The ROYAL MARSDEN
NHS Foundation Trust

Integrated Governance Monitoring Report

April - September 2021

Quarters One and Two 2021/22

NHS

Contents

1 Introduction

1.1.1 Welcome to The Royal Marsden's Integrated Governance Monitoring Report.

1.1.2 The Integrated Governance Monitoring Report is a six-monthly review of the governance of care, research and infrastructure provided at The Royal Marsden. Together with the monthly quality account, the six-monthly safer staffing report, the Board scorecard and the annual quality account (part of the Trust's annual report) it is part of The Royal Marsden's monitoring of safety and assurance of quality of service.

1.1.3 The Integrated Governance Monitoring Report is published on the Royal Marsden's website, www.royalmarsden.nhs.uk.

1.1.4 The Care Quality Commission's (CQC) fundamental standards are intended to help providers of health and social care to comply with the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The CQC's inspection framework for cancer services, based on the fundamental standards, is shown in section 9. This report is structured to mirror the inspection framework.

1.1.5 Unless otherwise specified text, tables and charts refer to April to September 2021/22.

2 Executive summary

2.1 Is care safe?

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

2.1.1 Incident, complaints and claims investigations

26 incident investigations were completed, and remedial actions were identified. (Incidents, Complaints and Claims Investigations and Serious Incidents Reporting, page 10)

2.1.2 Safeguarding of adults at risk

Nine reportable adult safeguarding concerns were raised at the Trust's Chelsea and Sutton sites (there were nine in the previous six months).

Five urgent applications were made under the Deprivation of Liberty Safeguards (Four in the previous six months). (Safeguarding of Adults at Risk page 18)

2.1.3 Pressure ulcers

There were 53 patients with Trust attributable pressure ulcers. (This is a decrease from previous six months which had 59). (Incidence of Trust Acquired Pressure Ulcers, page 16)

2.1.4 Mandatory Training

Overall, statutory and mandatory training compliance at the end of reporting period was 90.3%. (Mandatory Training, page 22)

2.2 Is care effective?

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

2.2.1 Clinical audit

The Clinical Audit Committee approved 27 new clinical audit proposals and 6 national audit proposals were presented in Quarter 1 & 2. (Clinical Audit, page 45)

2.2.2 Sepsis

For April-September 2021, the data shows that 99% of patients were appropriately screened for sepsis. One patient was identified that did not meet the target. This data accords with previous quarters and half-years and shows that the recognition of sepsis is being maintained at a high level. Of these patients, 97% met the target of receiving antimicrobials within an hour. For the patients where the target was not achieved, feedback has been provided. (Sepsis, page 56)

2.3 Are staff caring?

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

2.3.1 Paediatric and Teenage Psychological Support Service

The service received 190 new referrals and 1,276 sessions were offered in the service in Quarters 1 and 2. This is a significant increase compared to the same period last year (955 sessions) as well as an increase from the last two quarters of 2020/21 (1,178). The increase in number of sessions offered is believed to reflect an increased complexity in problems families are referred for, with some families generating multiple individual referrals, requiring more intensive input, and for longer duration. (Paediatric and Teenage Psychological Support Services, page 59)

2.3.2 Adult Psychological Support Service

The service received 576 new referrals of these 514 met eligibility criteria and were offered a triage appointment (Adult Psychological Support Service, page 62)

2.4 Are staff responsive to people's needs?

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

2.4.1 Concerns and complaints

The Trust received 47 new complaints relating to NHS patients and 7 new complaints relating to private patients. All were acknowledged in three days or less.

41 complaints relating to NHS patients and eight complaints related to private patients were completed. Respectively, 63% and 100% of the NHS and private care complaints received a response by the agreed deadline. (Concerns and Complaints, page 68)

2.4.2 Letters of praise

The Head of Assurance received 337 letters of praise. (Letters of praise, page 73)

2.4.3 Freedom of information

The Trust received 217 requests during Quarters 1 and 2, compared to 154 in the last two quarters of the previous year. Of the 217 requests received, 102 were answered within 20 working days (47%). Compliance for this period is in line with the same period last year (46.7%) and is mainly attributable to a combination of pandemic challenges and an increase in the number and complexity of the requests received by the Trust. (Freedom of information, page 74)

2.5 Are staff well led?

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

2.5.1 Information Governance

The Trust's final submission was "Standards Met", which means that all mandatory assertions were met, by the revised deadline. Furthermore, as part of the national Toolkit submission, the Trust is required to achieve a target of 95% for Information Governance training. The Trust's year-end total for training compliance was 95%. (Information Governance, page 83)

2.5.2 Non-Clinical Training and Development

This period saw the launch of three flagship leadership programmes:

- Leading Excellence is aimed at consultants and those in bands 8b – 8d leadership roles and has been designed and delivered in conjunction with Henley Business School. There are 34 participants on the first cohort.
- Leading for Change is a clinical leadership programme for managers in bands 7 and 8b and has been designed and delivered by The Royal Marsden School. There are 12 participants in the first cohort.
- Operations Manager Programme. A 15-month level 5 apprenticeship for all managers, designed and delivered by Hult Ashridge Business School has attracted 12 participants on cohort 1. (Non-Clinical Training and Development, page 86)

2.6 Conclusion

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

3 Safe

3.1 Incident, complaints and claims investigations and serious incident (SI) reporting

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

3.1.1 Number of Incident, complaints and claims investigations (including SIs) completed this financial quarter and site

	Chelsea	Sutton	Total
Number of Investigations	15	11	**26**

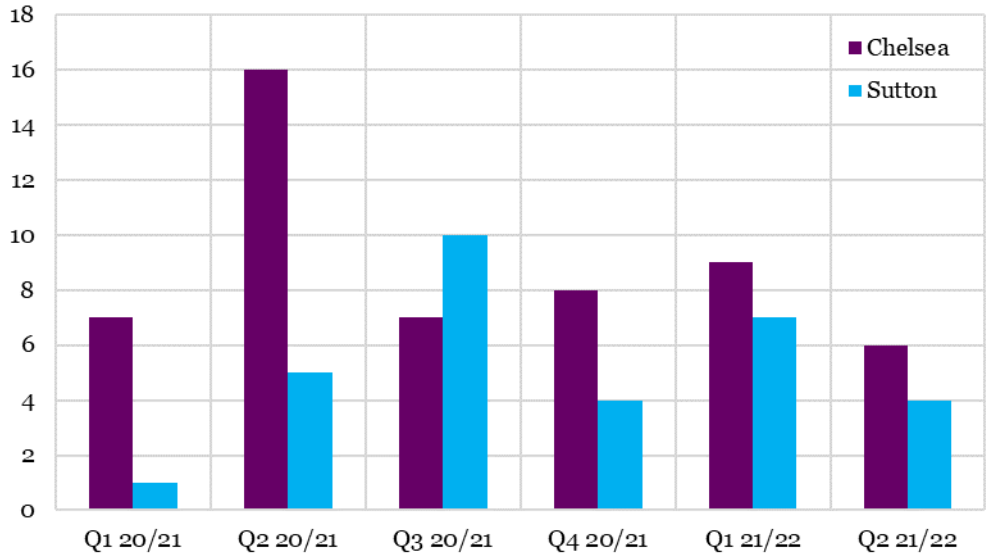
3.1.2 Incident investigations may be undertaken on low graded incidents that had the potential to cause significant harm. If an incident occurs that is graded moderate harm or above, a specific process needs to be followed to meet the requirements of the duty of candour.

Incident grading

Green	None/insignificant harm
Yellow	Low harm
Orange	Moderate harm
Red	Severe harm/death

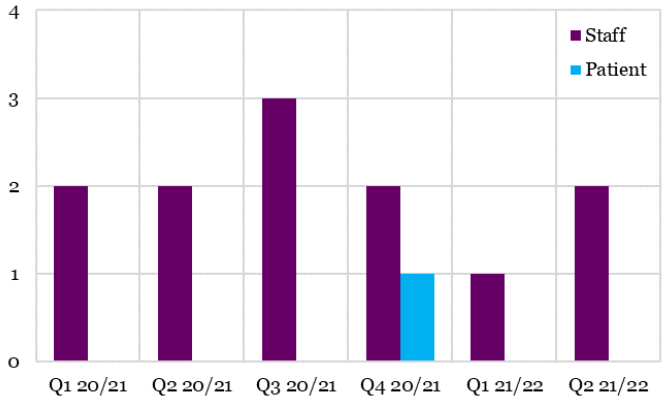
3.1.3 The Being open and duty of candour policy incorporates this requirement, and the Risk Management team supports staff with this process to ensure compliance. Compliance is audited six monthly and presented to the Integrated Governance and Risk Management Committee.

3.1.4 Number of Incident, complaints and claims investigations (including SIs) completed by financial quarter and site



3.2 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations incidents this quarter

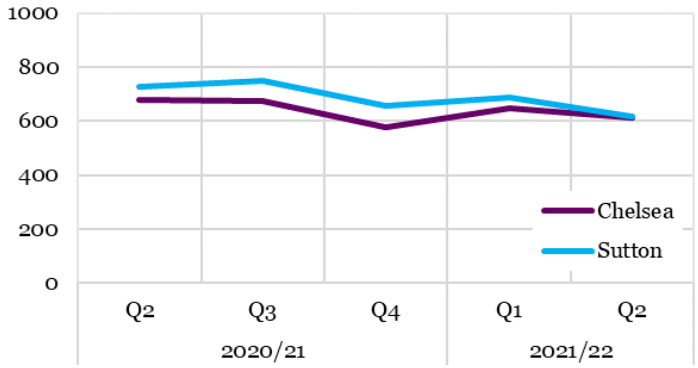
There were three incidents involving a staff member reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). There were no patient reportable incidents.



3.3 Incident statistics

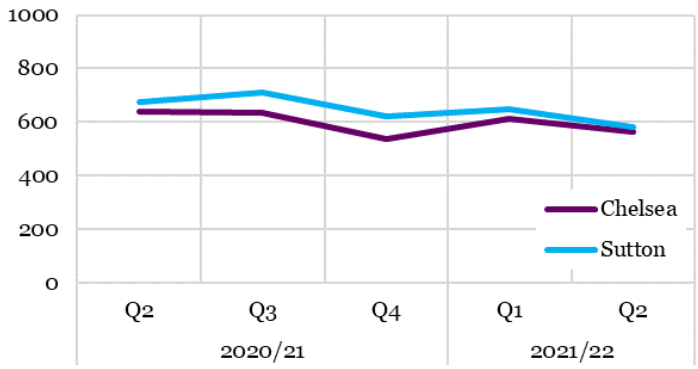
For Quarter 1, 13 attributable incidents were reported, mainly medication and over 50% of incidents were no harm and the remainder low harm. For Quarter 2, 15 attributable incidents were reported, 73% of incidents were no harm and the remainder low harm.

3.3.1 All reported incidents



3.3.2 All attributable incidents

Only attributable incidents are represented in the following sections.

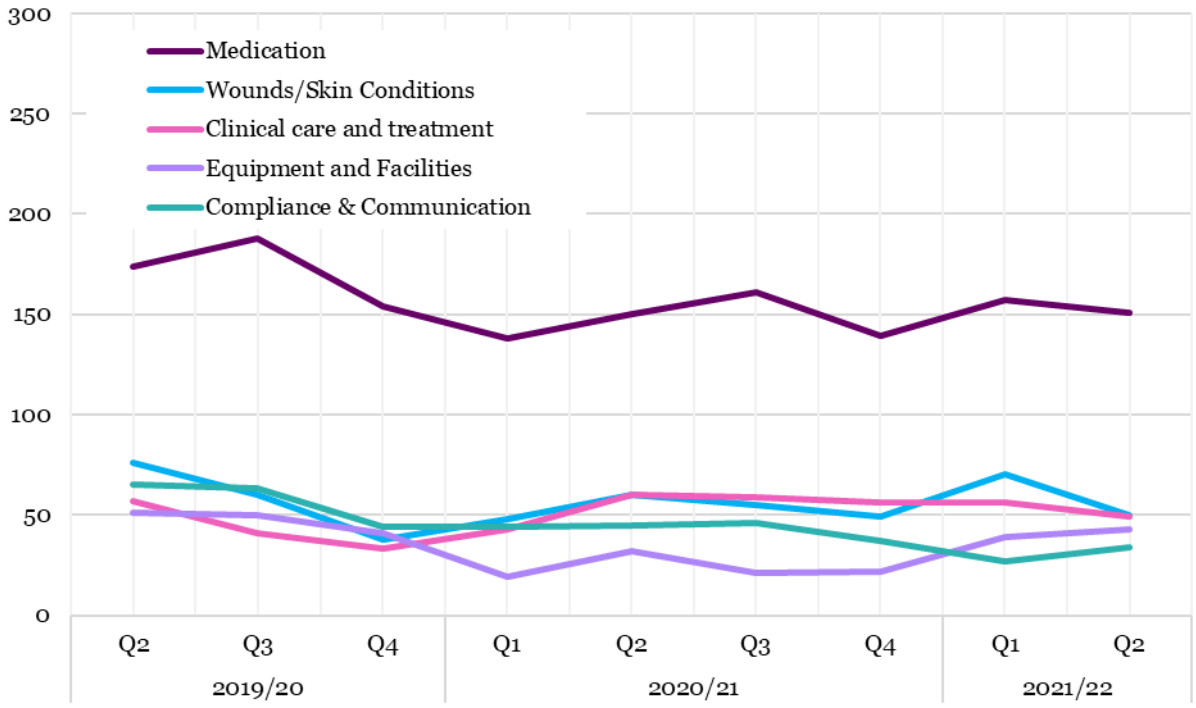


3.3.3 Patient safety incidents – top five categories

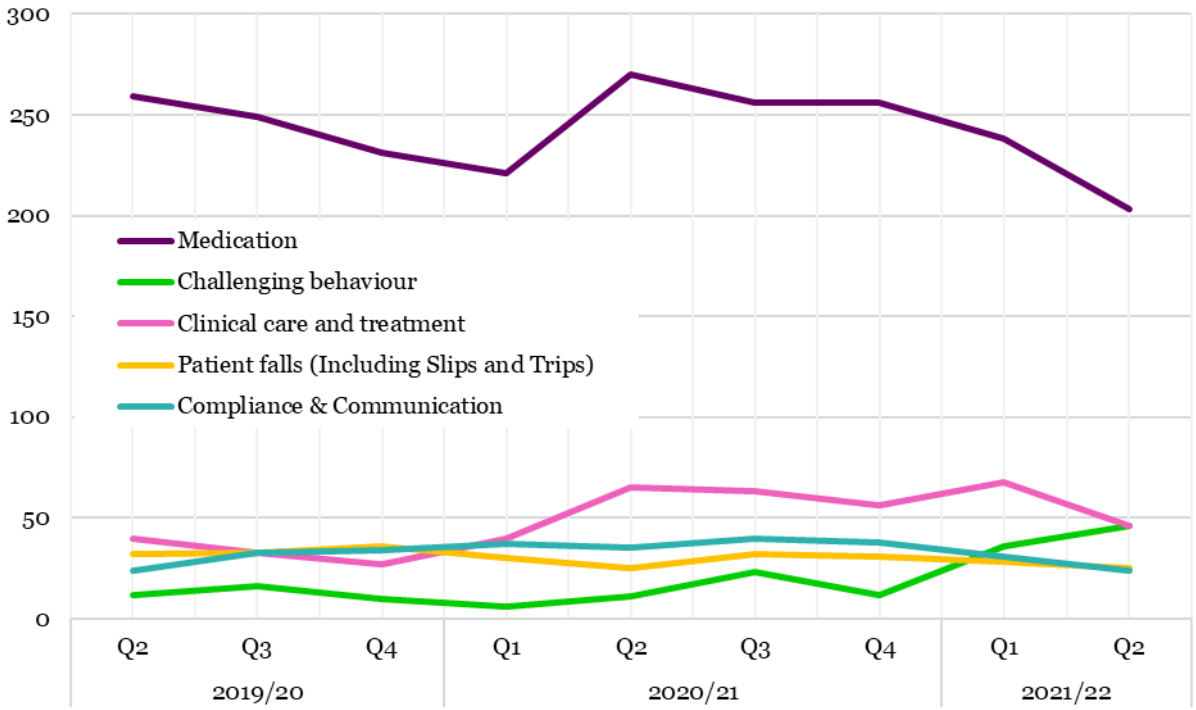
Patient safety incidents are those incidents that could have or did lead to harm for one or more patients.

The charts show the five categories with the largest number of incidents in Quarter 2, and in previous quarters.

Chelsea



Sutton

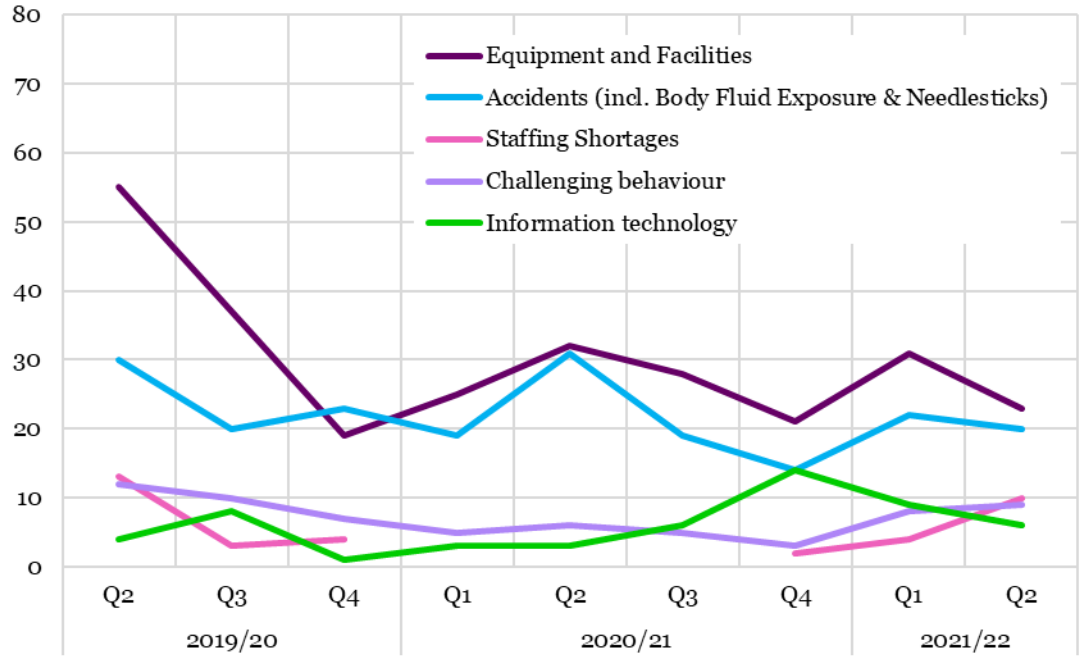


3.3.4 Non-patient safety incidents – top five categories

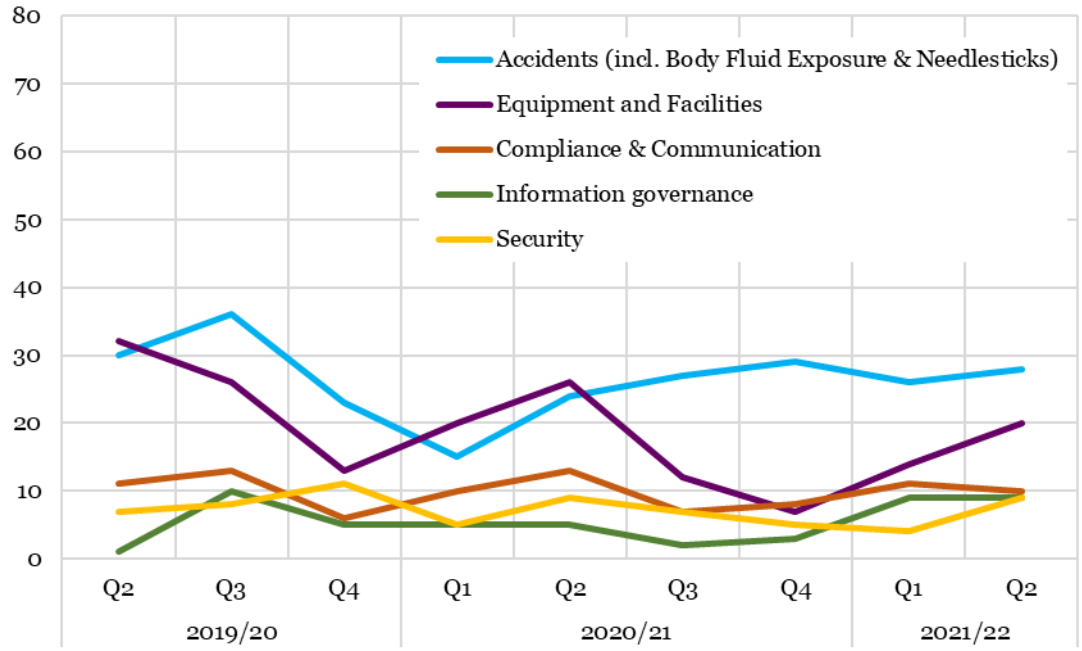
Non-patient safety incidents are those incidents that do not directly involve a patient.

