developing local and trustwide improvement plans for identified areas of concern.

How improvements will be measured and monitored

Results will continue to be passed to the ward sisters and matrons each month, and we will take action following any comments for improvements. The results will continue to be included in our monthly quality account to the board. The results are also included in the terms of reference of the new Patient Experience Strategy group, chaired by the Chief Nurse.

Priority 7b

To continue using the 'Friends and Family Test' question for patients receiving community care. (The Friends and Family Test question asks people who use NHS services whether they would recommend the services to others.)

Target

For the Friends and Family Test results to be above 90% and to increase patient satisfaction.

'The information we receive from patient feedback can help us tailor our services to the needs of our patients and can offer useful suggestions. It can be difficult for a service to demonstrate the need for services through quantitative data alone. Patient feedback can help us to justify current services and explain the need for changes or new services in the patient's words, which is so valuable."

Anna Lovegrove
Occupational Therapy Lead, Community Neuro Therapy Team
Sutton Community Healthcare Services

What we did in 2016/17

- We continued to routinely ask patients receiving community services the Friends and Family Test question as part of our patient experience surveys.
- Since 1 April 2016, community services have used the same service provider as The Royal Marsden to gather feedback. This has streamlined the process of gathering, reviewing and acting on feedback.
- We have gathered feedback through paper surveys (written and picture, and easy-read forms), online surveys, and an app on mobile devices.
- Patient Champions in each service have shared monthly feedback with their teams, and encouraged staff to ask patients for feedback throughout the year.
- Patients' comments have been discussed at team meetings, and incorporated into service changes where possible.

How we performed in 2016/17

Friends and Family Test

We met the overall target set for 2016/17. In response to the question 'How likely are you to recommend this service to friends and family if they needed similar care or treatment?'. 98% of patients would recommend our services to friends and family.

During quarter 1 (1 April 2016 to 30 June 2016), 322 patients responded to our survey.
98% of patients would recommend our services to friends and family.

During quarter 2 (1 July 2016 to 30 September 2016), 322 patients responded to our survey.
99% of patients would recommend our services to friends and family.

During quarter 3 (1 October 2016 to 31 December 2016), 843 patients responded to our survey.
97% of patients would recommend our services to friends and family.

During quarter 4 (1 January 2017 to 31 March 2017), 778 patients responded to our survey.
97% of patients would recommend our services to friends and family.

During the year, April 2016 to March 2017, we received feedback from 2184 patients in total,
98% of whom would recommend our services to friends and family.

Some examples of patient feedback comments are as follows.

Night nursing
"Both my wife and I have received excellent care from your staff. They are always bright and cheerful. They are all prepared to listen to our minor conditions bearing in mind that we are both in our 90s."

Family nurse partnership
"All my questions were answered and a solution found to everything. Treated lovely as always."

Health visiting
"Nurse was friendly, informative and communicated effectively. Seen in a timely manner. Encouraged to talk about concerns and ask questions."

Children's dietetics
"The programme was designed around my son's needs and his special needs status was thoroughly understood and adapted to."

School nursing

"Understanding and compassionate."

Adult speech and language therapy

"I felt so comfortable speaking to my therapist about myself and how I feel without feeling like I was judged. It also has given me something to look forward to and she frequently makes me laugh. When our sessions are over I am left with a smile on my face and very motivated. She is the best!"

Actions to improve our performance

- Routinely asking patients to give feedback through printed surveys.
- Using apps and website links to invite patients to provide feedback.
- Including feedback from patients in the weekly newsletter that is produced by the Divisional Director.
- Service managers and patient champions in each team monitoring patient feedback each month and providing a report to their clinical area at team meetings.
- Making sure that survey forms which mention specific members of staff are given to those staff to be included in their development records.
- Teams discussing feedback which highlights possible improvements, and taking appropriate action.
- In quarter 4, the things you said, and the things we did, these included the following.

Musculoskeletal and outpatient physiotherapy

You said:

"Appointments could be timed rather than a wait and be seen system. Long waiting time a) for the appointment in the first place and b) at the clinic after arrival, crammed waiting room. More prompt follow up appointment scheduling system will be beneficial. That is, a system that does not involve patients ringing the hospital on a later date to check if the appointment calendar is open for follow up appointments. I understand the rationale behind an assessment clinic but it felt very rushed."

We did:

The Musculoskeletal Service have changed their model of providing services to give direct access for patients as soon as they need the service. During quarter 4, this system was modified in response to feedback from patients. Appointments in "Assess and Treat" clinics are now given in hourly time slots, and patients are seen on a first come, first served basis within those slots. This has reduced the waiting time for the appointments and the number of patients in the clinic at any one time. Further work is being carried to streamline the process for getting follow-up appointments, with the hope that these are booked before the patient leaves the clinic after a visit.

Community nursing

You said:

"Actual treatment excellent and very professional but sometimes do not arrive as scheduled."

We did:

Community nurses aim to arrive within a given time period (either a morning appointment or an afternoon appointment), but this is not always possible. However, when staff are delayed, we will always try to phone the patient to let them know. The team administrator also spends time contacting patients if their visits need to be rescheduled to a different day.

Heart-failure service

You said:

"As a layman, it sounds very good but involving and a lot to absorb all at once but will have a go at it. I'm sure all of this has been discussed before, but for an elderly person – age and condition have a lot to accept something similar visited of all this literise. I hope don't mind me bringing this subject out. Thank you for your visit for and advice."

We did:

Clinicians will review what information a patient should have to meet their individual needs.

Podiatry

You said:

"Care was personal and tailored. Appointment times fall behind though."

We did:

Delays are sometimes unavoidable due to some appointments taking longer than expected. If appointments are delayed, we apologise to those waiting.

Falls-prevention service

You said:

"Move to afternoon and could be longer."

We did:

We are holding extra falls classes, in the afternoon and the morning. With these extra classes, there will be more time available.

Health visiting

You said:

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

We did:

There is usually a quiet room available at each drop-in session if parents want to be seen privately. The team are reviewing how this is publicised to service users.

How improvements will be measured and monitored

- Team-specific reports will allow services to monitor and tackle issues throughout the year. Survey results will be reported back to the Clinical Commissioning Group (via the Clinical Quality Review Group) every three months.
- Feedback is also provided to all services through divisional and service-led team meetings.
- Service managers are to report on 'You said, We did' actions at monthly internal performance meetings.

Priority 8

To increase the percentage of staff who would recommend The Royal Marsden to friends or family needing care.

Target

For more than 95% of surveyed staff to say that they would recommend The Royal Marsden.

The quotes below are samples from the anonymous comments staff provided in quarter 1 (1 April 2016 to 30 June 2016) on why they would recommend The Royal Marsden to friends or family needing care.

"A junior doctor recently summed up care/staff in the Breast Unit as 'brilliant brains and kind hearts' – I think this stands across the hospital and I would not hesitate to recommend RMH should friends or family need treatment."

The quotes below are samples from the anonymous comments staff provided in quarter 1 (1 April 2016 to 30 June 2016) on why they would recommend The Royal Marsden to friends or family as a place to work.

"Over the past year I have been made to feel welcome and part of the team and organisation. From lead management to the front reception. The culture is one of friendliness and openness."

Three times a year, we ask staff to respond to the Friends and Family Test question: 'How likely are you to recommend this organisation to friends and family if they needed care and treatment'. In all three surveys, over 95% of staff said that they would recommend us, meaning that this target has been met.

Each year we carry out the National Staff Survey, asking staff how strongly they agree with the statement: 'If a friend or relative needed treatment, I would be happy with the standard of care provided by this trust.' In 2016/17, 91% of staff either agreed or strongly agreed with the statement. This is an improvement from 2015/16, which saw 90% of staff either agree or strongly agree with this statement.

What we did in 2016/17

– We ran the staff Friends and Family Test to get feedback on how likely staff would be to recommend us for care or treatment.

– We continued to share the responses to this and the findings of patient surveys with staff.

How we performed in 2016/17

Friends and Family Test

The results of the Friends and Family Test are shown in table 8.

Table 8: Staff response to the question 'How likely are you to recommend this organisation to friends and family if they needed care and treatment'

	4th quarter of 2015/16	**1st quarter of 2016/17**	**2nd quarter of 2016/17**	**3rd quarter of 2016/17**	**4th quarter of 2016/17**
Would recommend	96%	**95.5%**	**100%**	**Does not apply**	**95.4%**
Would not recommend	1.8%	**0.9%**	**0%**	**Does not apply**	**0.7%**

The number of staff responding to the Friends and Family Test during 2016/17 remains higher than in 2015/16. There were 555 responses in quarter 4 of 2016/17, compared with 163 responses in quarter 4 of 2015/16. The survey for quarter 2 focused on identifying ways to develop our leaders, and so was only circulated to the Leadership Team. The staff response rate was good. This survey is not carried out in quarter 3 as it coincides with the national NHS staff survey.

Workforce Race Equality Standard

The Workforce Race Equality Standard requires all NHS organisations to demonstrate how they are dealing with race-equality issues in staffing areas such as recruiting, and promoting staff. There has been a marked reduction in the percentage of staff experiencing bullying, harassment or abuse from other staff members. There has also been an increase in the number of staff from black and ethnic-minority backgrounds (BME staff) who believe that there are equal opportunities. Table 9 provides a breakdown.

Table 9: Staff survey results

Key finding		**Royal Marsden result 2016**	Royal Marsden result 2015	Royal Marsden result 2014	Average for acute specialist trusts
Percentage experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White	**17%**	17%	19%	21%
	BME	**17%**	15%	21%	18%
Percentage experiencing harassment, bullying or abuse from staff in the last 12 months	White	**22%**	21%	23%	24%
	BME	**28%**	24%	27%	28%
Percentage believing we provide equal opportunities for career progression or promotion	White	**91%**	90%	90%	89%
	BME	**78%**	76%	72%	75%
Percentage who have personally experienced discrimination at work from a manager, team leader or other colleagues in the last 12 months	White	**5%**	5%	6%	5%
	BME	**11%**	12%	14%	11%

Over the last 12 months, we have taken a number of steps to support our Equality and Diversity Strategy, including developing a Black and Minority Ethnic Network to share the experiences and views of BME staff and consider appropriate action to take. We have also launched a mediation service to reduce the number of grievances that reach a formal level.

Actions to improve our performance

- Promoting staff surveys to encourage more responses from staff.
- Reviewing the comments given in response to the Friends and Family Test question to identify areas where further improvements could be made.
- Increasing individual accountability for taking action on the findings from local and national survey results.
- Raising awareness of the Workforce Race Equality Standard and actions being taken to deal with issues that arise.

How improvements will be measured and monitored

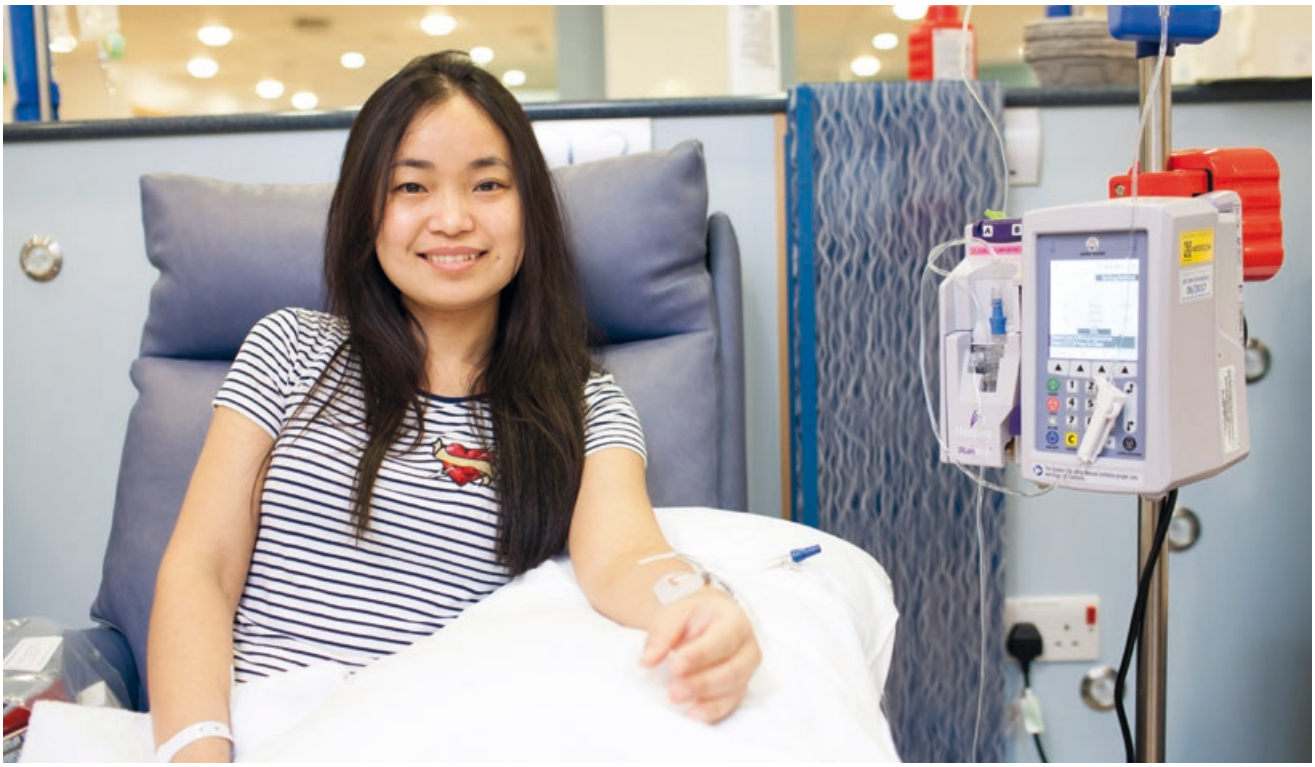
- Results from the Friends and Family Test and the Annual Staff Survey will be analysed and reviewed by the Workforce and Education Committee and a set of targeted actions will be agreed to support continuous improvement and increase the number of staff responding.
- All action plans will be regularly reviewed by the Workforce and Education Committee to chart progress.

