The ROYAL MARSDEN
NHS Foundation Trust

Quality Account 2013/14

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Quality Account

What is a Quality Account?

All NHS hospitals or trusts have to publish their annual financial accounts. Since 2009 as part of the movement across the NHS to be open and transparent about the quality of services provided to the public, all NHS hospitals must publish a Quality Account. The public and patients can also view quality across NHS organisations by viewing the Quality Accounts on the NHS Choices website: www.nhs.uk

The dual functions of a Quality Account are to:

1. Summarise performance and improvements against the quality priorities and objectives we set ourselves for 2013/14.
2. Outline the quality priorities and objectives we set ourselves going forward for 2014/15.

To begin with, we have detailed how we performed in 2013/14 against the priorities and objectives we set ourselves under the following categories:

Safe care

Effective care

Patient experience

Where we have not met the priorities and objectives that we set ourselves, we have explained why, and outlined the plans we have put in place to ensure improvements are made in the future.

Secondly, we have outlined our quality priorities and objectives for 2014/15 under the same categories. We have detailed how we decided upon the priorities and objectives we have set ourselves, and how we will achieve and measure our performance. The regulated statements of assurance are also included in this part of the report.

The Quality Account is an important document for the Board, which is accountable for the quality of the service provided by the trust and can be used in the scrutiny and leadership of the Trust. Frontline staff are encouraged to use the Quality Account to compare or benchmark their practice with other trusts or, if comparable information does not exist to help improve their service.

For patients, carers and the public the Quality Account should be a document that is easy to read and understand, and highlights key areas of safety and effective care delivered in a caring and compassionate way. It should also show how a trust is concentrating on any improvements that can be made to care or experience; it is also hoped that it may also help patients with choice.

It is important to remember that some parts of the Quality Account are compulsory. They are about important areas – and generally they are presented as numbers in a table at the end of this Quality Account. If there are any areas of the Quality Account that are difficult to read or understand or you would like any help with the content, please contact us via our Patient Advice and Liaison Service (PALS) on 0800 783 7176 or online at www.royalmarsden.nhs.uk

The Quality Account is divided into four sections:

Part 1
A statement on quality from the Chief Executive (CE)

Part 2
Performance against priorities for quality improvement 2013/14 and statements of assurance

Part 3
Outline of quality priorities 2014/15 and an explanation of who the Trust has involved in determining the priorities including statements from key stakeholders such as Healthwatch (replaced Local Involvement Networks from April 2013), Health and Wellbeing Boards (HWB) and the Commissioners of Services. It is important to note that with the new architecture of the NHS, The Royal Marsden NHS Foundation Trust will work more closely in 2014/15 with the two Clinical Commissioning Groups in Sutton and Merton to ensure that the Quality Account also reflects their needs.

Part 4
Review of quality performance

Part one

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

The quality of patient and family care and experience is central to all that we do at The Royal Marsden. The Royal Marsden NHS Foundation Trust is the largest comprehensive cancer centre in Europe and together with its academic partner The Institute of Cancer Research (ICR) is responsible for the largest research programme in cancer in the UK.

This year has been another outstanding year for the Trust as we have continued to achieve high ratings from our two major regulators, Monitor and the Care Quality Commission (CQC). Our ongoing commitment to meet the challenges of continuing to deliver quality care and experience within a cost-effective framework underpins our corporate objectives for 2013/14:

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 quality improvement is evidenced by the following achievements in April 2013 – March 2014:

Customer Service Excellence Standard

The Royal Marsden is proud to have been the first hospital in 2008 to be awarded the Customer Service Excellence Standard (CSE) as a mark of public services that are 'efficient, effective, excellent, equitable and empowering – with the citizen always and everywhere at the heart of public services provision' (CSE 2008). We are assessed regularly and on 18 December 2013 the Trust was found again to be compliant and retained the award for the sixth year.

The Information Standard

The Information Standard is an independent certification for organisations producing evidence-based health and care information for the public. Any organisation achieving the Information Standard has undergone a rigorous assessment to check that the information they produce is clear, accurate, balanced, evidence-based and up-to-date. The Trust was first certified four years ago and was also invited to assist in piloting the updated standards. In November 2013 the Trust achieved the standard against the pilot standards which have now been finalised. Providing patients with clear and accurate information is an important part of the patient's journey and the Trust is pleased to have maintained this quality standard.

Our staff leading quality

All of our staff place quality at the centre of care on a daily basis and this was also recognised externally in 2013/14. The Trust's Head and Neck Unit took the award at the Quality in Care Excellence in Oncology Awards for 'Improving the quality of life and experience of care for people living with cancer'. At the same awards our radiotherapy staff were commended for their work on the HeartSpare trial, which aims to reduce the risk of heart disease from breast radiotherapy in the 'Cancer team of the year' category. Separately, our Chief Nurse was awarded a Lifetime Achievement Award by the European Oncology Nursing Society which honours individuals who, during their working lifetime, act as inspirational leaders; and our Nurse Consultant for Palliative Care was awarded a Macmillan Clinical Excellence and Fellowship awards.

Capturing our patient experience in the community

Our successful integration with Sutton and Merton Community Services continues and we have implemented a new customer feedback system for our patients who are cared for by our community staff. This new system allows us 'real-time' access to the results and enables us to give our services and teams feedback and quality improvement suggestions immediately after our patients have passed them on to us.

Further embedding our values

For several years The Royal Marsden has promoted a set of 16 distinct values (appendix 2) that help us ensure that our patients receive the best possible treatment and care. Following the publication of the Francis Report our staff have become even more committed to making these values more visible. Staff in the Critical Care Unit have identified four core values that they believe are the most important to them and what they aspire to be and redefined what they mean to them. This process is being cascaded throughout the Trust.

The Royal Marsden School

The School continues to be a key part of the organisation through its delivery of high quality education in cancer care, leadership, ongoing professional development and training. For the third consecutive year it was awarded 100% in the assessment of its Quality and Contract Performance Management, confirming its position as the best performing provider in London of Continuing Personal and Professional Development (CPPD) for nurses and allied health professionals.

This is the fifth year that we have published a Quality Account and we are grateful for the feedback we received on last year's Quality Account from patients, carers, the public through Healthwatch, the Health and Wellbeing Boards (HWB) and our commissioners and governors.

Last year saw the publication of many high profile national reports such as the Berwick Review into patient safety and the Government's response to the Francis Report with key messages for everyone working in the health and care system. We welcome mandates or actions that will improve any aspects of patient care, outcomes or experience and look forward to being involved in this work as it progresses in 2014.

We are also very proud of the excellent hard work that the staff of The Royal Marsden undertake on a daily basis and their everyday commitment to safety and quality. We have aimed to demonstrate this within this Quality Account and enable our staff to personally articulate the importance of this in their roles via personal quotes throughout the document.

I would like to thank all patients, carers, staff, Healthwatch, HWB, governors and commissioners who have contributed to this Quality Account for 2013/14.

I can confirm on behalf of the Board of The Royal Marsden NHS Foundation Trust that to the best of my knowledge, the information presented in this Quality Account is accurate and fairly represents the range of services we provide.

Cally Palmer CBE
Chief Executive
29 May 2014

Part two

Performance against priorities for quality improvement 2013/14 and statements of assurance

Introduction

The table below summarises the specific quality priorities and targets we set ourselves for Safe care, Effective care and Patient experience for 2013/14 in the Trust.

The priorities marked with * were mandatory quality indicators in 2013/14 and remain mandatory for 2014/15. There were three new (^) quality priorities for 2013/14.

Table 1: Quality priorities and targets for 2013/14

Safe care		
Priority 1*	**Priority 2***	**Priority 3***
*Reduction in Healthcare Associated Infections (MRSA bacteraemia and *Clostridium difficile* infections) Applies to acute beds at The Royal Marsden and patients of Sutton and Merton Community Services (SMCS)	*Rate of patient safety incidents and percentage resulting in severe harm or death (in 2012/13 the number of deaths from serious incidents per 100 admissions was 0; the number of severe harms from incidents per 100 admissions was 0.012) Applies to acute beds and SMCS	*Percentage of admitted patients risk assessed for venous thromboembolism
Less than one MRSA bacteraemia Less than 11 *Clostridium difficile* infections (report in Quality Account the number of *C.difficile* infections per 100,000 bed days)	Reduction in the rate of patient safety incidents per 100 admissions and the proportion that have resulted in severe harm or death	Maintain above 95% the number of patients who have a completed venous thromboembolism risk assessment
Effective care		
Priority 4	**Priority 5**	**Priority 6**
Reduction in community acquired category 3 and 4 pressure ulcers: applies to SMCS	Increase the number of patients that die in their preferred place of death (the National Primary Care Snapshot Audit in End of Life Care (2009) found that the number of patients achieving their preferred place of death is 42%) Applies to acute and SMCS	Increase the numbers of patients who have been offered a Holistic Needs Assessment
Reduce the incidence of severe community acquired pressure ulcers (category 3 and 4)	Achieve more than 42% of patients dying in their preferred place of death	Increase the proportion of designated patients who will be offered a Holistic Needs Assessment by the end of 2013/14
Priority 7*		
*Avoidance of emergency readmissions to hospital within 28 days of discharge		
Reduction in the number of avoidable readmissions to hospital within 28 days of discharge		

Patient experience		
Priority 8	**Priority 9***	**Priority 10***
Reduction in chemotherapy waiting times and improvement in patient experience related to waiting times	*Ensure that we are responding to inpatients' personal needs	*Percentage of staff who would recommend The Royal Marsden to friends or family needing care Introduce a Patient Experience survey for SMCS
Reduction in chemotherapy waiting times at Sutton and Chelsea sites, and improvement in the patient experience related to waiting times	Improvement in responses to five questions (in the CQC national survey described above) as monitored through the Inpatient Frequent Feedback Surveys	To maintain or increase the staff survey result to this specific question in the survey To achieve a baseline measurement and if possible benchmark with other community services
Priority 11	**Priority 12**	
^Improve communication, particularly when patients arrive for first appointments	^Reduce the length of time a patient waits for medicines or equipment at the point of discharge	
Increase or maintain the high percentage of positive comments in dedicated patient feedback	Increase or maintain the high percentage of positive comments in dedicated patient feedback	
Childrens services (SMCS)		
Priority 13		
^The uptake of immunisation working in partnership with primary care		
Increase the percentage of children receiving preschool immunisations in partnership with GPs		

Priority 1

Reduce the incidence of Healthcare Associated Infections (HCAIs). Reduction in Healthcare Associated Infections (Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia and *Clostridium difficile* infections). Applies to patients in our hospitals at The Royal Marsden and patients of Sutton and Merton Community Services.

Target

To reduce the number of *Clostridium difficile* Infections (CDI) to 11 in 2013/14 or less and maintain a very low incidence of Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia.

"The Infection Prevention team work closely with clinical teams to ensure potentially infectious side rooms are decontaminated using Hydrogen Peroxide Vapour to reduce the risk of HCAI in our vulnerable patient group."

Sarah Whitney
Clinical Nurse Specialist
Infection Prevention and Control

What did we do in 2013/14?

Patients with cancer are more vulnerable to infection and if an infection is sustained, they are more likely to develop serious complications from it. We therefore see reducing the incidence of HCAIs as an essential safety and quality priority. This priority was selected in 2009/10 and remained an important priority in 2013/14. The Infection Prevention Team undertakes and oversees extensive audit programmes focusing on environmental hygiene and standardisation of cleaning and decontamination processes. Appropriate antimicrobial prescribing is crucial in ensuring the reduction of *Clostridium difficile* infection alongside prompt and effective treatment and care for any patients suffering with diarrhoea especially amongst the immune suppressed who are particularly at risk of this type of infection. The Trust has tested for *Clostridium difficile* in every case of diarrhoea in a patient, even though the guidance does not require this. It has been agreed that the Trust will only need to report cases to Public Health England (previously Health Protection Agency) where testing was required in line with their guidance. A robust process of screening and treating all patients for MRSA is implemented and audited to ensure the risk of bacteraemia is reduced as much as possible.

How did we perform in 2013/14?

The Trust continues to implement the Hydrogen Peroxide decontamination programme across Sutton and Chelsea to minimise the transmission of HCAI.

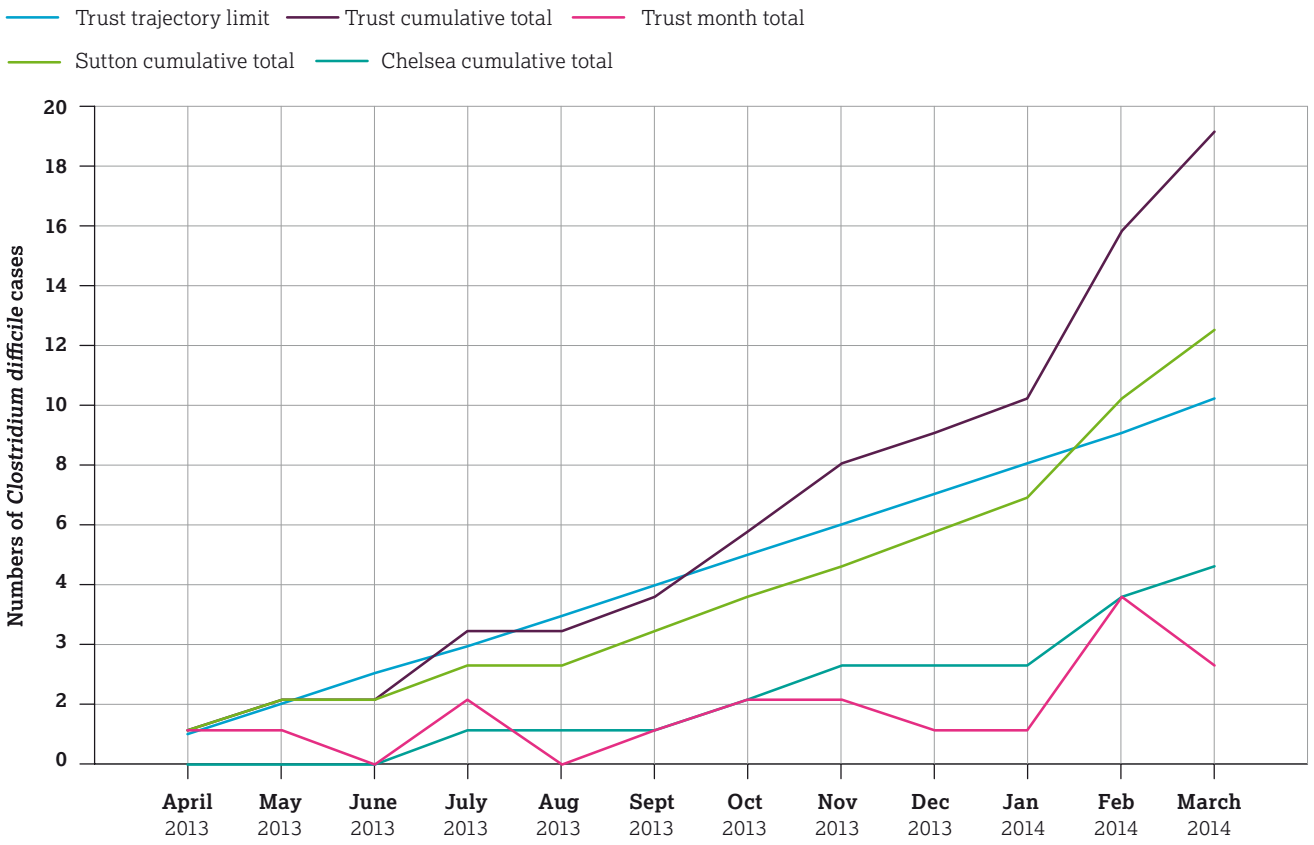
The Trust maintained excellent hygiene standards by way of regular peer review audits on each clinical area and importantly ensured the correct cleaning products and standards were maintained to reduce the risk of *Clostridium difficile* infection. On a daily basis the infection prevention team prioritised the use of isolation rooms to ensure the risk of cross infection is reduced.