The charts show the five categories with the largest number of incidents in Quarter 2, and in previous quarters.

Chelsea



Sutton



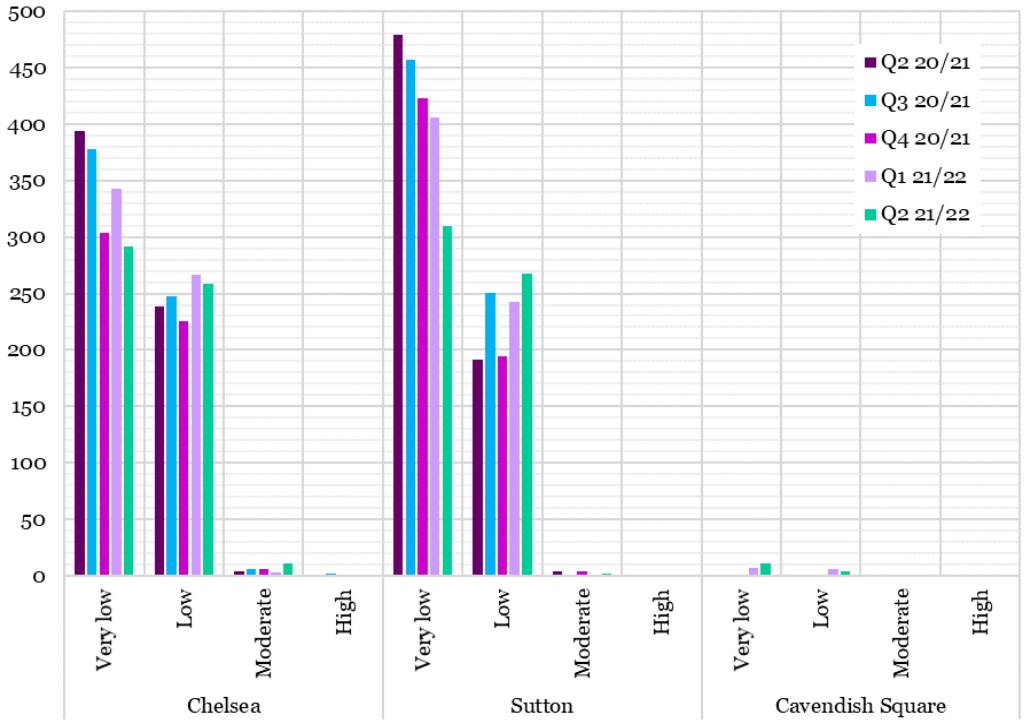
3.3.5 **Severity**

The following table shows for the Chelsea and Sutton site the number of incidents by severity for the last five quarters.

		Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22
Chelsea	No harm	410	423	348	407	347
	Low/minor (minimal harm)	218	201	177	197	198
	Moderate (short term harm)	9	8	10	9	17
	Severe/major (permanent or long term harm)	0	1	0	0	0
	Death/catastrophic (caused by the incident)	1	1	0	0	0
Sutton	No harm	483	542	433	461	386
	Low/minor (minimal harm)	185	162	179	184	190
	Moderate (short term harm)	6	5	9	5	4
	Severe/major (permanent or long term harm)	0	0	0	0	0
	Death/catastrophic (caused by the incident)	0	0	0	0	0
Cavendish Square	No harm	0	0	0	9	11
	Low/minor (minimal harm)	0	0	0	4	4
	Moderate (short term harm)	0	0	0	0	0
	Severe/major (permanent or long term harm)	0	0	0	0	0
	Death/catastrophic (caused by the incident)	0	0	0	0	0

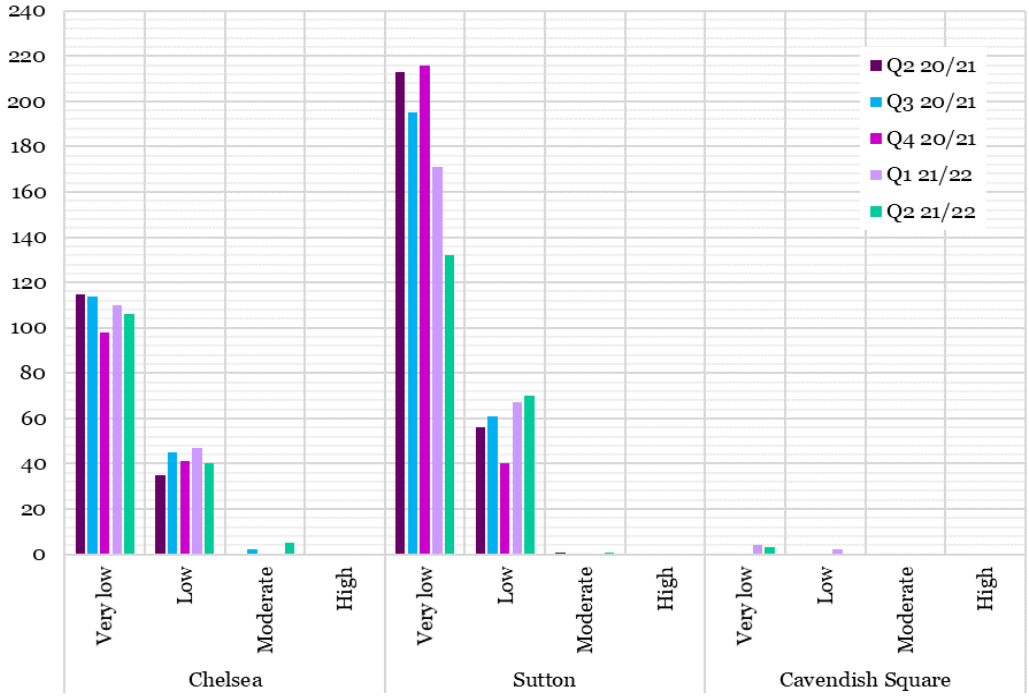
3.3.6 **Risk grade**

The chart shows for the Chelsea, Sutton and Cavendish Square sites the number of incidents by risk grade for the last five quarters.



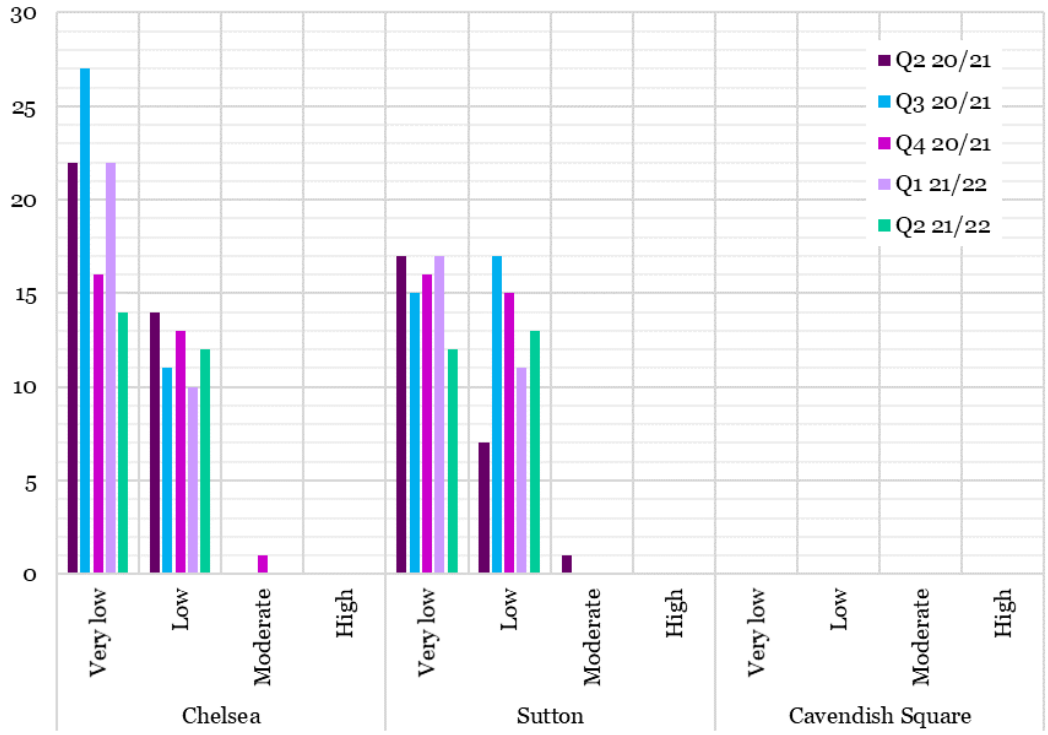
3.3.7 **Medication incidents by risk grade**

The chart shows for the Chelsea, Sutton and Cavendish Square site the number of medication incidents by risk grade for the last five quarters.



3.3.8 Patient-fall incidents by risk grade

The chart shows for the Chelsea, Sutton and Cavendish Square site the number of patient fall incidents by risk grade for the last five quarters. There have been no patient falls reported at the Cavendish Square site since opening in Quarter 1 2020/21.



3.4 Incidence of Trust acquired pressure ulcers

3.4.1 The number and severity of hospital acquired pressure ulcers are used internationally as a proxy for the effectiveness of care provision. Many people with cancer and or co-morbidity are more vulnerable to tissue damage for the following reasons: multiple hospital admissions, frailty, multiple drugs including high dose steroids (decreases skin elasticity), immobility, malnutrition, or susceptibility to infection.

3.4.2 Data for this report was taken on 6th October 2021 from DATIX. Data may have been updated since.

3.4.3 Table 3.4.6 shows how many patients developed pressure ulcers attributable to the Trust.

3.4.4 Number of patients with attributable pressure ulcers

Month	Apr	May	Jun	Jul	Aug	Sep
Overall number of patients with pressure ulcers attributable to the Trust	7	3	8	14	11	10
Number of patients with attributable pressure ulcers Category 1	0	0	1	2	3	2
Number of patients with attributable pressure ulcers Category 2	6	2	5	9	3	5
Number of patients with attributable pressure ulcers Category 3	0	0	2	1	2	1
Number of patients with attributable pressure ulcers Category 4	0	0	0	0	0	0

Number of patients with attributable pressure ulcers Unstageable		0	0	1	3	0
Number of patients with attributable DTI	1	1	0	1	0	2

3.4.5 Please note some patients may develop more than one pressure ulcer.

Description of European Pressure Ulcer Advisory Panel (EPUAP) pressure ulcer classification system.

EPUAP	**Description of Category/Stage**
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).
Unstageable	Depth unknown - Full thickness tissue loss in which the base of the ulcer is covered by slough.
DTI	Depth unknown - Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue.

3.5 Safeguarding children

The report will focus on achievements, key challenges and risks for this period, actions taken to minimise and mitigate the risks and key priorities for the next quarter.

3.5.1 **Key Achievements**

- Section 11 audit (Children's Act 2004) providing assurance that the Trust is fulfilling their responsibilities to safeguard children and promote their welfare completed and approved by Trust Safeguarding Board.
- Trust Domestic Abuse Task and Finish Group re-established following suspension during the Covid-19 pandemic
- Continued to be an active member of the Sutton Local Safeguarding Children Partnership and relevant subgroups and provide assurance of safeguarding duties during Covid-19 period.
- Safeguarding alerts implemented on the Trust clinical recording system

3.5.2 **Key Challenges and Actions Taken**

Domestic abuse is the most reported concern for children and continues to be the highest reported category of abuse for adults in the Trust, many of whom have children. Staff continue to identify concerns at an early stage and refer to early help support services promptly to help manage risk and support child and adult victims of abuse. However, early help services remain extremely limited in many areas due to continuing Covid-19 restrictions increasing the time staff need to allocate to families experiencing domestic abuse to ensure they receive adequate support and advice. The Trust task and finish group is reviewing both staff training and patient pathways for child and adult victims of domestic abuse to address these challenges.

The Trust is also a member of NHSE Domestic Violence and Abuse Clinical Reference Group.

3.5.3 **Safeguarding Children's Activity**

Quarters 1 and 2 activities for safeguarding children across the Trust saw a significant increase in Quarter 1 compared to Quarter 3, 2020/21. There was a decrease in Quarter 2 activity that is in line with that seen in Quarter 4, 2020/21.

Of note there were:

- 73 contacts in Quarter 1
- 67 contacts in Quarter 2
- Four children subject to a child protection plan
- Seven children subject to a child in need plan
- Four Looked after children

The highest reported safeguarding concern was children experiencing domestic abuse. For many children this was also associated with experiences of neglect and poor parental mental health. Neglect was the second most reported concern in safeguarding children and correlated with children not being brought to scheduled appointments and /or treatment.

The number of safeguarding enquiries received does not reflect the increasing complexity of cases that require liaison with external statutory and voluntary services, primary care, and attendance at statutory child protection, safeguarding and risk management meetings.

Table 1 – Number of Safeguarding Referrals to Children's Social Care

Number of Safeguarding concerns raised to local authorities	**Quarter 1 2021/22**	**Quarter 2 2021/22**
Statutory Referral (MASH)	6	4
Early Help Referral	6	2
MARAC (Multi Agency Risk Assessment Conference)	2	1

Referrals to children's social care predominantly related to domestic abuse, neglect, and mental health. Two referrals were made for suspected physical abuse.

3.5.4 Key Priorities for Quarter 1 and 2 2021/22

- Support the Trust recovery from Covid-19 and maintaining statutory safeguarding responsibilities
- Review staff domestic abuse training needs
- Continue to prepare the organisation for Liberty Protection Safeguards and implementation of changes relating to young people aged 16-17 years of age
- Increase staff awareness and use of safeguarding safety alerts

3.5.5 Conclusion

Safeguarding children remains a high priority within the Royal Marsden NHS Foundation Trust through a continued and consistent commitment to ensuring the Trust's responsibilities are fulfilled. The Trust is pleased with the achievements in this busy period.

3.6 Safeguarding adults

This report reflects the Safeguarding Adults activity for Quarter 1 and Quarter 2, 2021/22 for the Royal Marsden NHS Foundation Trust. The Trust Safeguarding Adult's agenda includes leadership around Safeguarding adults at risk; Mental Capacity Act, Deprivation of Liberty Safeguards; Prevent and Dementia and Learning Disabilities.

3.6.1 Key Achievements

- Safeguarding adults' team now attend all Divisional Governance Meetings to support discussion and review and learning from safeguarding related incidents

- ❖ Continued to be an active member of the Sutton SAB and Bi-Borough SAB and relevant subgroups and provided assurance of safeguarding duties during Covid-19 period
- ❖ Darzi Fellow for Patients with Additional Needs engaged with patients and their family about their experience of services.
- ❖ Delivered ad-hoc safeguarding briefings at ward hand-0vers

3.6.2 **Key Challenges and Actions Taken**

The Trust continues to recognise that domestic abuse is the highest reported category of abuse for adults in the Trust. Guidance developed during Covid-19 lockdown to support working with patients remotely where there are concerns about domestic abuse continues to be applicable. This guidance previously distributed to staff and promoted on the Trust intranet remains available as a resource to staff together with advice from the adult safeguarding team. The Trust Domestic Abuse Task and Finish group continue to work with external partners to monitor and review policy, procedures and pathways and training for staff.

3.6.3 **Safeguarding Adults Activity**

Quarters 1 and 2 activities for safeguarding adult's enquiries and DoLS Applications across the Trust saw a slight reduction of activity in Quarter 2.

New contacts for advice:

- ❖ 129 new contacts in Quarter 1
- ❖ 130 new contacts in Quarter 2

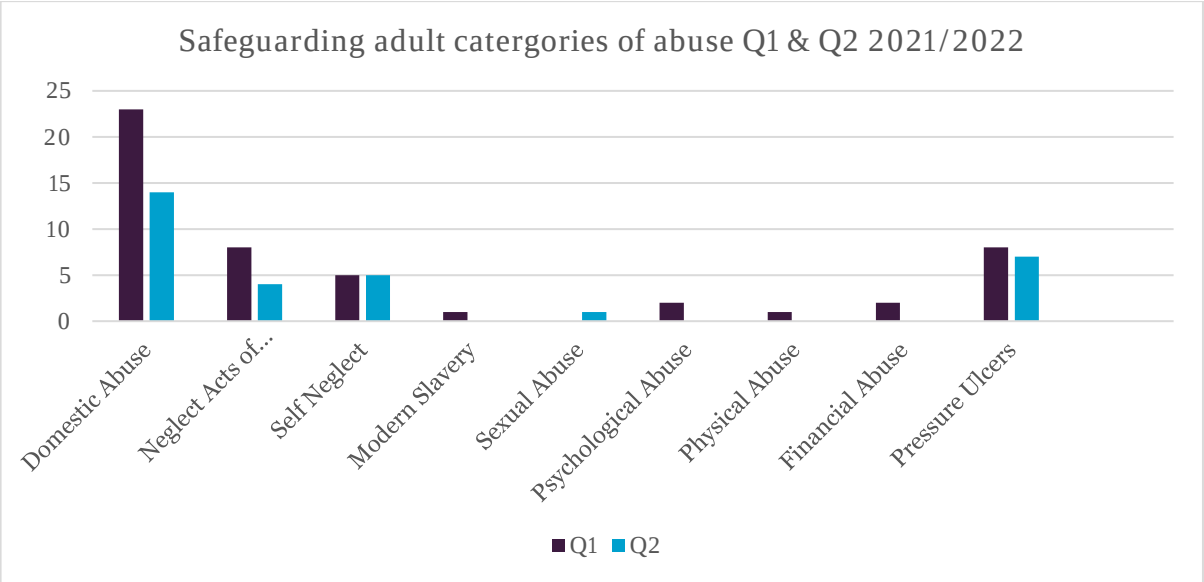
Table 1 – Safeguarding adult activity Quarters 1 & 2, 2021/22

Activity Theme	Quarter 1	Quarter 2
General Vulnerability	31	25
MCA	27	56
Safeguarding	61	36
Learning disability	5	11
Other	5	2
Total	129	130

Domestic abuse continued to be the highest self-reported concern by patients. The second highest concern reported by staff was neglect and acts of omission, specifically relating to pressure area management of patients being transferred from other hospitals or admitted from the community.

The number of enquiries received regarding patients with general vulnerabilities does not reflect the complexity of cases that required onward referral for Care Act needs assessments or referral to community services and in some instances a review of support provision within the Trust to support continued access to cancer services.

Table 2 – Categories of Abuse reported –Quarters 1 & 2, 2021/22



A total of nine safeguarding concerns raised where the statutory safeguarding threshold was met or there were high risk concerns identified. Domestic abuse was the highest reported category of abuse. Some concerns raised were not reported as the patient did not want a safeguarding referral to Adult Social Care. In all non-reportable concerns, risk and safety were assessed and appropriate support services discussed with the patient.

Table 3 – Number of Safeguarding Adults Concerns Raised

Number of Safeguarding concerns raised to local authorities	**Quarter 1 2021/22**	**Quarter 2 2021/22**
Chelsea	**0**	**3**
Chelsea non reportable	0	5
Sutton	**4**	**2**
Sutton non reportable	2	0

3.6.4 Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

The safeguarding adults team continue to receive a high number of contacts for advice regarding the Mental Capacity Act and Deprivation of Liberty Safeguards.

There was a reduction in DoLS applications during this period. Five urgent applications were made. There were two applications made in Quarter 2 also had applications for extension requests.

Table 4 – Number of Urgent Deprivation of Liberty Safeguards applications

	Quarter 1	**Quarter 2**
Urgent DoLS applications	3	2
Urgent DoLS extensions	0	2
Awaiting Assessment	0	0

3.6.5 **Liberty Protection Safeguards (LPS)**

Nationally the LPS implementation has been delayed until April 2022 with confirmation awaited from the Department of Health and Social Care on the actual date which is likely to be moved for a third time. The Trust LPS task and finish group suspended during this reporting period, will resume quarterly meetings in Quarter 4. Key aspects of the implications for the Trust are being addressed through the impact assessment due to be completed in Quarter 4. There is an ongoing focus on using the time for planning and training all staff on the application of the Mental Capacity Act 2005 to patient care as this will be a key issue for the Trust in the roll out of Liberty Protection Safeguards.

Key Risks – application of the Mental Capacity Act to patient care when indication and completion of the Mental Capacity Assessments and Best Interest Decision.

Risk that staff are not appropriately completing the Trust Record of Assessment of Mental Capacity and Best Interests Decision documentation for adults that lack capacity appropriately. The adult safeguarding team continue to work with all services to improve the quality of assessments and the application of the Mental Capacity Act to patient care.

3.6.6 ***PREVENT***

All NHS staff in contact with patients and the public are required to have basic *Prevent* awareness training. The aim of *Prevent* is to help identify vulnerable persons who are at risk of engaging in or supporting terrorism or terrorist activity. There have been no referrals made to the relevant Channel panels during this period by the Trust.

Awareness training is provided in two levels: basic awareness and the *Workshop to Raise Awareness of Prevent (WRAP).* Trust compliance measurable against the National NHS compliance target of 85%. The Trust achieved 90% compliance for basic awareness and 85% for WRAP training.

Staff are now being targeted to complete e-learning for both basic awareness and WRAP training to increase compliance.