Priority 9a

To reduce waiting times at chemotherapy appointments and improve patients' experiences relating to waiting times.

Target

For 80% of patients to be satisfied with the length of time they had to wait to start their treatment.



'We are continuously trying to improve the patient experience and are pleased with the progress made. We are looking to reduce this again in the next financial year through further detailed analysis and large scale improvement projects such as implementation of pre-made doses of chemotherapy."

Jatinder Harchowal
Chief Pharmacist

To understand and improve chemotherapy waiting times, it is important to analyse the reasons behind delayed treatment times.

By reducing the waiting times for patients, we aim to improve patient satisfaction with the process.

What we did in 2016/17

- We set up a multidisciplinary group to lead on improving waiting times at chemotherapy appointments.
- A focus group was held to discuss the factors leading to delays in chemotherapy treatment.
- An audit of 132 patients on the Medical Day Unit in Sutton evaluated the times taken to receive chemotherapy, and the reasons for any delays to treatment. A further audit of 87 patients took place at the Medical Day Unit in Chelsea.
- Patient-satisfaction levels were recorded through Friends and Family Test questionnaires given out by the outpatient pharmacy, Boots UK.

How we performed in 2016/17

The focus group found that the following contributed to delays:

- Drugs and IVs arriving late due to delays in that team, or due to late orders.
- Cannulations (where a needle is placed into a vein) taking longer than 30 minutes. There were both one-off and repeated difficulties where limited feedback was given to allow extra time for these patients in the future.
- Bloods not being done within 24 hours of treatment.
- Consent being missing.
- Delays in samples being received by the lab (possibly due to bundling of samples, or delays in samples being transported around the hospital).
- Chairs not always being available (possibly due to appointments overrunning).
- Patients arriving late (for example, due to delays in parking).
- Overrunning or limited seating.
- No waiting space for early arrivals.
- Staff shortages.
- Patients being overbooked due to treatment times running over.
- Patients not wanting appointments late in the day.
- The need to finish new treatments by 5pm.
- The length of appointment given to the patient being unrealistic or incorrect.
- Information being wrong or incorrectly entered.
- Over-testing of bloods – not all markers needing to be tested for certain treatments.

The audits carried out in the Medical Day Units at both sites compared delayed waiting times against the above reasons for delay. For Sutton, a total of 132 patients were recorded as being late in the audit period, and 147 other factors were identified in 21 cases.

For Chelsea, 86 patients were recorded as being late in the audit period, and 107 factors were identified in 11 cases.

The results showed various causes for delay, with the most common reasons being delays associated with cannulation (the Sutton site) and a shortage of staff (the Chelsea site).

Sutton

The top six reasons for delays, accounting for approximately 70% of all appointments, were as follows.

Table 10: Sutton site: top six reasons of chemotherapy starting late

Issue	Frequency
Difficulty in cannulation	17%
Availability of nursing staff	16%
Chemotherapy drugs not available	12%
Patient arriving late	10%
Repeat bloods needed	10%
Further medical review needed	6%

Chelsea

The top four reasons for delays, accounting for approximately 82% of all appointments, were as follows.

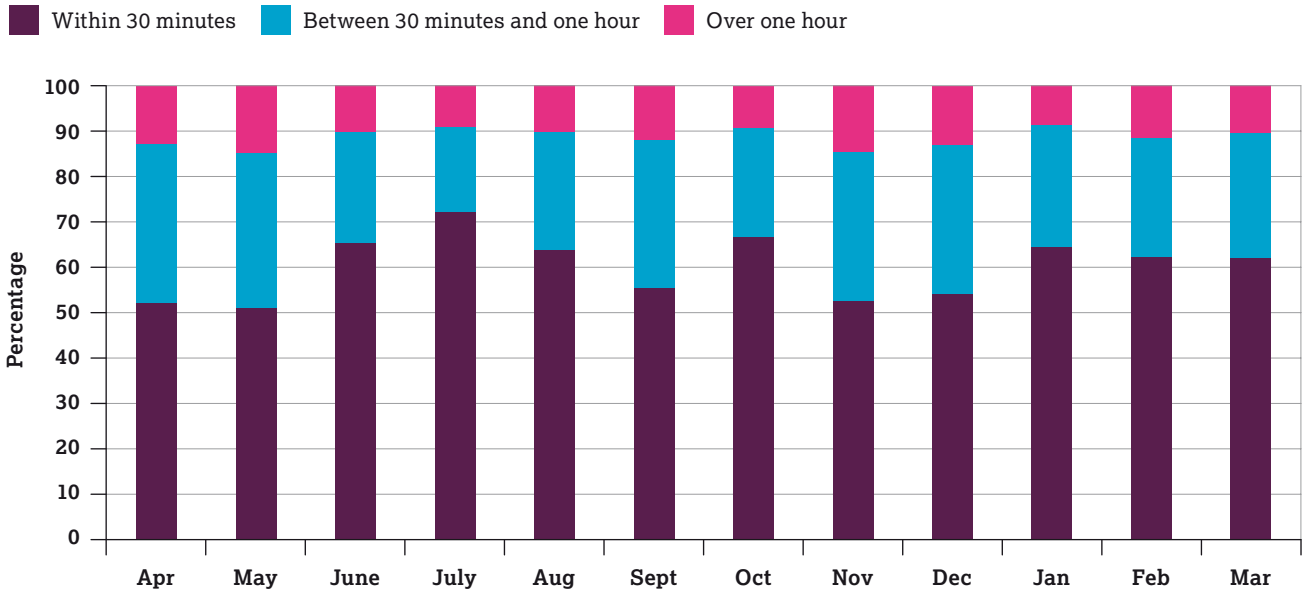
Table 11: Chelsea site: top four reasons of chemotherapy starting late

Issue	Frequency
Availability of nursing staff	33%
Chemotherapy drugs not available	26%
Appointments overrunning	12%
Patient arriving late	11%

The variation between sites is possibly due to different processes, staffing and environments within the two hospitals.

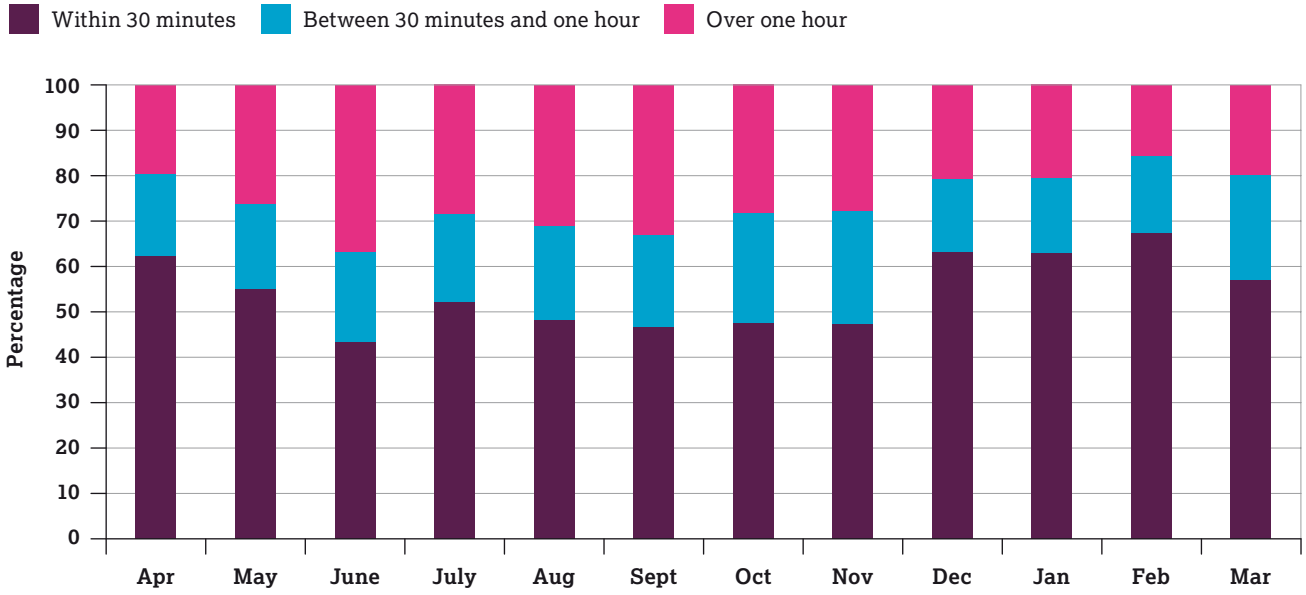
The results for Sutton (graph 4) show that over the one-year period from 1 April 2016 to 31 March 2017), on average, over 80% of patients wait less than an hour between the appointment time and the time that treatment starts.

Graph 4: Sutton chemotherapy waiting times



Graph 5 shows the waiting times for the Chelsea site over the one-year period (from 1 April 2016 to 31 March 2017). These results show that for most months, 70% of patients wait less than an hour between the appointment time and the time that treatment starts. In the last quarter this has improved to an average of 80% of patients waiting less than an hour.

Graph 5: Chelsea chemotherapy waiting times



The differences in the results for Sutton and the results for Chelsea may be due to the different specialities between sites.

The results of our audits provide a baseline (starting point) that allows us to target actions to improve overall waiting times. However, the audits did not evaluate the patient experience of waiting times.

The next step of this project is to gather this information.

Actions to improve our performance

- Producing a targeted action plan to reduce delays caused by each reason identified.
- Sharing learning of good practice which may contribute to reducing the length and number of
- delays.
- Continuing to monitor chemotherapy waiting times at each site.
- Producing a 'chemotherapy journey' educational video for patients, which will highlight scheduling issues contributed to by patients missing or arriving late for appointments.
- Further evaluating the results of the audit data to spot any trends that could account for cannulation issues and delays.
- Carrying out an audit to look specifically at the patient experience of waiting-time delays, and gathering feedback on how the patient experience could be improved.

How improvements will be measured and monitored

- There will be regular audits of patient experience of chemotherapy waiting times.
- Actions to improve waiting times will be evaluated by measuring the full waiting time and identifying delays and the reasons for them.

Priority 9b

To reduce waiting times in outpatient clinics and improve patients' experiences relating to waiting times.

Target

For no more than 8% of patients to have to wait more than one hour.

"The Outpatients Department is often the first impression people have of The Royal Marsden so we always strive to make it a warm, welcoming and efficient place for our patients to visit."

Senior Staff Nurse
Outpatients Department

Within our outpatient departments we aim to have excellent communication with our patients to make sure that they have a positive experience, particularly at their first appointment.

What we did in 2016/17

- We carried out a full review of the skills of all nursing and administrative staff at both sites to make sure there is appropriately skilled staff in each clinic. As part of this review we met each clinical unit to discuss their specific needs relating to skills and admin support.
- As part of our planning for a new outpatient building, we held 'process-mapping' sessions at the Sutton site to outline each step patients take in their treatment to highlight areas of potential congestion, and find solutions for these.
- We started work to create two new clinic rooms in Sutton by relocating offices and the ECG room.
- We took steps to increase the number of phlebotomy chairs in Sutton.
- We continued to assess all information relating to the causes of delays through 'exception reporting' by nurses in each clinic. We pass this information to the Cancer Services Business Units (CBUs) for them to make appropriate changes.
- We introduced a new Clinical Assessment Unit (CAU) in Sutton to speed up the transfer of acutely ill patients from outpatients, to reduce blockages in clinics.
- We developed nurse clinics, and clinics for other healthcare professionals, to run alongside medical clinics to reduce waiting times. This includes chemo-toxicity clinics, dressings clinics, and acupuncture clinics.

We created a process for referring unwell patients to the CAU.

How we performed in 2016/17

In response to a request from the Council of Governors, we monitored the number of people in the main Chelsea and Sutton outpatient departments who waited less than 15 minutes. The table below shows an improvement from April, when 63% of people were seen within 15 minutes, to December, when 69% of people were seen within 15 minutes.

Table 12 below shows that we achieved our target of less than 8% of patients waiting more than one hour for treatment.

Table 12: Chelsea and Sutton waiting times 2016/17

	Waiting time			
	Less than 15 minutes	15 to 29 minutes	30 to 60 minutes	More than one hour
April 2016	63%	19%	13.6%	4.7%
May 2016	66%	18%	11.9%	4.2%
June 2016	68%	18%	11.2%	3.1%
July 2016	66%	18%	11.9%	4.1%
August 2016	65%	18%	11.8%	4.6%
September 2016	68%	18%	11.1%	3.0%
October 2016	67%	18%	11.8%	3.6%
November 2016	66%	19%	11.8%	3.3%
December 2016	69%	18%	10.5%	2.2%
January 2017	69%	17%	11%	3%
February 2017	68%	18%	11%	3%
March 2017	68%	17%	11%	4%

Actions to improve our performance

- Observing clinics and waiting areas.
- Discussing the 'patient journey' with each patient during one of their visits, as well as holding focus groups to gather feedback. A patient journey describes what events (such as surgery, chemotherapy, radiotherapy) are likely to happen after a patient is diagnosed with cancer.
- Holding process-mapping sessions at the Sutton site to clarify each step the patient will go through and highlight bottlenecks and potential solutions.
- Continuing to develop an effective clinic model in Rapid Diagnostic Access Clinic (RDAC) at both sites to determine capacity, and follow this model within outpatients.
- Repeating a survey on patients' satisfaction with the new waiting areas in Sutton.
- Reception staff continuing to update the visual display screen and make regular announcements to tell patients about clinics that are running late.
- Creating two more clinic rooms in Sutton by relocating offices and the ECG room.
- Increasing the number of clinic co-ordinators within clinics.
- Increasing the number of phlebotomy chairs in Sutton to reduce blockages in patient flow and allow a quicker turnaround of blood results in clinics.
- Continuing to review the skills of all nursing and administrative staff at both sites to make sure there is appropriately skilled staff in each clinic.
- Meeting with each clinical unit to find out their specific needs in terms of skills and admin support.
- Continuing to audit all information relating to the causes of delays, and passing this information to the cancer services business units so they can make appropriate changes.
- Introducing a new Clinical Assessment Unit in Sutton to speed up the transfer of acutely ill patients away from outpatients, to reduce blockages in clinics.
- Developing clinics led by nurses and other healthcare professionals to run alongside medical clinics to reduce waiting times.
- Increasing the number of telephone clinics, including some that are led by nurses.
- Continuing to review clinic templates following work with NHS Elect to improve efficiencies of time in the clinics.
- Reviewing the check-in and registration process and reviewing all paperwork sent to patients before their appointments to make sure it is clear and to reduce repetition.
- Reviewing and improving the experience for patients when attending the pre-assessment clinics to reduce waiting times.