The Trust total number of attributable *Clostridium difficile* cases for the year was 19 against a target of 11 and MRSA bacteraemia is 1 meaning we have breached on both these reportable indicators.

Table 1: Number of attributable MRSA bacteraemia and *Clostridium difficile* cases

Infection	Number attributable 2010/11	Number attributable 2011/12	Number attributable 2012/13	**Number attributable 2013/14**	**Royal Marsden annual level 2013/14**
MRSA bacteraemia	2	1	0	**1**	**≤1**
Clostridium difficile	34	18	15	**19**	**11**

Graph 1: Number of attributable *Clostridium difficile* (CDI)



What actions are we planning to improve our performance?

Key plans to improve HCAI rates include a focus on antimicrobial prescribing audits and the prescribing of proton pump inhibitors to reduce *Clostridium difficile* infection. MRSA treatment takes time and work is underway to ensure the time between prescribing MRSA treatment and significant events such as surgery or high dose chemotherapy is sufficient to reduce the risk of a blood stream infection even further.

How will improvements be measured and monitored?

Improvements will be monitored by the monthly Infection Prevention and Control Team meeting. This is a multidisciplinary meeting chaired by the Chief Nurse, who is the Director of Infection Prevention and Control for the Trust. Bacteraemia caused by both meticillin-resistant and meticillin-sensitive *Staphylococcus aureus* (MRSA and MSSA), vancomycin-resistant enterococci (VRE) and Escherichia coli will be reported externally to the new Public Health England, as will all confirmed *Clostridium difficile* infections. Numbers of selected infections will be monitored internally to the Board in the Trust Board Scorecard and published in the quarterly Integrated Governance Reports. Reduction in HCAIs remains a priority for 2014/15 to prevent further harm to patients.

Priority 2

To reduce the rate of patient safety incidents that have resulted in severe harm or death. Applies to acute beds and Sutton and Merton Community Services (SMCS).

Target

Reduction in the rate of patient safety incidents per 100 admissions and the proportion that have resulted in severe harm or death. In 2012/13 the number of deaths from serious incidents per 100 admissions was 0; the number of severe harms from incidents per 100 admissions was 0.010.

"The Trust promotes and supports an open culture regarding incident reporting and investigation. This ensures that the organisation learns from its mistakes in order to reduce the risk of incidents being repeated."

Kate Rumble
Head of Risk Management

How did we perform in 2013/14?

Patient safety incidents resulting in severe harm or death

This year is the second time that this indicator has been required to be included within the Quality Account alongside comparative data provided, where possible, from the Health and Social Care Information Centre. The National Reporting and Learning Service (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database on a voluntary basis designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process.

The Trust reports all patient safety incidents reported on Datix to the NRLS. Prior to NRLS producing their six monthly reports, the Trust resubmits all patient safety incidents which captures changes made as a result of investigations. The NRLS does not update its previously reported figures so these changes may not be reported by the NRLS and the data held by the Trust may not be the same as that reported by the NRLS.

The tables below separate out the information for firstly the acute hospital sites of Chelsea and Sutton and secondly for SMCS. Previously this data has been presented as a combined table. Both tables show an increase in reporting which is due to an increased awareness of incident reporting overall; this is deliberate and beneficial.

Table 1 shows that the Chelsea and Sutton sites (acute hospital) have made an improvement and reduced the rate of reported incidents that caused severe harm or death from 0.010 in 2012/13 to 0.008 in 2013/14.

Table 1: Chelsea and Sutton patient safety incidents

Measure	2012/13	Q1	Q2	Q3	Q4	**2013/14**
Inpatient and daycase admissions and regular day attendees	61,366	15,291	16,098	16,106	16,611	**64,106**
Rate of reported patient safety incidents (severe harm or death), per 100 admissions	0.010	0.013	0.006	0.000	0.012	**0.008**
Number of patient safety incidents (severe harm or death)	6	2	1	0	2	**5**
Total patient safety incidents	2137	586	635	568	563	**2352**
Patient safety incidents (severe harm or death) as % of all patient safety incidents	0.28%	0.34%	0.16%	0.00%	0.36%	**0.21%**

Table 2 shows that there have been no patient safety incidents resulting in severe harm or death for the period 2013/14 within SMCS.

Table 2: Sutton and Merton Community Services patient safety incidents

Measure	2012/13	Q1	Q2	Q3	Q4	**2013/14**
Number of contacts (total number of face to face and non face appointments attended and 'outcomed')	532,119	136,535	133,394	137,125	134,333	**541,387**
Rate of reported patient safety incidents (severe harm or death), per number of contacts	0	0	0	0	0	**0**
Number of patient safety incidents (severe harm or death)	0	0	0	0	0	**0**
Total patient safety incidents	869	220	269	213	281	**983**
Patient safety incidents (severe harm or death) as % of all patient safety incidents	0%	0%	0%	0%	0%	**0%**

Benchmarking with national data

The National Reporting and Learning Service report that for the period April-September 2013 the proportion of incidents resulting in severe harm or death remains less than 1% of all incidents reported. For the period April 2013 to March 2014, The Royal Marsden is well below this rate at 0.21% for the hospitals during 2013/14 and 0% for SMCS as displayed in the tables above.

What did we do in 2013/14?

- We strengthened the use of the World Health Organisation (WHO) Surgical Safety Checklist to promote the safety of patients in the pre, peri and post-operative period.
- We invested in new digital assisted defibrillators throughout the Trust to be used in the event of cardiac arrest.
- We strengthened the use of the national venous thromboembolism prevention and treatment algorithims across the Trust.
- We continued to work on preventing medication errors and falls.

What actions are we planning to improve our performance?

- To increase the use of the Team Simulation for Emergency situations to other clinical teams.
- Introduce the use of the new National Early Warning System which will be audited throughout 2014/15.
- Investigate the use of the relevant computerised systems to ensure clinical teams intervene early when patients deteriorate.

How will improvements be measured and monitored?

- Through the specialist Morbidity and Mortality meetings
- Clinical audit
- National mandatory audits

Priority 3

Reduction in venous thromboembolism (VTE) events/clot formation. Percentage of admitted patients risk assessed for venous thromboembolism.

Target

Maintain above 95% the number of all appropriate patients who will have venous thromboembolism (VTE) assessment within 24 hours of admission and receive the appropriate dose of prophylaxis.

"The clinical teams continue to work hard to ensure that all patients are promptly assessed for the risk of VTE and that the appropriate preventative measures are in place."

Steve Scholtes
Senior Nurse Manager/Matron for Cancer Surgery

VTE is a collective term for deep venous thrombosis and pulmonary embolism. A deep vein thrombosis is a blood clot that forms in a deep vein (usually in the leg) and sometimes a clot breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism. VTE can be avoided by giving preventative treatment (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.

How did we perform in 2013/14?

We have achieved the NHS Commissioning for Quality and Innovation (CQUIN) target of 95% compliance for ensuring all of our patients are appropriately assessed for risk of VTE in 2013/14. We have continued to monitor our compliance with appropriate prophylaxis prescription as part of a Key Performance Indicator (KPI). Furthermore we have also achieved this at more than the 95% level of appropriate prophylaxis being prescribed to prevent VTE.

VTE	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4	**2013/14 Q1**	**2013/14 Q2**	**2013/14 Q3**	**2013/14 Q4**
Quarter target	96%	97%	97%	96%	**98%**	**97%**	**95%**	**97%**
Prophylaxis prescribed	96%	96%	96%	96%	**98%**	**97%**	**100%**	**98%**

What did we do in 2013/14?

The multidisciplinary VTE Steering Board is now well established and VTE risk assessment for all appropriate patients is embedded clinical practice in the hospital. All elective inpatients are sent information leaflets in advance of their admission to inform them of what they can do to help prevent clot formation. Furthermore, posters and patient information leaflets are available in the clinical areas or from Patient Advice and Liaison Service (PALS).

More specifically the steering group has directed the following actions:

- Ensured that every confirmed diagnosis of a hospital acquired VTE undergoes a root cause analysis (RCA) to determine the underlying cause of the VTE and if any other preventative action could be taken. The consultant in charge is asked to fill in a specific VTE RCA of the patient. Compliance with this is now measured as part of our CQUIN programme.
- Performance managed the compliance with risk assessment; detailed performance reports are sent out to appropriate staff daily. Appropriate prophylaxis prescriptions are monitored monthly.
- The VTE risk assessment may be completed using either the patient's drug chart, this also contains information on appropriate prescribing for the junior doctors, or risk assessment may be completed within the electronic clinical documentation system as part of the clerking process.
- The day units are developing a specific patient information leaflet which advises patients to consider buying stockings if they notice a reduction in energy levels and reduced mobility when at home.
- Updating of the VTE patient information booklet in line with NICE guidance published in June 2012.
- An audit of patients' receipt of written and verbal information around VTE on their admission (audit underway at time in May 2014).

What actions are we planning to improve our performance in 2014/15?

- Daily score cards will be sent to VTE leads to check on progress
- Monthly compliance checking VTE reassessment within 24 hours
- All hospital acquired thrombosis will be reviewed by consultants who will check for recurring themes
- Monthly VTE Steering Group meetings have been scheduled
- VTE discussion and presentation at each Junior Doctor's induction
- Ongoing audit of patient information and support received in the outpatient departments
- Developing specific patient information for patients in day care
- Ensuring there is minimal delay when patients present with a potential clot, review time from attendance to appropriate radiological intervention quarterly
- Plan to audit whether patients are provided with both written and verbal VTE patient information (plan to start following approval in February 2014).

How will improvement be measured and monitored?

VTE incidents and performance with assessment and prevention procedures will be monitored by the VTE Steering Board. Performance will also be monitored at the Key Performance/CQUIN Steering Board and through the monthly Board scorecard. The Trust has achieved its targets; however this will continue to be included as a priority for 2014/15 as this remains an important indicator of improvement in protecting patients from avoidable harm. In 2014/15 the actions described above will be ongoing and embedded into practice. This will be demonstrated by ongoing monitoring and audit of compliance.

Priority 4

Reduction in community acquired category 3 and 4 pressure ulcers: applies to Sutton and Merton Community Services (SMCS).

Target

To reduce the incidence of severe community acquired category 3 and 4 pressure ulcers.

"The Community Nursing Teams have developed their knowledge and skills extensively both in the management and prevention of pressure ulcers within the community environment, which is often diverse and challenging. This knowledge has caused a change in the culture of pressure ulcer treatment within the Community Nursing Teams and has improved the quality of care provided to patients."

Jane Hopping
Clinical Nurse Specialist for Quality and Safety
Sutton and Merton Community Services

What did we do in 2013/14?

This remains a challenging but important priority for SMCS and we have continued to focus upon the prevention and management of pressure ulcers for the benefit of patients. A review of the entire caseload of patients was undertaken in January 2014, to provide assurance of the accuracy of reporting the incidence of category 1, 2, 3 and 4 pressure ulcers. By identifying the category 1 and 2 pressure ulcers in a timely manner and ensuring that all appropriate patient assessments, treatments and provision of pressure relieving equipment is in place, it is anticipated that the development of avoidable category 3 and 4 pressure ulcers will be diminished.

How did we perform in 2013/14?

Table 1 shows the number of category 3 and 4 pressure ulcers that were acquired in either the community or hospital setting. The number of category 3 pressure ulcers increased in February 2014, which can be attributed to improved reporting of all pressure ulcers as incidents. We have maintained less than 0.25% of the total number of community nursing accepted referrals acquiring category 3 or 4 pressure ulcers whilst under the care of SMCS for the last two years.

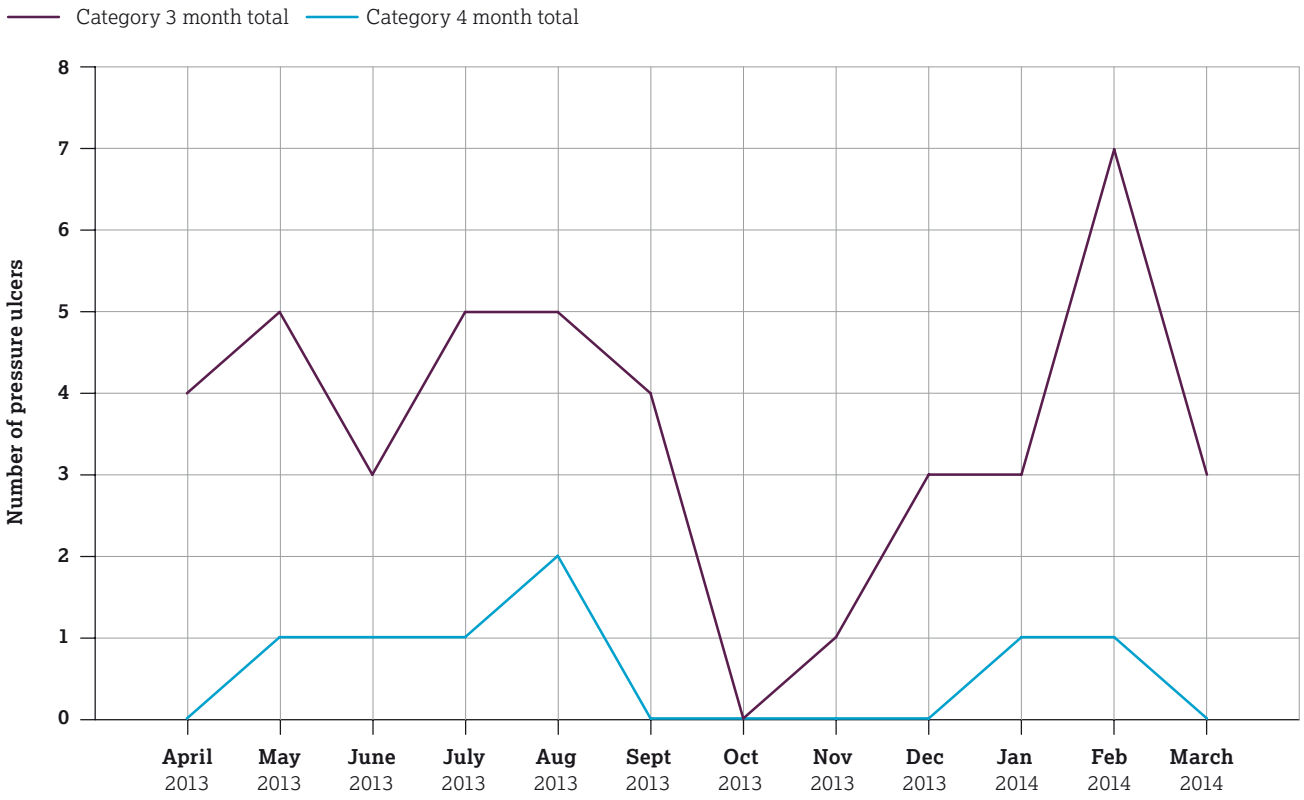
From April 2013 to March 2014, 50 patients acquired category 3 and 4 pressure ulcers and some patients acquired more than one pressure ulcer.

Table 1: number of acquired category 3 and 4 pressure ulcers

	2012/13		2013/14	
	Community	Hospital	**Community**	**Hospital**
Category 3	38	2	**43**	**7**
Category 4	9	1	**7**	**0**

Graph 1 outlines the number of pressure ulcers (category 3 and 4) that were acquired within the community setting during the period April 2013 to March 2014.

Graph 1: Community acquired category 3 and 4 pressure ulcers



What actions are we planning to improve our performance?