***Prevent* training Compliance (Target 85%)**	**Quarters 1 & 2**
Basic awareness	90%
Workshop to raise awareness of *Prevent* (WRAP)	85%

3.6.7 **Dementia and learning disabilities**

The Trust continues to be an active member in the Sutton Learning Disabilities mortality Review (LeDeR) steering group hosted by the Clinical Commissioning Group (CCG) and share learning across the organisation. The Trust did not make any referrals to the LeDeR programme during Quarters 1 or 2.

The Darzi Fellowship research project began in Quarter 1 of 2021/2022 focusing on supporting people with additional needs being diagnosed and treated for cancer, and their experiences of services. The final report will be completed in October 2022, when available outcomes from the report will be incorporated into the work plan for Quarter 4, 2021/22 and going forward into 2022/23.

Tier 1 and 2 Dementia training affected by Covid-19 restraints continues to be available via e-learning. The training delivered in partnership with the Admiral Nurses services has been put on hold until such time as training sessions can be delivered safely in training rooms.

3.6.8 **Training and staff development**

Staff compliance with training is monitored through the electronic system (Wired) with a target of 90% across all levels. There is regular targeting of staff to attend sessions.

Safeguarding Children and Adults Compliance Summary (*as of October 2021*)

Area	Target	Q1 2021/22 compliance	Q2 2021/22 compliance
Safeguarding Adults Level 1	90%	92%	93%
Safeguarding Adults Level 2	90%	90%	93%
Safeguarding Adults Level 3	90%	88%	77%
Wrap	85%	88%	77%

Training is a large component of safeguarding work which enables staff to understand their roles in relation to safeguarding the patient from abuse. Safeguarding adults' levels 1 and 2 training are currently being delivered via e-learning, accessible to all staff online at a time to suit them. The Safeguarding Adult's level 1 and 2 training compliance remains above the 90% target, despite the ongoing pressures and impact of COVID-19.

Level 3 training is being delivered via online workshops; nationally accredited e-learning level 3 modules are also available. We are currently below our target in level 3 training, due to the new requirement of staffing groups to complete this topic in line with the NHS England "*Intercollegiate Adult Safeguarding: Roles and Competencies for Healthcare Staff*".

Divisional Directors are sent Monthly Compliance Dashboards, providing information, and highlighting key areas requiring improvements. Staff are followed up with via email for low compliance topics on a regular basis, automated reminders for all upcoming training are sent to staff.

3.6.9 Key Priorities for Quarter 3 and 4, 2021/22

- Continue to support the Trust recovery from Covid-19 and maintaining statutory safeguarding responsibilities
- Review training, resources, and support for staff on Mental Capacity Act, capacity assessments and Best Interest Decisions
- Continue to prepare the organisation for Liberty Protection Safeguards
- Continue the roll out of the Safeguarding Intercollegiate Training guidance and requirements

3.6.10 Conclusion

Safeguarding Adults remains a high priority within the Royal Marsden NHS Foundation Trust through a continued and consistent commitment to ensuring the Trust's responsibilities are fulfilled. The Trust is pleased with the achievements in this busy period.

3.7 Mandatory Training

Statutory and mandatory training forms part of the Trust's risk management strategy to minimize risk to patients, visitors, and staff. In addition to the ongoing use of the Learning Hub mandatory training and appraisal compliance reporting system, progress against these topics is reported to divisions through the monthly scorecard and Progress Resource Group meetings.

Overall, statutory, and mandatory training compliance at the end of reporting period was 90.3% against a target of 90%.

The table below shows mandatory training compliance for the core topics as at the end of September 2021.

The figures for the overall compliance rates are shown against the red/amber/green (RAG) rating where:

- Red is less than 50%
- Amber is 50% to 1% below target
- Green is at or above target.

Mandatory training topics	Update frequency requirement (in years)	Target	Overall Trust compliance rate end of March 2021 (Q3 & 4)	Trend	Overall Trust compliance rate end of September (Quarter 1 & 2)
Adult basic life Support	1	90%	**85%**		**90%**
Blood transfusion (generic update)	2	90%	**87%**		**90%**
Conflict resolution for frontline staff	3	90%	**81%**		**89%**
Consent awareness (medical staff)	2	90%	**64%**		**77%**
Equality and diversity	3	90%	**94%**		**96%**
Fire awareness	1 (clinical) 2 (other)	90%	**84%**		**91%** **94%**
Infection prevention and control	1 (level 1) 2 (level 2)	90%	**87%**		**96%** **88%**
Information governance	1	95%	**92%**		**93%**
Medicines management (clinical staff)	1	90%	**91%**		**92%**
Manual handling – back care awareness (non-patient handling)	3	90%	**91%**		**94%**
Manual handling (patient handling)	1	90%	**85%**		**71%**
Paediatric basic life support	1	90%	**69%**		**94%**
Risk management awareness	1 (managers) 3 (other)	90%	**86%**		**92%**
Risk training for senior managers	1 (managers)	90%	**79%**		**91%**
Safeguarding vulnerable adults (level 1)	3	90%	**90%**		**93%**
Safeguarding vulnerable adults (level 2)	3	90%	**65%**		**75%**

Mandatory training topics	Update frequency requirement (in years)	Target	Overall Trust compliance rate end of March 2021 (Q3 & 4)	Trend	Overall Trust compliance rate end of September (Quarter 1 & 2)
Safeguarding vulnerable adults (level 3)	3	90%	**91%**		**95%**
Safeguarding children (level 1)	3	90%	**88%**		**93%**
Safeguarding children (level 2)	3	90%	**53%**		**79%**
Safeguarding children (level 3)	3	90%	**68%**		**89%**
WRAP (Prevent)	Once only	85%	**83%**		**54%**
Harm Free Care (clinical staff)	1 (clinical)	90%	**64%**		**75%**
Venous thrombo-embolism (medical staff)	Once only	90%			**75%**

Targets for compliance are set at 90% with the exception of the Conflict Resolution which is set to 80%, Workshop to Raise Awareness of Prevent (WRAP) at 85% and Information Governance at 95%. WRAP and Information Governance is set at 85% and 95% nationally respectively whilst Conflict Resolution is set by the Trust.

The E-learning and Systems Integration Manager has continued to support the development and updating of an effective learning management system and implementation of the digital pathway during the Covid-19 pandemic. The Learning and Development team has also supported the development of in-house e-learning programmes as part of the digital pathway.

Regular monthly dashboards are provided to Divisional Directors and reminders are sent to all staff on a regular basis. Regular attendance at sister and matron meetings provides communication on key areas for improvement. These remain the key strategies for maintaining and improving the overall compliance rate in all topics.

3.8 Local Induction

The overall compliance rate for Local Induction at the end of the reporting period is 69% against the Trust target of 85%.
Regular monthly-targeted follow-up with Divisional Directors and three-monthly reminders to line managers remains the key strategy for improving the Local Induction compliance rate. Local Induction non-compliance rates are included on monthly dashboards sent to Divisional Directors along with those who require a local induction to be completed for follow up.

3.9 Infection Prevention and Control

3.9.1 Mandatory Surveillance

All trusts are required to submit data on specified infections to the Healthcare associated Infection (HCAI) Data Capture System (DCS). The required data includes all cases of *Clostridium difficile* toxin and bacteraemia caused by Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive Staphylococcus aureus (MSSA), *E.coli*, *Klebsiella* species and *Pseudomonas aeruginosa*.

Revised targets show a reduction for *C.difficile* (56 instead of 67) and *E.coli* (52 instead of 65) from previous year. New targets have been set for *P. aeruginosa* and *Klebsiella* species.

Indicator	Q2 *DCS reportable	Q2 attributable	YTD†	YTD attributable	Target	Variance from Target	Forecast
MRSA‡ Bacteraemia	0	0	0	0	**0**	0	
S. aureus Bacteraemia	4	4	5	1	N/A	N/A	
E. coli Bacteraemia	13	6	31	21	52**	31	
Klebsiella sp Bacteraemia	8	6	14	10	33**	N/A	
Pseudomonas aeruginosa Bacteraemia	10	4	17	9	21**	N/A	

	Q2 DCS reportable	Q2 DCS attributable HOHA COHA	YTD HOHA COHA	*CDT* lapse in care YTD: total against target	Target	Variance from target	Forecast
C. difficile toxin	32	20 (14 HOHA) (6 COHA)	34 (22 HOHA) (12 COHA)	NA	56**	33	

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

† YTD: year to date ‡ MRSA: meticillin-resistant *Staphylococcus aureus* ** *N/A: not applicable*

HOHA: Hospital Onset Healthcare Associated *COHA: Community Onset Healthcare Associated*

3.9.2 **MRSA**

There were zero cases of MRSA bacteraemia's in 2020/21.

3.9.3 **Staphylococcus aureus bacteraemia**

There were 4 cases of MSSA BSI, all attributable to the Trust. The first case, thought to be osteomyelitis related. The second one was SSI related. The patient was colonised with MSSA, decolonisation was undertaken before surgery, but it is uncertain if the protocol was carried out correctly by the patient's carer. Further investigation will be done by the SSI nurse. The third case was associated with extravasation post Intravenous (IV) chemo administration. The patient developed a phlebitis; cannula was removed and another one was inserted due to chemotherapy. The last case was line related in a colonised patient. The patient pulled out the lines multiple times due to confusion.

As part of an overall review into how we can reduce blood stream infections a multidisciplinary group has reviewed the aseptic technique competency and an annual refresher is being rolled out for all staff who give IV medications including chemotherapies.

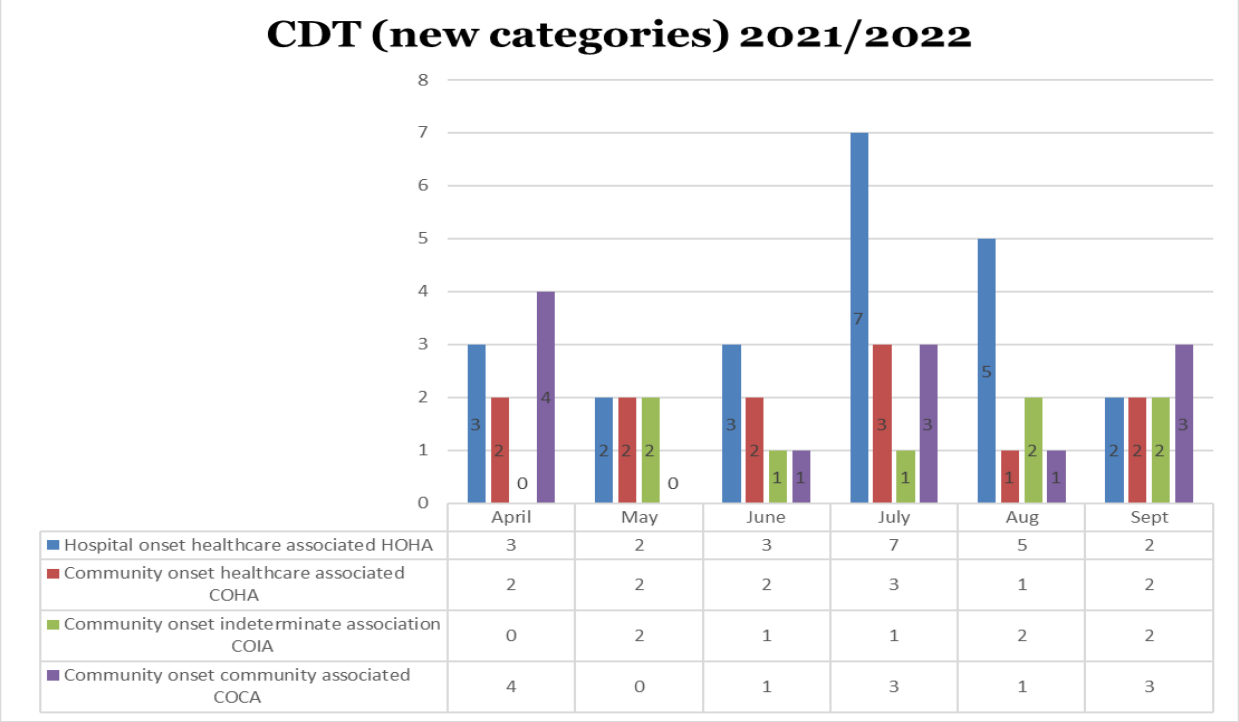
3.9.4 Clostridium difficile infection

All stool samples found to be *C. difficile* toxin (CDT) positive are reported to the Public Health England Data Collection Scheme (DCS).

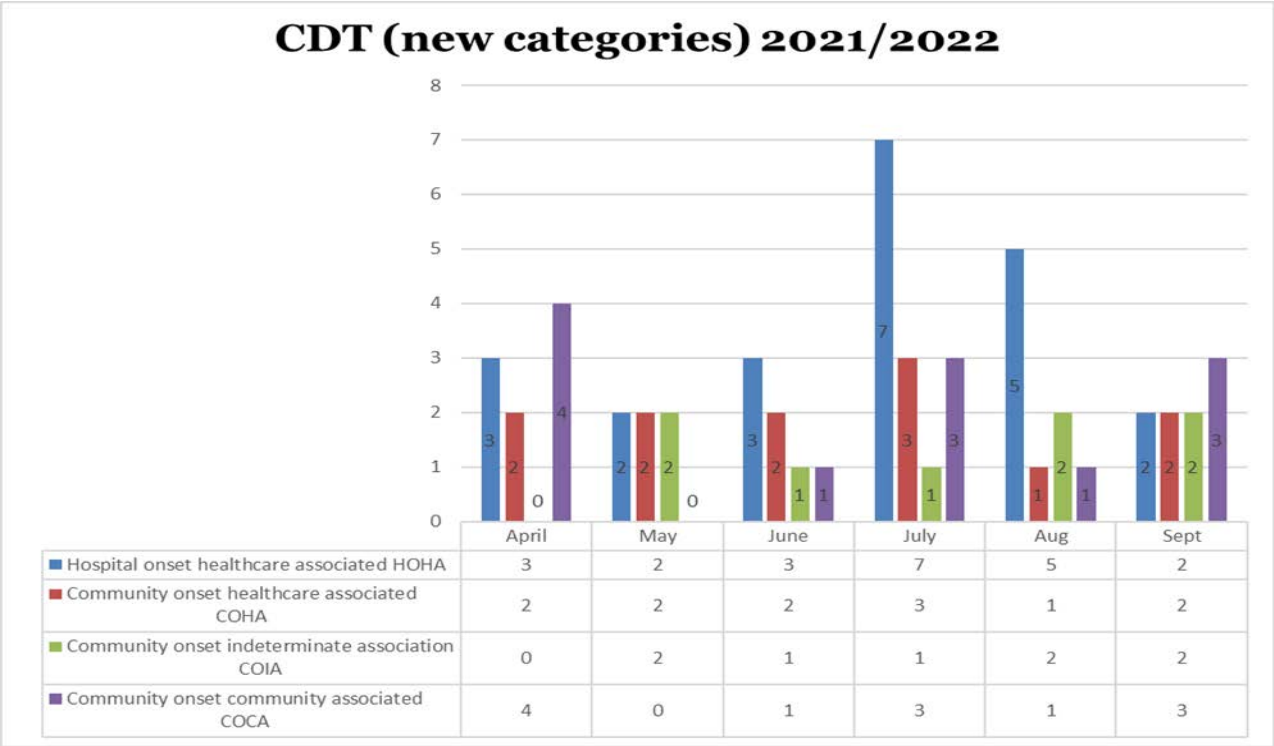
Cases reported to the DCS are assigned as follows:

- Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission.
- Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.
- Community onset indeterminate association (COIA)
- Community onset community associated (COCA)

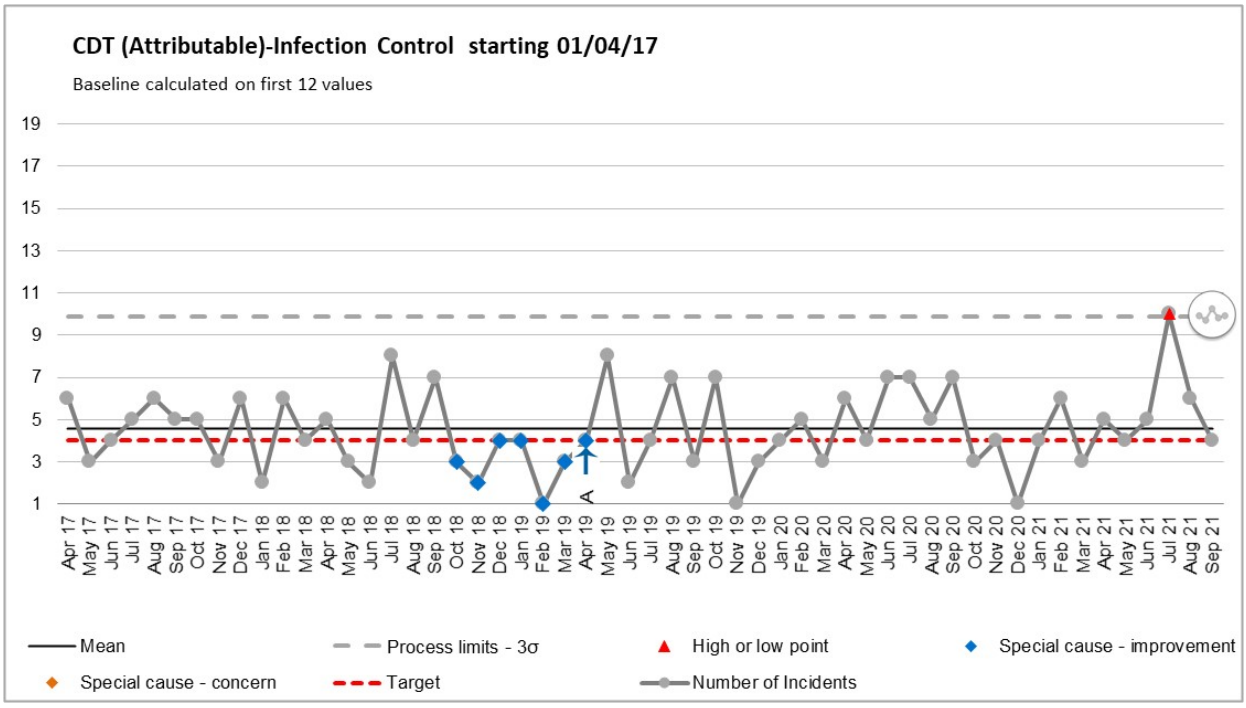
C.difficile cases continue to be reviewed internally at the monthly Infection review panel chaired by the Chief Nurse or deputy. The trajectory has been reduced from 67 to 56 by NHSE/I. To date the Trust is over trajectory. This is in part due to an increase in cases over the summer which included a confirmed outbreak involving 3 patients on Burdett-Coutts ward and some unrelated cases on McElwain ward which have not been linked via ribotyping. Measures for improvement have been put in place including enhanced IPC visiting and auditing of environmental hygiene and hand hygiene. The numbers have been lower in August and September with no further cases on Burdett-Coutts Ward



	April	May	June	July	Aug	Sept
Hospital onset healthcare associated HOHA	3	2	3	7	5	2
Community onset healthcare associated COHA	2	2	2	3	1	2
Community onset indeterminate association COIA	0	2	1	1	2	2
Community onset community associated COCA	4	0	1	3	1	3



	April	May	June	July	Aug	Sept
Hospital onset healthcare associated HOHA	3	2	3	7	5	2
Community onset healthcare associated COHA	2	2	2	3	1	2
Community onset indeterminate association COIA	0	2	1	1	2	2
Community onset community associated COCA	4	0	1	3	1	3