How improvements will be measured and monitored

- We will audit the number of patients transferred to the Clinical Assessment Unit from outpatients to prevent clinic delays.
- We will monitor progress at monthly meetings to monitor scorecards of patient-safety incidents, staff training and Friends and Family Test responses, and to develop action plans.

Priority 10a

To increase the number of relevant community services patients who have a falls-risk assessment completed.

Targets

1. For the Adult Services team to develop a falls-risk assessment.
2. For at least 65% of patients who are identified as being at risk of falls to have a falls-risk assessment.

"Staff awareness has increased regarding the importance of identifying patients at risk of falling and the strategies that can be put into place to reduce this risk."

Chris Dyson
Clinical Service Manager for Unplanned Care Services
Sutton Community Healthcare Services

What we did in 2016/17

- Members of the falls team worked closely with the community nursing teams to develop a falls-risk assessment that was then incorporated into the service's 'holistic assessment' document. The holistic assessment document makes sure that practitioners identify patient-centred health and social-care needs based on the activities of daily living. This allows for care that is tailored to individual patients, and supports joined-up working to reduce duplication and provide responses in good time.
- We improved the management of urgent falls referrals to make sure a prompt assessment was carried out by an appropriate community-team member.
- We put in place a new patient pathway for urgent falls referrals from London Ambulance service to reduce the number of avoidable hospital attendances.
- Our Community Nursing Service has incorporated a falls-risk assessment into their full assessment of patients.
- Our Community Prevention of Admission team now prioritise all urgent falls referrals and assess patients at most risk, urgently putting in place strategies to reduce the risk of further falls and making onwards referrals to the falls-prevention service if necessary.

How we performed in 2016/17

- We met the first target when the Adult Services team developed a falls-risk assessment.
- We achieved the second target as 75% of patients who were identified as being at risk of falls had a falls-risk assessment. See table 13 for more details.

Table 13: Number of falls-risk assessment completed at first assessment visit

	Number of falls-risk assessments completed at first assessment	Percentage each month	**Percentage over quarter**	Target of 65% achieved or not achieved
April 2016	121	63%	**Quarter 1 (1 April to 30 June) 71.5%**	Achieved
May 2016	161	78.9%		
June 2016	151	71.9%		
July 2016	301	87.7%	**Quarter 2 (1 July to 30 September) 87.6%**	Achieved
August 2016	275	85.7%		
September 2016	290	89.2%		
October 2016	224	77.2%	**Quarter 3 (1 October to 31 December) 83.3%**	Achieved
November 2016	264	84.6%		
December 2016	268	87.6%		
January 2017	229	72.7%	**Quarter 4 (1 January to 31 March) 74.7%**	Achieved
February 2017	239	73.8%		
March 2017	231	78%		

Actions to improve our performance

- The Community Services team continuing to carry out falls-risk assessments during the first visit to the patient.
- The Community Services team making sure all strategies for preventing falls are in place.
- Developing closer links with social-care providers and Sutton Age UK.
- Reviewing the current 'falls prevention service' to identify areas where improvements could be made to reduce waiting times for patient reviews.
- Investigating potential training providers for 'Extend Training' to provide falls-prevention classes. ('Extend training' is a credited well-recognised national exercise programme that supports improvement to movement, balance and co-ordination.)
- Keeping this priority for 2017/18.
- Continuing to monitor our performance in assessing patients at risk of experiencing falls, and the number of falls-prevention classes attended.

How improvements will be measured and monitored

- Reporting will continue to be monitored through quality accounts reporting and through community services' monthly performance reporting to the Clinical Commissioning Group.

Priority 10b

To reduce the number of medication incidents causing moderate or low harm to patients under the care of community services to less than four for the year.

Target

For a medicine review (reconciliation) to take place during the first assessment of a patient after being discharged from hospital or after a secondary-care consultation.

"Staff can see clear evidence of improvement in practice and safer care delivery to patients by undertaking medicine reviews during first assessment."

Liz O'Brien
Clinical Integrated Locality Manager, Sutton and Cheam Locality
Sutton Community Healthcare Services

What we did in 2016/17

- The Community Nursing Service included medicine reviews in their holistic assessment of patients.
- We improved our performance in identifying prescribing errors from both primary-care and secondary-care settings.
- We put an 'escalation process' in place for staff to raise concerns if they cannot read the doctor's handwriting on the form that allows them to give medicines to patients. (In community services, the doctors fill in a document called 'authorisation to administer medicines document'. This allows staff to give medicines safely to patients.)
- We improved incident-reporting on both near misses and unsafe information relating to medicines.

How we performed in 2016/17

- From April 2016 to March 2017 we met the target of 90% of medicine reviews (reconciliations) being carried out during the first assessment of a patient after they were discharged from hospital or after a secondary-care consultation. See table 14 for more details.
- From 1 April 2016 to 30 June 2016, 90.9% of patients had a medicines review during the first assessment visit by community services.
- From 1 July 2016 to 30 September 2016, 90.6% of patients had a medicines review during the first assessment visit by community services.
- From 1 October 2016 to 31 December 2016, 91.8% of patients had a medicines review during the first assessment visit by community services.
- From 1 January to 31 March 2017, 90.5% of patients had a medicines review during the first assessment visit by community services.

Table 14: Number of patients who had a medicine review at the first assessment visit

	Number of patients who had a medicine review at the first assessment visit	Percentage each month	**Percentage over quarter**	Target of 90% achieved or not achieved
April 2016	171	89.1%	**Quarter 1 (1 April to 30 June) 90.9%**	Achieved
May 2016	189	92.6%		
June 2016	191	90.9%		
July 2016	311	90.6%	**Quarter 2 (1 July to 30 September) 90.6%**	Achieved
August 2016	295	91.9%		
September 2016	290	89.2%		
October 2016	269	91.03%	**Quarter 3 (1 October to 31 December) 91.8%**	Achieved
November 2016	284	87.8%		
December 2016	281	87.6%		
January 2017	290	92.06%	**Quarter 4 (1 January to 31 March) 90.5%**	Achieved
February 2017	282	87.3%		
March 2017	274	92.6%		

Actions to improve our performance

- Community services continuing to review patients on their caseload. The review will include administering or prompting medicines (making sure that patients have taken their medicines at home), to make sure all strategies for preventing medication incidents are in place.
- Working with the clinical lead of the Clinical Commissioning Group (CCG) to find out whether processes need to be redefined to reduce current variations across the system.
- To carry out an audit of our 'transcribing of medicines' documents within patients' care records.
- Continuing with this priority so that the number of medication incidents causing moderate or low harm to patients under the care of community services is reduced to less than four each year.

How improvements will be measured and monitored

- The Executive Medicines Management Committee will continue to monitor any near misses which are reported, as well as all other medication incidents and outcomes, at their monthly meetings.
- Performance will also be monitored as part of the CCG's monthly Clinical Quality Review Group meetings through a monthly scorecard. This scorecard will also be reviewed at each meeting of the Trust board.

Reviewing progress of the quality improvements in 2016/17 and choosing the new priorities for 2017/18

In January 2017, NHS England published the quality accounts: reporting arrangements for 2016/17. We chose to include the mandatory (must do) set of quality indicators for requirements for 2016/17. Some of the indicators are not relevant to us (for example, ambulance response times), so we have not included them.

In February 2017, NHS Improvement issued 'Detailed requirements for quality reports for foundation trusts 2016/17'. They also issued 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17' as from 2011/2012 all acute trusts must have their Quality Accounts checked by external auditors.

However, we also felt it was important to consult with our members and council of governors to incorporate their views about 'quality' into the quality account.

The process for agreeing the quality priorities for 2017/18 was as follows.

October 2016

Held a Patient Experience and Quality Account meeting to review progress in quarter 1 (1 April 2016 to 30 June 2016) against our priorities for 2016/17.

October 2016

Sent out a survey to foundation trust members to choose quality priorities for 2017/18.

November 2016

Held an event for foundation trust members on 29 November 2016 to carry out a survey and vote on quality priorities for 2017/18.

February 2017

Held a Patient Experience and Quality Account meeting to review progress during quarter 3 (1 October 2016 to 31 December 2016) against our priorities for 2016/17.

March 2017

Held a Council of Governors meeting to review results of previous surveys and voting on quality priorities for 2017/18.

Council of Governors chose a quality priority for 2017/18.

Drafted the final version of the quality account s. Draft reviewed by external stakeholders for 30 days. Draft reviewed by the Integrated Governance and Risk Management Committee, the Nursing, Radiography and Rehabilitation Advisory Committee, and the Trust Consultative Committee.

April 2017

Stakeholders returned comments and statements are included in appendix 1.

Held a Patient Experience and Quality Account meeting to review progress during quarter 4 (1 January 2017 to 31 March 2017) against our priorities for 2016/17.

Draft reviewed by the Trust Board committee and quality priorities for 2017/18 agreed.

Plain English Campaign reviewed draft.

May 2017

Approved at the Finance and Audit committee as delegated by the Board. Final annual quality account included as part of the trust's annual report and sent to NHS Improvement.

June 2017

Final annual quality account published with Plain English Campaign's Crystal Mark. Annual quality account published on the NHS Choices website and the trust's website.

Table 16 below summarises our quality priorities for the last four years.

Table 16: Quality priorities 2013 to 2017

2013/14	2014/15	2015/16	2016/17
Reduce the incidence of healthcare-associated infections (mandatory priority)	Reduce the incidence of healthcare-associated infections (mandatory priority)	Reduce the number of cases of healthcare-related infections (mandatory priority)	To reduce the number of cases of healthcare-related infections (MRSA and clostridium difficile infections). Mandatory
Reduce the rate of patient-safety incidents and the percentage resulting in severe harm or death (mandatory priority)	Reduce the rate of patient-safety incidents and the percentage resulting in severe harm or death (mandatory priority)	Reduce the rate of patient-safety incidents and the percentage resulting in severe harm or death (mandatory priority)	To reduce the rate of patient-safety incidents and the percentage resulting in severe harm or death
Maintain the percentage of admitted patients assessed for the risk of venous thrombo-embolism (mandatory priority)	Maintain the percentage of admitted patients assessed for the risk of venous thrombo-embolism (mandatory priority)	Maintain the percentage of admitted patients assessed for the risk of getting a venous thrombo embolism – a blood clot in the vein (mandatory priority)	To maintain the percentage of admitted patients assessed for the risk of venous thromboembolism (getting a blood clot in a vein).
Reduce the incidence of category-3 pressure sores (full-thickness skin loss) and category-4 pressure sores (full-thickness tissue loss) developing in patients while they are receiving community care (applies to Sutton and Merton Community Services)	Reduce the incidence of category-3 pressure sores (full-thickness skin loss) and category-4 pressure sores (full-thickness tissue loss) developing in patients while they are receiving community care (applies to Sutton and Merton Community Services)	Reduce the incidence of category-3 pressure sores (full-thickness skin loss) and category-4 pressure sores (full-thickness tissue loss) developing in patients while they are receiving community care	To reduce the incidence of category-3 pressure sores (full-thickness skin loss) and category-4 pressure sores (full-thickness tissue loss) developing in patients while they are receiving community care.
Increase the number of patients who die where they have chosen to die			
Increase the number of patients who have a holistic needs assessment (an assessment that considers all aspects of a person's needs, such as emotional, social and cultural needs, not just their medical needs)	Increase the number of patients who have a holistic needs assessment (an assessment that considers all aspects of a person's needs, such as emotional, social and cultural needs, not just their medical needs)		
Reduce the number of emergency readmissions to hospital within 28 days of discharge (mandatory priority)	Reduce the number of emergency readmissions to hospital within 28 days of discharge (mandatory priority)	Reduce the number of emergency admissions to hospital within 28 days of patients being discharged (mandatory priority)	To reduce the incidence of emergency readmissions to hospital within 28 days of patients being discharged.