A large programme of work continues by Sutton and Merton Community Services to address pressure ulcer prevention and management strategies, which is led by a group of key stakeholders. All category 3 and 4 incidents are investigated and presented at panels every two weeks to identify root causes and to learn from incidents to improve care for patients. The findings from panels are presented to the Trust's Integrated Governance and Risk Management Committee and shared with commissioners. From these panels the following pieces of work will also continue as follows:

- Reviewing the category 1 and 2 pressure ulcers and ensuring that all appropriate care is in place for these patients.
- Shared learning for teams by encouraging representative attendance from each locality at panels and sharing all action plans with community nursing teams.
- Training programmes for internal staff are now mandatory on pressure ulcer prevention and management, including the importance of documenting patients' assessments, care plans and the availability of pressure relieving equipment for patients.
- Training and education for local authority staff (formal carers) is available.
- Work on joint care planning with local authority staff that provide care to patients known to the community nursing teams.
- Provision of the expert resource of a Tissue Viability Nurse in each of the four current community nursing localities.
- The Pressure Ulcer Prevention and Management policy will be reviewed and updated to reflect any changes in documentation and processes.

How will improvement be measured and monitored?

All category 3 and 4 incidents will continue to be investigated and presented at twice monthly panels to identify root causes and to learn from incidents to improve care for patients. The findings from panels will be presented to the Trust's Integrated Governance and Risk Management Committee and shared with commissioners.

Priority 5

To increase the number of patients that die in their preferred place of death. Applies to acute and Sutton and Merton Community Services.

Target

To achieve more than 42% of patients dying in their preferred place of death.

"The Palliative Care team works closely with the multidisciplinary team to provide the best possible care for patients and their families. This is achieved by the prevention and relief of symptoms and in supporting patients to discuss their wishes and preferences around death and dying."

Anna-Marie Stevens
Macmillan Nurse Consultant
Palliative Care

What did we do in 2013/14?

To increase the numbers of patients dying in their preferred place of death where previously indicated and recorded on Coordinate my Care (CMC) to over 42% as reported in The National Primary Care Snapshot Audit in End of Life Care (2009). Coordinate my Care is a communication clinical service that aims to coordinate end of life care for patients who often receive care from multiple providers, allowing patients to have choice and improved quality of end of life care. Coordinate my Care is hosted by The Royal Marsden NHS Foundation Trust.

How did we do in 2013/14?

The group of patients analysed for this quality priority are those known to The Royal Marsden (i.e. patients known to the acute trust). Each quarter Coordinate my Care collects all the data around patients known to The Royal Marsden who have died and if they achieved their preferred place of death.

Of the 13 patients who died that were registered with Coordinate my Care, eight achieved their preferred place of death, a further one person died at home, one person died in a nursing home (which was their usual residence) and for the remaining three people no actual place of death was recorded.

What actions are we planning to improve our performance?

Education

- Palliative care inhouse study days to include advance care planning
- Nursing education on identifying progression in relation to end stages of life
- Close partnership working between palliative care and oncology teams
- Education and training for nursing homes in Sutton and Merton to help facilitate optimal end of life care and care planning.

Multidisciplinary team working

- Involvement of Hospital2Home team when patients are being officially discharged from hospital with no further follow up appointments scheduled
- Use of the weekly Palliative Care multidisciplinary team meeting to ensure that preferred place of care and death is being addressed for patients known to the Palliative Care team

Support and engagement

Support and active engagement with Coordinate my Care following its roll out across London with associated education programme to:

- Highlight the importance of addressing preferences with patients for end of life care
- Improve documentation between different healthcare providers to ensure smooth transfer of accurate, up to date information on end of life care preferences

How will improvement be measured and monitored?

- Weekly review of outcomes for preferred place of care and death for patients referred to the Hospital2Home service
- Weekly reporting on 'preferred place of death' from the Coordinate my Care team. This information is then disseminated to lead clinician and lead end of life commissioner within each Clinical Commissioning Group
- Monthly/quarterly reporting on interventions in nursing homes of Sutton and Merton to commissioners
- Ensure all data is being entered accurately to Electronic Patient Record to validate Coordinate my Care.

Priority 6

To increase the number of patients who are offered a Holistic Needs Assessment.

Target

Increase the proportion of designated patients who will be offered a Holistic Needs Assessment (HNA) by the end of 2013/14.

"Holistic Needs Assessment and care planning allows us to work in partnership with anyone affected by cancer to ensure they receive individualised care."

Natalie Doyle
Nurse Consultant
Living With and Beyond Cancer

The National Cancer Survivorship Initiative (NCSI) has delivered a programme of work designed to improve patient outcomes and their experience of healthcare.

A key intervention identified as being the most important building block for achieving good outcomes in 2014 is the Recovery Package: a combination of assessment and care planning, treatment summary and cancer care review, and patient education and support events (Health and Wellbeing clinics).

A Holistic Needs Assessment (HNA) is a process of gathering information from the patient and/or carer in order to inform discussion and develop a deeper understanding of what the person living with and beyond cancer knows, understands and needs.

If the patient chooses to identify any concerns or needs then a care plan is completed which takes into account any holistic needs that have been raised by the patient. In quarters 3 and 4, 34 new patients chose to identify needs and a further five identified holistic needs at the end of their treatment.

Holistic Needs Assessment is not a one-off exercise, but is the basis of assessment and care planning from diagnosis onwards.

How did we perform in 2013/14?

An audit of data from October to December 2013 showed that 649 of 817 (79%) newly diagnosed patients that were seen by Clinical Nurse Specialists were offered a Holistic Needs Assessment. This shows an improvement from the previous year when from October 2012 to December 2012, 231 out of 805 (29%) newly diagnosed patients seen by Clinical Nurse Specialists were offered a Holistic Needs Assessment.

What did we do in 2013/14?

The Trust is in the process of rolling out Holistic Needs Assessment and Care Planning for patients with all tumour types at two designated points in the patient pathway in line with the agreed London Cancer Alliance metrics of 25% achievement in quarter 1 and quarter 2 increasing to 50% achievement for quarter 3 and quarter 4. This target has been achieved.

The metric states that each person will be “offered” an Holistic Needs Assessment and those accepting will have a care plan developed. Thirty-nine patients chose to have a care plan developed.

A Holistic Needs Assessment should be offered:

– Firstly within 31 days of diagnosis or transfer of care to The Royal Marsden

– Secondly at a point six weeks from completion of primary treatment (to note this varies for each tumour type)

In addition to this, The Royal Marsden was chosen as a prototype site for the Macmillan electronic Holistic Needs Assessment (eHNA) project, to test the electronic Holistic Needs Assessment and provide feedback to shape further development.

Currently eHNA is underway for breast and gynaecology patients at the start and end of treatment. Uniquely, at The Royal Marsden Macmillan Patient Support Worker’s lead the assessment with CNS support for care planning and reviewing.

What actions are we planning to improve our performance?

Practical support is also being offered to all those undertaking Holistic Needs Assessment from a variety of sources and individual teams and Clinical Nurse Specialists are undertaking service evaluations to demonstrate the strengths and weaknesses of their own areas and develop action plans.

How will improvement be measured and monitored?

Data collection started in quarter 1 and quarter 2 and during quarter 3 and quarter 4 a spreadsheet has been designed to enable monthly collection of data by each Clinical Nurse Specialist (Key Worker). Data is then submitted to the Divisional Clinical Nurse Director (DCND) and will be monitored, collated and submitted by the DCND and the Nurse Consultant Living With and Beyond Cancer (LW&BC) quarterly to the London Cancer Alliance and The Royal Marsden Quality Account.

Due to incomplete data collection in quarter 4 work will be undertaken to improve the data collection method.

Priority 7

Avoidance of emergency readmissions to hospital within 28 days of discharge.

Target

To achieve a reduction in the number of avoidable readmissions to hospital within 28 days of discharge.

"The 28 day rule assists in reducing patients' anxiety at an important stage of their treatment pathway."

Steve Scholtes
Senior Nurse Manager/Matron for Cancer Surgery

How did we perform in 2013/14?

Graph 1 shows the percentage of patients that were readmitted within 28 days from April 2012 to March 2014. Readmissions have remained below 1% of all admissions since April 2012. Some emergency readmissions following discharge from hospital are an unavoidable consequence of the original treatment, however some can be potentially avoided through ensuring the delivery of optimal treatment according to each patient's needs, careful planning and support for self-care. Since 2012/13 trusts are expected to include in their Quality Account the percentage of patients of all ages and genders who were readmitted within 28 days of being discharged; and the national average for the above percentage (NHS Operating Framework 2012/13). It is important to note that some readmissions will inevitably include patients who are admitted with side effects of treatment therefore it may be difficult to explain any differences between The Royal Marsden with other acute trusts.

Graph 1: Percentage of emergency readmissions within 28 days

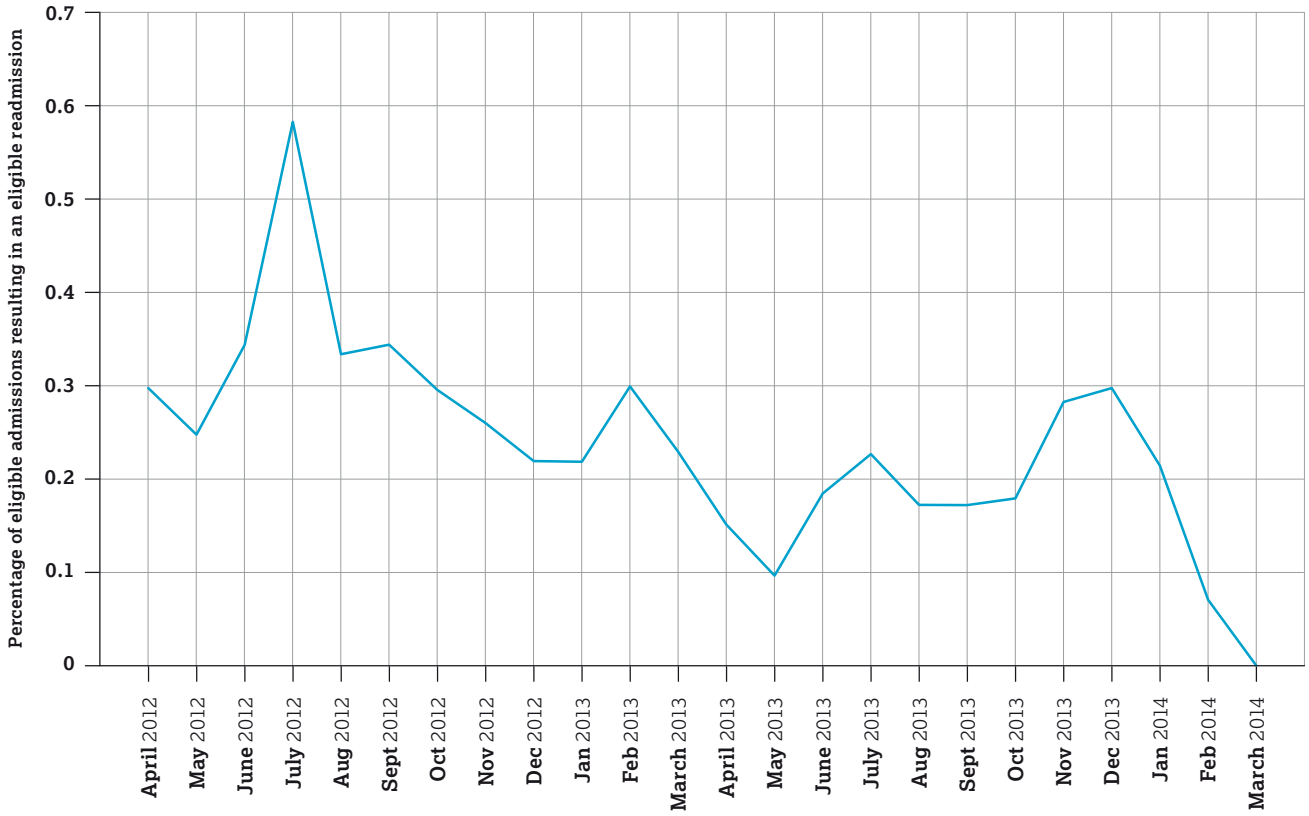


Table 1: Number of patients that were readmitted within 28 days from April 2013 to March 2014.

Month	Number of patients readmitted within 28 days
April 2013	6
May	4
June	7
July	10
August	7
September	7
October	8
November	12
December	12
January	10
February	3
March	0
Total	**86**

What did we do in 2013/14?

Together with the South West London Acute Commissioning Unit we undertook an external audit of all readmissions over a 12 month period.

The results were presented at the Clinical Quality Review Group (CQRG).

What actions are we planning to improve our performance?

- Continuous review and evaluation of clinical care especially using the Enhanced Recovery Programme (ERP)
- Working together to ensure optimal discharge planning
- Monthly prospective audit to monitor rates.

Priority 8

Reduction in chemotherapy waiting times and improvement in patient experience related to waiting times.

Target

To reduce chemotherapy waiting times at Sutton and Chelsea sites and improve the patient experience related to waiting times.

"Within the medical day units we are committed to delivering high quality care and the patient experience is at the heart of everything we do."

Judith Pears
Service Manager
Cancer Services Division

What did we do in 2013/14?

The management of chemotherapy times involves ensuring that it is always safe to proceed to chemotherapy following its complex preparation in an aseptic unit (where staff are gowned and gloved to prepare chemotherapy). Furthermore several checking procedures have to be undertaken. In addition, the data below also includes patients who are on clinical trials. Some chemotherapy research studies need up to four hours preparation time once go-ahead for treatment has been confirmed.

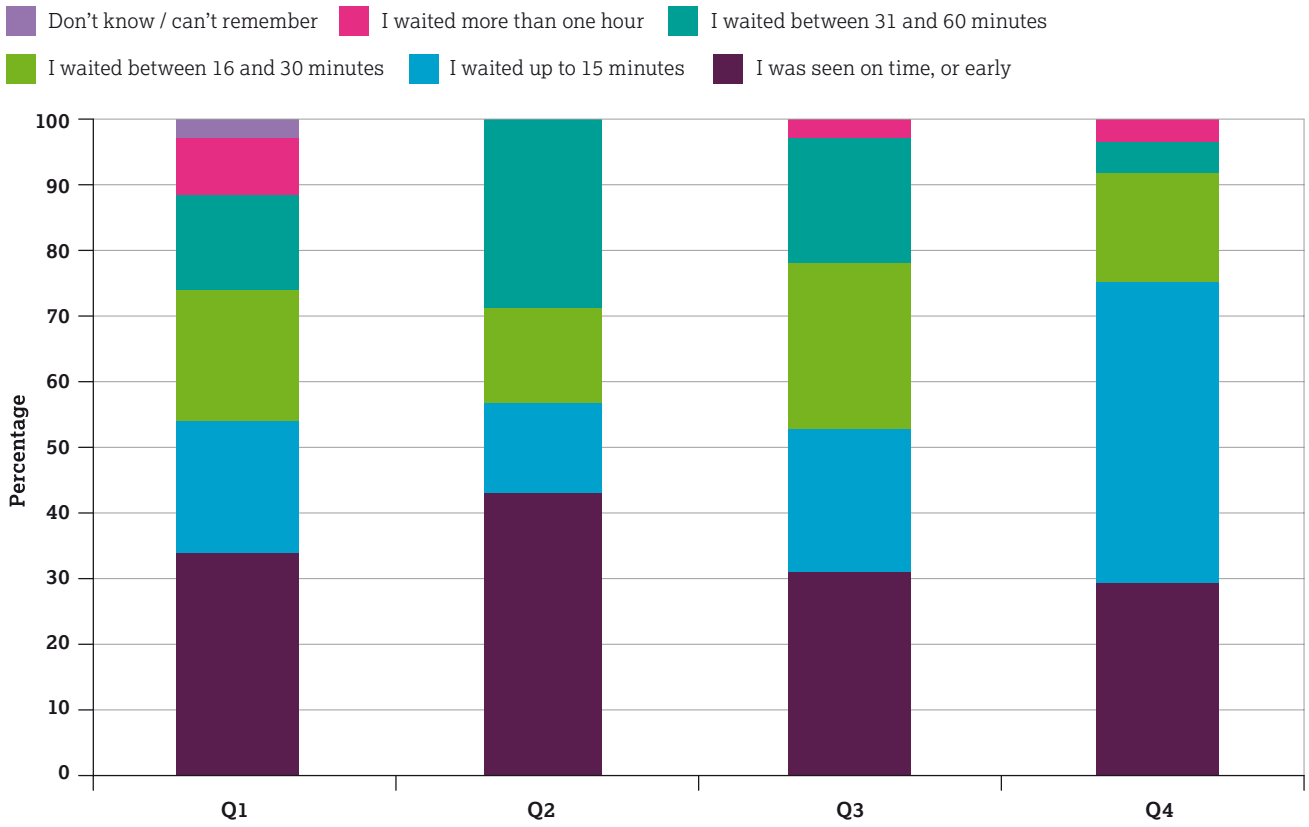
How did we perform in 2013/14?