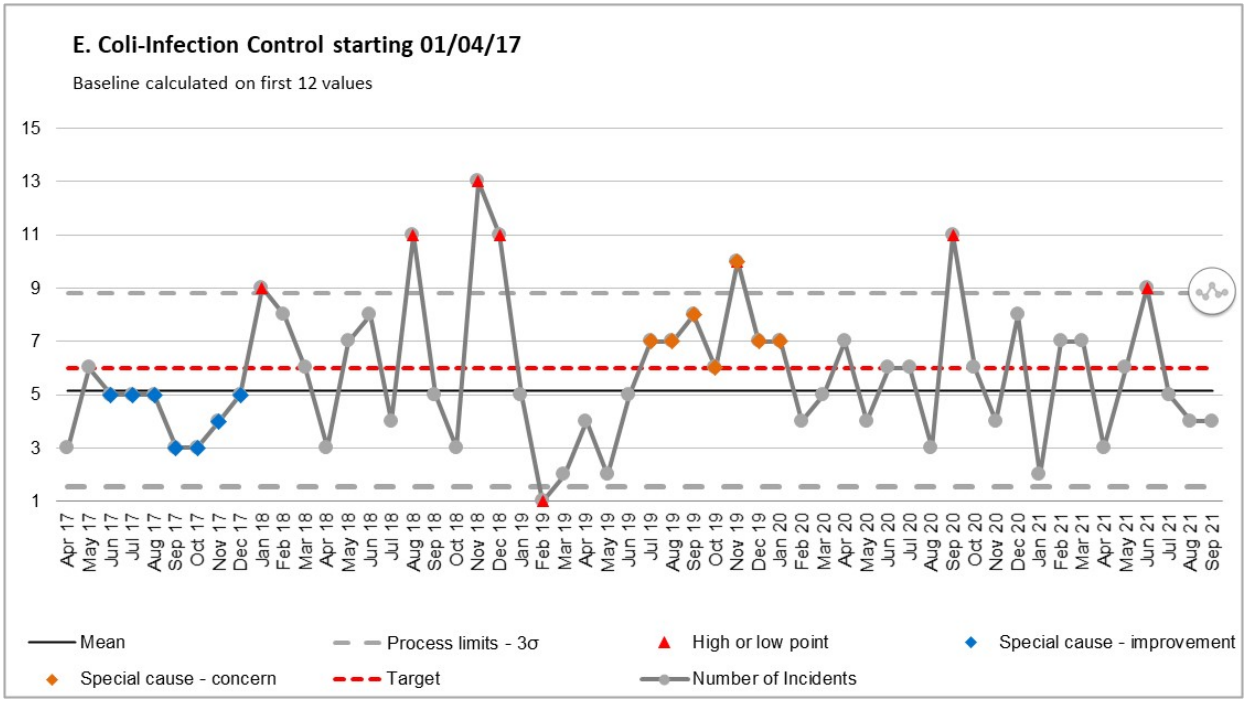


CDT Statistical process control chart

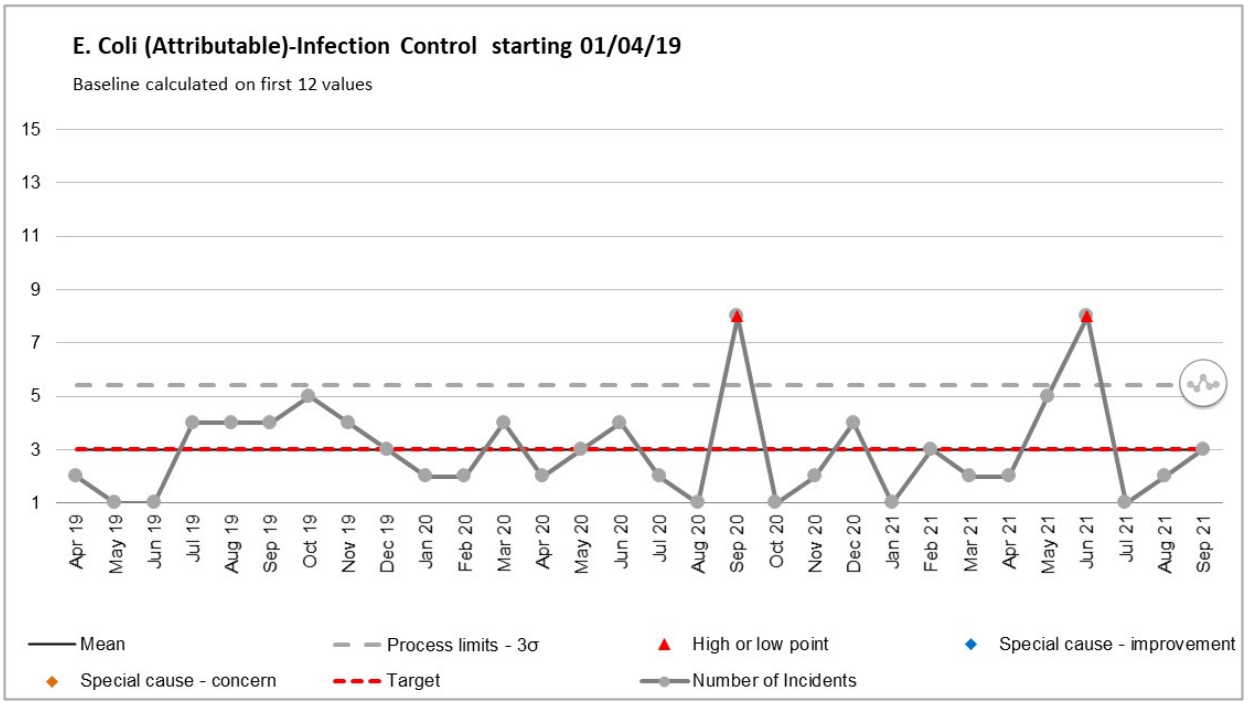
3.9.5 E.coli bacteraemia

We continue to work towards the *E.coli* objective set by NHS Improvement. This has been reduced from 65 to 52.

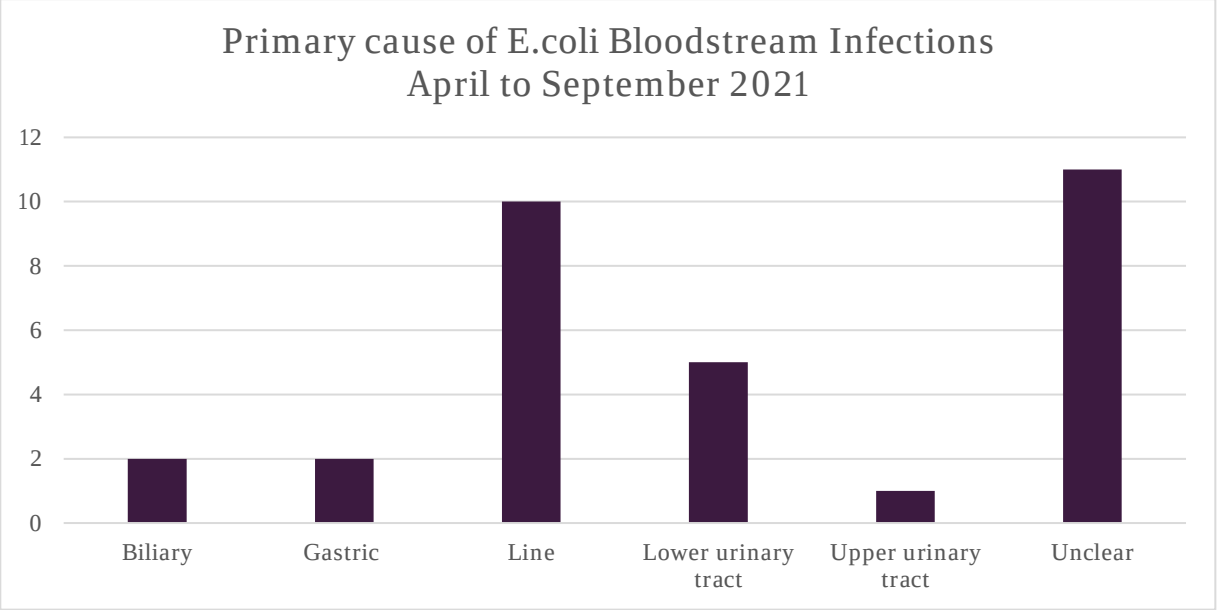
There was a total of 13 cases in Quarter 2 of which 6 were attributable occurring more than 48 hours after admission. This is a reduction from Quarter 1 and brings us in line with trajectory. Each case continues to be reviewed for any themes which can be used for improvement. Most cases are linked to the complex nature of the patients and chemotherapy is a common theme along with biliary or urosepsis.



Statistical process control chart E.coli total numbers since 2017



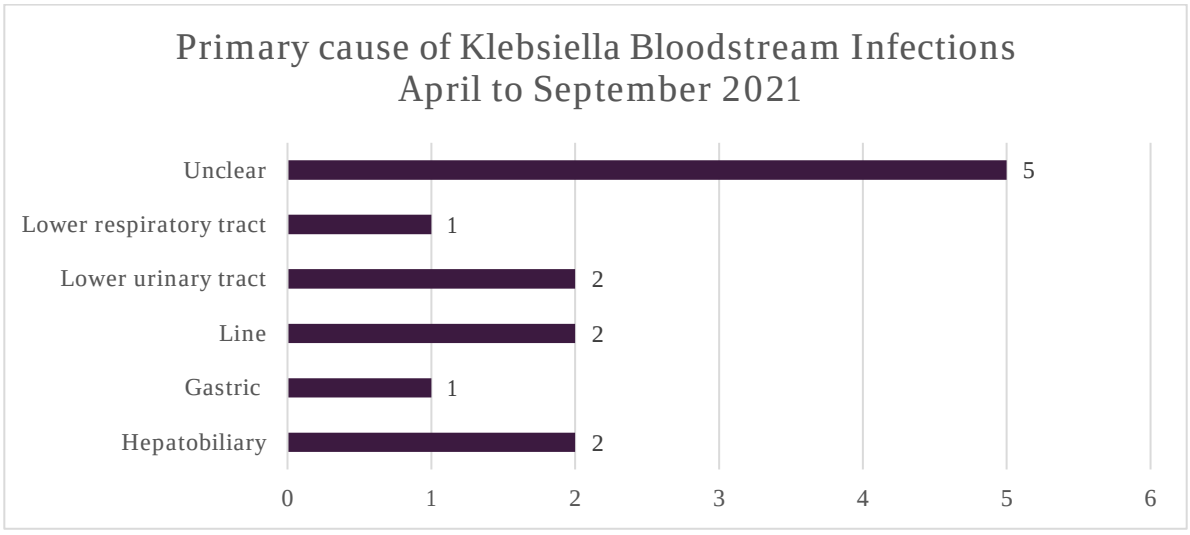
Statistical process control chart Statistical process control chart E.coli attributable numbers for 2019/2020

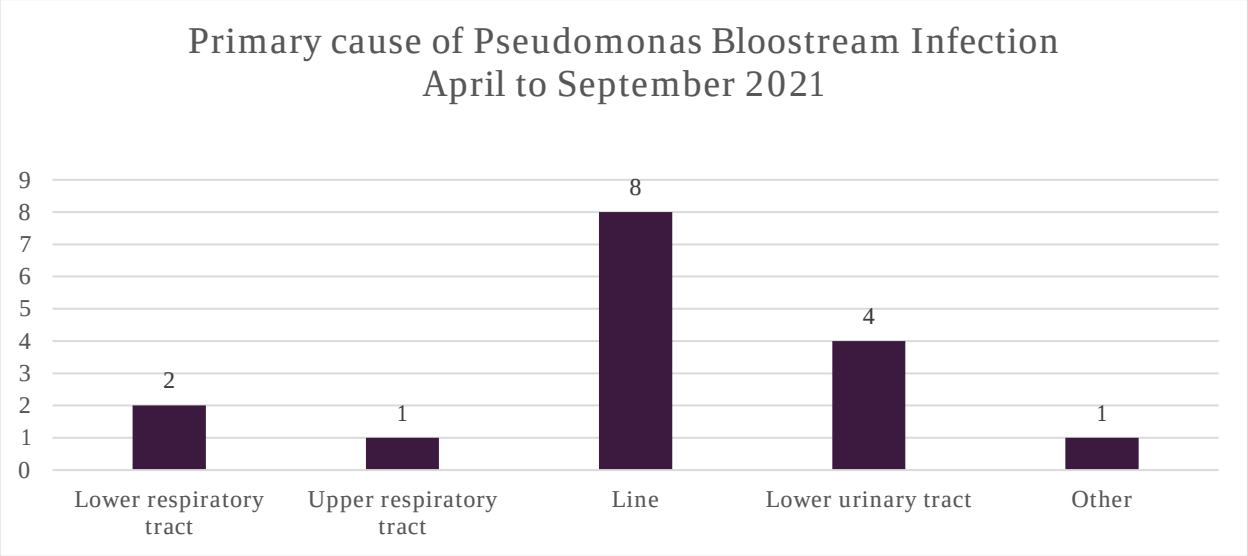


3.9.6 **Pseudomonas and Klebsiella**

There were 10 cases of *Pseudomonas aeruginosa* bacteraemia and 8 of *Klebsiella* species seen in Quarter 2. The cases were examined to see if there are any links, in particular to water outlets but typing of samples yielded no connection. Thus far we have not connected any clinical cases to areas where we have intermittent *Pseudomonas* issues.

We continue to monitor water outlets in augmented care units for *Pseudomonas aeruginosa*. We have had an ongoing issue with one sink on the Critical Care Unit (CCU), this is despite changing the plumbing completely. Emphasis continues to be put on the cleaning and the general use of the taps to ensure these isolates are not a result of poor practice. There is a growing body of evidence suggesting that sinks are best removed from critical care bed spaces with corresponding reductions in gram negative infections, and this is the next step which needs to be explored by the IPC Team, Critical Care Team and Estates. Basins could still be provided in ante rooms and corridors but alcohol handrubs would be used within patient bed spaces.





3.9.7 **Legionella**

The Trust was notified about a patient who had Legionella pneumophilia isolated in September. The patient had attended the Trust on 3 occasions, once for a chemo boost and twice for a blood test. It is unlikely that the patient could have been exposed at these appointments as no obvious water source that could aerosolize Legionella was present. Checks have been ordered on water samples from the Medical Day Unit in Sutton and the blood room as a precaution. Public health will be looking at alternative sources including the patient's home.

3.9.8 **Covid-19**

Covid-19 is an infectious disease caused by the most recently discovered coronavirus1. Covid-19 pandemic affecting many countries globally is the biggest public health threat of this generation. There have been more than 9.3 million confirmed cases of Coronavirus in the UK.

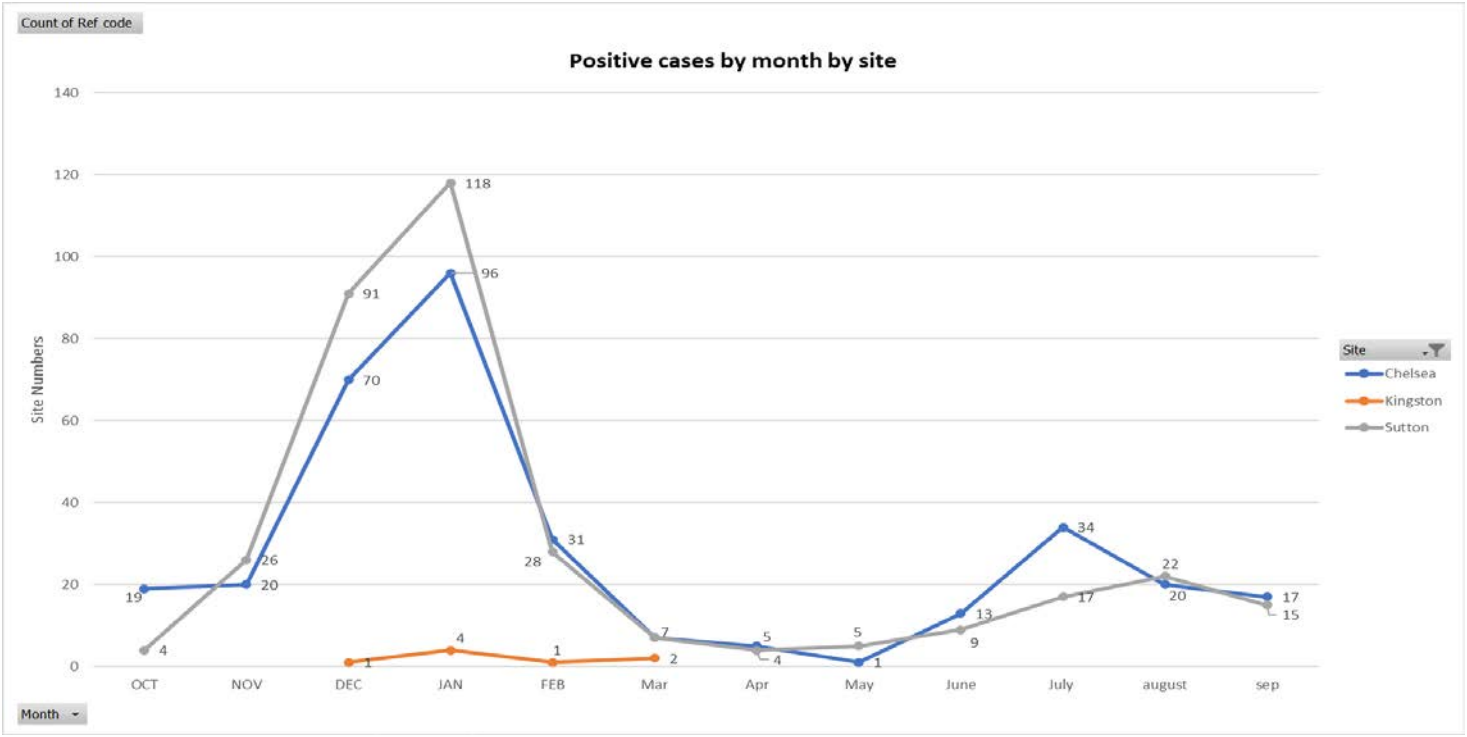
At the Royal Marsden, we continue to see a number of positive cases of Covid-19 both in patients and staff. There were 19 in-patients (not hospital acquired) and 48 outpatients that tested positive from July to September 2021. There were 66 staff that tested positive in July to September 2021.

Patients coming into the Trust for Elective day case procedures and in-patient admissions were asked to self- isolate for 3 days prior to admission and take a Covid-19 test 3 days prior to admission. Patients admitted into the Haematology unit were asked to self- isolate for 7 days prior to admission and take a Covid-19 test 3 days prior to admission. Patients admitted into the Trust are now managed in new patient pathways – low risk pathway (patients that have self-isolated), medium risk pathway (patients that have self-isolated), high risk pathway (Covid positive or symptomatic patients). All patients are symptom checked on arrival.

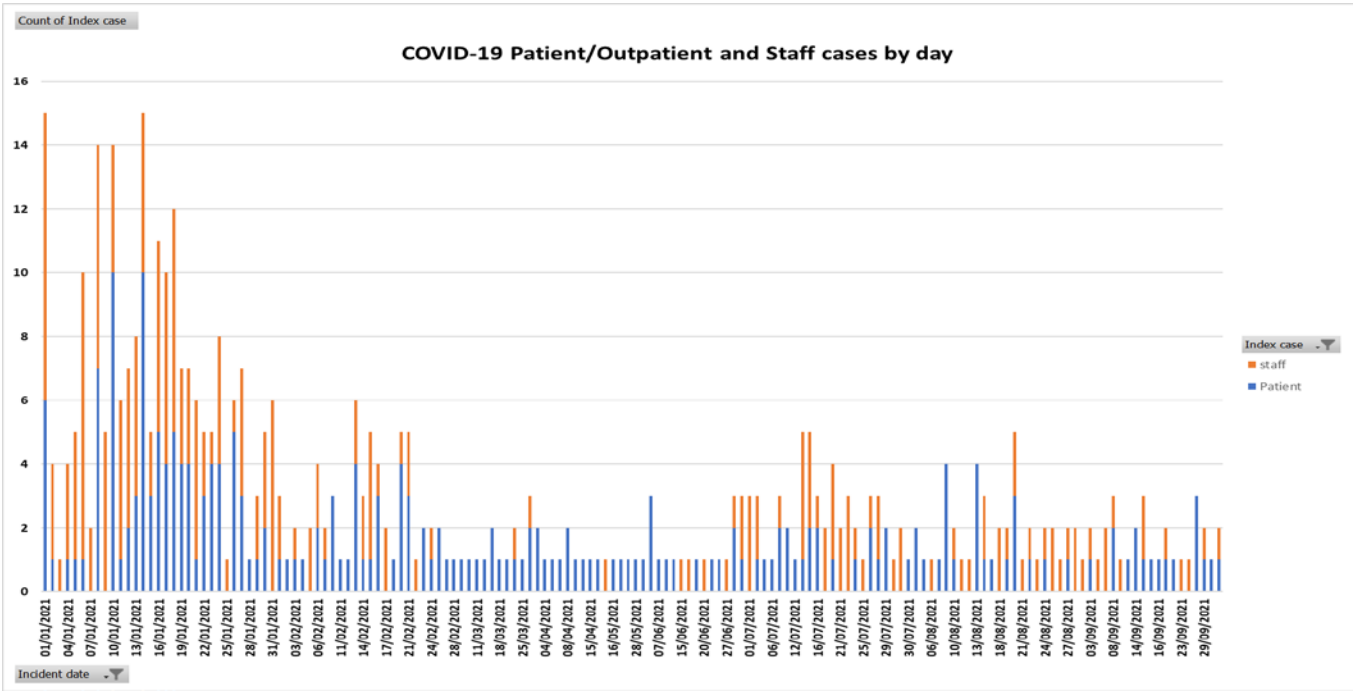
The Trust is gradually moving away from lockdown restrictions by welcoming visitors in a controlled way on selected wards (Low risk pathway). Only one nominated visitor will be allowed to visit for up to one hour, but they must comply with rules to ensure everyone remains safe.

The Trust has continued with the staff screening program which started in April 2020. This has allowed us to identify asymptomatic carriage among staff and reduce onward spread to other staff or patients.