2013/14	2014/15	2015/16	2016/17
Make sure that we are responding to inpatients' personal needs (mandatory priority) Introduce a patient survey for Sutton and Merton Community Services (mandatory priority)	Make sure that we are responding to inpatients' personal needs (mandatory priority) Introduce a patient survey for Sutton and Merton Community Services (mandatory priority)	Make sure that we are responding to inpatients' personal needs (mandatory priority) To continue using the 'Friends and Family Test' question for patients receiving community care (mandatory priority)	a To make sure that we are responding to inpatients' personal needs. b To continue using the 'Friends and Family Test' question for patients receiving community care. (mandatory)
Improve communication, particularly at first appointments	Improve communication, particularly at first appointments		
Reduce waiting times at chemotherapy appointments and improve patients' experiences relating to waiting times	Reduce waiting times at chemotherapy appointments and improve patients' experiences relating to waiting times	Reduce waiting times at chemotherapy appointments and improve patients' experiences relating to waiting times. Reduce waiting times in outpatient clinics and improve patients' experiences relating to waiting times	a To reduce waiting times at chemotherapy appointments and improve patients' experiences relating to waiting times. b To reduce waiting times in outpatient clinics and improve patient experiences relating to waiting times
Increase the percentage of staff who would recommend The Royal Marsden to friends or family needing care (mandatory priority)	Increase the percentage of staff who would recommend The Royal Marsden to friends or family needing care (mandatory priority)	Increase the percentage of staff who would recommend The Royal Marsden to friends or family needing care (mandatory priority)	To increase the percentage of staff who would recommend The Royal Marsden to friends or family needing care. (mandatory priority)
Reduce the length of time a patient waits for medicines or equipment when they are discharged	Reduce the length of time a patient waits for medicines or equipment at the point when they are discharged	Reduce the length of time a patient waits for medicines when they are discharged.	For patients to be given information about the side effects of medicines to take after being discharged.
Increase the uptake of immunisation, working in partnership with primary care	Improve health outcomes for children in reception class, in line with the 'Healthy Child Programme 5-19. (This programme sets out a framework of services for children and young people to promote good health and well-being.)	Make sure that children in Sutton and Merton have high levels of protection against disease within the local communities. Measure the number of girls who receive the HPV (human papilloma virus) immunisation, and the number of school-leavers receiving the booster for diphtheria, polio and tetanus, and report findings across Merton and Sutton boroughs.	To increase the number of relevant community-services patients who have a falls-risk assessment. To reduce the number of medication errors causing moderate of low harm to patients under the care of community services to less than four a year.

Statements of assurance from the Board

Review of services

During 2016/17, we provided or subcontracted comprehensive cancer services and community services.

We have reviewed all the information we have on the quality of care provided by all our relevant health services.

The income generated by the health services reviewed in 2016/17 is equal to the total income generated from providing relevant health services in 2016/17.

The information provided in part three of this quality account covers the three aspects of quality – patient safety, clinical effectiveness and patient experience.

Taking part in clinical audits

At The Royal Marsden we undertake many clinical audits for quality improvement. We take part in all the national cancer audits which apply to us. This allows us to compare ourselves against other hospitals in England and sometimes across the world. We also have a comprehensive programme of local clinical audits which clinical staff including consultants, junior doctors, nurses and allied health professionals carry out regularly to improve local areas of care.

During 2016/17, 20 national clinical audits and four national confidential enquiries covered relevant health services that The Royal Marsden provides.

National clinical audit and confidential enquiries

National confidential enquiries are inspections that are carried out nationally to investigate areas of care where there may have been problems or where the patients may be particularly vulnerable. All hospitals are asked to take part in the enquiries so that all care across England can be monitored.

During 2016/17 The Royal Marsden registered for or took part in 20 (100%) of the national clinical audits and all (100%) of the national confidential enquiries it was eligible to take part in (see table 17). We could not take part in many of the national audits because The Royal Marsden only has patients with cancer.

The national clinical audits and national confidential enquiries that The Royal Marsden took part in, and which information was collected for in 2016/17, are listed below alongside the number of cases included in each audit or enquiry as a percentage of the number of registered cases required under the terms of that audit or enquiry (tables 17 and 18).

Table 17: National clinical audits we took part in during 2016/17

No	National clinical audit	Took part in?	Percentage of cases included in the audit
1	National Oesophago-Gastric cancer audit (OG) Audit	Yes	100%
2	National Bowel Cancer Audit (NBOCAP)	Yes	100%
3	National Lung Cancer Audit (NCLA)	Yes	100%
4	National Emergency Laparotomy Patient (NELA) Audit Year 3	Yes	100%
5	National Prostate Cancer (NPCA)	Yes	100%
6	Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme (CMP)	Yes	100%
7	Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
8	National Head and Neck Cancer Audit (HANA)	Yes	100%
9	NHS Blood and Transplant (NHSBT) National Comparative Audit of Patient Blood Management in adults undergoing elective, scheduled surgery	Yes	100%
10	The British Association of Urological Surgeons (BAUS) Nephrectomy audit 2016	Yes	100%
11	BAUS Radical Prostatectomy audit 2016	Yes	100%
12	BAUS Total Cystectomy audit 2016	Yes	100%
13	BAUS Retroperitoneal Lymph Node Dissection 2016	Yes	100%
14	The British Association of Endocrine & Thyroid Surgeons (BAETS)	Yes	100%
15	National Health Service Cancer Screening Programme (NHSCSP) Audit of Invasive Cervical Cancer	Yes	100%
16	The iBRA2 (implant breast reconstruction evaluation) Study: a national audit of practice and outcomes of implant breast reconstruction	Yes	100%
17	National reaudit of Adjuvant Breast Radiotherapy Technique and Tumour Bed Boost Practice in Early Breast Cancer after Breast-Conserving Surgery 2014	Yes	100%
18	The Association of Breast Surgery (ABS) & NHS Screening Audit	Yes	100%
19	The Breast Cancer Clinical Outcome Measures (BCCOM) Project	Yes	100%
20	National Mastectomy Decisions Audit (MASDA)	Yes	100%

In 2016/17 we reviewed the reports of 14 national clinical audits. Where appropriate, we will take the following actions to improve the quality of healthcare we provide. Please see table 18 for details of actions.

Table 18: National clinical audit reports published and actions taken

No	National clinical audit reports published in 2016/17	Description of actions
1	National Bowel Cancer Audit (NBOCAP) 2016	Report reviewed by surgeons and discussed at Surgical Audit Group meeting.
2	National Oesophago-Gastric cancer audit (OG) Audit 2016	Report passed to audit lead and to surgeons.
3	NCLA annual report 2016	Report reviewed by Lung Department at MDT meeting.
4	Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme (CMP)	Report discussed at the surgical audit group meeting.
5	Sentinel Stroke National Audit Programme (SSNAP)	Report reviewed in community services and presented to the Clinical Audit Committee. Action plan completed.
6	National Comparative Audit of Lower Gastrointestinal bleeding and the Use of blood	Report passed to surgeons and anaesthetists at the Surgical Audit Day. Action plan completed.
7	The second Patient report of the National Emergency Laparotomy Patient Audit	Findings of the report discussed at surgical audit group meeting. Action plan completed.
8	BAUS Analyses of Radical Prostatectomy 2015 Dataset	Surgeons reflected on the findings.
9	BAUS Analyses of Nephrectomy 2015 Dataset	Surgeons reflected on the findings.
10	BAUS Analyses of Total Cystectomy audit 2015 Dataset	Surgeons reflected on the finding.
11	National Prostate Cancer Audit Third Year Annual Report –Results of the NPCA Prospective Audit and Patient Survey 2016	Report passed to Urology audit lead and to consultant clinical oncologist in Radiotherapy.
12	Initial Results from the RCR's UK National audit of Anal Cancer Radiotherapy 2015	Report passed to Multidisciplinary Radiotherapy Departmental Audit Meeting.
13	NHS BSP & ABS (breast screening programme and Association of Breast Surgery) audit of screen detected breast cancers 2014-15	Report presented to the Surgical Audit Group.
14	The Implant Breast Reconstruction evAluation (iBRA) Study: a national multicentre audit of the practice and outcomes of immediate implant-based breast reconstruction	Feedback from national presentations passed to the Surgical Audit Group

Table 19: National confidential enquiries we were eligible to take part in during 2016/17

No	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies	Took part in	Percentage of cases included
1	Mental Health in General Hospitals	Yes	100%
2	Young People's Mental Health Study	No	Not applicable
3	Non Invasive Ventilation	Yes	100%
4	Cancer in Children, Teens and Adults	Yes	Still collecting data for this study

The reports of two national confidential enquiries were reviewed by The Royal Marsden in 2016/17. The Royal Marsden intends to take the following actions to continue to improve the quality of healthcare provided. Please see table 20 for details of actions.

Table 20: National confidential enquiries reports published and actions

No	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies	Description of actions (local)
1	Treat the cause (2016) Acute Pancreatitis Study	The local NCEPOD reporter presented the recommendations of the report to the Clinical Audit Committee and Integrated Governance and Risk Management Committee.
2	Treat as one (2017) Mental Health in General Hospitals	The local NCEPOD reporter presented the recommendations of the report to the Clinical Audit Committee and Integrated Governance and Risk Management Committee.

Between April 2016 and March 2017, the reports of 82 local clinical audits and local action plans were reviewed by The Royal Marsden's Clinical Audit Committee. Some examples of audits completed between April 2016 and March 2017, and the actions taken, are given below.

If you need more information about the local audits, please contact the Quality Assurance department on 020 7808 2702 or email QualityAssurance@rmh.nhs.uk

Table 21: Local audits reviewed and examples of some of the actions we plan to take

Name of local audit	Actions and learning arising from the audit
Acute pain management documentation re-audit	Results to be presented at matrons' and sisters' meetings and at Fulham Road pain collaborative meeting.
	Hold a pain roadshow to raise further awareness of acute pain management.
	All missed observations will be entered on Datix (our web-based incident-reporting system).
	The patient-controlled analgesia (PCA) observations chart will be updated to include space to record respiratory rate.
A retrospective audit to establish the current practice of advance care planning and referral to specialist palliative care services within the lung oncology outpatient setting	An advanced care plan framework will be introduced in the lung oncology department, and will be assessed to see whether this has any effect on referrals to specialist palliative care services and early advanced-care planning discussions.
A prospective clinical audit comparing radiographer and clinician based localisation for metastatic spinal cord compression (MSCC) to assess the feasibility of a radiographer led service	Publish a report in British Institute of Radiology journal.
	Introduce a radiographer-led service for patients with MSCC whose cancer has spread to the spine.
Pharmacy interventions audit (including cytotoxic prescribing)	Prescribers will be contacted and treatment discussed at the point of discharge to reduce the risk of recurrence.
Audit of the knowledge and skills of Sutton's health-visiting teams to support mothers effectively in their chosen method of feeding	All staff will attend yearly mandatory training on infant feeding.
	We will advertise breastfeeding apps (approved and supported by UNICEF) to staff and mothers to raise awareness of the United Nations Children's Fund's standards. Details will be advertised in leaflets and on the Sutton Community Health Services website.
	We will raise awareness of infant feeding through a newsletter for health visitors.
	New health visitors will need to complete an infant-feeding assessment with the Infant Feeding Coordinator.
Audit of antimicrobial point prevalence	In line with the trust antimicrobial stewardship programme, training and enforcement will focus on making sure that all relevant sections of the drug chart are filled in, such as noting if the patient has any allergies.
	Intravenous antimicrobials will be switched where appropriate.
	We will make sure relevant microbiology samples are sent and antimicrobial therapy changed in line with the most appropriate medicine for the infection.
Benchmarking outcomes: major head and neck cancer surgery : Case mix adjustment in outcome audit after surgery for head and neck squamous cell carcinoma (HNSCC)	Findings were presented to the Surgical Audit Group.
	The audit results confirmed that practice is consistent with other regional units in head and neck squamous-cell-carcinoma care after surgery.
How is RMH doing?	No future action is needed.

Name of local audit	Actions and learning arising from the audit
Pharmacy inpatient experience survey	We will raise awareness of the Medicine Information Service.
	The 'Hello My name is…' campaign will be introduced to the pharmacy service to help make sure patients know they are speaking to a member of the pharmacy team.
	Standards for this audit will be used for future audits about inpatient experience.
Falls risk assessment process audit	Further training will be provided to both nursing and pharmacy staff.
	Discussions about an individual patient can take place when the nurse on admission has completed the Patient Handling Assessment, the At Risk of Falls Assessment, and the Prevention Care Plan. Medicine reviews (reconciliations) will be carried out by the pharmacist.
	The Patient Handling Assessment Review Chart will be revised.
	The Falls Prevention and Management Policy will be amended to include the responsibility of attaching red 'falls' stickers to the corner of patients' drug charts.
Audit of The Royal Marsden prescribing adherence to NICE CG140 Opioids in palliative care	Greater emphasis will be given to the 'Strong Opioid' information leaflet at the induction of new doctors.
	Leaflets will be supplied to wards and clinics and given to patients with outpatient prescriptions.
	There will be regular discussions around guidelines at Continuing Medical Education meetings.
	We will carry out spot-checks of prescribing and documentation.
	We will review the Strong Opioid Initial Prescription template.
Oral Opioid Use in the Children and Young Person's Unit	Junior doctors will be educated at induction about prescribing laxatives to patients on opioids.
	We will educate nursing staff at the annual pain-study day on prescribing laxatives to patients on opioids and the importance of giving patients and parents information on taking painkillers during chemotherapy and radiotherapy treatment.
	We will rewrite patient information to make sure it takes account of all the concerns raised by parents.
	The Pain Clinical Nurse Specialist's role will include making sure that information about taking painkillers during chemotherapy and radiotherapy treatment is given to patients and parents.
Deprivation of Liberty Safeguards (DoLS): an audit into current local practice of a 16-bed specialist cancer critical care unit (CCU)	The steps that need to be taken in pre-consent for surgical patients will be simplified.
	We will continue to provide education on DoLS, including further work at induction.
	CCU will change our DoLS policy.
	A field for CCU care will be included in the Anaesthetic Medical Sheet on ICIP.

Name of local audit	Actions and learning arising from the audit
Re-audit to asses chemotherapy prescribing errors at The Royal Marsden hospital post e-chemo implementation	A report will be presented to the DTC, International Organisation for Standardisation (ISO) chemotherapy committee and executive medicines safety group.
	We will carry out another audit when e-chemo has been put into practice.
Sepsis admissions to critical care unit	We will make sure anti-microbial guidelines are strictly followed.
	We will raise awareness of sepsis with CCU staff.
	We have started a programme of sepsis road shows at The Royal Marsden.
	We have joined the 'Sign up to Safety' campaign.
	We will improve lactate measurement.
End of life care on the critical care unit	There has been an improvement in decisions made by the multidisciplinary team.
	Communication between doctors and nurses will be improved.
	We will provide more decisions about ceilings of care before a patient is admitted to the Critical Care Unit.
	We will provide more training and education.
	The Palliative Care team will be involved early on to make the transition between active treatment and withdrawal easier.
	We will provide regular debriefing.
	We will introduce a teaching programme for end-of-life care in the Critical Care Unit.