Patients are asked to give their feedback in real time. As they leave the outpatients department volunteers ask patients to give their responses on hand held devices to a variety of questions about their appointment. This is the fifth year that patients have been asked to answer questions about their experience.

As displayed in figure 1, there has been a gradual improvement in the number of patients seen either on time or early whilst there has been a significant decrease in patients waiting between 30 minutes to one hour. This improvement was delivered via the following interventions:

- Introduction of a new appointment system at Chelsea site to improve treatment appointments and reduce waiting times
- Planned introduction of scheduling system at Sutton from April 2013
- Improvements in pre-prescribing of chemotherapy to give pharmacy time to prepare chemotherapy in advance of the visit
- Production of a new patient information leaflet to inform patients about the process of chemotherapy production
- Improved communication between the staff and patients to keep them informed about their wait
- Announcements are made every 30 minutes in the outpatients department if clinics are running behind
- Individual staff have been tasked to inform individuals in the Medical Day Unit of the reason why they have to wait.

Figure 1: How long after the stated appointment time did the appointment start?



What actions are we planning to improve our performance?

The Trust is working hard at reducing the chemotherapy waiting times and improving the patient experience through the following:

- New information leaflets explaining the visit for treatment
- Waiting time information for display on the Medical Day Unit (MDU) has been implemented
- Staff will continue speaking with individual patients when delays to appointments occur
- Improved alignment of the medical staff daily schedule with the configuration of MDU appointment times.

How will improvement be measured and monitored?

Results will continue to be discussed with the outpatient teams and where relevant action plans compiled to make improvements. The results will continue to be reviewed at the Patient Experience and Quality Account committee every quarter.

Priority 9

Ensure that we are responding to inpatients' personal needs.

Target

To improve in the responses to five questions related to 'improving responsiveness to personal needs of patients'. These five questions are taken from the national inpatient survey which is reported by the Care Quality Commission.

"Since the introduction of the Friends and Family Test lots of positive feedback has been received, this has been reassuring and boosting for staff. The comments and feedback are used in ward meetings to locally target areas for improvement."

Richard Schorstein
Matron
Private Care

What did we do in 2013/14?

Delivery of personalised medicine is one of the Trust's strategic priorities. It is therefore important that we understand the patient experience when they attend outpatient departments, day units and inpatient areas. We have been asking patients to tell us about their experience since May 2009 using frequent feedback hand-held devices in our day units and outpatient areas and the matrons are responsible for developing action plans in response to recurrent concerns. Since 2012 these started being used in the inpatient areas.

How did we perform in 2013/14?

Inpatient Survey 2013 CQUIN data

The NHS Commissioning for Quality and Innovation (CQUIN) groups together five questions from the annual national inpatient survey that indicate how trusts perform in 'improving responsiveness to personal needs of patients'. The following five questions are below and the first table shows the most recent results and the second table shows the scores over the previous three years.

Q32 Were you involved as much as you wanted to be in decisions about your care and treatment?

Q34 Did you find someone on the hospital staff to talk to about your worries and fears?

Q36 Were you given enough privacy when discussing your condition or treatment?

Q56 Did a member of staff tell you about medication side effects to watch for when you went home?

Q62 Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

An external organisation was commissioned by The Royal Marsden and 75 other trusts to undertake the Inpatient Survey 2013. The results in table 1 are taken from that data and show that The Royal Marsden exceeded the average results compared to the other 75 trusts. The Royal Marsden had a response rate of 60% compared with 46% in the other 75 trusts.

Table 1: 2012 and 2013 results

	Q32	Q34	Q36	Q56	Q62
The Royal Marsden 2013	**73.8%**	**61.1%**	**82.1%**	**63.2%**	**92.4%**
All trusts 2013	54.8%	38.4%	72.7%	40%	69.8%
The Royal Marsden 2012	**78.3%**	**61.3%**	**85.1%**	**60.6%**	**89%**
All trusts 2012	54.6%	37.7%	71.7%	39.6%	70%

In previous years the Patient Experience CQUIN results were calculated and reported by the Care Quality Commission for all trusts participating in the National Inpatient Survey for The Royal Marsden. Table 2 shows results for the previous years. These were not calculated and used as a measure by the Care Quality Commission for the 2013 survey. Overall the Care Quality Commission reported that 156 trusts participated in the 2013 survey with an average response rate of 49% (62,400 patients) with the Trust's response rate of 60% (474 patients).

Table 2: CQUIN results 2010-12

Year	Q32	Q34	Q36	Q56	Q62	Overall CQUIN score
2012	86.8	76	92.2	73	93	84.2
2011	83.4	75.7	91.6	70.4	92.8	82.8
2010	82.3	74.6	90	68.4	94.5	82

Friends and Family Test

The NHS "Friends and Family Test" was announced by the Prime Minister on 25 May 2012. All trusts were expected to be "live" by 1 April 2013. Nationally all patients are asked a simple question to identify if they would recommend a particular A&E department or ward to their friends and family. The results of the test will be used to improve the experience of patients by providing timely feedback alongside other sources of patient feedback. It will highlight priority areas for action.

The Royal Marsden elected to be an early implementer site and therefore started collecting the data in February 2013. Outside all wards across the Trust there is a poster and collection box. All adult patients who have been an inpatient for more then one night are asked to complete the Friends and Family Test form and then to put it straight into the collecting box. Once a week the forms are collected and an external company collates and presents the data.

The national mandated 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 select their answer from the following scale:

– Extremely likely

– Likely

– Neither likely nor unlikely

– Unlikely

– Extremely unlikely

– Don't know.

The Royal Marsden has then chosen to add a second question:

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

Patients answer this question with free text comments. Comments are reviewed by the matrons and ward staff and where appropriate actions are taken.

Table 3: Trust's results for both NHS and private care inpatients

2013/14	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Average**
Trust net promoter score (out of 100)	95	95	95	94	95	93	90	90	88	90	87	92	**92**
Average score (NHS and private care) (out of 5)	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.86	4.92	**4.9**
Number of responses	189	142	254	170	222	243	149	256	191	290	119	508	**Total: 2733**

^ following a low response rate in February 2014 ward staff were asked to ensure the cards were handed out and the methodology for collecting cards was changed.

The table below shows the number of patients that were discharged each quarter and how many responded. The Trust achieved the target set for the response rate each quarter.

Table 4: Response rates of the number of patients discharged each quarter

	2013/14				
Quarter	Q1	Q2	Q3	Q4	**Total**
Discharges	2191	2471	2234	1681	**8577**
Responses	585	635	596	711	**2527**
Response rate	27%	26%	27%	42%	**29.5%**
Target	25%	25%	25%	25%	**25%**

National Friends and Family Test results reporting

NHS England displays the information that has been collected each month for 170 Acute NHS trusts and independent sector providers for inpatients. Data in http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

Nationally, for March 2014 the overall average inpatient score for NHS trusts and independent sector was 73 with specialist hospitals scoring higher than general acute trusts.

For the month of March 2014, The Royal Marsden was in the top ten of trusts nationally with a score of 94. Table 5 shows the results for the Trust over each quarter to date taken from the national dataset.

Table 5: National Friends and Family Test data showing The Royal Marsden score

The Royal Marsden	Q1	Q2	Q3	Q4	**2013/14**
Overall FFT score	95	94	92	91	**93**
Response number	585	635	450	711	**2381**

What actions are we planning to improve our performance?

The Trust will continue to monitor the response rates each month and will take appropriate actions to ensure that patients are given the opportunity to respond to the Friends and Family Test after they have been discharged from the hospital.

How will improvement be measured and monitored?

Results will continue to be disseminated to the ward sisters and matrons each month and actions will be taken following any comments for improvements that are made. The results will continue to be reviewed at the Patient Experience and Quality Account committee every quarter and reported each month to The Royal Marsden Board.

Priority 10: Part A

Monitoring of the percentage of staff who would recommend The Royal Marsden to friends and family.

Target

To maintain or increase the staff survey result to this specific question in the annual national staff survey.

"Sharing the Friends and Family Test results with local teams and through meetings helps staff keep in touch with how patients experience our services. Staff also provide valuable insights into where we need to improve our services more."

Sam Greenhouse
Assistant Director Organisational Development

The national staff survey is conducted annually. In 2012/13, 87% (421/485) of staff agreed with the statement:

If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust which is used as an indicator of this priority.

What did we do in 2013/14?

We continued to discuss patient services with staff and work with them to identify and implement ways in which services could be improved. We shared outcomes of patient surveys and our monitoring reports with staff. The results of these tests are used to plan improvements and shared with staff both in the local ward areas and more widely across the Trust including in open meetings held by the Chief Executive.

How did we perform in 2013/14?

In the 2013/14 staff survey 87% (1450/1670) of staff agreed with the following statement:

If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. This maintains the high rate of last year's result.

In 2013/14 all staff (rather than a sample) had the opportunity to give feedback through the staff survey. Therefore there are much higher numbers of respondents than previous years. The same rates of agreement have been achieved.

Table1: Numbers of staff responding to question in national staff survey

	Agreed or strongly agreed	Neither agree nor disagree	Disagreed or strongly disagreed
2013	**1450 (87%)**	**179 (11%)**	**41 (2%)**
2012	421 (87%)	51 (10%)	13 (3%)
2011	408 (85%)	55 (11%)	19 (4%)

What actions are we planning to improve our performance?

- Continue to encourage staff feedback on how our patient services could be improved
- Regular promotion of quality monitoring reports and other information on our performance, including the patient 'friends and family' test responses to staff
- Conduct quarterly staff 'friends and family' tests.

How will improvement be measured and monitored?

- Conduct quarterly staff 'friends and family' tests from quarter one 2014/15 onwards.

Priority 10: Part B

Introduce a patient experience survey for Sutton and Merton Community Services (SMCS).

Target

To achieve a baseline measurement and if possible benchmark with other community services.

"Patient survey feedback has demonstrated the importance of producing good quality service information leaflets. Through consistent and accurate information, many concerns about services can be alleviated and patients can better understand their role in treatment and rehabilitation."

Susan Bedford
Patient and Public Engagement Manager
Sutton and Merton Community Services

What did we do in 2013/14?

SMCS used the validated CARE (Consultation and Relational Empathy) measure as its patient experience survey in 2013/14.

The CARE measure was provided to service users over a given time period. This ranged from one week to three months, depending on service caseload numbers. Alternative versions of the measure were available and included:

– Tamil and Polish translated measure

– The Visual CARE measure for patients who had cognitive or communication difficulties

– An amended version of the Visual CARE measure for children age 12 years and over and a version for parents of children under the age of 12 years.

The measures were returned in the following ways:

– Outpatient and clinic settings – return boxes

– Community based services – self-addressed envelopes

– Community nursing services – phone surveys from an independent service.

How did we perform in 2013/14?

To ensure high quality standards within the organisation, only an answer of 'excellent' or 'very good' was deemed to be an acceptable measure of satisfaction. All services had an 80% target for patient satisfaction as part of their key performance indicators.

Total of valid patient questionnaires returned = 1559

The division achieved a target score of 80% or higher (for combined excellent and very good responses) for all ten questions.

SMCS managed to maintain its 80% target this year whilst increasing user feedback by a further 92% from last year's data. The average scores for a combined excellent and very good score were reduced slightly however the improved participation from services ensures a wider selection of views was reported.

What actions are we planning to improve our performance?

The 2013/14 patient experience results show that 50 survey returns were not achievable for each of the participating 33 services. In future, samples should reflect the current caseload numbers for each service at the time of survey delivery.

Retrieval of paper data was hampered by local collection methods and postal errors. A centralised data collection method will reduce errors and facilitate real time reporting.

The survey should be delivered in the most appropriate method for the service e.g. paper, phone or web link.

The majority of service users either chose not to comment on the service or made a positive comment. Of the 73 comments made highlighting dissatisfaction (4.68% of total respondents) there were three main themes: a lack of staff continuity, unrealistic service expectations and poor empathy of staff. SMCS has the following mechanisms planned or in place to improve performance and patient experience for 2014/15:

– Community nursing is now using a T-card system to identify and distribute workload. This aims to improve efficiencies and continuity of visiting staff.

– All of the clinical teams within SMCS are involved in a review of their service information leaflets for patients. This commenced in 2013 and it is anticipated that all services will have up to date literature outlining service expectations by the end of 2014/15.

– An increased range of patient experience surveys will identify any areas of poor patient experience. Currently patients are encouraged to report such experiences via the Patient Advice and Liaison Service (PALS) or to make a formal complaint. This information is highlighted in all new service information leaflets.

To increase the range of patient experience information obtained, SMCS have developed three more surveys for 2014/15:

– SMCS Generic Survey – a general survey about quality of care, information etc.

– Carer Survey – a survey asking how well SMCS support carers to care.

– Health Visiting Survey – specifically for health visiting service users.

How will improvement be measured and monitored?

For 2014/15 SMCS will move to a different computerised system to deliver and collate patient experience. This will reduce errors in data retrieval and provide greater flexibility for obtaining patient experience feedback in the future. Real time access to reports will enable services to monitor and action issues throughout the year. It is anticipated that surveying the patient experience will extend to a further 13 services making a total of 46 participating services.

Following the last two years results it is appropriate to increase the target of the CARE Measure results to 85%.

The new additional patient experience surveys will keep an 80% target for satisfaction.

Priority 11

^Improve communication, particularly when patients arrive for first appointments.

Target

Increase or maintain the high percentage of positive comments in dedicated patient feedback.

"Communicating effectively within Outpatients is a key priority to enhance the patient experience by keeping everyone well informed."

Toria Ward
Matron/Nurse Practitioner

Within our outpatient departments we strive to communicate well to our patients ensuring that they have a good experience particularly when attending for their first appointment.

We are continually seeking feedback on our communication and for several years have asked patients to give feedback in real time of their outpatient experience including questions around communication. As they leave the department, volunteers ask patients a variety of questions about their appointment using a hand held device. The matrons and sisters are responsible for developing action plans in response to recurrent concerns. The results of these surveys are also shared with patients and staff at a local and Trust level.

What did we do in 2013/14?

- Purchased additional information display screens to inform patients of waiting times in clinics
- Commenced reception staff putting out regular tannoy announcements to update patients on all clinics running more than 30 minutes late
- Devised and implemented Outpatients (OPD) leaflet informing patients of what to expect during their OPD visit and contact details for further information
- Implementation of staff board – informing patients of name of doctors and nurses (with photographs) in clinics for that day
- Patient information board regularly updated informing patients of recent patient feedback results and actions we have taken to date
- Administrative coordinator role introduced into high volume clinics to assist with coordination and smooth running of clinic and to ensure reception staff informed of clinic times enabling them to update patients via tannoy/display screens
- Improved signage across the Trust including way finder assisting patients finding there way to OPD (particularly on first visit)
- Designed new posters ‘What is your key worker’ informing patients around the role of the ‘key worker’ and amendments made to clinical nurse specialist (CNS) contact cards to clearly state that they are their ‘key worker’
- Revision and update of information on the Trust’s outpatient internet website page
- Refurbishment of clinic rooms and purchasing of new chairs for waiting areas.