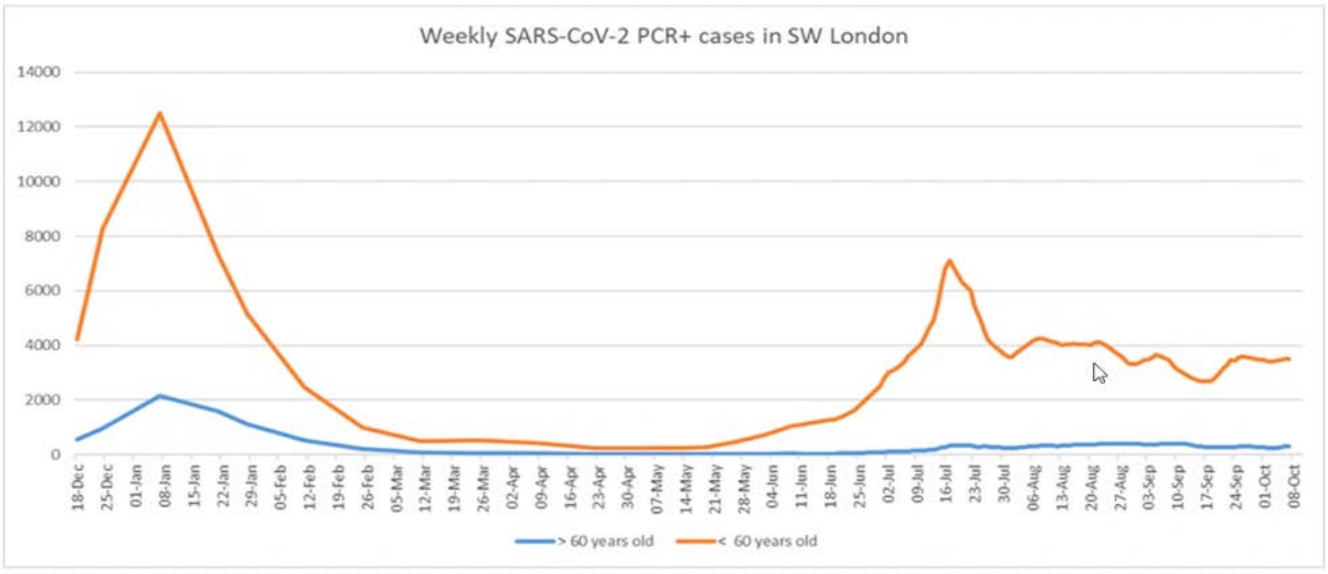
Despite national relaxation of precautions Covid-19 precautions remain in place within the Trust, including face coverings, social distancing, hand hygiene, regular surface cleaning and increased ventilation.



Number of COVID-19 cases by site for October 2020 to September 21.



Number of patient and staff COVID-19 cases for January 2021 to Sepember 2021



3.9.9 **Listeria monocytogenes**

We identified *Listeria monocytogenes* from an overseas private patient on Wiltshaw Ward. The patient was an outpatient. The patients last inpatient stay was for 7 nights in August. The patient is also known to have developed *C.difficile* in September. The health protection team have been notified and they will undertake further investigations. It is unlikely to be connected with the hospital.

3.9.10 **Aeromonas infection**

There was an unusually high number of Aeromonas infection for the reporting period. There were 3 cases of bloodstream infection, 2 fluid drain, 1 wound swab and 1 stool sample. Preliminary investigation did not yield any commonalities except that all patients are Royal Marsden patients (2 patients were admitted to the Critical Care Unit, and 3 were in Out-Patients Department). A meeting with PHE was held on 26/10/21 with the actions to be completed such as:

1. Water sampling – there should be a structured way of looking where patients were admitted. Contact food and water authority to help water sampling as all patients were not in the same ward/unit.
2. Look at outbreaks of diarrhoea (*E.coli and C.difficile*) in relation to where these clusters of Aeromonas infections were.
3. Cleaning -Commode cleaning/ toilet cleaning to be investigated if they were cleaned to a high standard and in a timely manner.
4. Food – liaise with catering on the menu being served i.e fish.
5. Continue to monitor new cases.

3.9.11 **Surgical Site surveillance**

SSI Surveillance has fallen behind during the summer due to staff vacancy. A SSIS Surveillance staff nurse has been in post since late September and has written a SSISS assurance project in draft. Within this assurance project is a short- term action plan and a concurrent gap analysis.

3.9.12 **Catheter Associate Urinary Tract Infections (CAUTI)/ Harm Free Care**

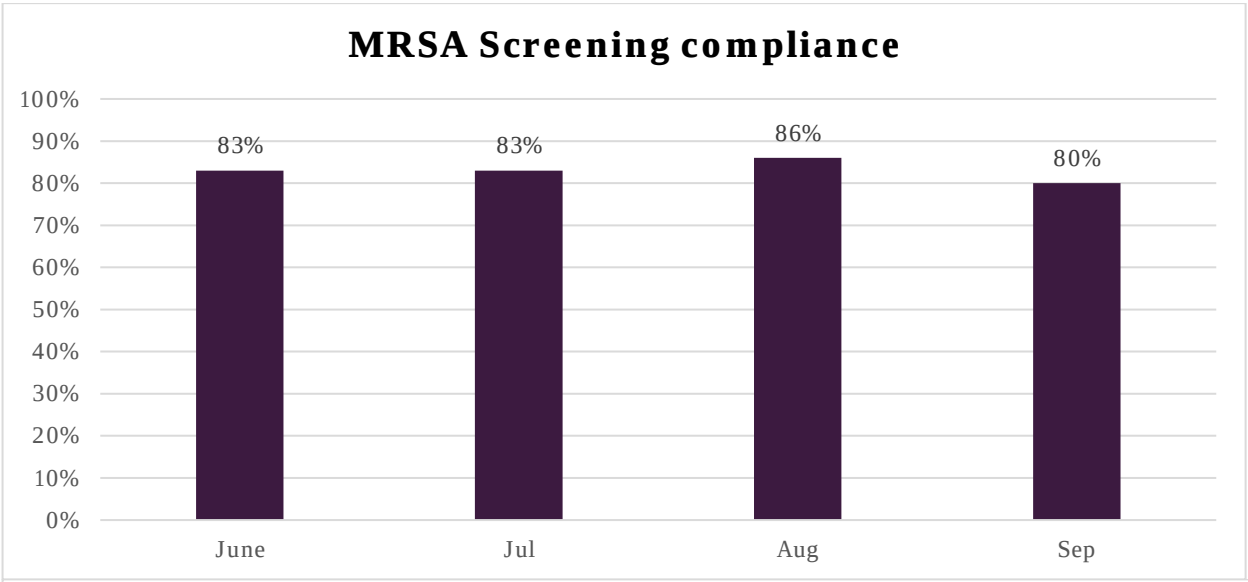
The Infection Prevention and Control Team has continued to ensure that all staff are aware of the standard definition of CAUTI, available on RM Matters to support the early

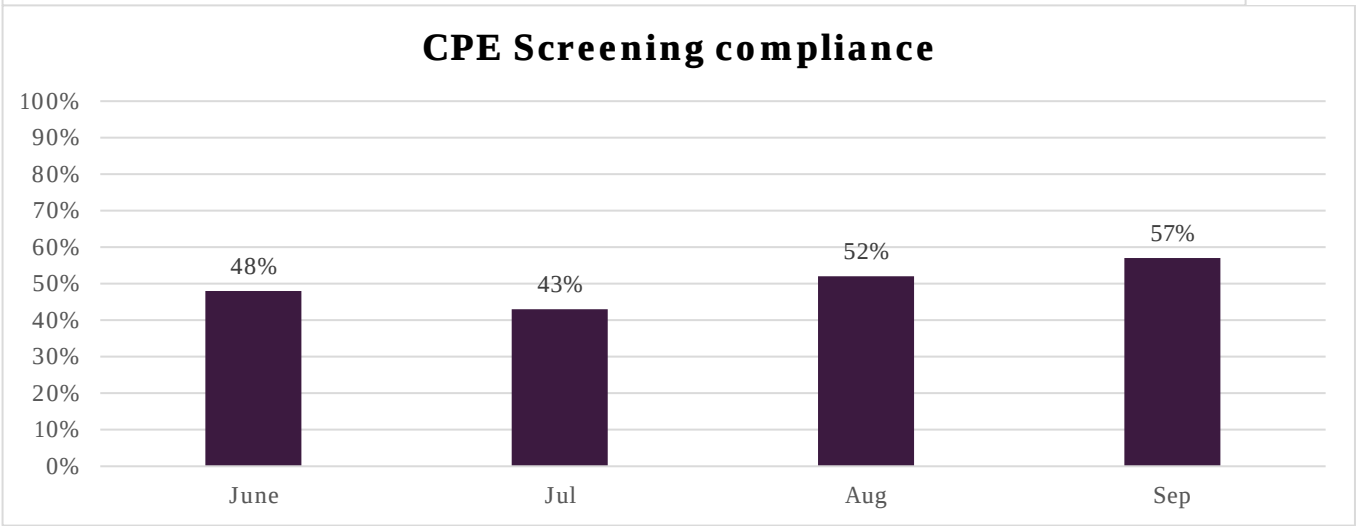
recognition of any possible CAUTI cases. Cases are reported on DATIX and will initiate an investigation with the aim of identifying any lapses in care and improvements to be made.

To provide confidence that the positive catheter specimens of urine are accurately interpreted by clinical staff, the IPC team run a weekly lab report and follow the results.

To ensure a high-quality clinical care for patients is maintained, the monthly High Impact Interventions audit for catheter care are monitored for completion and actions taken on results. Catheter in-situ are also audited in the Big 5 audit carried out monthly by IPCNs.

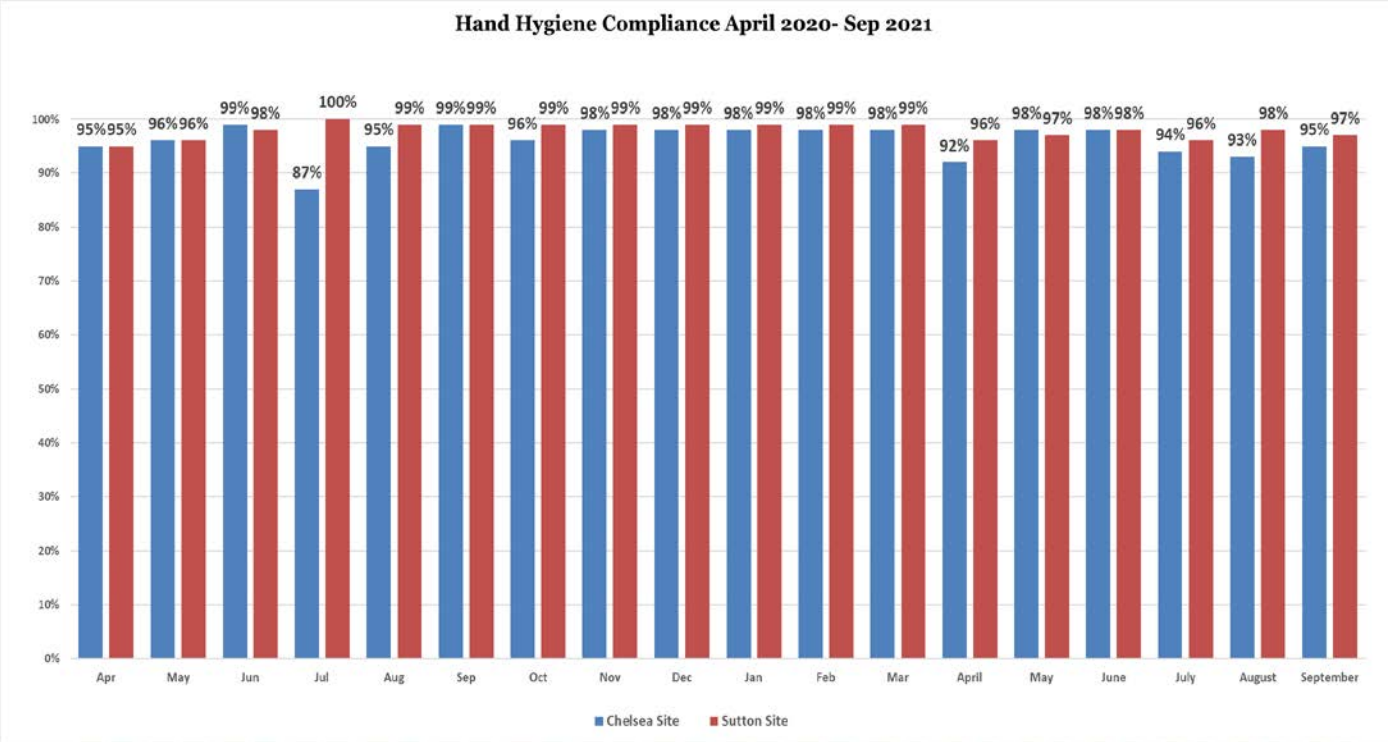
3.9.13 MRSA and CPO screening on admission





3.9.14 Hand hygiene

The hand hygiene compliance scores for the Trust are shown in graph below. Hand hygiene across the Trust is good with good access to clinical hand wash basins and alcohol hand rub available in key areas. Hand hygiene auditing is undertaken by link staff using app. Additional verification audits are undertaken in each ward by the IPC Team as part of regular audit process.

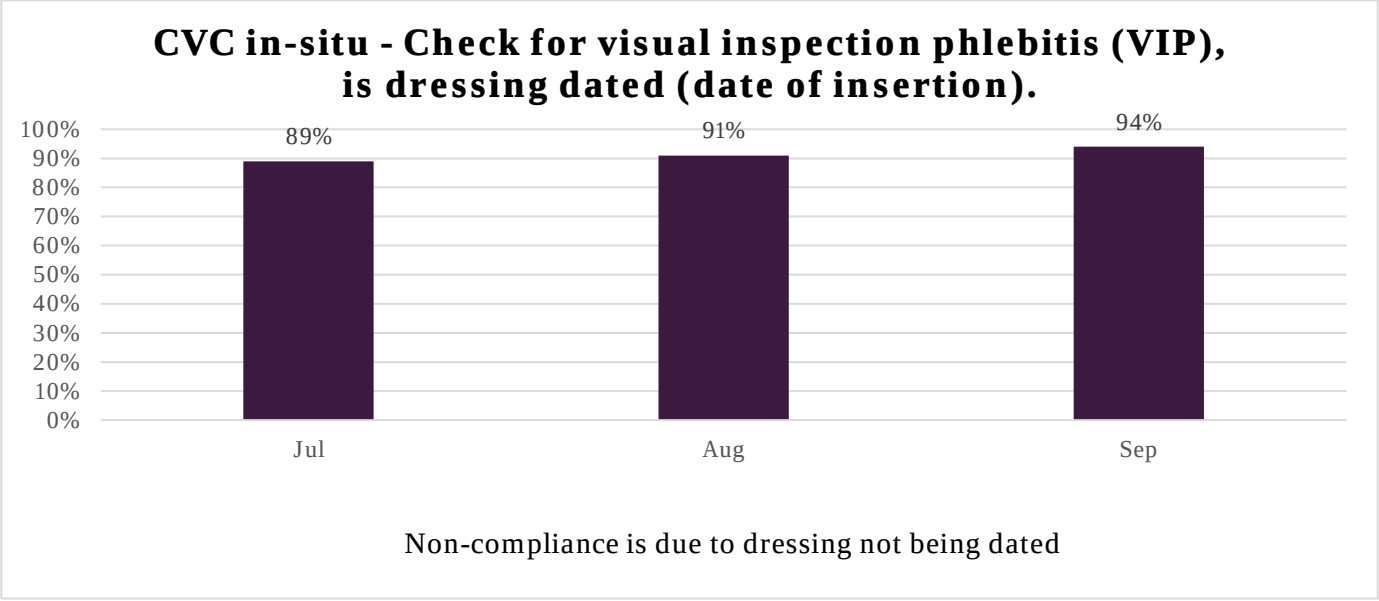


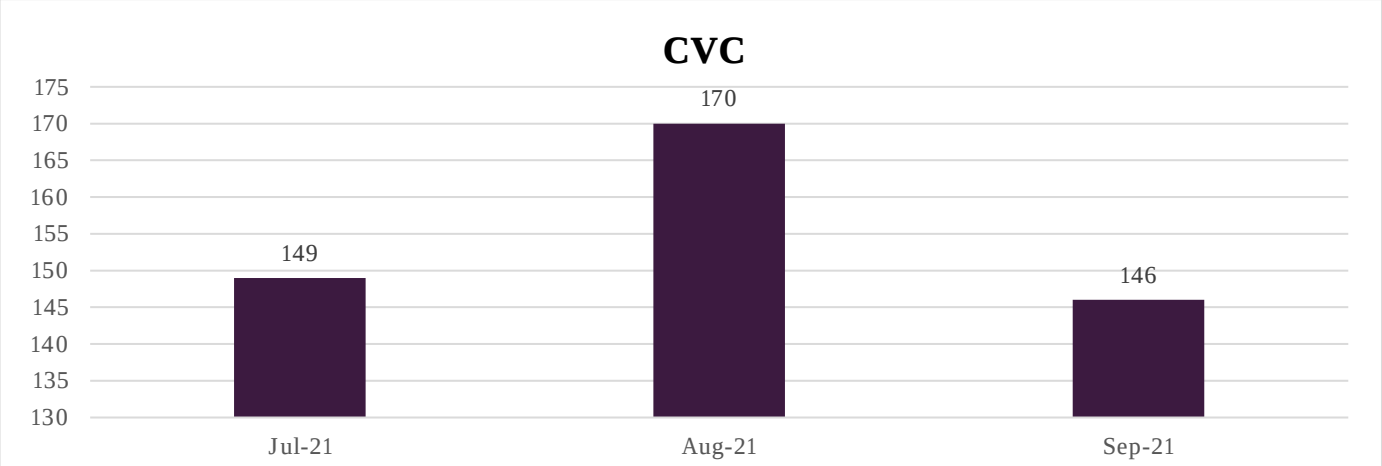
3.9.15 **IPC Quality Assurance Audits**

3.9.15.1 BIG 5 Audit

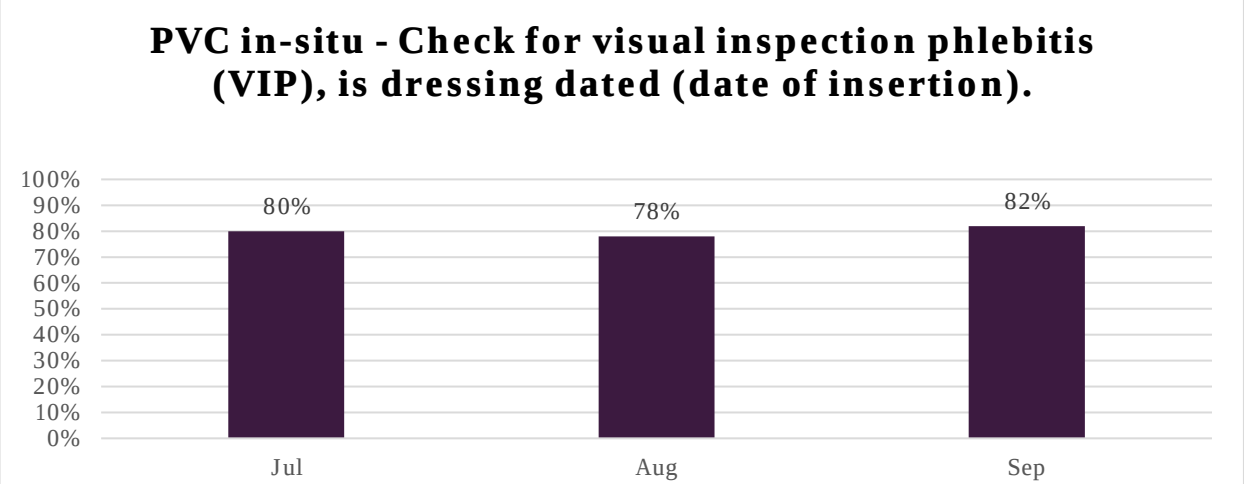
The Big5 audit was initiated in May 2021 to enable regular point prevalence observations across the key performance categories1 that are crucial for the prevention of infections, namely: clinical devices in situation e.g., CVAD, PVC, Urinary catheter, documentation of clinical sites in situation e.g., VIP last 24 hours; Bristol stool chart last 48 hours; patient bedside tidiness and cleanliness, and near patient medical equipment cleanliness.