Taking part in clinical research

The Royal Marsden and The Institute of Cancer Research form the largest centre for cancer research in Europe. This is important because it means that our patients and our staff are always aware of the latest research in treatments, medicines and therapies that make such a big difference to outcomes and patients' experiences of care. If you would like to find out more about our research work, visit our website at www.royalmarsden.nhs.uk.

From April 2016 to March 2017, we recruited 4239 patients as part of 542 different clinical studies in research approved by a research ethics committee.

Revalidation of doctors

This year (April 2016 to March 2017), 21 doctors were due for revalidation (the process of making sure that doctors, except trainees, can stay registered). The Royal Marsden made 16 positive recommendations for revalidation to the General Medical Council (GMC). This is 76% of all doctors due for revalidation in this year. We had to recommend five doctors for deferral to the GMC. (A deferral is when an appraisal is delayed and the trust must ask the GMC to agree to delay.) Three of these were valid deferrals due to consultant exams, sickness and giving up the licence to practice. The two other deferrals were not valid as there was not enough evidence for a revalidation recommendation to be made.

At the end of March 2017, 98% of eligible doctors were recorded as having completed an appraisal in the last 12 months. An annual report on appraisal and revalidation was presented in May 2016, with a clear action plan to increase the number of doctors with a valid appraisal and reduce the number of deferrals to the GMC.

We also have processes in place to support and improve our compliance and governance arrangements. We will complete an internal audit this financial year, and we report our appraisal rates to NHS England each quarter.

Commissioning for Quality and Innovation (CQUIN)

Commissioning for Quality and Innovation is a mechanism for commissioners to reward quality by linking a proportion of our income (2 to 2.5% in 2016/17) to our success in meeting quality-improvement goals.

The provisional total payment (waiting to be confirmed) if we achieve the quality improvement and innovation goals is £1,142,773.

The total payment we received for the Local Quality Incentive Scheme (LQIS) in 2015/16 was £847,000.

CQUIN goals for 2016/17 have been agreed with commissioners in the following subject areas for cancer specialist services and for community services. Further details of the agreed goals for April 2016 to March 2017, and for the following 12-month period, are available on the website at www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/.

Cancer specialist services

1. NHS England Acute CQUIN schemes

- Clinical Utilisation Review (CUR)
- Enhanced supportive care access for advanced cancer patients
- Nationally standardised dose banding for adult intravenous systemic anti-cancer treatment
- Adult critical care
- Development of risk stratified pathways
- The Royal Marsden Macmillan Hotline

2. CCG CQUIN schemes

- NHS Staff Health and Wellbeing
- Enhanced supportive care access for advanced cancer patients
- Development of risk stratified pathways
- The Royal Marsden Macmillan Hotline
- Living with and Beyond cancer

Community Services

- Falls prevention
- Venous leg ulcers
- Wellness and promotion of self-care.
- Reducing inequalities in health screening – the over 75s check.

Acute CQUIN goals 2016/17

Table 22 shows our position against each quarter's milestones.

Table 22: Acute NHS England CQUIN milestones

Acute NHSE CQUIN scheme	Milestone	Q4 2016/17	Q3 2016/17	Q2 2016/17	Q1 2016/17
Clinical Utilisation Review (CUR)	For performance to be in line with trajectory	Achieved	Achieved	Achieved	Achieved
	To complete an evaluation of the pilot against criteria agreed in quarter 3				
Enhanced support care	To develop a plan for roll out	Achieved	Achieved	Achieved	Achieved
	For success to be as expected				
Dose banding	For performance to be as expected	Achieved	Achieved	Achieved	Achieved
Adult critical care	For performance to be as expected	Achieved	Achieved	Achieved	Achieved
Development of risk stratified pathways	For actions to be in line with plan	Achieved	Achieved	Achieved	Achieved
The Marsden Macmillan Hotline	Progress against action plan and success metrics, as set by the commissioners	Achieved	Achieved	Partly achieved	Achieved
	For us to have held a focus group with patients				

Acute CCG CQUIN goals Q4 2016/17

Table 23 shows our position against each quarter's milestones.

Table 23: CCG CQUIN milestones

Acute CCG CQUIN scheme	Milestone	Q4 2016/17	Q3 2016/17	Q2 2016/17	Q1 2016/17
NHS Staff Health and Wellbeing	For health and wellbeing initiatives to have been introduced (Providers should have put their initiatives into practice and actively promoted these services to staff.)	Achieved	Achieved	Achieved	Achieved
	For us to provide healthy food for NHS staff and visitors				
	To improve the number of flu vaccinations given to frontline clinical staff				
Enhanced support care	To develop a plan for roll out	Achieved	Achieved	Achieved	Achieved
	For our success to be as expected				
Development of risk stratified pathways	For our actions to be in line with plan	Achieved	Achieved	Achieved	Achieved
The Royal Marsden Macmillan Hotline	For us to have made progress against our action plan and success metrics	Achieved	Achieved	Achieved	Achieved
	For us to have held a focus group with patients				
Living With and Beyond Cancer	For us to develop an action plan for 2017/18	Achieved	Achieved	Achieved	Achieved

Community Services CCG CQUIN goals Q4 2016/17

Table 24 shows our position against each quarter's milestones.

Table 24: Community CCG CQUIN milestones

Community CQUIN scheme	Milestone	Q4 2016/17	Q3 2016/17	Q2 2016/17	Q1 2016/17
Falls Prevention	For the progress we have made towards our action plan to be as expected	Achieved	Achieved	Achieved	Achieved
Venous Leg Ulcers	For our performance to be as expected	Achieved	Achieved	Achieved	Achieved
	For us to have made progress against our action plan				
	For us to use a patient journey/story at the commissioner's meetings				
Wellness and Promotion of Self-care	For us to have made progress against our action plan and that progress to have been measured against success metrics	Achieved	Achieved	Achieved	Achieved
	For us to have held focus groups with patients				
Reducing inequalities in health screening	For us to have evaluated the pilot, including assessing patient experience	Achieved	Achieved	Achieved	Achieved

Commissioner confirmation of achievement

Acute NHS England (NHSE)

NHSE have confirmed that we will receive full payment for quarter 1. For quarter 2, NHSE commissioners have confirmed that we will receive full payment, except for The Royal Marsden Macmillan Hotline where NHSE withheld 50% of the payment due to a delay in us launching the hotline.

However, NHSE have agreed to reconsider at the end of quarter 4, when we will receive full payment if we have caught up with our milestones.

Acute CCG

Sutton CCG has confirmed 100% achievement for the Acute CCG schemes for quarter 1, 2 and 3 and we are waiting for confirmation of quarter 4.

Community services

Sutton CCG has confirmed 100% achievement for the year.

What others say about The Royal Marsden

Registration with the Care Quality Commission (CQC)

The Royal Marsden NHS Foundation Trust (the Trust) must be registered with the Care Quality Commission. Their current registration status is 'registered with no conditions'.

To date, the Care Quality Commission has not taken enforcement action against the Trust during 2016/17.

To date, The Royal Marsden has not been involved in any of the CQC's special reviews or investigations during 2016/17.

Care Quality Commission ratings

During the year 2016/17, we had a routine inspection by the CQC. The final report was published in January 2017. For cancer and community services overall, the CQC rated us as 'Good'.

The Royal Marsden's services have been rated 'Outstanding' for the Chelsea site, and for radiotherapy, critical care, and chemotherapy at the Sutton site.

We have also been rated 'Outstanding' for the quality of our caring environment.

The Royal Marsden has been rated 'Good' for services for children and young people, haematology, the treatment of adult solid tumours, and outpatient care (Chelsea site).

In 2011 The Royal Marsden accepted responsibility for Community Services in Sutton. Sutton Community Healthcare Services was inspected by the CQC and rated 'Good' for services for children and young people, and for end-of life care. Adult Community Services were rated as 'requiring improvement', mainly in documentation and staffing levels.

Table 25: CQC overall Trust ratings January 2017

Overall rating	Good
Are services at this trust safe?	Good
Are services at this trust effective?	Good
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Areas that need to be improved

In April 2017 we attended the Quality Summit (where CQC inspectors meet with us and commissioners to agree the actions that need to be taken). As a result of that meeting we will develop an action plan and send it to the CQC. The areas that need to be improved are set out in the following three tables.

Table 26: The Royal Marsden – Sutton site

Area that needs improving	Regulation that applies and why it was not being met (quoted from the CQC report)
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014: Safe care and treatment. 12 (1) (2) (a) (b) 12 (1) (2) (a) (b) The world health organisation (WHO) five steps to safer surgery checklist was not being used in the outpatients department even though a range of procedures were being carried out for which it should have been used. The five steps to safer surgery checklist was not used in the outpatients departments. The hospital must take action to: – Ensure the safer surgery checklist is consistently implemented for all surgical procedures in the outpatients department including the five steps of team brief, sign in, time out, sign out, and debriefing. Reg 12 (1) (2) (a) (b) – Ensure adequate audit and monitoring systems are in place to monitor performance and compliance of the safer surgery checklist to guide improvement. Reg 12 (1) (2) (a) (b)

Table 27: The Royal Marsden – Sutton Community Healthcare Services

Area that needs improving	Regulation that applies and why it was not being met (quoted from the CQC report)
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for Consent The provider had failed to ensure care and treatment was provided with the consent of the relevant person. Staff were not clear about who could consent on the patient's behalf and how this information should be recorded in patient's records. Deprivation of Liberty Safeguards were not always understood and mental capacity was not consistently appropriately assessed and recorded for patients who may lack capacity.

Table 28: The Royal Marsden – Sutton Community Healthcare Services

Area that needs improving	Regulation that applies and why it was not being met (quoted from the CQC report)
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 17 HSAC (RA) Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of services provided in the carrying on of regulated activity (including the quality of the experience of service users in receiving those services). The provider had failed to ensure that their audit and governance systems were effective in relation to community services for adults.

Quality of information

Good-quality information is very important for effectively providing the best patient care.

During 2016/17 the Trust sent the Secondary Uses Service records to be included in the Hospital Episode Statistics (a database containing details of all admissions, outpatient appointments and Accident & Emergency care at NHS hospitals in England). The percentage of the Trust's records published in the statistics, and which included the patient's valid NHS number, was 99.94% for admissions, 99.96% for outpatient appointments, and none for A&E care (The Royal Marsden does not have an A&E). The percentage of records that included the valid General Medical Practice Code for the patient's GP practice was 99.6% for admissions and 99.7% for outpatient appointments. See table 29 for more information.

Table 29: Percentage of complete records provided

Details included		Admissions – inpatient and day case	Outpatient appointments
Patient's NHS number	2013/14	99.9%	99.8%
	2014/15	99.9%	99.9%
	2015/16	99.9%	99.9%
	2016/17 – first quarter	99.96%	99.94%
	2016/17 – second quarter	99.94%	99.93%
	2016/17 – third quarter	99.96%	99.94%
	2016/17 – fourth quarter	99.90%	99.89%
	2016/17	**99.94%**	**99.93%**
Patient's GP practice	2013/14	99.8 %	99.8%
	2014/15	99.5%	99.6%
	2015/16	99.8%	99.8%
	2016/17 – first quarter	99.8%	99.7%
	2016/17 – second quarter	99.7%	99.7%
	2016/17 – third quarter	99.6%	99.8%
	2016/17 – fourth quarter	99.6%	99.7%
	2016/17	**99.7%**	**99.7%**

Although the quality of information is very good, the Trust aims for continual improvement. The Trust performs the following actions to improve the quality of information.

- A dedicated data-quality team is responsible for running routine checks and reports to identify mistakes and inconsistencies.
- Monthly communications throughout the Trust promote the importance of accurate information and data collection for all trust staff.
- Trustwide audits of the quality of key information points are conducted once a year.

Information Governance Toolkit attainment levels

The Information Governance Toolkit is a legal framework under which NHS organisations must assess themselves against Department of Health policies and standards. On 31 March 2017, our Information Governance Toolkit assessment provided a final score of 88% for version 14, with all requirements scored at level 2 or above and so rated 'satisfactory (green)'. The Information Governance Toolkit is available on the Health and Social Care Information Centre (HSCIC) website (www.nww.igt.hscic.gov.uk/).

Payment by Results clinical coding error rate

In 2016/17, the 'Payment by Results (PbR) data assurance framework' provides assurance over the quality of the information that payments in the NHS are based on. Clinical coding is translating the medical terminology written by clinicians into a coded format for statistical, clinical and financial purposes. Clinical coding describes a patient's complaint, diagnosis, treatment and reason for getting medical attention. The accuracy of clinical coding was audited at 50 acute trusts. 40 of those trusts were chosen because of the high number of cases where there was a change in payments in previous audits. We were not chosen to take part in this national audit, so in table 30 we have included information from our own audit.

Table 30: Clinical coding

Coding accuracy	2013/14 (figures taken from the Information Governance Clinical Coding Audit in December 2013)	2014/15 (figures taken from the Information Governance Clinical Coding Audit in January 2015)	2015/16 (figures taken from the Information Governance Clinical Coding Audit in January 2016)	**2016/17 (figures taken from the Information Governance Clinical Coding Audit signed off in February 2017)**
Primary diagnosis correct	94.0%	94.0%	95.0%	**90.5%**
Primary procedure-code correct	94.9%	93.0%	95.5%	**95.5%**
Secondary diagnosis correct	97.5%	92.3%	96.4%	**93.25%**
Secondary procedure-code correct	95.8%	90.3%	90.4%	**92.25%**

Reporting against core indicators

Please see appendix 3 for the quality indicators where national information is available from the Health and Social Care Information Centre.

Part 3

Other information

Please see part 2 of this report for an overview of the quality of care offered by the trust.