How did we perform in 2013/14?

(Combined average results for across site: Sutton and Chelsea)

The following show the questions that patients are asked and the responses.

Q2 Did you understand the purpose of your visit and what to expect?

Quarter 2013/14	Q1	Q2	Q3	Q4
Yes, completely	91%	91%	95%	96%
Yes, to some extent	8%	7%	4%	3%
No	1%	1%	1%	1%
Don't know	0%	1%	0%	0%

Q3 When you arrived at the outpatients department were you greeted politely at reception and made to feel welcome?

Quarter 2013/14	Q1	Q2	Q3	Q4
Yes	98%	99%	99%	99%
No	2%	1%	1%	1%
Don't know / can't remember	0%	0%	0%	0%

Q7 Were you kept informed about your waiting times?

Quarter 2013/14	Q1	Q2	Q3	Q4
Yes	58%	63%	55%	50%
No, but I would have been liked to have been kept informed	21%	18%	25%	33%
No, but I didn't mind	21%	18%	19%	15%
Don't know / can't remember	0%	1%	1%	2%

Q10 Did the member of staff explain the results of the tests in a way that you could understand?

Quarter 2013/14	Q1	Q2	Q3	Q4
Yes, completely	85%	80%	80%	91%
Yes, to some extent	10%	10%	10%	6%
No	3%	7%	10%	2%
Don't know	2%	3%	0%	1%

Q11 Did the member of staff listen to what you had to say?

Quarter 2013/14	Q1	Q2	Q3	Q4
Yes, definitely	93%	92%	94%	93%
Yes, to some extent	4%	6%	5%	6%
No	0%	0%	0%	1%
Don't know	3%	2%	1%	0%

Q12 If you had any worries / concerns about your condition or treatment, did you feel able to discuss them with the staffing charge of your area?

Quarter 2013/14	Q1	Q2	Q3	Q4
Yes, completely	88%	88%	92%	90%
Yes, to some extent	8%	9%	7%	8%
No	1%	1%	1%	2%
Don't know	3%	2%	0%	0%

Q14 If you were given any new medications, or medications were changed did the staff explain the reason for change in a way you could understand?

Quarter 2013/14	Q1	Q2	Q3	Q4
Yes, completely	79%	75%	70%	85%
Yes, to some extent	8%	7%	5%	8%
No	10%	12%	25%	7%
Don't know	3%	6%	0%	0%

Q15 Were you given any written or printed information about your condition or treatment?

Quarter 2013/14	Q1	Q2	Q3	Q4
Yes	87%	94%	95%	98%
No, but I would have liked it	11%	4%	4%	2%
Don't know / can't remember	2%	2%	1%	0%

Q21 Were you allocated a 'key worker', or someone to contact if you are concerned about your care / treatment before your next appointment?

Quarter 2013/14	Q1	Q2	Q3	Q4
Yes	62%	76%	76%	78%
No	34%	21%	22%	21%
Don't know	4%	3%	2%	1%

What actions are we planning to improve our performance in 2014/15?

- Continue with Patient Experience Working Group taking actions and new initiatives forward to improve the patient experience / communication
- Increase the number of display screens in OPD to include Trust and department initiatives
- Regular review of Picker patient feedback data – questions have been reviewed to better reflect the areas we need feedback on and the picker action plan to be reviewed quarterly and fed back to the Integrated Governance and Risk Management committee
- Ensuring patients requiring blood tests pre first appointment are informed of this and have their clinic appointment scheduled accordingly
- Reduce the number of same day scans to prevent waiting times and enhancing patient experience and smooth running of clinic
- Introduce a robust system to monitor doctors' leave in order to pro-actively manage clinic numbers and reduce waiting times
- Introduce nurse-led telephone clinics for follow up patient to reduce the number of face-to-face appointments and prevent patients from attending the hospital unnecessarily
- Introduce nurse-led chemotherapy toxicity assessment clinics to reduce the waiting times for patients attending a chemotherapy clinic
- Implementation of a patient reminder system using text messages to remind patients of their appointments and enable them to cancel or change their appointment more easily
- Demand and capacity analysis to be undertaken by the clinical units
- Close liaison with the London Cancer Alliance to review the most appropriate pathways for patients
- Review of all patient information leaflets

How will improvement be measured and monitored?

- Monthly Picker data analysis and action planning
- Implementation of the 'Friends and Family Test' in outpatient areas
- Regular review of waiting times
- OPD and Rapid Diagnostic Assessment Centre Steering Group regular review
- OPD patient experience monthly meeting regular review.

Priority 12

^Reduce the length of time a patient waits for medicines or equipment at the point of discharge.

Target

Increase or maintain the high percentage of positive comments in dedicated patient feedback.

"The Trust has a multidisciplinary approach to discharge planning and recognises the importance of discharge as part a patient's journey. We have made information available and more accessible at the patient's bedside making patients feel more involved in the discharge planning process."

Scott Pollock
Discharge and Vulnerable Adult Lead

Medication

What did we do in quarter one of 2013/14?

An audit of discharge medication prescribing time and turnaround time showed that a considerable number of discharge prescriptions arrived either after 5pm the evening before or on the morning of discharge.

A multidisciplinary team reviewed the discharge medication prescribing process, roles and responsibilities to inform redesign of the pathway and process. The importance of prescribing discharge medication well in advance of discharge and as soon as the medication requirements are known was highlighted to prescribers.

There had been a number of incidents associated with delays in discharge because of a lack of a particular syringe driver (which administer subcutaneous medication continuously). Previously these syringe drivers had been distributed to the wards and were managed locally, however a large number of drivers went missing and were not returned (this equipment would often go home with the patient). Therefore the equipment loan library, in response to these incidents has developed a new system where they hold the reserve syringe drivers and each syringe driver is provided on a named patient basis. This has now led to a reliable central stock as each syringe driver is now logged out, and its ongoing requirement in and out of hospital is then subsequently checked by the team and fewer are lost.

How did we perform in quarter two and quarter three 2013/14?

Some improvement in performance of planned discharge and medication availability at discharge, particularly on those wards with a dedicated Medicines Management Technician.

A number of discharge prescriptions were still written immediately before discharge. There have been no incidents associated with delays in discharge because of the lack of the subcutaneous syringe driver.

What actions are we planning to improve our performance?

We are in the final stages of awarding a contract for a partner to provide different medication supply options. The multidisciplinary team will then review redesign of the pathway and process and will make proposals for pathway redesign in quarter four. We will continue to monitor the accessibility of the syringe driver. A monthly report is sent to the clinical engineering lead which is then actioned.

How will improvement be measured and monitored?

- Audit of discharge prescription prescribing time and availability at discharge.
- Number of discharges delayed by medication supply.
- Audit of syringe driver availability completed quarterly.

Discharge

What did we do in 2013/14?

In 2013/14 we piloted a patient bedside tool to ensure patients were informed of their discharge plans including if they required medicines for discharge and when they were on the ward. The tool is called “ticket home” and in the first two months there has been an improvement in the number of patients who have had medicines at the time they were due to be discharged. However, this initiative has proven challenging in the non-elective patient group. Attention will be focussed on elective surgical patients.

We will also develop a pilot where a member of the discharge team reviewing all patients who are being discharged in the next 24/48hrs to ensure medical review and to take out medications (TTOs) have been prepared in advance of the discharge date.

What actions are we planning to improve our performance?

– Roll out the ticket home project involving elective surgical patients in the first instance

– Continue to have a daily monitoring role for the discharge team.

How will improvement be measured and monitored?

Both the ticket home and discharge review project will continue and will be monitored and reported to the Non-Elective Working Group and the Chief Operating Officer operational meetings.

Priority 13

The uptake of immunisation working in partnership with primary care.

Target

Increase the percentage of children receiving preschool immunisations in partnership with GPs.

"In order to improve life chances and outcomes for children we have been working in partnership with GPs to improve their reporting of primary childhood immunisations data. This will enable children who are missing immunisations to be identified and immunised at the earliest point; thus improving the children's health and reducing their risk of serious illness and increasing the local uptake of immunisations in Sutton and Merton."

Anne Howers
Children's Clinical Services Director
Sutton and Merton Community Services

What did we do in 2013/14?

As providers of the CHIS (Child Health Information System), we have responsibility for the management of the database containing information about immunisations given to children aged 0-19. As the immunisation schedule evolves, the Child Health Information System is responding in its ability to report on new immunisations given. Rotavirus, childhood 'flu vaccine and meningitis B may all be added for reporting in the coming year, 2014/15.

As such, the Child Health Information System team has been communicating monthly with every GP practice, informing them of the children on their lists who are missing or due a preschool immunisation and which immunisation it is. The advent of a new electronic reporting system commissioned for GP practices and run by an external company has effectively reduced this communication, as the latter system extracts all the required data. However, management of these data is still required (i.e. identifying those children missing immunisations, in order to maintain the most accurate data); therefore, the Child Health Information System team continues to send monthly reports to practices where children's immunisations are missing.

In order to ensure the greatest accuracy of immunisation data, significant effort has been made by the Child Health Information System team to ensure that the caseloads are maintained accurately. This involves discharging children no longer registered with practices, thereby ensuring percentages reported to COVER (Cover of Vaccination Evaluated Rapidly) are the best reflection of the immunisation coverage achieved.

The Service Manager for Children's Information and Public Health continues to attend a joint borough immunisation meeting, at which there is representation from Public Health England, Clinical Commissioning Group immunisation leads and borough public health departments. The Royal Marsden attends as the provider and the group works to find partnership solutions to increase promotion and uptake of immunisations in local populations.

The Service Manager has commenced meeting regularly with the Clinical Commissioning Group lead for immunisations and has agreed to send information to both Clinical Commissioning Group leads regarding any practice that appears not to be engaging with our failsafe processes (missing immunisations, registration and deregistration of patients) in order that they can be followed up.

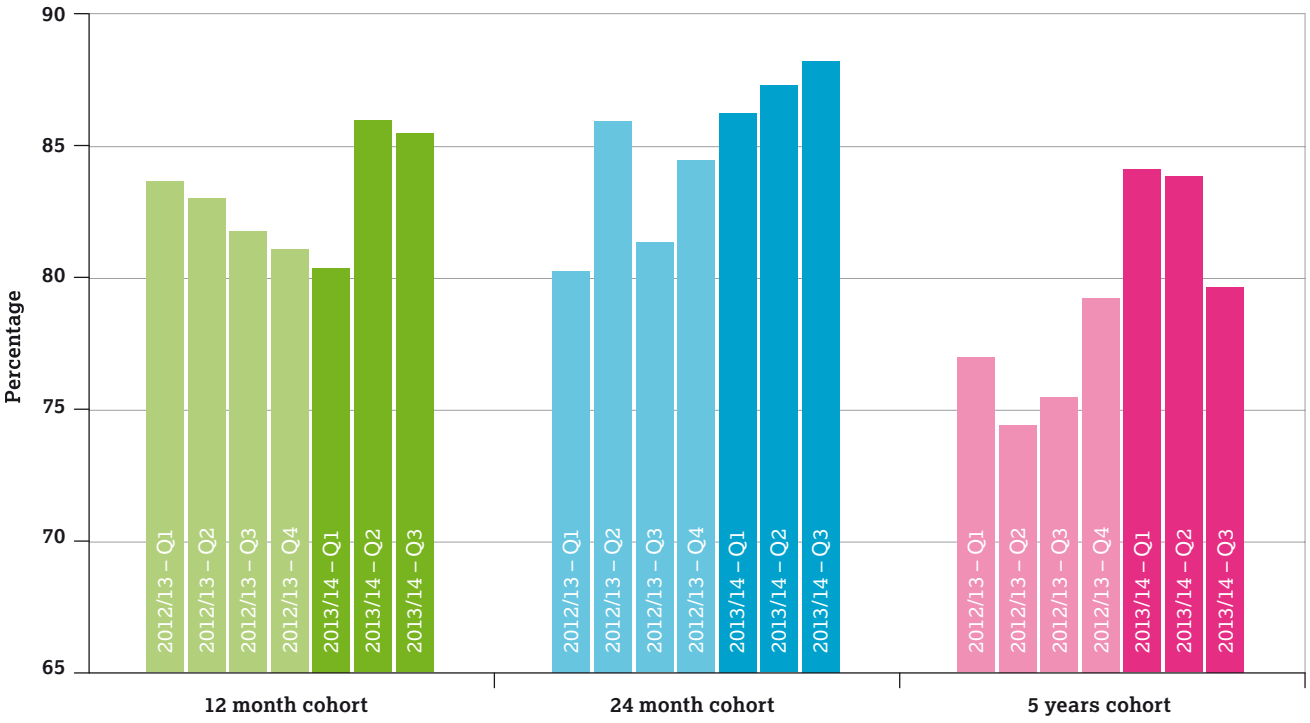
How did we perform in 2013/14?

GP engagement continues and monthly contacts are made with every practice in relation to children's GP registrations and deregistrations. We now regularly receive electronic reports about registrations and deregistrations into the Healthy Child Programme administration team from 41 practices; this is an increase from 27 last month. Practices which have not yet become involved are in discussion with the project lead. There remain 10 practices outstanding – five in Merton and five in Sutton – that have not yet commenced electronic notification of registrations and deregistrations. Meetings are now booked with practices to endeavour to move this forward.

'Missing immunisations' reports continue to be sent out monthly to all general practices in Sutton and Merton. The GPs make three attempts to contact the children who have missed a vaccination and, if these attempts fail, they can send a list to the health visitor to follow up.

The graph below shows the levels of immunisation achieved by local practices over the last two financial years, using practices' own data as collected and processed by the Child Health Information System. Note that data for the final quarter of 2013/14 are due to be submitted to NHS England and to Public Health England only at the end of May 2014, so figures were not available for presentation at the time of this report's publication. Each cohort below shows the date that the child reached at the time of the immunisation.

Cover 2012/13 – 2013/14 percentage of the population immunised



2013/14 data shown up to Q3 only; Q4 data are not available until end of May 2014

What actions are we planning to improve our performance?

We are continuing to work with each practice and to monitor data flows and returns. These have shown significant improvement throughout the year.

Health visitor update sessions were delivered to all health-visiting teams across the Trust and discussions held regarding the importance of emphasising and reminding clients of the immunisation programme and its timeline.

How will improvement be measured and monitored?

Monthly reports are sent to the Clinical Quality Review Group (attended by commissioners and providers), demonstrating the actions and improvement in each general practice's preschool immunisation rates; and the immunisation COVER data is sent quarterly to NHS England and to Public Health England.

Part 3

Outline of Quality Improvements in 2013/14

Monitor issued 'Detailed requirements for quality reports 2013/14' in February 2014. From 2011/12, all acute trusts are required to have limited assurance work performed on their Quality Accounts and Monitor issued '2013/14 Detailed guidance for external assurance on quality reports' in February 2014 to assist trusts. The Royal Marsden chose to include the proposed core set of quality indicators for requirements for 2013/14. Some of the indicators are not relevant to us e.g. ambulance response times, therefore these have been excluded.

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

The process for agreeing the priorities for quality improvement were as follows:

October 2013

- Key milestones and timetable outlined at the Patient Experience and Quality Account group were agreed. Members of the patient experience feedback group were: governors, Healthwatch, Sutton Health and Wellbeing Board, patients and carers, matrons from the hospital, and Sutton and Merton Community Services.