Feedback was given to nurse in-charge to ensure areas of non-compliance are rectified in a timely manner and good practices emphasized. Monthly reports are circulated to ward manager, matrons, DND's, Chief nurse and Deputy chief nurse. Findings are presented in the Quality Safety Risk meeting. Four months of audit data have been collected. Full analysis is yet to be undertaken but the trend is towards improvement. The example data for September is shown below:

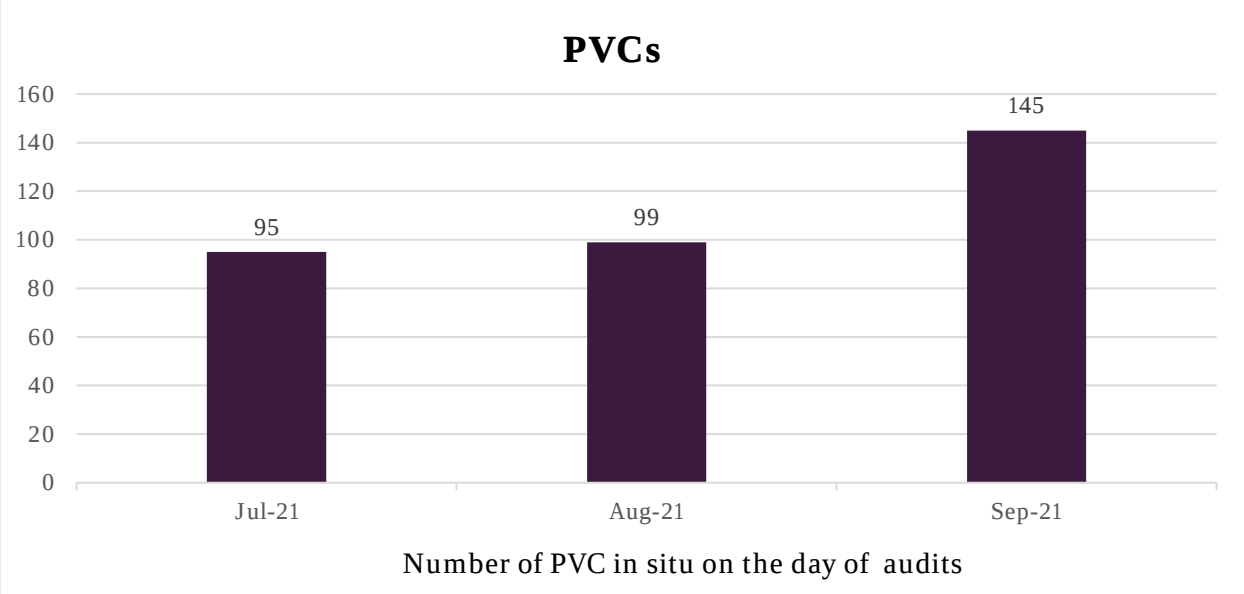




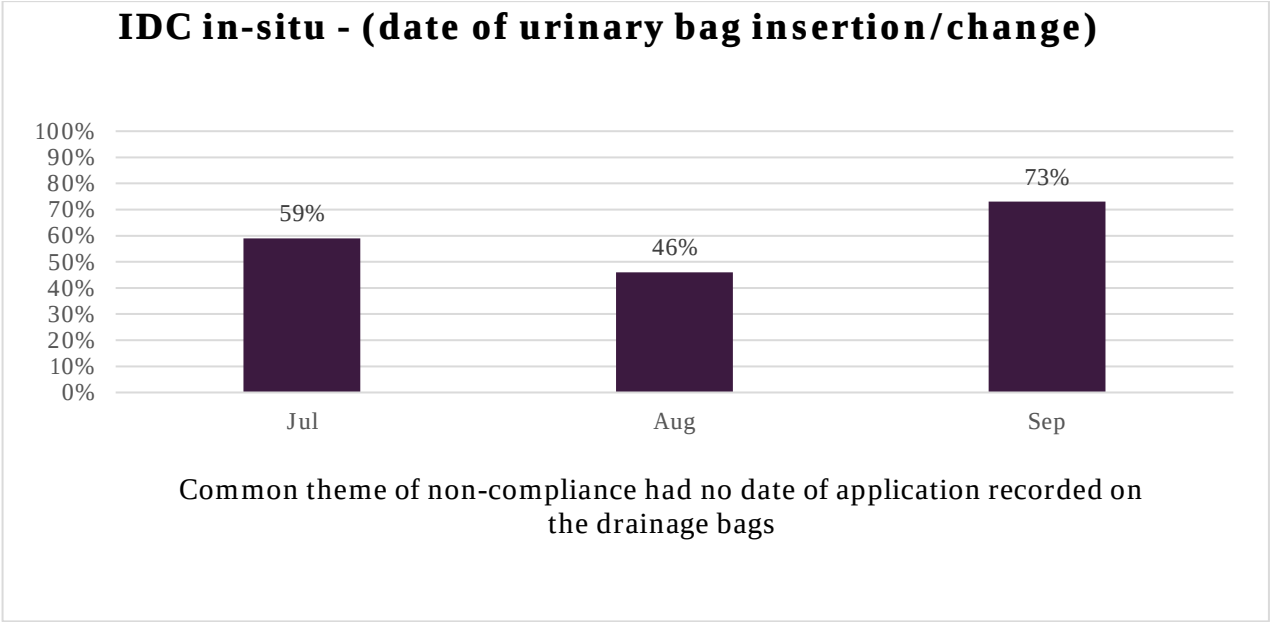
Number of CVC in situ on the day of audits



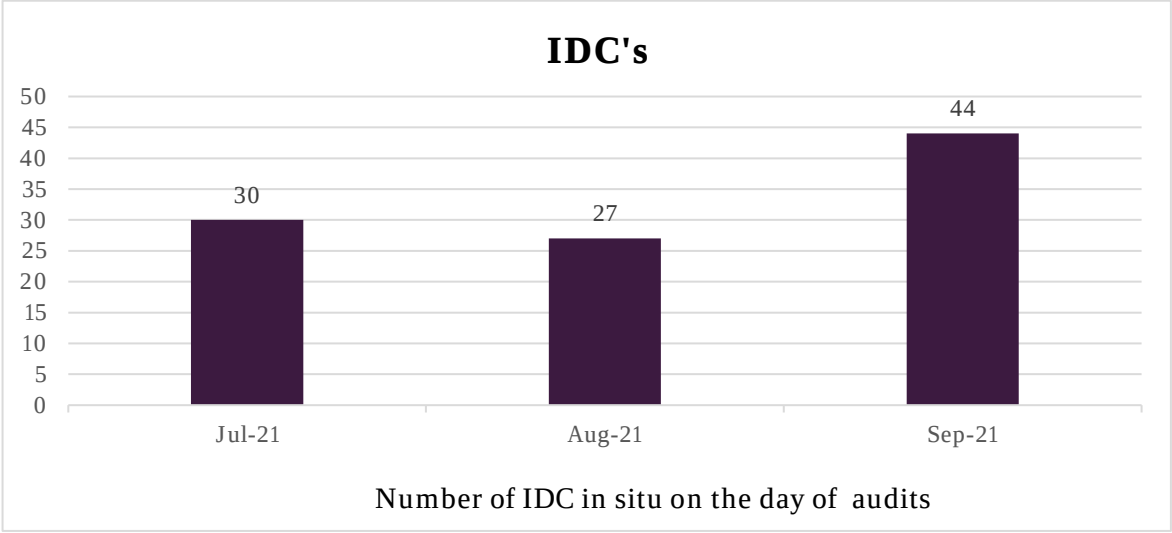
Common theme of non-compliace due to insertion sites not being visible and not dated



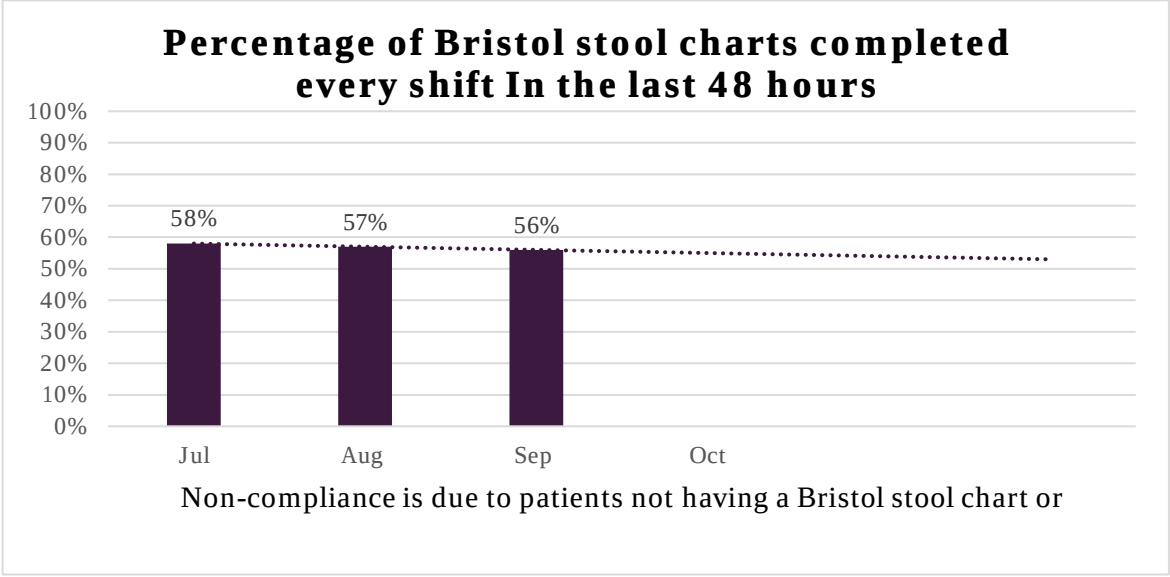
Number of PVC in situ on the day of audits



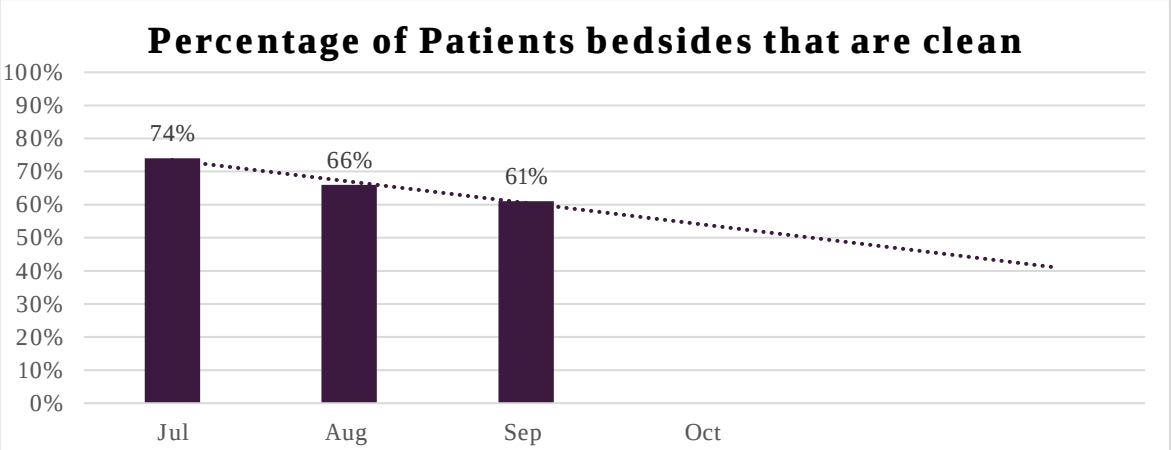
Common theme of non-compliance had no date of application recorded on the drainage bags



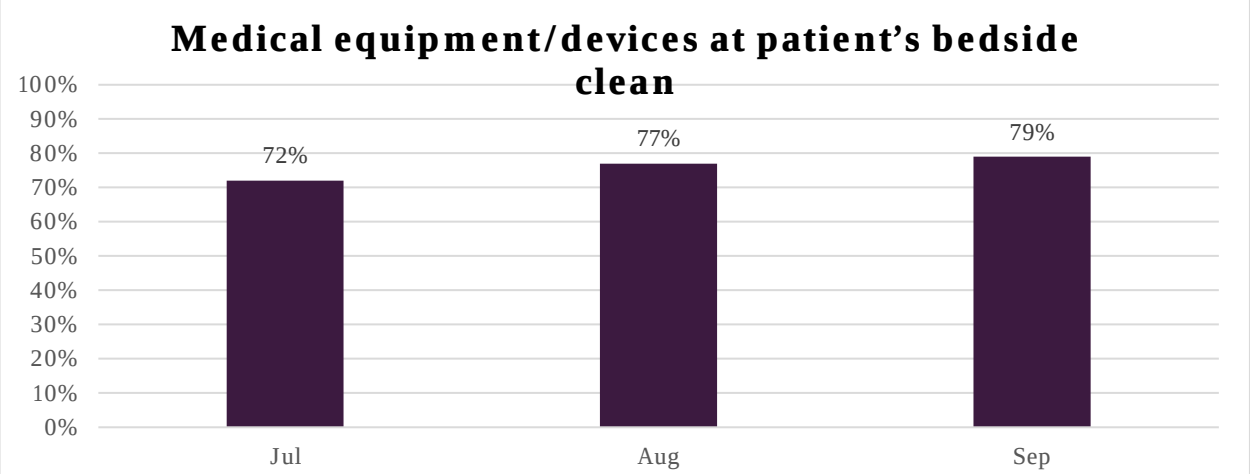
Number of IDC in situ on the day of audits



Non-compliance is due to patients not having a Bristol stool chart or



Common theme from each month are dirty floors & dust at high



Common theme of non-compliance include dusty equipment, dirty IV pumps,

3.10 Human Tissue Authority (HTA)

3.10.1 The Human Tissue Authority's approach to regulation is based on 4 guiding principles: consent, dignity, quality and openness & honesty. These principles not only inform the work of the HTA, but also the work of establishments working under an HTA licence. The Trust is licensed for the procurement, testing, processing, storage, therapeutic use and disposal of various types of cells for human application.

3.10.2 Compliance with HTA regulations ensures that patient welfare is the focus of the Trust's work and that stem cell harvesting and transplantation are performed safely and effectively following proper consent. Compliance requires an appropriately qualified team of personnel working to high standards to ensure the best possible service provision. On-site visits by inspectors have temporarily been replaced with virtual inspections. The Trust is undergoing a virtual inspection at the time of writing this report.

3.10.3 **Audits**

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

3.10.3.2 Audits performed in the period from May 2021 to September 2021:

- ❖ Critical process audit – viability testing
- ❖ Critical process audit Low pressure vessel filling
- ❖ Vertical audit – receipt of harvest from apheresis, sampling, and testing
- ❖ Audit of potency and stability of stored cells
- ❖ Stem cell lab records audits
- ❖ Critical process audit – closed processing
- ❖ Critical process audit – cryopreservation of cells using controlled rate freezer
- ❖ Critical process audit – Open cell processing
- ❖ Re-audit of additional environmental monitoring
- ❖ Re-audit of clean room hatch cleaning

There were no significant findings.

3.10.3.3 Independent audits are performed against HTA standards to ensure that all standards are audited during an inspection cycle. Governance and Quality standards were audited during this period.

3.10.4 **Adverse events, reactions, and incidents**

3.10.4.1 Under the European Union Tissue and Cells Directive (EUTCD) the HTA maintains a system for tissue establishments to report serious adverse events and reactions. The SCTL collates, evaluates, and investigates errors, accidents and incidents according to Trust protocols and in order to comply with HTA regulations.

During this period 3 incidents were reported to the HTA. 2 have been resolved and closed and one incident is currently under formal investigation.

3.11 External Accreditations Report

3.11.1 **ISO9001:2015 Radiotherapy and Chemotherapy**

The ISO9001:2015 Radiotherapy service has gained accreditation for a further 3 years until May 2024. The six-monthly Surveillance Visit was completed remotely for the Chelsea Site on the 5th of October 2021. The Assessment manager was impressed with the high-quality service that Radiotherapy continues to offer to its patients. The second part of the assessment will take place on 27th October 2021 at the Sutton site. The effectiveness of the Quality Management System continues to be monitored through the Multi-Professional Team Quality Assurance (Radiotherapy) Committee which meet on a regular basis.

The ISO9001:2015 Chemotherapy service has gained accreditation for a further 3 years until May 2024. The six-monthly Surveillance Visit is scheduled for the 2nd November 2021. The effectiveness of the Quality Management System continues to be monitored through the Quality Assurance in Systemic Anti-Cancer Therapy Committee which meet on a regular basis. The process for obtaining a scope extension for the new Cavendish Square Facility is underway and this facility has been bought into the scope of the

Chemotherapy service Quality Management System. It is hoped that our existing accreditation will cover this facility by the end of 2022.

3.11.2 Quality Standard for Imaging (QSI)

Radiology completed their new document submission process in September 2021 in preparation for their upcoming re-accreditation visit on the 3rd and 4th November 2021. The documentation submission process was changed significantly this year where to demonstrate evidence of application to the standard was required as apposed insuring that there was documented policies and procedures in place in how the standard was achieved. The Document submission process was hosted on a SharePoint location as the UKAS Web based submission tool has now been decommissioned. The documentation submission process involved the upload of over 180 pieces of evidence provided across the Imaging service and from Quality Assurance. The re-accreditation will include the scope extension for newly opened Cavendish Square facility.

The updated Quality Standard for Imaging 2021 is due for publication in late October 2021. The earliest our centre can transition to this standard will be Autumn 2022. Following publication of this standard the transition will be managed through the Quality Assurance in Diagnostic Imaging Services Committee meetings through completion of a gap analysis.

3.11.3 JACIE/Immune Effector Cell Standard (IEC)

An Interim audit was completed against the 6th Edition of the JACIE standard, and the evidence was submitted to the JACIE office on 20th April 2021. The JACIE office have now closed this audit and no findings were noted. The 8th Edition of the JACIE standards were published in May 2021 and a gap analysis is underway with the senior management team within Hemopoietic Stem Cell Transplantation. The centre is next due for assessment against this standard in October 2023

3.12 UKAS - Pathology Accreditation to ISO15189:2012

3.12.1 All diagnostic laboratories at The Royal Marsden have now achieved or maintained accreditation to ISO 15189:2012.

3.12.2 All UKAS activity remained remote and online for Quarter 1 and then for Quarter 2 started to return to onsite assessments.

3.12.3 A Blood Sciences Quality Manager was appointed and commenced their role during the reporting period, to replace the Blood Transfusion Quality Manager and perform some additional quality system management in the other sections in Blood Sciences.

3.12.4 An extension to scope (ETS) was submitted for the new flow cytometers in Immunophenotyping and the assessment was combined with the surveillance visit in August 2021. This went very well with only two findings for the ETS and some minor findings for the surveillance assessment.

3.12.5 Planning is in advanced stages to submit an Extension to Scope to UKAS for Molecular Diagnostics and Cytogenetics to be accredited together as Clinical Genomics, estimated date of joint assessment is Quarter 4 2021-22.

3.12.6 Clinical Genomics was granted UKAS accreditation (UKAS reference 20653)

3.12.7 Cellular Pathology had a very successful remote surveillance assessment in July 2021 showing a huge improvement in management of non-conformities and documents on iPassport.

3.12.8 Internal quality audits of processes continued to be carried out regularly covering the full scope of activities in all departments of the Pathology services.

3.12.9 iPassport development has continued through this time with monthly training offered by the Quality Team and a push on nonconformity management with appropriate root cause analysis and corrective actions performed within the agreed timescale of two months.

3.12.10 A Point of Care Testing Lead Biomedical Scientist was appointed and terms of reference for the new Point of Care committee have been agreed. This will ensure development and improvement for all point of care testing devices and processes.

3.13 Operating theatres

3.13.1 The Theatres Team works closely with the Procurement Team to review quality in equipment replacement and cost efficiency in procurement. This provides the service with good quality indicators to meet with the high level of financial demand while delivering quality safe care to patients at The Royal Marsden. Seven brand new laparoscopic systems with state-of-the-art technology and wireless connectivity have been made available for clinical use at Theatres London to support complex minimal access procedures.

3.13.2 The Theatres Team worked with the wider clinical areas in monitoring patient safety with a six-monthly Local Safety Standards for Invasive Procedures (LocSIPPs) report submitted to the Trust's Integrated Governance and Risk Management Committee. A joint LocSIPPs group quarterly meeting continues to monitor quality and safety aspects of patient safety practice in the Trust. Theatres L/S has been a major partner in the success of RMH/RM Partner cancer hub with more than four thousand cases being completed from October 2020 until end of March 2021. The contributions are attributed to the excellent commitment and compassion from the teams cross sites with the excellent support from the support services at the Trust and the cancer hub senior leadership team. In total during the year of covid the trust through the cancer hub has completed 8,675 operations across sites.

3.13.3 The staff continue to work tirelessly to support the surgical pressures to help to clear the cancer backlog while observing safe practice of PPEs in managing Covid-19 risk.

3.13.4 The introduction of MIS during Covid-19 pandemic is another success story for the surgical hub with a careful review or a robust Standard Operating Procedure in managing the risks when carrying out laparoscopic and robotics in the theatres. A major contribution to the success in relaunch of elective surgery at the the Trust Theatres in London and Sutton is attributed to the detailed and robust protocol from the anaesthetic team in managing the risk of Aerosol Generating Procedure (AGP) such as intubation and extubation of patient. Managing risk during AGP in both the theatres and endoscopy with stringent PPE protocol has allowed safe delivery of care and service from our teams.

3.13.5 With the introduction of safe MIS during Covid-19 pandemic, the service also has continued working with Airseal insufflation and smoke evacuation system to provide an assurance to the personnel with high level of filtration efficacy during a MIS case.

3.13.6 Theatres L/S continue to deliver high standards of care despite the pressure on staff to conform to the wearing of PPE during procedures. The teams have demonstrated their compassion and kindness during this challenging time, which is the unique, value representing the RMH NHSFT values as a whole.

3.13.7 Theatres has recently been approved funding from the Charity and Cancer services to fund our 2nd Robotic Nursing Fellowship. This will enable one of the theatres nurses to complete university post grad course to become a Surgical Care practitioner and then once completed become part of the HPB and OG service to support the ever-increasing robotic service.

3.13.8 The Chelsea site theatres continue to recruit practitioners to support the services. The current vacancies in the anaesthetic support team are high which is not unusual as this is one profession that is hard to recruit in London and nationally. Nevertheless, the service is

monitoring its agency and bank staff usage with a balance of permanent and agency staffing to deliver safe provision of service to all the patients.