Review of quality performance (previous year's performance)

Table 31: National targets

Cancer waiting times targets	National target – 2016/17	Performance – quarter 1 2016/17	Performance – quarter 2 2016/17	Performance – quarter 3 2016/17	Performance – quarter 4 2016/17	**Overall performance 2016/17**
All urgent GP referrals seen within 14 days	93%	93.88%	97.38%	98.67%	97.73%	**96.85%**
All referrals for breast symptoms seen within 14 days	93%	93.14%	95.99%	96.70%	95.91%	**95.35%**
Treatment within 31 days of decision to go ahead for first treatment	96%	99.27%	98.09%	98.34%	97.39%	**98.29%**
Subsequent surgical treatment started within 31 days of decision to go ahead with surgery	94%	95.30%	94.42%	94.06%	95.15%	**94.79%**
Subsequent drug treatment started within 31 days of decision to go ahead with drug treatment	98%	99.83%	99.65%	99.44%	98.80%	**99.43%**
Subsequent radiotherapy treatment started within 31 days of decision to go ahead with radiotherapy treatment	94%	98.34%	97.21%	98.08%	96.68%	**97.55%**
Treatment started within 62 days of urgent GP referrals (Reallocated position shown in brackets)	85%	77.25% (86.88%)	75.01% (82.20%)	77.75% (87.02%)	77.94% (85.31%)	**76.83% (85.23%)**
Treatment started within 62 days of recall date for urgent screening-centre referrals (Reallocated position shown in brackets)	90%	84.38% (93.33%)	91.53% (90.00%)	93.33% (92.59%)	90.82% (89.57%)	**90.00% (91.20%)**

Note: The reallocated position adjusts the trust's figure for late referrals of patients to the trust.

Time from referral to start of treatment – patients should start treatment within 18 weeks of referral.

Complex rules and guidance apply to how performance against these targets is measured and reported. As a specialist provider, receiving referrals from other trusts, a key issue is reporting progression for patients who were first referred to other providers.

The 'incomplete pathways' measure in the table below represents the proportion of patients at the end of the reporting period who are still waiting for treatment and have waited for less than 18 weeks since their initial referral.

Table 32: referral time to treatment

	Overall 2014/15	Overall 2015/16	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17	**Overall 2016/17**	National target 2016/17
Referral time to treatment (RTT), incomplete pathways	95.8%	95.2%	96.15%	95.54%	96.70%	96.83%	**96.34%**	92%

This is the only NHS waiting-time standard which is reported while the patient is still waiting. For this reason, it creates unique challenges in making sure the most up-to-date information is reported accurately each month. We rely on receiving information rapidly from external sources to assess whether the patient is on an 18-week pathway (18 weeks of treatment) and to determine the start date of the pathway.

This year, in order to tackle the challenges above, we calculated a revised figure for Referral Time to Treat standard. This was in order to assess the size of the changes that are made to information during the 18-week pathway. The revised figure showed that the materiality was negligible (approximately 0.02%). We offered to provide the revised figure to NHSE but they did not consider this necessary as there was little difference between the figures.

Table 33: Access targets

	Percentage of operations cancelled by the Trust at the last minute	Percentage of cancelled operations not subsequently performed within one month
2012/13	0.5%	0%
2014/15	0.7%	0%
2015/16	0.5%	0.04%
Quarter 1 of 2016/17	0.4%	0%
Quarter 2 of 2016/17	0.4%	0%
Quarter 3 of 2016/17	0.3%	0%
Quarter 4 of 2016/17	0.6%	0%
Overall for 2016/17	**0.4%**	**0%**

Outpatient waiting times

The number of outpatients attending appointments has increased by between 3% and 5% a year over the past five years. See the table below for the numbers for the year from 1 April 2014 to 31 March 2017. Despite more patients attending, the length of time patients wait has been maintained.

Table 34: Outpatient waiting times – number of patients seen and time waited

Period or quarter	Patients seen within 30 minutes	Patients seen after 30 minutes but within one hour	Patients seen after one hour	Grand total
Total 2014/15	129369	20702	992	159993
Total 2015/16	133995	18744	9788	162527
Quarter 1 2016/17	34326	4708	2433	41467
Quarter 2 2016/17	34275	4517	2578	41370
Quarter 3 2016/17	34147	4216	2283	40646
Quarter 4 2016/17	36476	4405	2096	42977
Total 2016/17	**139224**	**17846**	**9390**	**166460**

Table 35: Outpatient waiting times – percentage of patients seen and time waited

Period or quarter	Patients seen within 30 minutes	Patients seen after 30 minutes but within one hour	Patients seen after one hour	Grand total
Total 2014/15	80.9%	12.9%	6.2%	100.0%
Total 2015/16	82.4%	11.5%	6.0%	100.0%
Quarter 1 2016/17	82.8%	11.4%	5.9%	100.0%
Quarter 2 2016/17	82.8%	10.9%	6.2%	100.0%
Quarter 3 2016/17	84.0%	10.4%	5.6%	100.0%
Quarter 4 2016/17	84.9%	10.2%	4.9%	100.0%
Total 2016/17	**83.6%**	**10.7%**	**5.6%**	**100.0%**

Plain English Campaign's Crystal Mark does not apply to this appendix 1

Appendix 1

Statements from key stakeholders

Overview and Scrutiny Committee
(received 9 March 2017)

Thank you for sending the Quality Account to us. The Royal Borough of Kensington and Chelsea has an excellent working relationship with The Royal Marsden. The Quality Account gives a useful overview of the work and performance of trusts. The Royal Marsden is a world-renowned cancer care organisation.

Only a small proportion of The Royal Marsden's patients are from the scrutiny committee's borough. We are, however, very proud that The Royal Marsden is based in the Royal Borough.

Best wishes,

Charles Williams

Cllr. Charles Williams
Chairman, Adult Social Care and Health Scrutiny Committee
The Royal Borough of Kensington and Chelsea

Council of Governors
(received 18 April 2017)

Statement from the Council of Governors on the Quality Account 2016/17

The Council of Governors of The Royal Marsden review the Quality Account presented by the Chief Nurse at each of its quarterly meetings where it discusses priority quality issues. The Patient Experience and Quality Account Group, a Working Group of the Council of Governors, reviews feedback from patients, including the frequent feedback surveys, and has influenced the questions used in these surveys to reflect patients' interests. Members' events provide the opportunity to liaise with Governors and staff to help develop and select the forthcoming priorities for quality improvement. Prior to our Members' Event in November 2016, members were asked to complete a survey in preparation for the event and indicate what they thought the priorities should be for the following year. Feedback from this survey was used for discussion at the Members' Event, where members once again used electronic voting pads to vote for their preferred priorities in areas relating to patient safety, clinical effectiveness and patient experience. The Governors are always grateful to get further views from members and non-members which assist their on-going deliberations.

Governors would like to acknowledge the impressive standards maintained again this year. The Quality Account shows that all of the priority targets have been met in 2016/17. We confirm that patient safety continues to be paramount and a priority for reducing harm from sepsis will feature as an additional indicator in the 2017/18 Quality Account.

Improvements in the presentation of data are introduced by The Royal Marsden each year to make the Quality Account more succinct, interesting and readable by the general public as well as by healthcare professionals. Governors continue to see enhancements in the layout of the information, making it easier to read, and understand (in plain English). Based on their involvement and the feedback they have received from members and non-members, Governors fully endorse the key priorities for improvement as set out in the Quality Account.

Council of Governors
April 2017

Healthwatch Sutton
(received 30 March 2017)

Healthwatch Sutton's primary focus with regards to this quality statement centres around the services provided by Sutton Community Services. We are pleased to see that the Trust achieved the target for Friends and Family Test results for Community Services (above 90%). Similarly the target achieved for carrying out 'falls assessments' for those receiving community services is also very welcome.

During 2016-17 Healthwatch Sutton has not received a large volume of feedback, either negative or positive about the services provided by the Royal Marsden NHS Foundation Trust. As such, we have no particular areas of service quality that we feel should be incorporated in to the priorities for this year 2017-18. The continuation of the metrics quoted above from last year should ensure a continued improvement in the quality of service provided by the Trust.

Healthwatch Kensington & Chelsea (received 28 March 2017)

We welcome the opportunity to comment on The Royal Marsden Healthcare Trust Quality Accounts (QA), and to comment on the quality of the services commissioned locally to meet the health needs of local residents.

We are pleased to have worked with the Trust this year through the Patient Experience and Quality Accounts Steering group.

Our members commend The Royal Marsden Healthcare Trust for its achievements this year, including; research excellence, high standards of academic performance and receiving 'Outstanding' following the CQC inspection for the Chelsea site, Radiotherapy, Critical Care and Chemotherapy (Sutton Site).

Comments on Quality Accounts (QA) 2016/17

QA Presentation

Overall accessibility of QA

We commend the Trust on its 'What is a Quality Account overview' and 'introduction to The Royal Marsden NHS Foundation Trust' which provide a good background to the Quality Accounts. We welcome the Trust's clear use of headings and sub-headings throughout the QA.

In order to make the QA more user-friendly the Trust should consider using a more accessible font i.e. Arial or Calibri with a minimum font size of 12 for the main body of the text. There are also some inconsistencies in formatting which may want to be reviewed.

Use of graphs and tables

Our members welcome the use of graphs and found the line graphs on page 33 comparing the Trust to the National average particularly useful. However, on occasions the graphs are complex (e.g. bar chart page 45) and the use of a table may be more appropriate. Equally a bar chart could be used to demonstrate the results of the Friends and Family Test as opposed to pie chart.

We feel that the table used on page 8 clearly presents the priorities for the year 2016/17 and the progress the Trust has made to date. The use of a key could make the colour coding clearer to users. Whilst it is helpful to see the priorities for the previous year and the upcoming year, we believe that it is not necessary to show the priorities from the last seven years (page 57).

Quotes

We welcome the Trust's use of quotes for example patient experiences on page 36 however the formatting could be reviewed to ensure that the quotes stand out to readers.

Patient Engagement

Always Events

We commend The Royal Marsden for its involvement with the Always Events programme and were interested to hear about the patient experience video that was produced. We would strongly recommend placing the key themes and lessons learnt on the Trust's website.

Patient experience

We commend the Trust for organising a Patient Experience Steering Group and are grateful for having the opportunity to be involved with this.

Our members have been impressed by the Trust's use of 'listening posts' to collect patient feedback and feel that it may be worth acknowledging the posts in the QA. Whilst the QA references collecting patient feedback and includes some quotes from patients it would be useful to find out more about the emerging themes around what is working well and what improvements could be made.

Easy read

We commend the Trust for providing easy-read versions of patient surveys in community care settings and were wondering whether this is also the case for hospital inpatients, as it is not referenced in Priority 7a.

Targets

We would recommend for future patient experience targets to incorporate how the trust does on providing timely, correct and clear information to patients.

Conclusion

Our members commend The Royal Marsden for its ongoing commitment to patient care and engagement. We are interested to hear the outcome of the recent Customer Service Excellence Standard assessment and look forward to hearing about the progress of the Always Events programme as it is rolled out across the Trust.

In the future, the Trust may want to consider producing a short summary of the QA with key points and quotes that could be advertised across the Trust's services and available online and in an easy-read version.

We look forward to continuing to work with The Royal Marsden NHS Foundation Trust in improving the care and support of patients.

NHS England (Specialised Commissioning (London))

(received 21st April 2017)

Statement from NHS England for The Royal Marsden NHS Foundation Trust Quality Account 2016/17

NHS England has reviewed the Quality Report information provided by The Royal Marsden NHS Foundation Trust (RM) and our view is that the report is accurate and comprehensively represents the Trust's quality profile. NHS England has worked closely with the Trust to ensure we have the right level of assurance in place and the Trust has demonstrated a continued commitment to quality and good engagement with commissioners. This year we have continued to see quality improving across RM sites and the Trust has a robust action plan and quality review process in place and provides high-quality care for patients with dedicated, well-training, specialist staff.

Of particular note is the continued focus on reducing the incidence of emergency readmissions through utilising the Enhanced Recovery Programme (ERP) including introducing an acute oncology out-of-hours admission prioritisation guide; the work undertaken to support patients with understanding the purpose and side effects of their medication by reviewing and changing pharmacy workflows enabling pharmacy Medicines Management technicians to counsel patients at the point of discharge; the extensive work the Trust has undertaken to help reduce waiting times in outpatient clinics to improve patients' experiences; and the Trust achieving its target on the percentage of inpatients who would recommend the Trust with an average across the year of 98% of inpatients saying that they would recommend the Trust. This is higher than the national average of 96%.

This is a very positive Quality Report from RM. There are still areas for improvements to be made and as Commissioners we will continue to work with the Trust and monitor these areas and work with our RM colleagues to ensure that patients at RM continue to receive the best quality care.

Gwen Kennedy
Interim Director of Nursing South London
NHS England (London Region)

Patient Carer and Advisory Group
(received 30 March 2017)

Members of the Patient and Carer Advisory Group have considered The Royal Marsden's Quality Account for the period 2016/17. In our opinion, the Quality Account clearly demonstrates that the Trust has continued to take steps to improve further the quality of care it provides and the experience of its patients and their carers, both in the hospital and the community. We are satisfied that robust arrangements are in place to monitor the Trust's performance against its stated objectives.

We are pleased to note that each of the quality priorities and targets (both those mandated and those set by the Trust itself) to ensure safe and effective care and to improve the patient experience was achieved in 2016/17. In particular, we endorse the actions taken over the period to reduce the waiting times in chemotherapy and outpatient clinics. It is very pleasing to note that fewer than 5% of outpatients had to wait more than one hour (against the Trust's target of 8%) with between 60% and 70% of patients being seen within 15 minutes of their appointment time. We also commend the continued efforts to improve care for patients in community services, including the steps taken to increase the number of patients who have a falls risk assessment undertaken to significantly more than the target of 65% and to ensure that a medicines review takes place for over 90% of patients during their first assessment after their hospital discharge. The excellent response to the Friends and Family Test from both out-patients and inpatients of the Trust and from those receiving community services is well deserved by the Trust. It is also good to see that more than 95.5% of staff surveyed say that they would recommend The Royal Marsden to friends or family needing care.