November 2013

- Review of first draft of the annual Quality Account 2013/14 priorities and progress
- Members' event to discuss progress with developing and selection of quality priorities

January 2014 – Review of progress

- Review second draft of annual Quality Account 2013/14
- Agreed on process for selecting quality priorities

February 2014 – Engagement

- Final draft of annual Quality Account 2013/14
- Senior Nurse and Therapies committee invited to review priorities
- Patient Experience and Quality Account group select quality improvement priorities
- Chief Nurse to discuss and agree measurable targets alongside relevant Trust staff
- Engagement and refinement – penultimate draft to Council of Governors, Healthwatch, Commissioners, Specialist commissioners, Health and Wellbeing Board, Patient and Carer Advisory Group; to comment and provide a statement about the annual Quality Account
- Draft to Royal Marsden staff for comments.

March 2014 – Engagement

- Patient Experience and Quality Account group finalise quality improvement priorities and targets for 2014/15
- Draft to external stakeholders for comments and statements
- Council of Governors meeting to review draft and give comments
- Chief Nurse informs Board of progress to date and obtain approval of quality improvement priorities and targets for 2014/15

April and May 2014 – Engagement and refinement

- Progress against 2013/14 targets to be added to final draft of annual Quality Account
- Copy to marketing and communications department
- To external auditors for review
- Final copy to designer via marketing and communications team

May and June 2014 – Submission and publication

- Reviewed at the Trust's Audit committee
- Trust's Annual Report submitted to Monitor by 30 May 2014
- Trust to publish annual Quality Account on NHS Choices website and Trust website and submit copy to Department of Health by 30 June 2014
- The quality priorities for 2014/15

The proposed quality priorities and targets for 2014/15 are displayed in the table below. The priorities marked with * were mandatory quality indicators in 2013/14 and remain mandatory for 2014/15. New priorities are marked with ^

Table 1: Quality priorities and targets for 2014/15

Safe care		
Priority 1	**Priority 2**	**Priority 3**
*Reduction in Healthcare Associated Infections (MRSA bacteraemia and *Clostridium difficile* infections) Applies to acute beds at The Royal Marsden and patients of Sutton and Merton Community Services (SMCS)	*Rate of patient safety incidents and percentage resulting in severe harm or death (in 2013/14 the rate of severe harm or death from incidents per 100 admissions was 0.008 for acute and 0.00 for community) Applies to acute beds and SMCS	*Percentage of admitted patients risk assessed for venous thromboembolism (VTE)
Less than one MRSA bacteraemia Less than 16 *Clostridium difficile* infections (report the number of *Clostridium difficile* infections per 100,000 bed days)	Reduction in the rate of reported patient safety incidents per 100 admissions that have caused severe harm or death to below 0.01	Maintain above 95% the number of patients who have a completed VTE risk assessment
Effective care		
Priority 4	**Priority 5**	**Priority 6**
*Avoidance of emergency readmissions to hospital within 28 days of discharge	Reduction in community acquired category 3 and 4 pressure ulcers: applies to SMCS	Increase the numbers of patients who have a Holistic Needs Assessment
Reduction in the number of avoidable readmissions to hospital within 28 days of discharge to below 0.3%	^Reduce the number of acquired category 3 and 4 pressure ulcers whilst under the care of SMCS to less than 0.2% ^90% of category 3 and 4 pressure ulcers both inherited and acquired whilst under the care of community services have improved to category 1, 2 or healed between the start and the end of the quarter	To increase the proportion of designated patients who will be offered a Holistic Needs Assessment to 80% by the end of 2014/15

Patient experience		
Priority 7	**Priority 8**	**Priority 9**
*Ensure that we are responding to inpatients' personal needs Introduce the Friends and Family Test question for SMCS clients	*Percentage of staff who would recommend The Royal Marsden to friends or family needing care	Reduction in chemotherapy waiting times and improvement in patient experience related to waiting times
Remain in the top 20% of trusts for the Friends and Family Test for hospital inpatients To establish a baseline for the Friends and Family Test and to increase patient satisfaction using the CARE measure to over 80% for SMCS	To maintain or improve the response to this specific question in the survey to more than 87%	To improve the chemotherapy waiting times at Sutton and Chelsea so that no more than 10% of patients wait more than one hour
Priority 10	**Priority 11**	
Improve communication, particularly when patients arrive for first appointments	Reduce the length of time a patient waits for medicines at the point of discharge	
To improve or maintain the high percentage of positive comments in dedicated patient feedback above 90% on arrival at clinic appointments	Reduce the number of patients by 10% who wait for more than two hours	
Children's services		
Priority 12		
^To improve health outcomes for children in reception year in line with the 'Healthy Child programme 5-19 years' by screening information from the health visiting service and the parent questionnaire		
Where health needs have been identified a health assessment is conducted by the school nursing service in 90% of children in reception year and where appropriate a plan of care will be agreed with the parents/carers		

The table below summarises the quality objectives and priorities of the trust for the last five years. Sutton and Merton Community Services (SMCS) are detailed from 2011/12 onwards.

2009/10	2010/11	2011/12	2012/13	2013/14
Safe care (*= mandatory)				
Incidence of healthcare associated infections	Reduction of healthcare associated infections	Reduction of healthcare associated infections	*Reduction in Healthcare Associated Infections	*Reduction in Healthcare Associated Infections
Reduction in medication errors	Reduction in medication incidents	Reduction in medication incidents	*Rate of patient safety incidents and percentage resulting in severe harm or death	*Rate of patient safety incidents and percentage resulting in severe harm or death
Incidence of falls	Reduction in falls	Reduction in falls (hospital services). A 15% increase in number of falls screens compared to 2010/11 (SMCS)		
	Assessment, monitoring and treatment of venous thromboembolism	Reduction in venous thromboembolism (blood clots)	*Percentage of admitted patients risk assessed for venous thromboembolism	*Percentage of admitted patients risk assessed for venous thromboembolism
		Compliance with national health visiting targets: new birth visits (SMCS)	Compliance with national health visiting targets: new birth visits (SMCS)	
		Safeguarding children priorities – compliance with national guidance and training (SMCS)		
Mortality rate, hospital standardised mortality ratio (HSMR)	Reduction in the hospital standardised mortality ratio (HSMR)	Reduction in the hospital standardised mortality ratio (HSMR)	Reduction in the hospital standardised mortality ratio (HSMR)	
Effective care (*= mandatory)				
Incidence of hospital acquired pressure ulcers	Reduction in the incidence of hospital acquired pressure ulcers	Reduction in the incidence of hospital acquired pressure ulcers (hospital services) Reduction in pressure ulcers especially grades 3 and 4 (SMCS)	Reduction in community acquired grade 3 and 4 pressure ulcers	Reduction in community acquired grade 3 and 4 pressure ulcers: applies to SMCS
			Achieve more than 42% of patients dying in their preferred place of death	Increase the number of patients that die in their preferred place of death
Effective length of stay	Reduced length of stay	Reduced length of stay		

2009/10	2010/11	2011/12	2012/13	2013/14
			Increase the numbers of patients who have been offered a Holistic Needs Assessment	Increase the numbers of patients who have a Holistic Needs Assessment
			*Reducing the number of emergency readmissions to hospital within 28 days of discharge	*Avoidance of emergency readmissions to hospital within 28 days of discharge
Patient experience (*= mandatory)				
Patients in pain	To be in top 20% of trusts for key areas on the national inpatient survey	To be in top 20% of trusts for key areas of national inpatient survey	*Improve or maintain a high score in relation to responding to inpatients' personal needs in the national survey	*Ensure that we are responding to inpatients' personal needs
Patients treated with dignity and respect	To be in top 20% of trusts for key areas on the national outpatient survey	To be in top 20% of trusts for key areas of national outpatient survey		^Improve communication, particularly when patients arrive for first appointments
Patients given enough information on discharge	Roll out of the real time patient feedback throughout the Trust	Roll out of the real time patient feedback throughout the Trust		
		New initiatives to improve the patient experience in 2011/12. 1) To reduce chemotherapy waiting times, 2) To improve the patient experience of hospital transport, 3) To improve communication at every part of the patient journey	Reduction in chemotherapy waiting times and improvement in patient experience related to waiting times	Reduction in chemotherapy waiting times and improvement in patient experience related to waiting times
			*Percentage of staff who would recommend The Royal Marsden to friends or family needing care	*Percentage of staff who would recommend The Royal Marsden to friends or family needing care* Introduce a patient experience survey for SMCS
				^Reduce the length of time a patient waits for medicines or equipment at the point of discharge
				The uptake of immunisation working in partnership with primary care

Statements of assurance from the Board

Review of services

During 2013/14 The Royal Marsden NHS Foundation Trust provided and/or sub-contracted comprehensive cancer services and Sutton and Merton Community Services.

The Royal Marsden NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 100% of the total income generated from the provision of relevant health services by The Royal Marsden NHS Foundation Trust for 2013/14.

The data reviewed in part three of this Quality Account covers the three dimensions of quality: patient safety, clinical effectiveness and patient experience. In all areas the data has been available to review the service.

Participation in clinical audits

At The Royal Marsden we undertake many clinical audits for quality improvement. We participate in all the national cancer audits which are applicable to the organisation. This allows us to benchmark 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 conduct regularly to improve local areas of care.

During 2013/14 22 national clinical audits and two 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 them so that all care across England can be monitored.

During 2013/14 The Royal Marsden registered and/or participated in 22 of the national clinical audits and all national confidential enquiries in which it was eligible to participate in (Table 1). Many of the national audits undertaken by other hospitals cannot be undertaken at The Royal Marsden because we only have patients with cancer.

The national clinical audits and national confidential enquiries that The Royal Marsden participated in, and for which data collection was completed for the period 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (Table 1 and 3).

Table 1: National clinical audits The Royal Marsden participated in 2013/14

No	National Clinical Audits	Participated	Cases submitted (%)
1	National Oesophago-Gastric cancer audit (OG) Audit	Yes	100% of cases diagnosed at the Trust
2	National Bowel Cancer Audit (NBOCAP)	Yes	100% of cases diagnosed at the Trust
3	National Lung Cancer Audit (LUCADA)	Yes	Note: tertiary trust Standards do not apply as most patients are not "first seen" at tertiary trusts Treatment data submitted
4	National Head and Neck Cancer (DAHNO)	Yes	100% of cases diagnosed at the Trust
5	National Emergency Laparotomy Audit (NELA)	Yes	Organisational audit completed. Data collection started in January 2014
6	National Prostate Cancer	Yes	Participated in organisational survey
7	Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Other National Audits			
8	Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme (CMP)	Yes	100%
9	The Association of Breast Surgery (ABS) and NHS Breast Screening Programme	Yes	100%
10	Breast Cancer Clinical Outcome Measures (BCCOM) Project	Yes	100%
11	National Health Service Cancer Screening Programme (NHSCSP) Audit of Invasive Cervical Cancer	Yes	100%
12	Royal College of Radiologists (RCR) National Audit of Current Patterns of Practice and Opinions on Prostate Brachytherapy in the UK 2013	Yes	100%
13	RCR survey of anal cancer chemoradiotherapy 2013	Yes	Participated in survey
14	RCR Audit Leads Survey 2013	Yes	Participated in survey
15	RCR NSCLC (Non-Small Cell Lung Cancer) Radical Radiotherapy audit	Yes	100%
16	The British Association of Urological Surgeons (BAUS) Nephrectomy audit 2013	Yes	100%
17	BAUS Total Cystectomy audit	Yes	100%
18	BAUS Radical Prostatectomy audit	Yes	100%
19	BAUS Retroperitoneal Lymph Node Dissection (RPLND)	Yes	100%
20	Pilot of a new national process for local study review by NHS Pharmacy (National Institute for Health Research (NIHR)	Yes	Pilot
21	National Comparative Audit of Blood Transfusion Programme: Red Cell Survey	Yes	Organisational survey
22	National Comparative Audit of Blood Transfusion Programme: Online National Patient Blood Management Survey	Yes	Organisational survey

The reports of 14 national clinical audits were reviewed by The Royal Marsden in 2013/14. The Royal Marsden will take the following actions to improve the quality of healthcare provided, where appropriate.

Table 2: National clinical audits published reports and actions taken in 2013/14

No	National Clinical Audit reports published in 2013/14	Description of actions
1	National Oesophago-Gastric Cancer Audit Report 2013	Report reviewed
2	National Bowel cancer Audit Report 2013	Report reviewed
3	National Head & Neck Cancer Audit 2012	Report disseminated
4	NHSCSP Audit of invasive cervical cancer National report 2011	Report disseminated
5	RCR National Re-audit of Radiotherapy in the Treatment of Malignant Spinal Cord Compression 2012	Report reviewed
6	RCR Caseload and Outcome after Brachytherapy 2013	Report disseminated
7	RCR UK Survey of Any Qualified Provider of Ultrasound Services 2012	Report disseminated
8	RCR National Audit of Appropriate Imaging 2012/13	Report disseminated
9	RCR National Audit of NPSA and RCR Safety Checklist for Radiological Interventions 2012/13	Report disseminated
10	BAUS Analyses of Nephrectomy dataset, June 2013	Report disseminated
11	BAUS Analyses of Prostatectomy Dataset, June 2013	Report disseminated
12	BAUS Analyses of Cystectomy Dataset, June 2013	Report disseminated
13	Sentinel Stroke National Audit Programme (SSNAP): second pilot report	Report disseminated
14	National Audit of Intermediate Care Report 2013	Report reviewed, to take part in 2014 audit

Table 3: National confidential enquiries The Royal Marsden eligible to participate in 2013/14

No	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies	Participated	% cases submitted
1	Tracheostomy care	Yes	100%
2	Subarachnoid Haemorrhage	Yes	100%
3	Gastrointestinal Haemorrhage	Yes	Ongoing
4	Lower Limb Amputation study	No	Not applicable
5	Sepsis	Yes	Ongoing

The report of two national confidential enquiries report was reviewed by The Royal Marsden in 2013/14. The Royal Marsden intends to take the following actions to continue to improve the quality of healthcare provided.

Table 4: National Confidential Enquiries reports published in 2013/14 and actions

No	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies	Description of actions (local)
1	Alcohol Related Liver Disease: Measuring the Units? (2013)	Not applicable.
2	Subarachnoid Haemorrhage: Managing the Flow (2013)	To be presented to surgical audit group meeting.

The reports of 73 local clinical audits and local action plans to improve the quality and outcomes of patient care were reviewed by Clinical Audit Committee of The Royal Marsden in 2013/14. The following actions are examples of some of the actions taken. Should you require more information about the local audits please contact the Quality Assurance department on 020 7808 2702 or email QualityAssurance@rmh.nhs.uk.

Title of local audit	Action points from local audit
Benefit and patients acceptability of a supervised preoperative fitness training programme	Presentation of results at surgical audit group meeting to raise awareness.
	Meeting with physiotherapy team to review evaluation and referral process.
	Patient survey planned to explore acceptability and logistic problems planned.
	Abstract submitted.
Anti-emetic use in paediatric inpatients	Review and update of anti-emetic guidelines.
Peer review – skin cancer patients 2012/13	To review GP and key worker fax-back process. To re-audit within a year.
Local management of B3 lesions with atypia/B4 lesions found on vacuum assisted breast biopsy	Re-evaluate the management of indeterminate (B3/B4) vacuum assisted breast biopsy lesions in relation to new clinical guidelines in six months' time.
Meeting nutritional needs – audit of food service	New protected mealtime posters printed.
	Food and nutrition policy reviewed.
Yoga patient experience survey	Yoga sessions commenced at Chelsea site.
	Patient survey planned.
Audit of cisplatin side effects for head and neck patients	Pharmacy proforma to be amended to record whether patient has been asked about tinnitus.
Neutropenic sepsis pathway audit	Continue audit in current format on monthly basis to monitor the Trust's performance.
	Change methodology after publication of recommendations from the London Cancer Alliance.
User survey for complaints handling	Ensure questions that are asked are answered directly.
	Ensure responses are easier to understand.
	Specify the intended actions with timescales in the responses.