3.13.9 The theatres have successfully recruited 2 theatre practitioners to attend the 'Theatres, anaesthetic and Perioperative course ' (TAP) at Guys Hospital in conjunction with Kings. They will complete this in March giving the anaesthetic support team two highly dual skilled practitioners to aid the vacancy rate alleviating bank and agency spend in the long term.

3.14 Endoscopy Suite

3.14.1 The Endoscopy Suite has successfully re-accredited and proudly holding next 5 years JAG Accredited status.

3.14.2 Endoscopy service at the Royal Marsden continue to deliver provision of service and continue to collaborate with South-West London endoscopy network in improving the service during recovery phase and to meet with cancer diagnostic and treatment waiting target.

3.14.3 Endoscopy workforce planning in ongoing to match service demand for safe provision of care. Endoscopy service is consistently receiving positive feedback from the patients via monthly Friends and Family Feedback.

3.14.4 Endoscopy staffing will meet the established requirement in early 2022 once successful recruitment is completed for this specialist area which is difficult to recruit in competitive London sectors.

3.14.5 The Endoscopy Decontamination unit at the Trust has passed the 2020 tracking, tracing, and quality audit. This audit is designed to meet the current MHRA, HTM, EU, International and Glennie guidelines on the reprocessing of Endoscopes.

3.15 Medicines optimisation

3.15.1 Antimicrobial Medicines Optimisation

3.15.1.1 Summary

1. Trust adherence to the Start Smart – then Focus principles increased to 97%
2. On average 68 inpatients are reviewed during AMS ward rounds
3. Antibiotic consumption decreased by 12%
   a. Watch category antibiotic consumption decreased by 9%
   b. Reserve category antibiotic consumption increased by 11%
4. Antifungal consumption increased by 3%

3.15.1.2 Conclusion and Priorities

The antimicrobial prescribing report demonstrates the positive impact a robust antibiotic stewardship programme has on increasing adherence to the Start Smart-then Focus principles and decreasing antibiotic consumption. To continue to develop antimicrobial stewardship at The Royal Marsden and improve patient care, the following will be prioritised:

1. Develop a robust antifungal stewardship programme to optimise antifungal prescribing in line with antibiotic prescribing.
2. Review prophylactic antimicrobial recommendations to ensure infections are effectively prevented in patients.
3. Increase oversight of outpatient antimicrobial prescribing and providing support to clinical teams in the outpatient setting.

3.15.1.3 Adherence to the Start Smart – then Focus principles

The UK five-year action plan for tackling antimicrobial resistance recommends that 100% antimicrobials are prescribed according to the Start Smart - then Focus principles. Adherence to the Start Smart – then Focus principles is on average audited twice a week across the Trust.

- On average 97% of antimicrobials in the Trust were prescribed according to the Start Smart – then Focus principles between October 2020 and September 2021.
- The antimicrobial pharmacists and microbiology consultants conduct antimicrobial stewardship wards twice a week on both sites of the Trust. On average 68 inpatients are reviewed during each Trust wide antimicrobial stewardship ward round. During the ward rounds antimicrobials are optimised to improve patient care and discontinued if no longer required.

3.15.1.4 Antibiotic Consumption

The UK five-year action plan for tackling antimicrobial resistance has set the target of decreasing antibiotic consumption by 15% by 2024.

- Antibiotic consumption decreased by 12% in 2020/21. Overall antibiotic consumption has decreased by 13% from the 2018/19 baseline so the Trust is on track to achieve the 15% target by 2024.
- There was a significant decrease in antibiotic consumption from April 2021. Antimicrobial consumption data is presented nationally per 1000 total admissions including day cases to take into consideration how busy Trusts are. In April 2021 NHS Digital changed how patient admission data is reported and switched from MAR data (Monthly Admissions records) to HES data (Hospital Episode Statistics). It appears the new HES data includes regular day attenders within the day case description, so it does not match the previous MAR data. Patients receiving anticancer therapy in the medical day units are classified as regular day attenders, so the inclusion of these patients has led to a significant decrease in antibiotic DDDs per 1000 total admissions. Antimicrobial consumption will be reviewed quarterly by the Antimicrobial Steering Committee to identify prescribing trends and develop quality improvement initiatives.

3.15.1.5 Antifungal Consumption

- Antifungal consumption increased by 3% in 2020/21. A peak in consumption at the beginning of the 2020/21 financial year corresponded with the first wave of the COVID-19 pandemic.
- There was a significant decrease in antifungal consumption from April 2021. This is due to NHS Digital changing how patient admission data is reported. This will be reviewed by the Antimicrobial Steering Committee to identify prescribing trends and develop quality improvement initiatives.

3.15.1.6 AWaRe Category Antibiotic Consumption

The World Health Organisation has categorised key antibiotics into three categories – Access, Watch and Reserve (AWaRe). The UK five-year action plan for tackling antimicrobial resistance has set the target of decreasing Watch and Reserve antibiotic consumption by 10% from the 2017 baseline by 2024.

- Watch category antibiotic consumption decreased by 9% in 2020/21. Overall watch category antibiotic consumption decreased by 14% from the 2018/19 baseline so the Trust has already achieved the 10% target before 2024.
- Reserve category antibiotic consumption increased by 11% in 2020/21. A peak in consumption at the beginning of the 2020/21 financial year corresponded with the first wave of the COVID-19 pandemic. Overall reserve category antibiotic consumption decreased by 12% from the 2018/19 baseline so the Trust has already achieved the 10% target before 2024.

- There was a significant decrease in antibiotic consumption from April 2021. This is due to NHS Digital changing how patient admission data is reported. This will be reviewed by the Antimicrobial Steering Committee to identify prescribing trends and develop quality improvement initiatives.

3.15.2 **Reducing harm from venous thromboembolism (VTE)**

Venous thromboembolism (VTE) is the number one cause of preventable deaths in hospital and undertaking risk assessments is a key safety priority for all patients, which is required to be completed within 24 hours of admission (NICE 89).

3.15.2.1 VTE risk assessment (VTERA) is a key safety priority for all patients, which is required to be completed within 24 hours of admission. It is also important to maintain a good quality of this assessment set out by Department of Health (DH).

Venous thromboembolism (VTE) is the number one cause of preventable deaths in hospital, and hospital acquired thrombosis (HAT) is the number one cause of VTE whilst in hospital and for up to 90 days after discharge. Following the mandating of VTE risk assessment for all hospital admissions in 2010, HAT events across England reduced by a staggering 8%, one of the single most effective actions to safe-guard patients from avoidable harm and fatality. Patient safety is a national priority – VTE risk assessment is a central part of this. The VTE link practitioner has been established to work with the VTE Steering group team to raise awareness and contribute to the national and local agenda.

Thrombosis is a life-threatening condition, and VTE risk assessment for all hospital admissions, saves lives.

- Prevent VTE – risk assess everyone being admitted into hospital, whilst there and at discharge
- Think Thrombosis – VTE can affect anyone, assess their risks
- Prevent VTE - saves lives, suffering, burden, and cost to the NHS

3.15.2.2 *'Think Thrombosis'* it is the easiest way to:

- Prevent
- Protect
- Inform

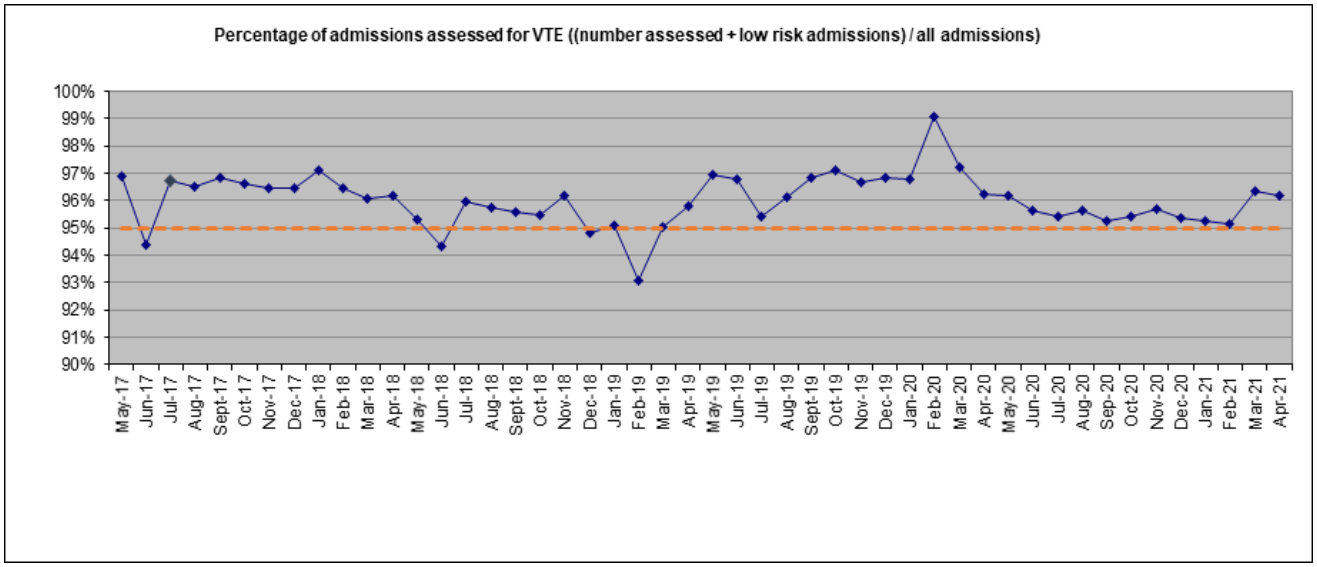
3.15.2.3 Reducing Harm from Venous Thrombus Embolism (VTE)

The Trust remains compliant with Venous Thrombus Embolism Risk Assessment (VTERA) for adult inpatients, achieving > 95% (Chart 3). VTE link nurse roles have been launched to further improve compliance. Electronic VTERA form for peri-operative patients was successfully launched 23rd November 2020. A HFC e-learning and a separate VTE e-learning module is currently being developed for doctors, nurses, pharmacists, ANPs and HCAs. Once developed, the module will become part of mandatory training.

3.15.2.4 How we performed in 2020/21

- Quarter 1: 96.0% inpatients assessed for VTERA.
- Quarter 2: 95.4% inpatients assessed for VTERA.
- Quarter 3: 95.5% inpatients assessed for VTERA.
- Quarter 4: 95.6% inpatients assessed for VTERA.

Chart 1: VTE Assessment



Quality Measure		**Target**
Risk assessment on admission	Completed	95%
	Correct	95%
Re-assessment if there is change in clinical condition		85%
Appropriate prophylaxis		100%

A quarterly audit led by pharmacy demonstrates standards are met (Quarter 4), with some clinical areas requiring further input and education to ensure sustainability. The audit standards are based on the criteria set out by the Department of Health and is undertaken once every three months and includes five patients per ward. There is a designated specialist pharmacist working closely with the lead practice educator to lead on VTE education and raising awareness within the Trust such as the launch of VTE link practitioner.

4 Effective

4.1 National Institute for Health and Care Excellence (NICE)

4.1.1 The National Institute for Health and Care Excellence (NICE) provides guidance, sets quality standards, and manages a national database to improve people's health and prevent and treat ill health. Further details about NICE and its work programmes are available at the NICE website www.nice.org.uk.

4.1.2 NICE standards assist the Trust in reviewing current practice against the latest standards and ensuring is safe, effective, and responsive to people's needs.

4.1.3 NICE published 51 items of guidance which were presented to the Integrated Governance and Risk Management Committee (IGRM) in Quarter 1 and 2. After the guidance was reviewed, 18 items were deemed relevant.

4.1.4 The IGRM committee also allocates NICE quality standards to clinical leads to review. During Quarter 1 and 2 there were six quality standards published by NICE, three of which were applicable to the Trust.

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

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

4.2 Clinical audit

4.2.1 The Clinical Audit Committee coordinates, evaluates and reviews all clinical audits and quality improvement projects in the Trust.

4.2.2 Four national audits were registered in Quarter 1 and 2:

- ❖ NCEPOD Epilepsy Study
- ❖ Radiology investigations at the time of diagnosis in paediatric patients with abdominal masses: South Thames Experience
- ❖ Management of patients with Post-operative Paediatric Cerebellar Mutism Syndrome (POPCMS)
- ❖ Head & Neck Squamous Cell Carcinoma of Unknown Primary (HNSCCUP)

4.2.3 The committee in Quarter 1 and 2 approved twenty-seven new clinical audit proposals and 3 re-audit proposals.

4.2.4 6 national audit reports were presented in Quarter 1 and 2:

- ❖ NCEPOD In Hospital Care of Out-of-Hospital Cardiac Arrests: Time Matters, received and noted.
- ❖ National Prostate Cancer Audit: Using the Cambridge prognostic Groups for risk stratification of prostate cancer in the NPCA: How could it impact our estimates of potential 'over treatment'

- ICNARC National Cardiac Arrest Audit Report
- National LCCOP Final report released
- National In-patient Falls
- National Emergency Laparotomy Audit (NELA) Covid-19 Report

4.2.5 Details of the reports for local audits and quality improvement projects presented and approved by the Clinical Audit Committee in Quarter 1 and 2 are shown in the following table.

4.2.6 Audits conducted at the Royal Marsden Hospital (Quarter 1 & 2)

Title	**Action plan, learning and outcomes**
Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study (COVIDSurg)	Reviewed at Surgical Journal Club, for information only.
Evaluation of the Solid Tumour End-of-Treatment Telephone Clinic (paediatrics)	1. End of treatment telephone clinic to continue for paediatric/ TYA solid tumour patients once a month 2. Member of CNS team to attend end of treatment consultant outpatient appointment 3. CNS team to discuss end of treatment telephone clinic purpose in advance with patients/ parents and ask their preference on timescale for receiving the call
Review of root-cause-analysis (RCA) completion timeframe	Improve compliance with RCA initiation within 48hours of a *C.difficile* positive result as per Trust *C.difficile* policy.
Availability of PD-L1 status in newly diagnosed Stage III, locally advanced, unresectable NSCL patients	1. PD-L1 should be requested immediately in all newly diagnosed stage III, locally advanced, unresectable NSCLC 2. PD-L1 report should be available within 5-10days of the diagnostic procedure 3. PD-L1 reports should be requested and scanned into EPR prior to new patient consultations 4. Re-audit in October 2021

Title	Action plan, learning and outcomes
Royal Marsden Staff Creativity and Wellbeing Week 2021	1. Look into how and when further similar events could be delivered at the Trust across the year (not only at the annual creativity and wellbeing week), and then what is needed in terms of funding and organisational input. 2. As there were 35 participants, out of approximately 3900 Royal Marsden staff it's important to consider with any future events, how to increase the participation of more staff across both Trust sites. What are the barriers preventing people from attending, and how can these be overcome? 3. For future arts-based wellbeing interventions it is recommended that a more detailed assessment of outcomes and the experiences of participants should be captured in order to demonstrate more robust evidence of benefit e.g., with more detailed pre and post testing of participants, or qualitative evaluation that is also able to explore the impact on the Trust more broadly.
TYA pre-MDT Clinic Survey	1. Comparative questionnaire for patient who have attended TYA MDT clinic 2. Patients wished they had discussed some topics during treatment which they never had the chance to do 3. 63% of patients would be interested at their current stage post treatment to attend a TYA clinic via a virtual platform. 4. 100% of patients would have liked to have attended a TYA clinic
Beam for Cancer'™: developing a digital health intervention to support optimal physical activity early in the pathway for those treated for cancer	1. Recommend a QIP with similar measurement and evaluation framework with additional measures pertinent to the live classes conducted. 2. Measures of continence and psychological and sexual health should be considered to assess the impact of the current on-demand content. 3. A specific QIP to build representative diversity into the platform should be considered.

Title	Action plan, learning and outcomes
Monthly Antimicrobial Prescribing Audit annual report 2020-21	1. Develop a robust antifungal stewardship programme to optimise antifungal prescribing in line with antibiotic prescribing 2. Develop a robust antiviral stewardship programme to optimise antiviral prescribing in line with antibiotic prescribing. 3. Review prophylactic antimicrobial recommendations to ensure infections are effectively prevented in patients. 4. Increase oversight of outpatient antimicrobial prescribing and providing support to clinical teams in the outpatient setting.
Care of patients in the last days of life audit 2020-21	1. Dissemination of audit results to palliative care team – quarterly basis. Audit and research meeting 2. Reiterate need to use principles of care documentation at Junior doctors' induction and nurse mandatory training – changed some aspects of content to highlight EPR documentation 3. Bereavement lead and PALS team to ensure GP letters and paperwork completed after death – reviewed at Palliative care MDT and followed up by team -PALs and Bereavement /Pal Care MDT chair 4. Findings to be reiterated to clinicians across the trust in Learning from Deaths email 5. Bereavement Survey instigated June 2019 to triangulate data on quality of care at the end of life –ongoing review of results 6. Re-audit on rolling basis to ensure compliance and momentum

Title	Action plan, learning and outcomes
Audit of adult anticipatory prescribing and adherence to recommendations from the Gosport inquiry	**Limitations:** 1. The number of PRN doses received prior to review by the SCPCT was estimated because time of the visit is not clearly documented on EPR. 2. Only four patients were co-prescribed sedatives and only one patient had a MAAR Chart completed during the period audited. **Recommendations:** 1. Present audit results at the Executive Medication Safety Group. 2. Medication Safety Bulletin to include a reminder about using a 24-hour maximum of 4 PRN doses for sedatives and opioids when these are prescribed on discharge. 3. Introduce quarterly audit of inpatients on syringe drivers to be carried out by ward pharmacist. 4. Set a target for standards 3, 4 & 5.
Trust-wide Audit of Safer Sharp Needles	**Actions:** 1. All risk assessments of safety needles to be reviewed. 2. Non-safer sharps to be removed from clinical area without an identified need. 3. Review period of risk assessments to be established. 4. Needlestick injuries in all clinical areas to be reviewed. 5. Senior leadership to review the Trust's approach to the implementation of safer sharp needles and the removal of the non-safer sharp needles. 6. Additional training and communication will be required prior to any changes. **Barriers to possible changes:** 1. Staff report using the safety needles can be more challenging. 2. Staff report that the blunt needles for drawing up are not always available.
Abdominal Radiograph Utilisation	1. Difficult to reliably ascertain if patients are meeting RCR referral criteria, however it would seem that many do not. 2. The majority of patients who undergo AXR are inpatients (86% of events). 3. Some patients undergo multiple AXR (16%) 4. Clinical information provided is frequently discordant with those in clinical notes.

Title	Action plan, learning and outcomes
Transition from children to adult services for patients diagnosed with Acute Lymphoblastic Leukaemia	1. Mapping and clarification of current pathway and processes for patients with ALL moving to adult services. 2. Meet with haematology team to discuss audit outcomes and action plan.
Audit of the Multi - Disciplinary Management of Bowel Obstruction in patients with gynaecological malignancy	1. Add guidance around management to SHO handbook 2. Present to Gynae Oncology Team 3. Ongoing education and training- junior doctors
Is primary thromboprophylaxis of palliative care cancer in-patients compliant with NICE Clinical Guideline 89	1. All patients over 16 admitted to hospital should be assessed for the risk of venous thromboembolism (VTE) and bleeding 2. Review patients' VTE status daily with consideration of whether prophylaxis LMWH appropriate

4.3 Patient and Carer Advisory Group

4.3.1 The Patient and Carer Advisory Group consists of current and former Royal Marsden patients and carers. The group elects one of its members as chair and it is given administrative support by a member of staff. The group works with the Trust on a variety of projects where the views of patients and carers can help make the hospital a better place for patients.

4.3.2 Members met with the Trust's Head of Therapies to discuss the reorganisation of the service and to work together on a project to raise the visibility of therapy services.

4.3.2.1 The Medical Director agreed to the group's request that the Trust consider addressing doctors' letters to the patient with a copy to the patient's GP which is a reversal of current practice. A project group including members was set up to lead the work.

4.3.3 The group maintained an ongoing dialogue with the Trust about making sure that the information provided to patients about Covid-19 control arrangements is kept up to date.

4.3.4 Assurance was received from the Trust that paper versions of patient literature that is now provided electronically will be available for patients who prefer that format.

4.3.5 The Head of Psychological Support, Pastoral Care and Patient Advice and Liaison Service (PALS) discussed with members the psychological support services offered by the Trust. Members described their experiences, including the sense of stigma when needing support. There was agreement that the service needs to be demystified.

4.3.6 Discussions were undertaken with staff after an unannounced introduction of e-mail reminders for appointments which had caused concern for some patients with anxiety about whether the reminders were legitimate or a scam. Members highlighted issues that staff were not aware of and in response, processes to inform patients about expecting e-mailed reminders were put in place.

4.3.7 Members regularly liaised with the Acting Chief Nurse about how patients were being protected from Covid-19 during the ongoing pandemic. Regular briefings were received including how a personal approach is being taken to encourage hesitant staff members to accept vaccination.

4.3.8 A question-and-answer session was held with the Clinical Research Fellow in Medical Oncology who is developing a senior adult oncology programme at The Royal Marsden. Members asked about access to care, the risk of under- or over-treatment and joining clinical trials. Members were told that the programme under development will provide assurance about these issues.

4.3.9 As way of an introduction, the new Chief Nurse met with members to hear how the Patient and Carer Advisory Group has improved the experience of patients at the Royal Marsden.