Overall, the Patient and Carer Advisory Group congratulate the Trust on its Quality Account and its achievements over the year. We were delighted (though not surprised) to see that many of the Trust's services and the quality of its caring environment were recognised as "Outstanding" by the CQC in its inspection in April 2016, within a rating of "Good" overall across all the Trust's service areas. The award of a Customer Service Excellence Award for a further year in March 2017 is also well deserved.

We look forward to working with the Trust to achieve further improvements in the patient experience over the coming year.

Fiona Stewart
Chair, Patient Carer and Advisory Group

Sutton Clinical Commissioning Group
(received 8 May 2017)

Thank you for asking NHS Sutton Clinical Commissioning Group (CCG) to review and comment on your Quality Accounts for 2016/17. Please find below the statement for inclusion in the final document:

The CCG has been working closely with the Trust during the year, gaining assurance of the delivery of safe and effective services. A range of indicators in relation to quality, safety and performance is presented and discussed at regular meetings between the Trust and CCG.

The information presented within the quality accounts is consistent with information supplied to the commissioner throughout the year. We can confirm that we have no reason to believe this Quality Account is not an accurate representation of the performance of the organisation during 2015/16.

The CQC rating for the Trust reflects the areas identified for improvements within an improvement action plan and the CCG continues to work with the Trust in reviewing these actions to provide additional assurance on the quality of services. Members of CCG staff have undertaken commissioner led visits during the year and feedback from CQC aligns to our own observations. The Trust has had some good success with its partners with patient pathways

that has enabled patients to be treated in the right place at the right time.

As a CCG we recognise how critical whole system support to this is and the on-going focus this will require. Community services have been key to the success of the Care Home Vanguard in Sutton.

The Trust should be congratulated on the leadership, approach and initial outcomes it has achieved this year on falls and the healing of wounds and on-going expertise in the care of people who are at the end of their lives. This good initial progress needs to be built upon in the coming year.

The CCG is supportive of the quality priorities for 2017/18 and will work with the Trust over the coming year to ensure all quality standards are monitored as set out in the reporting requirements of the NHS Contract. The CCG particularly support the Trust in improving falls assessments and notes the on-going workforce requirements for community services.

Mary Hopper
Director of Quality, Sutton Clinical Commissioning Group

Plain English Campaign's Crystal Mark does not apply to this appendix 2.

Appendix 2

Statement of Trust Directors' responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2016 to March 2017
  - papers relating to quality reported to the board over the period April 2016 to March 2017
  - feedback from commissioners dated 08/05/2017 and specialist commissioners 21/04/2017
  - feedback from governors dated 18/04/2017
  - feedback from local Healthwatch organisations dated 28/03/2017 and 30/03/2017
  - feedback from Overview and Scrutiny Committee dated 09/03/2017
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 07/06/2016
  - the [latest] national patient survey (The results of the 2016 survey are currently under purdah due to general election) Results of the previous 2015 survey will be referred to.
  - the [latest] national staff survey 09/03/2017
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 24/05/2017
  - CQC inspection report dated 19/01/2017
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Cally Palmer CBE
Chief Executive
26 May 2017

Charles Alexander
Chairman
26 May 2017

Plain English Campaign's Crystal Mark does not apply to this appendix 3.

Appendix 3

Quality Indicators where national data is available from the Health and Social Care Information Centre

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre.

The Royal Marsden NHS Foundation Trust considers that this data is as described as taken from the Health and Social Care Information Centre.

The Trust has taken actions to improve the percentage and so the quality of its services (see priorities for each indicator in Part 2 for further information).

Not all of the core indicators are relevant to The Royal Marsden NHS Foundation Trust for example those relating to the ambulance response times. The tables below show those core indicators which are relevant and how the Trust compares against other trusts. The tables show the highest and lowest national scores. The information is the latest that is made available nationally by the HSCIC. All information provided by the trust is validated and checked before it is reported.

Trust quality priority 1 (please see page 13 for more information)

Core indicator 24) The data made available to The Royal Marsden NHS Foundation Trust by the Health and Social Care Information centre with regard to the attributable cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.

Indicator 24: Rate of C. difficile infection.

January 2016 to March 2016: Number of apportioned C-difficile infections.	October 2015 to December 2015: Number of apportioned C-difficile infections.	National Average apportioned C-difficile infections per provider.) January 2016 to March 2016	Comparator Group	Comparator – Highest apportioned C-difficile infection rate (January 2016 to March 2016)	Comparator – Lowest apportioned C-difficile infection rate (January 2016 to March 2016)
11	8	9	All Acute Trusts	30	0

Trust quality priority 2 (please see page 16 for more information)

Core indicator 25) The data made available to The Royal Marsden NHS Foundation Trust by the Health and Social Care Information Centre with regard to the number, and where available, the rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Indicator 25a: Patient Safety incidents that resulted in severe harm or death

Indicator 25b: Patient Safety percentage that resulted in severe harm or death

Indicator	April 2015 to September 2015	October 2014 to March 2015	National Average (April 2015 to September 2015)	Comparator Group	Comparator – Highest (April 2015 to September 2015)	Comparator – Lowest (April 2015 to September 2015)
25a	1	1	2	Acute Specialist	9	0
25b	0.1%	0.1%	0.2%	Acute Specialist	1.8%	0.0%

Trust quality priority 3 (please see page 19 for more information)

Core indicator 23) The data made available to The Royal Marsden NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Indicator 23: Patients admitted to hospital who were risk assessed for venous thromboembolism

December 2016	November 2016	National Average (December 2016)	Comparator Group	Comparator – Highest (December 2016)	Comparator – Lowest (December 2016)
96.3%	97.6%	95.3%	Acute Trusts	100.0%	71.3%

Trust quality priority 4 (please see page 22 for more information)

Core indicator 19) The data made available to The Royal Marsden NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of patients aged – i) 0-15; and ii) 16 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

Indicator 19a: Patients readmitted to a hospital within 28 days of being discharged (Aged 0 to 15 years old)

Indicator 19b: Patients readmitted to a hospital within 28 days of being discharged (Aged 16 or over)

Indicator Description	April 2011 to March 2012	April 2010 to March 2011	National Average April 2011 to March 2012	Comparator Group	Comparator – Highest April 2011 to March 2012	Comparator – Lowest April 2011 to March 2012
19a	Data not published nationally as small numbers may allow identification of an individual					
19b	9.47%	7.94%	11.45%	Acute Specialist	14.09%	0%

Trust quality priority 7a (please see page 31 for more information)

Core indicator 20) The data made available to The Royal Marsden NHS Foundation Trust by the Health and Social Care Information Centre with regards to the trust's responsiveness to the personal needs of its patients during the reporting period.

Indicator 20: Responsiveness to the experience of care.

Adult Inpatient Survey April 2015 to March 2016	Adult Inpatient Survey April 2014 to March 2015	National Average April 2014 to March 2015	Comparator Group	Comparator – Highest April 2015 to March 2016	Comparator – Lowest April 2015 to March 2016
87.7	87.4	77.3	All trusts	88.0	70.6

Trust quality priority 7a (please see page 31 for more information)

Core indicator 21.1) Friends and family test – Patient. The data made available to The Royal Marsden NHS Foundation Trust by the Health and Social Care Information Centre for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2). The trust's score from a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

Indicator 21.1: Patient Friends and Family test: Inpatient

February 2017	January 2017	National Average (Feb 2017)	Comparator Group	Comparator – Highest (Feb 2017)	Comparator – Lowest (Feb 2017)
98%	97%	96%	All NHS Trusts	100%	76%

Trust quality priority 8 (please see page 39 for more information)

Core indicator 21) The data made available to The Royal Marsden NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

Indicator 21: Staff who would strongly recommend the Trust to their family or friends.

NHS Staff Survey 2016	NHS Staff Survey 2015	National Average (2016)	Comparator Group	Comparator – Highest (2016)	Comparator – Lowest (2016)
91%	90%	88%	Acute Specialist Trusts	95%	76%

Indicator code 12a:

The Value of the Summary Hospital-Level mortality Indicator ("SHMI")

The banding of the Summary Hospital-Level mortality Indicator ("SHMI")

October 2015 to September 2016	July 2016 to June 2016	National Average	Comparator Group	Comparator – Highest	Comparator – Lowest
Trust data not published nationally for this indicator.				Not applicable	Not applicable
Trust data not published nationally for this indicator.				Not applicable	Not applicable

Indicator 12b: The percentage of patient deaths with palliative care coded at either diagnosis or specialty level.

October 2015 to September 2016	July 2015 to June 2016	National Average	Comparator Group	Comparator – Highest	Comparator – Lowest
Trust data not published nationally for this indicator.					

Appendix 4

Our values

We, The Royal Marsden, are guided by 16 values that define our:

- characteristics (what we are);
- attitudes (how we act);
- relationships (how we relate to others); and
- emotions (how we feel).

Characteristics	Attitudes
Pioneering	Determined
Aspirational	Confident
Knowledgeable	Open
Driven	Resilient
Relationships	**Emotions**
Collaborative	Compassionate
Supportive	Positive
Trusted	Calm
Personable	Proud

Over the last year we have continued to focus on a different value each month and explored how our staff adopt these values in their daily work. Below we have some quotations from staff on the relationship 'personable' and the characteristic 'aspirational'.

Personable

Being personable is something we value as we believe being pleasant and friendly helps build trusting relationships and puts patients and their families at ease during a difficult time in their lives.

"It is paramount that we are personable because we are dealing with children and their family's lives that have just been shattered, and we are one of the first few people they see in hospital. Listening, getting down to the children's level and spending time with the family gives them reassurance."

Claire Riddell, Play Specialist in the Oak Centre for Children and Young People

Aspirational

Our staff 'aspire' to (aim for) excellence, and we believe that through this we always improve and develop ourselves, and the quality of the services we offer.

"One hundred per cent of the money saved by the Trust in reducing energy consumption will be reinvested back into clinical services and patient amenities. It's very important for us all to aspire to achieve this target as it's something that all staff can contribute towards."

He added: "We have already started to make changes, such as using super energy efficient LED lighting, upgrading heating, cooling and ventilation plants, implementing energy efficiency measures in new capital projects, and introducing low-carbon on site generation of heat and power at the Sutton site. The hospital is known as a centre of excellence for cancer treatment, but we also want to be champions of sustainability."

Ehsan Sattar, Energy Manager leading The Royal Marsden's Carbon Management Plan

Appendix 5

Sign Up to Safety: Patient Safety Improvement Plans

We joined the national Sign Up to Safety campaign in the summer of 2015. The aim was to reduce avoidable harm in three distinct areas – sepsis, medication errors and pressure sores. In each area, a safety group has been established.

The following tables show the aims and proposed actions relating to sepsis, medication errors and pressure sores.

Patient-safety improvement plans – increasing awareness, identification and treatment of sepsis and reducing death from it

Aims:

- to increase awareness of sepsis;
- to prevent sepsis;
- to recognise and manage, as early as possible, patients with sepsis;
- to reduce emergency admissions through early intervention strategies; and
- to have no avoidable deaths from septic shock from 1 June 2018.

Primary goals	Necessary actions
Prevent and control infection	– Effective handwashing. – Training in vascular access devices (for example, cannulas). – Central venous catheter bundles. These are a set of measures that, when carried out together, reduce the risk of infections from having tubes inserted into large veins. – Urinary catheter bundles. These are a set of measures that, when carried out together, reduce the risk of infections from having tubes inserted into the bladder. – Effective management of the use of antibiotics. – Sepsis screening – increase the numbers identified in the 'Golden Hour'. This is the time period in which early recognition and treatment can reduce the risk of sepsis progressing and so improve outcomes. – Educate patients and volunteers.
Identify and treat patients with sepsis as early as possible	– Management of neutropaenic sepsis. This happens when there is an infection related to a reduction in the number of white blood cells (neutrophils), which fight infections. – Patients with a NEWS points score of more than four are referred to the Critical Care Outreach Team (CCOT). The National Early Warning Score (NEWS) allocates points for changes to patient parameters such as heart rate, temperature, blood pressure and respiratory rate. The greater the abnormality, the higher the number of points. The points are added and if they are above four, this prompts a review by the Critical Care Outreach Team to decide if the patient needs to go to the Critical Care Unit. – Lactate measurement available 24/7 in hospitals. A raised lactate level in the blood of patients may be a sign of a severe infection. Measurement should be possible in patients all day, every day. – SBAR training. To help healthcare professionals get appropriate advice and action in good time, the SBAR tool has been introduced to provide a structure for communication between colleagues. The four letters of SBAR indicate the Situation (problem being discussed), Background (the medical history of the patient and treatment to date), Assessment (of the patient) and Recommendation (of the person leading the discussion).