Title of local audit	Action points from local audit
Annual audit of exclusions in the Sutton and Merton Diabetic Eye Screening Programme (Sutton and Merton Community Services)	To write to the GP Lead of a particular practice highlighting the high number of patients opting out.
	To review all temporary exclusions identified to ensure exclusion managed in accordance with local policy.
	To amend DESP administration policy.
	To investigate with software supplier the occurrences of patients being recorded as deceased but still appearing in the programme size and exclusion categories.
	To hold an exclusions workshop for all administration staff to provide refresher training on DESP exclusions policy and acceptable evidence required.
	Re-audit in 1 year.
Sutton and Merton DESP Slit Lamp Audit (Sutton and Merton Community Services)	Training and maintaining skills as a slit lamp examiner.
	Re-audit planned.
Developing a self-referral service to Children's physiotherapy for older children with cerebral palsy (Sutton and Merton Community Services)	Improving the communication of this new service to service users, improving on the content and format in the leaflet.
	Implement the service from September 2013 onwards.
	Audit efficacy of service in the next 1-2 years.

Consultant Treatment Outcomes has been published on the NHS Choices and The Royal Marsden website. The Royal Marsden will take the following actions to improve the quality of healthcare provided, where appropriate.

Consultant Treatment Outcomes reports and actions taken in 2013/14

No	Consultant Treatment Outcomes	Linked to NHS Choices from The Royal Marsden website	Description of actions
1	Urological surgery: nephrectomies	Yes	Report reviewed
2	Colorectal surgery	Yes	Report reviewed
3	Upper gastrointestinal surgery	Yes	Report reviewed
4	Head and neck cancer surgery	Yes	Report reviewed

Participation 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 major difference to outcomes and the experience of care. If you would like to find out more about our research work please go to our website www.royalmarsden.nhs.uk

The number of patients receiving relevant health services provided or subcontracted by The Royal Marsden from April 2013 to March 2014 that were recruited during that period to participate in research approved by a research ethics committee was 5272 patients into 303 different trials.

Revalidation of doctors

The Trust has made 55 positive recommendations in support of revalidation since April 2013. Established processes are in place to manage doctors' appraisal and revalidation, and these are supported by clear governance arrangements. Revalidation is reported and discussed at all levels including The Royal Marsden Board. The Trust reports externally on revalidation on a quarterly basis and in September 2013, received a "green" RAG rating from the NHS revalidation support team with regards to its systems to support.

Use of the CQUIN payment framework

Commissioning for Quality and Innovation (CQUIN) payments are a mechanism for commissioners to reward quality by linking a proportion of the Trust's income (2.4% – 2.5% in 2013/14) to the achievement of quality improvement goals.

Cancer specialist services CQUIN goals for 2013/14

The Trust's cancer specialist services achieved 100% of their CQUIN goals in 2013/14. This equates to approximately £3.7 million of income.

Sutton and Merton Community Services CQUIN goals for 2013/14

In 2013/14 Sutton and Merton Community Services (SMCS) achieved 94% of its CQUIN goals, and a bonus for exceeding the target for reductions in emergency department attendances in those aged under 18. The Trust met 100% of its NHS England CQUIN goals for SMCS. This equates to approximately £800,000 of income.

Goals for 2013/4 were agreed in the following subject areas for cancer specialist services and for SMCS:

Cancer specialist services:

- Friends and Family Test
- NHS Safety Thermometer – increasing the percentage of harm free care
- Dementia – identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow-up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers
- Venous thromboembolism – risk assessment and root cause analysis
- End-of-life care – improving care for patients approaching the end-of-life in hospitals
- Chemotherapy waiting times and patient experience
- Modernising outpatients – including patient information, improving waiting times, reducing non-attendances, improving the use of Choose and Book and reducing the proportion of inappropriate face-to-face contacts
- Agreed treatment plans within 24 hours of admission
- London Cancer Programmes best practice commissioning pathways
- Completion and submission of specialised dashboards
- Completion and submission of bone marrow transplant dashboard identifying unrelated donors.

Sutton and Merton Community Services:

- NHS Safety Thermometer – improving pressure ulcer recording and management
- Prevention of admission – including improving quality in nursing and residential homes by offering a training package to help management of key conditions

– Reducing emergency department attendances in those aged under 18 by helping families to manage minor ailments.

– Diabetic Eye Screening Programme

Previous years' performance

In 2012/13 cancer specialist services received 100% of its CQUIN goals. This equated to approximately £3 million of income. Sutton and Merton Community Services (SMCS) achieved 86.7% of its CQUIN goals in 2012/13, which equated to approximately £712,500 of income.

What others say about the provider

Statements from the Care Quality Commission (CQC)

The Royal Marsden NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "registered with no conditions".

The Care Quality Commission has not taken enforcement action against The Royal Marsden NHS Foundation Trust during 2013/14.

To assist the CQC during 2013/14 Sutton and Merton Community Services has participated in the special review of children transferring to adult care. The Royal Marsden has not participated in any investigations by the CQC during the reporting period, 2013/14.

Throughout the year the Trust reviewed the Quality Risk Profiles at the monthly Integrated Governance and Risk Management committee meetings and then when CQC changed the format to the Intelligent Monitoring Reports which show the risk rating that CQC gives the Trust based on quality indicators. The Intelligent Monitoring reports place the trust in Band 6 which is the lowest category of risk.

Data quality

Good quality information is very important in underpinning the effective delivery of the best patient care.

The Royal Marsden NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data, which included the patient's valid NHS number, was 99.9% for admitted patient care, 99.9% for outpatient care, and none for accident and emergency care (specialist cancer trust and community services without an accident and emergency department). See table 1 below.

The percentage of records that included the patient's valid General Medical Practice Code was 99.8% for admitted patient care, 99.8% for outpatient care and none for accident and emergency.

Table 1: Data quality – England and Wales

	% completeness					
	NHS number			GP practice		
	2011/12	2012/13	**2013/14**	2011/12	2012/13	**2013/14**
Inpatient and daycases	98.6	99.9*	**99.9**	99.0	99.7*	**99.8**
Outpatients	98.8	99.8*	**99.9**	99.1	99.7*	**99.8**

*The data shown for NHS number completeness 2012/13 is different than what was previously reported in the Annual Quality Account for 2012/13. This is because there was a change in definition between the two periods. The NHS number completeness previously included private patients, where this measure should only apply to NHS patients, as many private patients do not actually have an NHS Number.

Although data quality at The Royal Marsden is very good, the Trust strives for continual improvement. The Royal Marsden NHS Foundation Trust implements the following actions to improve data quality:

1. A dedicated data quality team are responsible for running routine validation checks and reports to identify errors and inconsistencies in data entry.
2. In 2013 Trust-wide monthly communications started promoting the importance of accurate information and data collection centrally for all Trust staff.
3. Trust-wide audits of data quality involving key information points are conducted annually.

Information Governance Toolkit attainment levels

The Royal Marsden Information Governance Toolkit Assessment overall score for 2013/14 was 88%, submitted on 31 March 2014 and was graded satisfactory. This maintains the score of 88% from 2012/13. The Information Governance Toolkit is available on the Health and Social Care Information Centre (HSCIC) website https://nww.igt.hscic.gov.uk/

Payment by results clinical coding error rate

The Royal Marsden was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission. However a full coding audit was carried out by a qualified coding auditor to standard coding methodology and the error rates reported for diagnoses and treatment coding are in table 2 below. 200 episodes were reviewed within the sample. These results should not be extrapolated further than the actual sample audited.

Table 2: Clinical coding

Coding errors	2009/10	2010/11*	2011/12	2012/13	**2013/14****
Primary diagnosis errors	5.0%	2.5%	3.5%	8.0%	**6.0%**
Primary procedure code errors	35.7%	2.1%	12.4%	4.7%	**5.11%**
Secondary diagnosis errors	7.2%	1.9%	2.9%	5.1%	**2.55%**
Secondary procedure code errors	12.8%	8.4%	26.4%	8.8%	**4.19%**

* The Trust was not eligible for an Audit Commission Clinical Coding Audit in 2010/11; these figures are therefore based on an audit commissioned by The Royal Marsden in November 2010.

**These figures are taken from the Information Governance Clinical Coding Audit in December 2013, which used the latest version of the NHS Health and Social Care Information Centre audit methodology.

Part four

Review of quality performance (previous year's performance)

National targets

Cancer waiting times targets	National target 2013/14	2013/14 performance Q1	2013/14 performance Q2	2013/14 performance Q3	2013/14 performance Q4	**2013/14 performance**
All urgent GP referrals seen within 14 days	93%	97.1%	94.9%	97.8%	96.8%	**96.6%**
All referrals for breast symptoms seen within 14 days	93%	94%	90.5%	95.8%	94.5%	**93.8%**
Treatment within 31 days of decision to treat for first treatment	96%	100%	98.6%	99.1%	99.2%	**99.2%**
Subsequent surgical treatment started within 31 days of decision to treat	94%	98.2%	97.2%	97%	97.9%	**97.6%**
Subsequent drug treatment started within 31 days of decision to treat	98%	100%	99.6%	100%	99.5%	**99.8%**
Subsequent radiotherapy treatment started within 31 days of decision to treat	94%	99.1%	99.5%	99.7%	99.5%	**99.5%**
Treatment started within 62 days of urgent GP referrals*	85%	85%	85.3%	89.7%	87.1%	**86.7%**
Treatment started within 62 days of recall date for urgent screening centre referrals*	90%	93.2%	93.2%	87.5%	91.7%	**91.3%**

* Figures include agreed reallocations between trusts

NHS 18 week targets

Target/ priority	National target 2013/14	2011/12 % achieved	2012/13 % achieved	**2013/14 % achieved Q1**	**2013/14 % achieved Q2**	**2013/14 % achieved Q3**	**2013/14 % achieved Q4**	National target 2014/15
Patients requiring admission who waited <18 weeks from referral to treatment (not national targets since 2010)	90%	94.8	96.0	**95.4**	**96.1**	**94.9**	**96.0**	90%
Patients not requiring admission who waited <18 weeks from referral to treatment (not national targets since 2010)	95%	98.8	98.6	**99.0**	**99.1**	**99.0**	**98.5**	95%

Access targets

Target/priority	National target 2013/14	2011/12 % achieved	2012/13 % achieved	**2013/14 % achieved Q1**	**2013/14 % achieved Q2**	**2013/14 % achieved Q3**	**2013/14 % achieved Q4**	National target 2014/15
Operations cancelled by the Trust at the last minute	Less than 5%	0.3%	0.5%	**0.5%**	**0.8%**	**0.5%**	**0.7%**	Less than 5%
Last minute cancelled operations not subsequently performed within one month	0%	0%	0%	**0%**	**0%**	**0%**	**0%**	0%

The Royal Marsden NHS Foundation Trust met all key performance waiting times and access targets in 2012/13 and 2013/14 with the exception of the breast symptomatic target during quarter two.

Appendix 1

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 (HSCIC).

The Trust considers 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 and shows the highest and lowest national scores.

Core Indicators

Trust quality priority 1

Core indicator 24) The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information centre with regard to the rate per 100,000 bed days of cases of *C.difficile* infection reported within the Trust amongst patients.

Period	**The Royal Marsden**	National highest (all acute and specialist trusts)	National lowest (all acute and specialist trusts)	Average NHS trusts
April 2012 to March 2013	**25.2**	30.8	0*	17.3
April 2011 to March 2012	**31.4**	58.2	0*	22.2

* The Trust is advised by HSCIC that the zero recorded here may be due to missing data from other trusts reported to the centre.

Trust quality priority 2

Core indicator 25) The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre 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.

Patient safety incidents: rate

Period	**The Royal Marsden**	National highest (all acute specialist trusts)	National lowest (all acute specialist trusts)	Average acute specialist trusts
October 2012 to March 2013	**13.3**	31.0	3.8	9.1
April 2012 to September 2012	**11.3**	24.6	3.1	7.8

Patient safety incident: number

Period	**The Royal Marsden**	National highest (all acute specialist trusts)	National lowest (all acute specialist trusts)	Average acute specialist trusts
October 2012 to March 2013	**1541**	1675	174	808
April 2012 to September 2012	**1305**	1720	99	758

Patient safety incidents resulting in severe harm or death: rate

Period	**The Royal Marsden**	National highest (all acute specialist trusts)	National lowest (all acute specialist trusts)	Average acute specialist trusts
October 2012 to March 2013	**0**	0.11	0*	0.03
April 2012 to September 2012	**0.03**	0.12	0*	0.03

* The Trust is advised by HSCIC that the zero recorded here may be due to missing data from other trusts reported to the centre.

Patient safety incidents resulting in severe harm or death: number

Period	**The Royal Marsden**	National highest (all acute specialist trusts)	National lowest (all acute specialist trusts)	Average acute specialist trusts
October 2012 to March 2013	**0**	21	0*	3
April 2012 to September 2012	**3**	26	0*	4
October 2011 to March 2012	**2**	6	0*	4.4
April 2011 to September 2011	**5**	11	0*	2.1

* The Trust is advised by HSCIC that the zero recorded here may be due to missing data from other trusts reported to the centre.

Trust quality priority 3

Core indicator 23) The data made available to the National Health Service trust or 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.

Period	**The Royal Marsden**	National highest (all acute and specialist trusts)	National lowest (all acute and specialist trusts)	Average acute trusts
October 2013 to December 2013	**95.49%**	100.00%	77.70%	95.77%
June 2013 to September 2013	**97.25%**	100.00%	81.70%	95.69%
October 2012 to December 2012	**97%**	100%	84.6%	-*
June 2012 to September 2012	**97%**	100%	80.9%	-*

* The Trust is advised by HSCIC that the zero recorded here may be due to missing data from other trusts reported to the centre.

Trust quality priority 7

Core indicator 19) The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged – i) 0-14; and ii) 15 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.

Patients aged 16+

Period	The Royal Marsden	National highest (all trusts)	National lowest (all trusts)	Average specialist trusts	England national
2011/12 data standardised to persons 2007/08	**9.47**	14.09	0*	9.73	11.45
2010/11 data standardised to persons 2007/08	**7.61**	17.10	0*	9.61	11.43

* The Trust is advised by HSCIC that the zero recorded here may be due to missing data from other trusts reported to the centre.

Trust quality priority 9

Core indicator 20) The data made available to the National Health Service trust or 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.

Average weighted score (out of 100)

Period	The Royal Marsden	National highest (all trusts)	National lowest (all trusts)	Average NHS provider
April 2012 to March 2013	**84.2**	84.4	57.4	68.1
April 2011 to March 2012	**82.8**	85.0	56.5	67.4

Trust quality priority 10

Core indicator 21) The data made available to the National Health Service trust or 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.

Period	The Royal Marsden	National highest (all specialist trusts)	National lowest (all specialist Trusts)	Average (acute trusts)
2013	**87**	94	40	67.4
2012	**87**	94	62	65

Appendix 2

Trust values

The Royal Marsden is shaped by a distinct set of 16 values that define what we are and how we behave.

Characteristics (What we are)	**Attitudes** (How we act)
Pioneering	Determined
Aspirational	Confident
Knowledgeable	Open
Driven	Resilient
Relationships (How we relate to others)	**Emotions** (How we feel)
Collaborative	Compassionate
Supportive	Positive
Trusted	Calm
Personable	Proud

Appendix 3

Statements from key stakeholders

Sutton Council Scrutiny Committee

Chair's statement

As Chair of Sutton Council's Scrutiny Committee I am pleased to provide some brief remarks on The Royal Marsden's Quality Account for 2013/14. The Account provides a useful overview of the work of the Trust and we appreciate the increasing presence regarding the work of the Sutton and Merton Community Services arm.

Sutton's Scrutiny Committee looks forward to working more closely with colleagues at The Royal Marsden over the coming year to better understand the priorities and issues covered in the Quality Account and share performance information on a more regular basis.

We also look forward to building on the success of the recent joint public meeting held with the Trust and our fellow scrutiny committee colleagues from Kensington and Chelsea.

Councillor Mary Burstow
9 April 2014

Merton CCG Governing Body member and Chair, SMCS Clinical Quality Review Group

Statement in response to The Royal Marsden Quality Account, in relation to Sutton and Merton Community Services

Merton CCG 'hosts' the contract for Sutton and Merton Community Services (SMCS) with other commissioners, including Sutton CCG and Public Health teams within Sutton and Merton Local Authorities. Their views have been sought in providing this feedback. We understand that NHS England, who also commission some community services (for example health visiting, immunisations) will respond separately.

The commissioners welcome the contribution of The Royal Marsden Executive colleagues at the monthly Clinical Quality Review meetings. We see the obvious commitment from The Royal Marsden management to strengthen the leadership of community services and thereby to make a difference for our patients in the community. We would also like to thank all the staff in SMCS for their dedication and commitment to patients in Sutton and Merton.

We note that several of the priority areas in this quality account (for the past year and future years) reflect community issues, and we share the ambition to improve care in these areas, including for example, reduction in community acquired pressure ulcers, the patient experience survey for SMCS, end of life care, immunisations and the staff survey. We note the improvements already made and welcome the openness and transparency with which these have been presented.

We look forward to working with the Trust over the next year on continued improvement in these areas.

Jenny Kay
Director of Quality, Merton Clinical Commissioning Group

Dr Caroline Chill
Governing Body member and Clinical Lead for community services, Merton Clinical Commissioning Group.

Chair, SMCS Clinical Quality Review Group
7 April 2014

Patient Carer Advisory Group

The Royal Marsden NHS Foundation Trust 2013/14 Annual Quality Account

Although the Quality Account is an important document for the Trust's Board it also sets out for the hospital's several constituencies a public assessment of its performance within the framework of the regulatory environment and, importantly, its priorities and objectives for quality improvement during the 2014/15 reporting year.

Putting patients first is the dominant recurring theme throughout the Quality Account. The Trust has, of course, responded to the Frances Report, but this response is only but one aspect of the rigor applied by all members of The Royal Marsden community to ensure that the hospital leads in all aspects of cancer care. Responding to inpatient needs, further reduction in chemotherapy waiting times and shortening the waiting time for medicines will favourably impact the patient experience and these are but a few examples of what are described in the Quality Account with, of course, detailed action plans.

We also need to be mindful of the challenges that exist in Sutton and Merton Community Services. The steps the Trust are seeking to implement to prevent and manage pressure ulcers demonstrates but one aspect of the focus the hospital is lending to improving care for patients in the Sutton and Merton community.

The Patient Carer Advisory Group acknowledges the dedication and loyalty of all Royal Marsden staff. We are very grateful for all they do as they care for patients and their families.

We commend this Quality Account.

Yours sincerely

Charles McGregor
Chairman
Patient Carer Advisory Group
28 April 2014

Statement from the Council of Governors on the Quality Account 2013/14

The Council of Governors routinely reviews Quality Accounts information and has discussed priority quality issues at each of the Council of Governors meetings.

A sub group of the Council of Governors, the Patient Experience and Quality Account Group, has also reviewed feedback from patients, including from the frequent feedback surveys, and has influenced the questions used in these surveys, to reflect patients' interests.

Governors agreed the process for developing and selecting priorities for quality improvement and they have met with patient, carer and public members at two Members' Events, in November 2013 and February 2014 where the focus centred on themes from the Quality Account. These events allowed Governors and members to discuss the current priorities and to feedback their views on future areas relating to patient safety, clinical effectiveness and patient experience.

Dr Carol Joseph, Public Governor for Kensington and Chelsea served as the representative at the Patient Experience and Quality Account Group, which was set up to assist and monitor the development of the Quality Account throughout the year.

The Royal Marsden strives to improve the presentation of data each year to make the Quality Account, now in its fourth year of publication, more succinct, interesting, and readable by the general public as well as by healthcare professionals. This year Governors have seen a considerable improvement in the layout of the information, making it easier to read and digest.

Based on their involvement and the feedback they have received from members and other patients and carers, Governors endorse the key priorities for improvement as set out in the Quality Account.

Dr Carol Joseph
Public Governor for Kensington and Chelsea
23 April 2014

Statement from Healthwatch Sutton

Despite its [of necessity] length, The Royal Marsden Quality Account is an easily navigable and intuitive document, and is exceptionally well-presented.

Having been part of The Royal Marsden Patient Experience Group for some while now, it is evident what you 'preach', you also 'practice'.

On behalf of all the patients and carers that Healthwatch Sutton represent, we are very pleased to be working with you, and very proud of you and all that you do.

Regards

David Williams
Vice Chair
Healthwatch Sutton
26 March 2014

Healthwatch Central West London response to The Royal Marsden NHS Foundation Trust Quality Account 2013/14

Healthwatch CWL appreciates our working relationship with The Royal Marsden NHS Foundation Trust. We acknowledge the good work of the Trust in ensuring improving quality of services for patients and in engaging a wide range of service users and the public for this purpose.

We commend overall improvements from last year in various quality areas; the Trust's actions to drive improvements including purchasing additional screens to inform patients on waiting times in clinics, and defibrillators in the Radiography suite to improve patient experience and safety. We are very pleased to note the strong performance of the Trust in the recent CQC Hospital Intelligent Monitoring inspections (March 2014).[1] However, we would like to comment specifically on the following areas:

Priority 5: Increase number of patients that die in their preferred place of death

We welcome the various initiatives the Trust has implemented to improve this outcome. We would also like to know what the Trust will put in place to ensure that the views of family and carers are also considered, particularly through end of life and after the death of a patient.

Priority 6: Increase number of patients who are offered a Holistic Needs Assessment (HNA)

We commend improvement in number of new patients offered a HNA (67%). However, we note only 2.5% of new patients have completed care plans. What will be done to both drive up the proportion of people receiving care plans and improve completed HNA rates?

Priority 7: Avoidance of emergency readmissions to hospital within 28 days of discharge

We acknowledge overall improvements in number of readmissions and plans to continually monitor rates. We however would like The Royal Marsden to state what actions it is taking to prevent readmissions, how the reasons for readmissions will be monitored, and what actions the Trust intends to take in order to address underlying causes.

1. http://www.cqc.org.uk/sites/default/files/media/reports/RPY_102v2_WV.pdf

Priority 9: Ensure that we are responding to inpatients' personal needs

Please state what actions the Trust will take to meet the target of improved responsiveness to the needs of patients, as there are no actions stated in the draft Quality Account.

Coding Errors

On page 64, clinical coding error rates were 6% for primary diagnosis error and 5% for primary procedure code error. These figures are worrying particularly if they are due to mitigating events or have resulted in a never event. The Trust should state where there are mitigating factors, impact and learning outcomes from these errors.

We understand the Trust intends to put a narrative with this section to address this point.

Accessibility

As mentioned in our statement last year, we would like the Trust to state how they plan to improve the profile and accessibility of quality accounts, particularly amongst people with low and no literacy rates. Again, we understand the Trust is aware of the need to include a glossary in the final version of the quality account.

We presume the Trust will extend this learning to all patient information leaflets as mentioned in priorities 3, 8 and 11.

Defibrillators in the Radiography Suite

We very much welcome the purchase of a large number of defibrillators for the Radiography Suite.

Care Quality Commissions Patient Experience Survey

We take note of national surveys carried out by the Care Quality Commission (CQC) of inpatient and outpatient experiences at The Royal Marsden NHS Foundation Trust. As dignity is a key priority for Healthwatch CWL, we would welcome further detail on how the Trust has improved and/or plans to improve on:

Inpatients (report from April 2013)[2]

- Noise on the wards
- Getting help from staff on the wards
- Single sex accommodation
- Collecting patients' views (about quality of care they received during their stay in hospital)
- Discharge planning including information post discharge and communicating with other providers on the patient pathway.

We are pleased to note the Macmillan Fellowship award for a staff members work on establishing the Hospital2Home service and would welcome further detail.[3]

Outpatients[4]

- Waiting times
- Cleanliness of facilities.

National Cancer Patient Experience Programme

We also note results from the National Cancer Patient Experience Programme, National Survey 2012/135 and scope for the Trust to improve in:

- Communications with patients on their treatment and tests
- Contact with Clinical Nurse Specialists
- Information on Support Groups
- Patients feel they treated as a set of cancer symptoms

In summary, we compliment the Trust on their efforts to continually provide quality care to all patients. We would like to continue our good relationship with The Royal Marsden NHS Foundation Trust and work together to improve dignity on the wards and person centred care in outpatients.

Ms SwabrinaNjoku
Borough Manager (Kensington and Chelsea)
Phone: 020 8964 1490
Email: swabrina.njoku@hestia.org
7 April 2014

2. http://www.cqc.org.uk/survey/inpatient/RPY

3. http://www.nursingtimes.net/nursing-practice/clinical-zones/cancer/macmillan-cancer-support-honours-macmillan-professionals-at-excellence-awards-2013/5065273.article

4. http://www.cqc.org.uk/survey/outpatient/RPY

5. National Cancer Patient Experience Survey 2012/13 http://www.quality-health.co.uk/resources/surveys/national-cancer-experience-survey/2013-national-cancer-patient-experience-survey-reports/2013-london-strategic-health-authority/47-the-royal-marsden-nhs-foundation-trust/file

Appendix 4

Statement of directors' responsibilities for the quality report

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. Monitor 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 foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing this quality report, directors have taken steps to satisfy themselves that the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual* 2013/14.

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 2013 to June 2014
- Papers relating to quality reported to the Board over the period April 2013 to June 2014
- Feedback from the commissioners dated 07/04/14
- Feedback from the Governors through the Council of Governors throughout the year dated 23/04/14
- Feedback from local Healthwatch organisations dated 26/03/14 and 07/04/14
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Regulations 2009, dated 22/04/14
- The 2013 national inpatient survey results, dated 16/01/14
- The 2013 national staff survey, dated 04/02/14
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 29/05/14
- CQC quality and risk profiles dated April 2013 to March 2014
- The Quality Report presents a balanced picture of The Royal Marsden NHS Foundations 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 Monitor's annual reporting 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

Mr R. Ian Molson
Chairman

Cally Palmer CBE
Chief Executive Officer
29 May 2014

Appendix 5

Independent 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 2014 (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 2014, 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 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.
- Number of reported cases of *C.difficile* for patients aged 2 or more.

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 Monitor.

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*;
- the Quality Report is not consistent in all material respects with the sources specified; 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 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 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 the documents specified within the detailed guidance.

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 ("ISAE3000"). 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.
- 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*.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Royal Marsden NHS Foundation Trust.

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 2014:

- 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*;
- the Quality Report is not consistent in all material respects with the sources specified; 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*.

Deloitte LLP

Deloitte LLP
Chartered Accountants
St Albans
29 May 2014

Glossary of terms

Bacteraemia
The presence of bacteria in the blood.

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

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

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

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's notes is translated into coded data and entered onto hospital information systems. Coding usually occurs after the patient has been discharged from hospital, and must be completed within strict deadlines in order for hospitals to receive payment for their activity.

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 (PCTs).

***Clostridium difficile* (*C.difficile*)**
Bacteria that are a significant cause of hospital acquired infections.

CNS
Clinical Nurse Specialist

Commissioning for Quality and Innovation (CQUIN)
The CQUIN payment framework enables commissioners to link a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

Consultation and Relational Empathy (CARE) measure
Patient survey used by SMCS. CARE is a person-centred process measure that was developed and researched at the Departments of General Practice in Glasgow University and Edinburgh University.

Coordinate my Care (CMC)
A clinical service sharing information between the patient's healthcare providers in order to coordinate care and record the patient's wishes as to how they would like to be cared for.

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

DAHNO
Data for Head and Neck Oncology

Datix
Proprietary web-based reporting system used to record incidents, complaints and patient comments.

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.

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

Francis Report
The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC and published in February 2013.

Health and Wellbeing board (HWB)
These have now replaced the overview and scrutiny functions of local authorities and have the power to call witnesses from local National Health Service (NHS) bodies and make recommendations which NHS organisations must consider as part of their decision-making processes.

Healthcare-associated infections (HCAIs)
An infection acquired during the course of healthcare.

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

Holistic needs assessment (HLA)
A process of gathering information from the patient and/or carer to inform discussion and develop a deeper understanding of what the person living with and beyond cancer knows, understands and needs.

Hospital2Home
An initiative developed by The Royal Marsden that supports patients' end-of-life care choices. The scheme gives patients in palliative care more confidence about choosing to be cared for at home by improving communication between hospital and community services.

HSMR
Hospital Standardised Mortality Ratio – an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than expected.

Hygiene Code
The Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infection.

ICR
Institute of Cancer Research

Information Governance
Ensures that organisations achieve good practice with data protection and confidentiality.

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

Key Performance Indicators
Used by an organisation to evaluate its success or the success of a particular activity in which it is engaged. Sometimes success is defined in terms of making progress toward strategic goals, but often success is simply the repeated achievement of some level of operational goal.

London Cancer Alliance (LCA)
The integrated cancer system across west and south London. It is clinically led and has responsibility for delivering specified care pathways for different tumour sites and for delivering safe and effective care for the populations it serves.

MDT
A Multidisciplinary Team is a group of healthcare professionals from different disciplines who work together.

Membership Council
A council of members consisting of elected and nominated representatives who assist in governing The Royal Marsden NHS Foundation Trust.

Meticillin-resistant *Staphylococcus aureus* (MRSA)
Bacteria that are a significant cause of hospital acquired infections

Meticillin-sensitive *Staphylococcus aureus* (MSSA)
Bacteria that are a significant cause of hospital acquired infections.

Monitor
The independent regulator of NHS foundation trusts.

National Cancer Survival Initiative (NCSI)
A partnership between NHS England and Macmillan Cancer Support with the aim of ensuring that those living with and beyond cancer get the care and support they need to lead as healthy and active a life as possible, for as long as possible.

National Early Warning System
Standardised assessment to efficiently identify and respond to patients who present with or develop acute illness. It is based on a simple scoring system in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in hospital.

National Patient Safety Agency (NPSA)
Shares learning from patient safety incidents occurring in the NHS.

NCIN
National Cancer Intelligence Network

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

OPD
Outpatients Department

PALS
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
The Patient and Carer Advisory Group work 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 an integral part in the continuing improvement of care and services provided by the Trust.

PEAT
Patient Environment Action Team assessments focus on the environment in which care is provided and the quality of non-clinical services such as food and privacy and dignity.

Picker Institute Europe
An organisation that administers patient surveys including the frequent feedback surveys which gather data from patients in real time using hand-held devices.

Pressure ulcers
Bed sores or pressure sores.

Prophylaxis
A measure taken to prevent a disease or condition.

Pulmonary Embolism (PE)
A blockage of a blood vessel in the lung.

Radiotherapy
Is the use of high energy rays to destroy cancer cells. It may be used to cure some cancers, to reduce the chance of recurrence or for symptom control.

RCR

Royal College of Radiologists

SMCS
Sutton and Merton Community Services – a division of The Royal Marsden NHS Foundation Trust.

T-card system
System used by Community Nursing to identify and distribute workload.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
NCEPOD is an independent charitable organisation that reviews medical and surgical clinical practice and makes recommendations to improve the quality of the delivery of care for the benefit of the public.

Venous thromboembolism (VTE)
Blood clot typically occurring in 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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