Primary goals	Necessary actions
Identify and treat patients with sepsis as early as possible	– Trigger tools for patients calling in from home. Patients, for instance those receiving chemotherapy, are given information on when to get medical advice (for example, if they have a temperature). Collectively, trigger tools are the parameters that should lead to patients phoning for medical advice. – Early referrals to the Critical Care Outreach Team are available in the hospitals at Fulham Road and Sutton, all day and every day. The Critical Care Outreach Team is made up of nurses trained in identifying, stabilising and increasing the level of care for patients who are critically ill for any reason. They work with the teams on the wards and in the Critical Care Unit. – Reliable communication at handover about patients who are at risk. – Clinical Site Practitioner to tell CCOT about after-hours emergency admissions. – Reporting to senior team, critical care and CCOT
Deliver the sepsis-six care bundle	– Delivery of sepsis-six (02, Blood cultures, Antibiotics, Fluids, Lactate measurement and urine output monitoring). The 'sepsis-six' are a group of interventions that may help treat patients with sepsis. The interventions are providing oxygen, taking blood cultures (a sample of blood sent to the microbiology laboratory to identify organisms making the patient unwell), giving antibiotics early on to fight the infection, measuring lactate (as high levels in the blood may indicate a severe infection), and measuring urine production (which generally falls as the patient becomes more unwell and increases when the patient improves). – Escalation of patients with severe sepsis or septic shock for critical-care review and admission. Patients who are severely unwell may need a higher level of care and be 'escalated' to get the Critical Care team's opinion on whether a patient needs to be moved to the Critical Care Unit. – Giving antibiotics within an hour of suspected sepsis. Since we joined the Sign up to Safety campaign, we have improved our success in meeting the target. Currently, all patients who are admitted to the Critical Care Unit with sepsis were already on antibiotics, or received them within an hour of sepsis being suspected. – Early control of the source of the sepsis. – Increase the number of nurses for administering antibiotics to the Patient Group Direction (PGD). Normally, medications are given on prescription by a doctor. Patient Group Directions (PGDs) are a mechanism by which authorised professionals can administer medications to groups of patients without there being a prescription from a doctor. In this case, if a patient is suspected of having a severe infection, a trained nurse could give an antibiotic to reduce the delay of getting a prescription. – Increase the number of nurses who can insert cannulas and have access to portacath devices. Portacaths are devices (ports) placed under the skin, attached to a tube tunnelled under the skin to enter a large vein. A needle can be inserted through the skin into the port to allow blood to be taken or medication to be given. The skin over the port reduces the risk of infection from the device staying in the body for a long period of time. – For sepsis patients admitted, gather information relating to IT Coding, morbidity and mortality rates, root-cause analysis. Identifying patients with sepsis allows us to gather valuable information on the number of patients with sepsis and their outcomes (morbidity – how unwell they become and how long they stay in hospital, as well as mortality – whether the patient dies due to the severe infection). Reviewing the notes of patients with sepsis can uncover ways to improve care for future patients. This is called root-cause analysis and is based on the idea that several factors (roots) can contribute to a problem (sepsis) developing. One way of identifying patients is by using information technology (IT) coding. This is where each episode of a patient's care is summarised into a variety of codes by dedicated professionals (clinical coders). This allows a large database to be searched to find information (for example, those patients with severe sepsis or septic shock).

Primary goals	Necessary actions
Raise awareness and education for staff, patients and carers	– RM School of Nursing formal teaching programmes. – Nurses new to cancer care module and Acute Cancer Care Module. We have a teaching school for nurses. It is planned to educate nurses in identifying sepsis, getting early help and starting treatment promptly. There are two modules – 'Nurses new to cancer care' and 'Acute cancer care' – which sepsis training can be part of. – Mandatory refresher training for staff on the six signs of sepsis and managing the condition. – Hold a Sepsis Roadshow twice a year, both on-site and in the community. – Standardise the approach to managing sepsis across all sites. – Simulation training. – Ward-based and community-based teaching sessions. – Embedding training for serious incidents. If there was a serious incident related to sepsis (where there is significant harm to the patient), then learning from investigations will be incorporated into training in order to reduce the risk of the event happening again.
Escalation and review. (Escalation involves getting help from more senior members of the team as well as increasing the amount of care for the patient, such as transferring them from the ward to the Critical Care Unit)	– Senior review of the patient (by a registrar or a consultant). – Review critical care and CCOT. – Review unplanned emergency admissions.
Produce clear management plans	– Clear criteria for emergency admission. – Clear management plans for those with ward-based ceilings of care. For some patients, transferring them to the Critical Care Unit is not appropriate. They have a 'ceiling of care' in place, where medical treatment is offered up to a limit (the 'ceiling') on the ward. Treatment options only available in the Critical Care Unit include breathing support from a mechanical ventilator, support to increase blood pressure and some artificial kidney support (dialysis). Patients staying on the ward will not receive these treatments. – Reporting on the 'Datix' incident form when patients meet the criteria for emergency admission but no bed is available. If a patient is severely unwell with an infection at home, they should be admitted to hospital as an emergency. Very occasionally it may be that the patient cannot be admitted due to a lack of beds. This would be reported as an incident on the Datix form, which is a summary of what happened and whether the patient came to any harm. These incidents are analysed by the risk management department to determine the risk of the situation arising again, and how severe the harm was, before making recommendations to reduce the risk of it happening again.

Patient-safety improvement plans – reducing harm from medication errors

Aims:

- to improve the pharmacy-led medicines reconciliation rates on admission to 100% by 2018;
- to reduce chemotherapy-prescribing errors by 20% by 2018; and
- to make sure allergies are recorded accurately for 100% of patients when they are admitted.

Primary goals	Necessary actions	Progress 2016/17
Prevention: – Reduce harm related to hypersensitivity and allergy reactions through consistent assessment and recording of patients' allergies when they are admitted – Introduce and use chemotherapy e-prescribing technology to reduce the opportunity for harm from prescribing errors – Reduce harm from the incorrect medicines being prescribed, or necessary medication not being prescribed, by improving pharmacy-led medicines reconciliation at admission and discharge – Implementation of the Medication Safety Thermometer – Education and raising awareness: – Produce a monthly dashboard showing progress with qualitative and quantitative metrics – Improve feedback given to doctors and NMPs about medication and prescribing errors	– Introduce electronic prescribing for chemotherapy, and give prescribers feedback on common errors. – Undertake regular chemotherapy audits to monitor error rates. – Use the medicines-safety thermometer. (The medicines-safety thermometer is a national tool to reduce the number of medication mistakes causing serious harm. The information is collected from wards. Each month, the results are fed back to all nursing and pharmacy staff. The results are also published on the monthly dashboards displayed in all ward areas. This raises awareness and empowers the nursing teams to make improvements locally.) – Have the medicines-safety thermometer tailored to the medicines-safety drivers for RM. – Have visible information about the medication safety thermometer on all wards. – Learning from RCAs: – MDT huddles for every high-risk medication error detected when collecting information for the medicines-safety thermometer. – Improved recording of near-miss prescribing errors. – Regularly send out a medication incidents summary to nursing, medical and pharmacy staff.	– Current medicines reconciliation rate – 100% (Medication Safety Thermometer Feb 2017) – A re-audit to assess chemotherapy prescribing errors at The Royal Marsden NHS Foundation Trust after e-chemo has been put into practice – over 42% drop in the number of errors detected from the 2011 audit cycle to the 2016 audit cycle. – Current documentation of allergies – 100% (Medication Safety Thermometer Feb 2017) – Monthly dashboard produced with medication safety thermometer data for each ward area. – Near miss reporting monitored monthly and bi-monthly through executive medication safety group.

Patient-safety improvement plans – reducing harm from pressure sores

Aims:

To reduce avoidable pressure sores:

– by 100% within hospitals; and
– by 50% within the community;
– by June 2018

Primary goals	Necessary actions and progress in 2016/17
Identify patients with pressure sores, or at risk of pressure sores, as early as possible	– Accurate assessment of risks and related conditions. – Complete the Pressure Ulcer Assessment and the Prevention & Management booklet when patients are admitted. – Have visible data – ward dashboards, safety thermometer and so on. – Patient stories. – Hold Pressure Ulcer Panel meetings.
Prevent pressure sores	– Use suitable devices – Aderma, prophylactic meplix border, heel-lift boots, mattresses and cushions. – Get patients moving around out of bed as early as possible. – Provide patient-education video and leaflets. – Follow the recommendations of the 'Stop the Pressure' campaign. – Intentional rounding.
Raise awareness	– Raise awareness of the extent of incidents and the effect on patients through ward meetings, nurse meetings, matron's meetings and so on. – Take part in the Sign up to Safety Pressure Ulcer Strategy group – Learning from RCAs (risk management feedback). – Develop a pressure-ulcer prevention strategy for in hospital and in the community. – Include 'Harm Free Care' as part of mandatory training. – Correct identification of pressure sores and moist lesions.
Reporting / review	– Community TVN's to confirm if a pressure sore is attributable and the category with 72hours of reporting. – RCAs to be completed within two weeks from allocation followed by one week with the manager for review prior to panel. – Panel reports to be completed by Divisional Nurse Directors within 48 hours. – Quarterly audits to be presented to the quarterly strategy group by Community Divisional Clinical Nurse Director.

Plain English Campaign's Crystal Mark does not apply to this appendix 6.

Appendix 6

Independent auditor's assurance report

Independent auditor's report to the council of governors of The Royal Marsden NHS Foundation Trust on the quality report

We have been engaged by the council of governors of The Royal Marsden NHS Foundation Trust to perform an independent assurance engagement in respect of The Royal Marsden NHS Foundation Trust's quality report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of The Royal Marsden NHS Foundation Trust as a body, to assist the council of governors in reporting The Royal Marsden NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Royal Marsden NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement (NHSI):

- Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer; and
- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with

- board minutes for the period April 2016 to March 2017;
- papers relating to quality reported to the board over the period April 2016 to 31 March 2017;
- feedback from the Commissioners dated 21 April 2017 and 8 May 2017 and;
- feedback from the governors dated 18 April 2017;
- feedback from Overview and Scrutiny Committee, dated 9 March 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2016;
- the latest national patient survey dated 8 June 2016;
- the latest national staff survey dated 17 March 2017;
- Care Quality Commission inspection report dated 19 January 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 26 April 2017; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

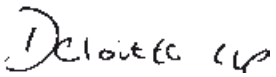
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.



Deloitte LLP
Chartered Accountants
London
26 May 2017

Appendix 7

Glossary

Bacteraemia Having bacteria in the blood.

Care Quality Commission (CQC) The independent regulator of health and adult social care services in England, including those provided by the NHS, local authorities, private companies or voluntary organisations. They also protect the interests of people detained under the Mental Health Act.

Carbapenemase-producing Enterobacteriaceae (CPE) Screening for this 'superbug' that is resistant to most antibiotics.

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

Clinical coding Clinical coding is the process whereby information written in the patient notes is translated into codes and entered onto hospital information systems. This usually happens after the patient has been discharged from hospital, and must be completed within strict deadlines so hospitals can receive payments for their services.

Clinical commissioning groups (CCGs) NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. They took over many of the functions of primary care trusts.

Clostridium difficile infection (C. diff) Bacteria that are a significant cause of infections arising in hospital.

CNS Clinical nurse specialist.

Commissioning for Quality and Innovation (CQUIN) A payment framework that lets commissioners link a proportion of a healthcare providers' income to the achievement of local quality-improvement goals.

Customer Service Excellence (CSE) Standard The Government's standard for customer service. This scheme replaced the Charter Mark.

Enhanced Recovery Programme A national scheme that places the patient at the centre of a multi-professional team to plan for greater partnership in care, improved quality of care and shorter lengths of stay in hospital.

EPR Electronic patient record.

Escherichia coli (E. coli) Bacteria that live in the intestines of humans and animals. Although most types are harmless, some cause sickness.

Foundation trust Foundation trusts have a significant amount of managerial and financial freedom when compared to NHS hospital trusts. They are considered to be like co-operatives, where local people, patients and staff can become members and governors and hold the trust to account.

Friends and Family Test (FFT) A simple questionnaire to get feedback about services. Patients are asked if they would recommend the services they have used and staff are asked if they would recommend the services offered at their workplace or if they would recommend it as a place to work.

Healthcare-associated infection An infection arising in a patient during the course of their treatment and care.

Healthwatch The new independent consumer champion to gather and represent the views of the public at a national and local level. Healthwatch England will work with local Healthwatch groups and has the power to recommend that the Care Quality Commission take action where there are concerns about health and social-care services.

Holistic needs assessment (HNA) A process of gathering information from the patient or carer in order to lead discussion and develop a deeper understanding of what the patient knows, understands and needs.

Information governance A process that makes sure that organisations achieve good practice relating to data protection and confidentiality.

Key performance indicators Organisations use key performance indicators to evaluate their success or the success of a particular activity.

Multidisciplinary team A team made up of healthcare professionals from different fields who work together.

Meticillin-resistant staphylococcus aureus (MRSA) Bacteria that are a significant cause of infections arising in hospital.

Meticillin-sensitive staphylococcus aureus (MSSA) Bacteria that are a significant cause of infections arising in hospital.

National Health Service Improvement (NHSI) The independent regulator of NHS foundation trusts.

National Institute for Health and Care Excellence (NICE) NICE reviews medicines, treatments and tests. It makes clinical guidelines and public-health recommendations.

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

Patient and Carer Advisory Group (PCAG) The Patient and Carer Advisory Group works to improve the experience of patients at The Royal Marsden. It is a self-managed group of patients, carers and members of the public who play a vital part in continually improving the care and services we provide.

Pressure ulcers Bed sores or pressure sores.

Prophylaxis A measure taken to prevent a disease or condition.

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.

Standardised mortality ratio An indicator of the quality of healthcare. It measures whether the death rate at a hospital is higher or lower than expected.

TTAs Discharge prescriptions – medicine 'to take away'.

Vancomycin-resistant enterococci (VRE) Bacteria that are resistant to the antibiotic vancomycin and can cause infections arising in hospitals.

Venous thromboembolism (VTE) A blood clot, typically occurring in the leg but which can form in any blood vessel.

Life demands excellence

At The Royal Marsden, we deal with cancer every day so we understand how valuable life is. And when people entrust their lives to us, they have the right to demand the very best.

That's why the pursuit of excellence lies at the heart of everything we do. No matter what we achieve, we're always striving to do more. No matter how much we exceed expectations, we believe we can exceed them still further.

We will never stop looking for ways to improve the lives of people affected by cancer. This attitude defines us all, and is an inseparable part of the way we work. It's The Royal Marsden way.

You can visit, write to or call The Royal Marsden using the following details:

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Notes

Notes


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