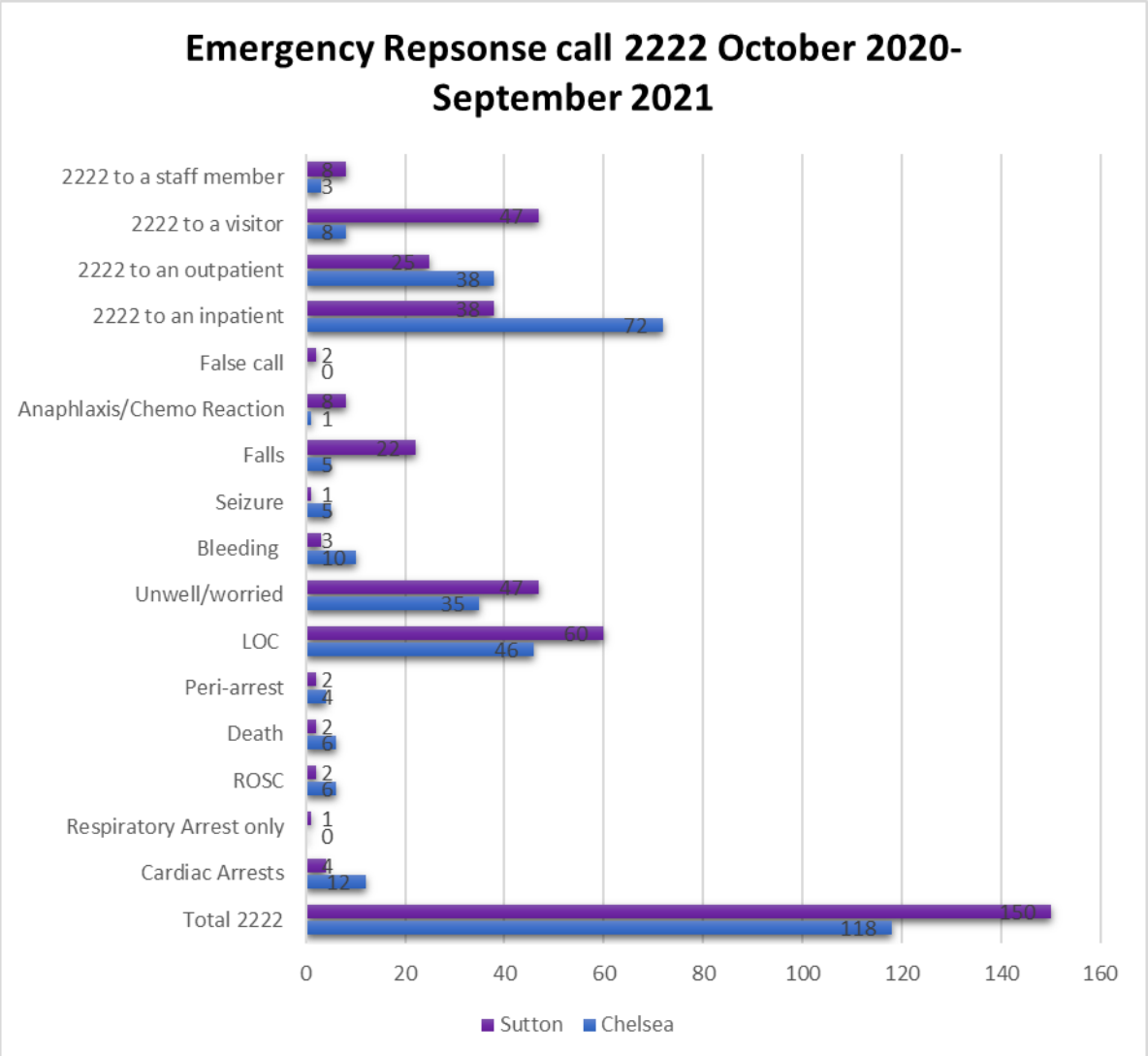
4.3.10 The Coordinate my Care Director of Nursing, Divisional Nurse Director, Cancer Services, and members began to explore how to champion the Coordinate my Care service at the Trust so that more patients register with the service. In developing urgent care plans in partnership with the patient members consider Coordinate my Care of great importance to an improved experience for patients.

4.3.11 Members represented the group on several Trust committees including the End-of-Life Steering Group, Clinical Audit Committee and Green Matters.

4.4 Resuscitation

This section covers a year from October 2020 to September 2021.

4.4.1 Emergency response calls (2222) – Chelsea and Sutton hospitals



4.4.2 Analysis

Chelsea

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

There were a hundred and eighteen adult emergency response 2222 calls, which included 4 peri-arrest calls for deteriorating patients, forty-six for loss of consciousness and vasovagal, five for seizures, five for falls, thirty-five for unwell patients or "worried criteria", ten for bleeding, one anaphylaxis and hypersensitivity.

Seventy-two of the calls were for inpatient areas, thirty- eight were in outpatient areas, eight were in non-clinical areas, and three were outside the hospital building.

Twelve calls were actual cardiac arrests: five of which were in the critical care unit and three in theatres. 2 on an in-patient ward and 2 in outpatients. six patients had return of spontaneous circulation and six patients died.

There were no false calls.

Sutton

The patients involved were mostly adult medical patients.

There were a hundred and fifty emergency response 2222 calls, of which ten were for paediatrics. Sixty for loss of consciousness and vaso-vagals, twenty-two for falls, fifty for unwell patients or "worried criteria", three for bleeding. There were eight for anaphylaxis and hypersensitivity.

There were two peri-arrests.

Sixty- two of the calls were for inpatient areas, thirty-five were in outpatient areas, forty-seven were in a non-clinical area, and eight were outside the hospital building.

Four calls were for actual cardiac arrests; one was in step-up and three in in-patient wards. Two had return of spontaneous circulation and two died. There was also a paediatric respiratory arrest.

There were two false calls.

4.4.3 Training

The adult basic life support compliance is 89.6% and paediatric basic life support compliance is 85.27%.

Due to the COVID-19 pandemic face to face training for Basic life support training was stopped. Members of staff therefore currently carry out an e-learning module. Going forward once face to face training is re-started staff members will have to complete the e-learning and then a practical element to prove their CPR skills. In order to ensure the demand is met we have trained resuscitation champions who are all ILS trained and are competent is carrying out these practical assessments.

4.4.4 Training

Two e-Advanced life support (e-ALS) course were held one in Quarter 3 and the second in Quarter 1.

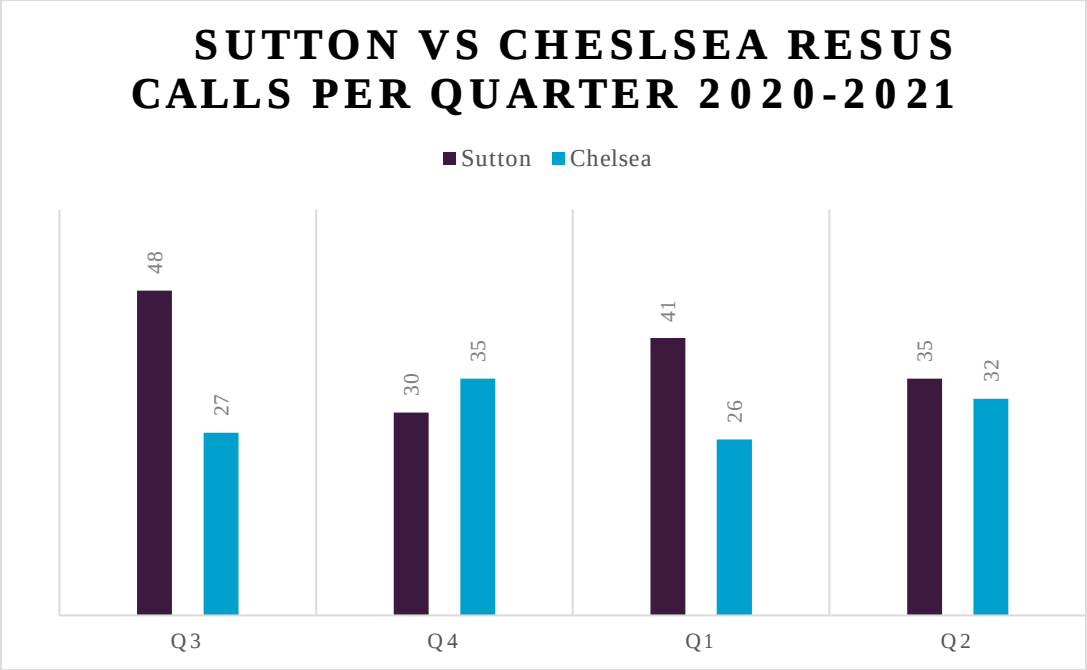
There was also one two-day Advanced life support (ALS) course held in Quarter 2.

There were 6 Immediate Life Support (ILS) courses in the year period and 27 e-ILS courses. There were an extra 2 ILs courses scheduled but were changed to 4 e-ILS courses to meet demand. There were also 13 paediatric Immediate Life support (pILS) courses held. The resuscitation team have also carried out 3 resus champion training days for when basic life support (BLS) courses are permitted to be face to face again. The have also carried out training including simulation training for the AOS ANPs at Cavendish Square.

4.4.5 2222 calls month on month October 2020- September 2021 – Chelsea compared to Sutton

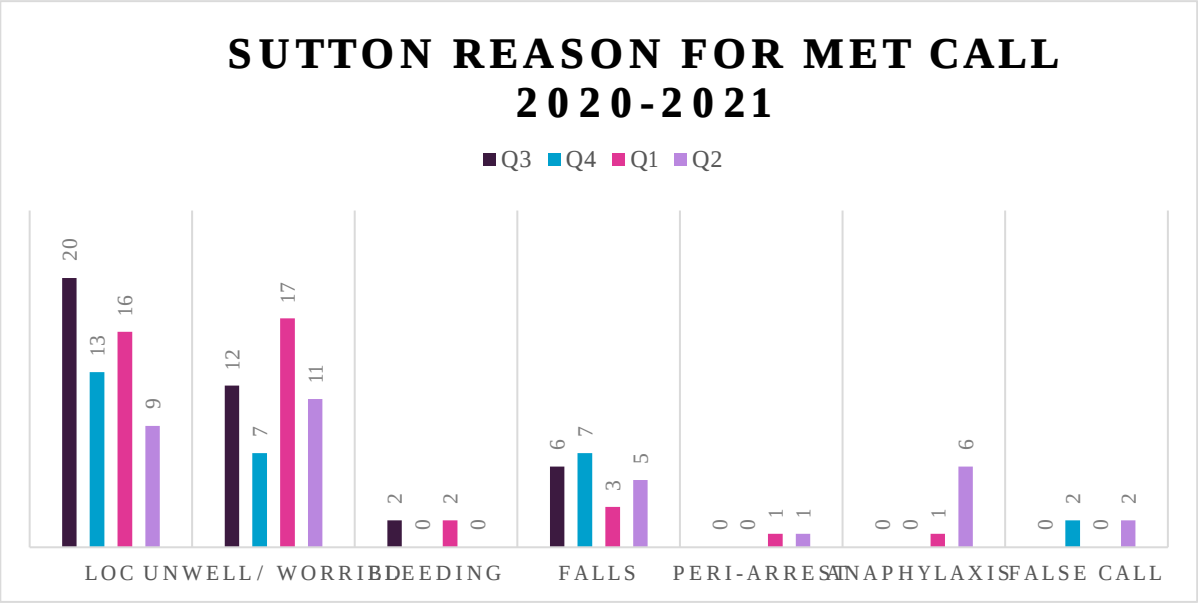
2222 calls, Chelsea: 118

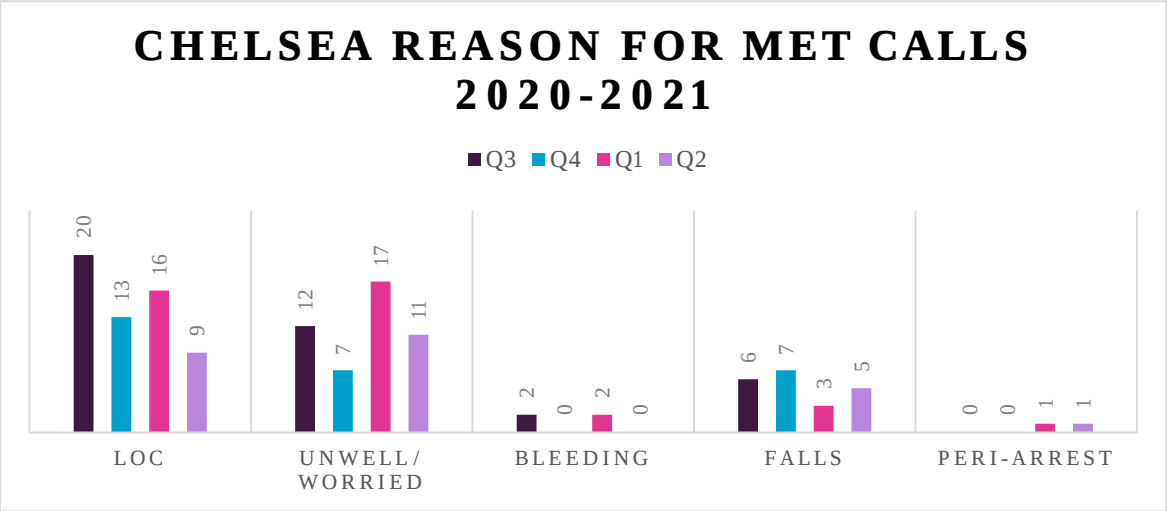
2222 calls, Sutton: 150



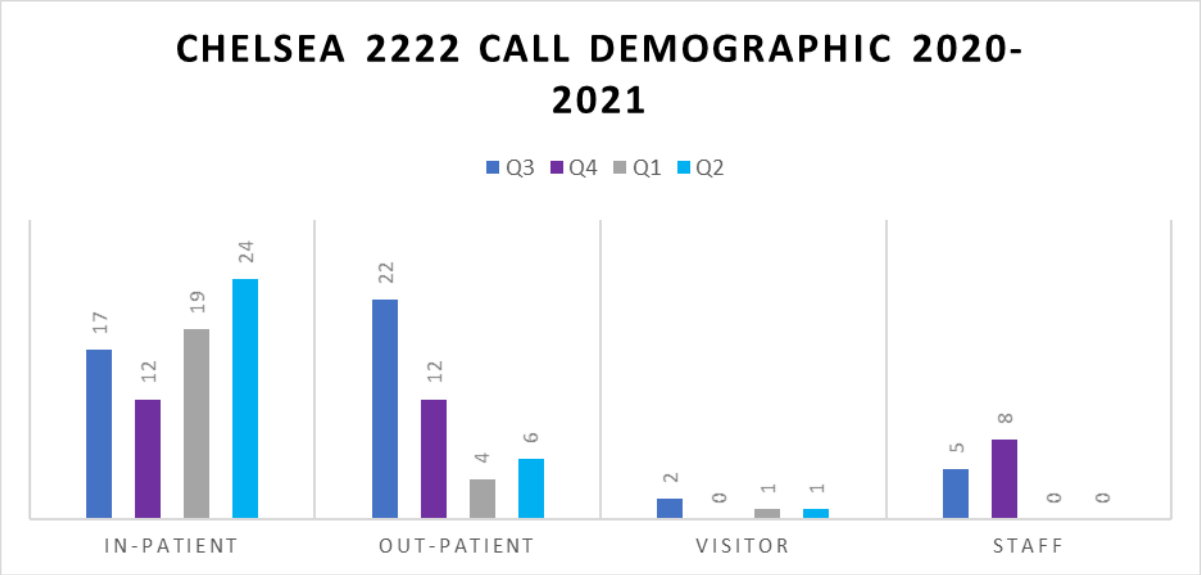
4.4.6 2222 calls October 2020- September 2021– by type of resuscitation call

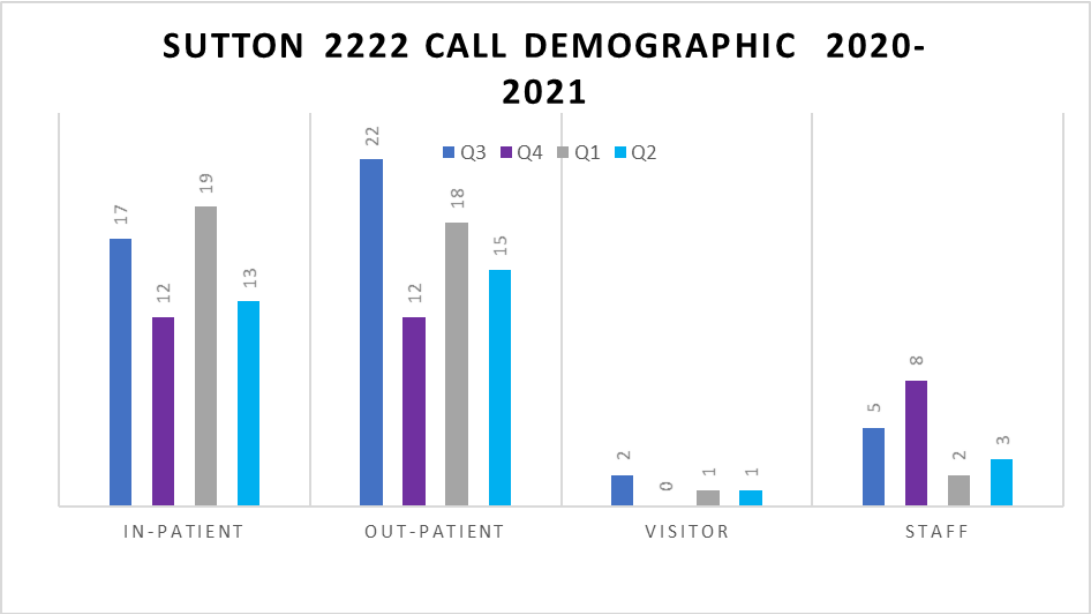
For both Chelsea and Sutton, the most common calls were for loss of consciousness/ vasovagal with Chelsea having 46 2222 calls for this and Sutton having 58 2222 calls. For both sites the second most common call was unwell/worried, Chelsea had 40 2222 calls for this and Sutton 47 calls for this. The worried/unwell patients consisted of seizures, desaturation, chest pain and high National Early Warning (NEWs) Scores. There were 2 false calls, both in Sutton, one was meant to have been received in Chelsea and the second was for the resuscitation bleep holders to retrieve their bag.





4.4.7 **2222 calls 2020/2021 Quarter 3 & 4 – by patient group**





4.4.8 2222 calls 2020/2021 Quarter 3 & 4 – Cardiac Arrests

Chelsea

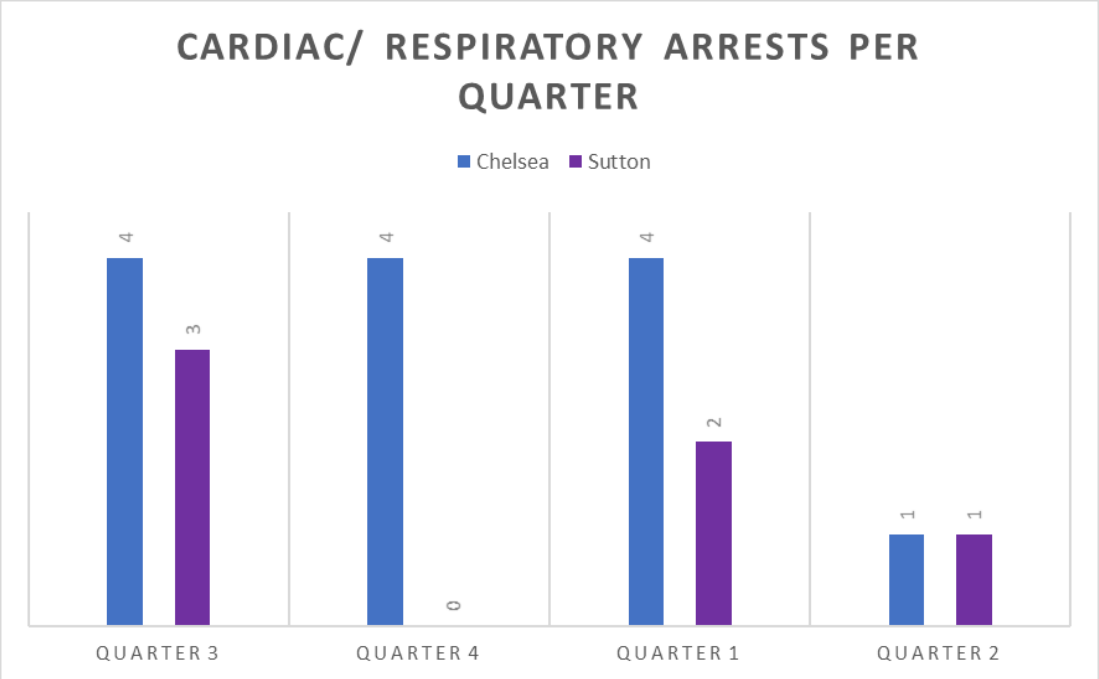
Total of 13 calls for Cardiac Arrests:

- 11 were inpatients at the Royal Marsden, 2 were outpatients in PP MDU. 4 on the ward. 4 in theatres and 3 on CCU.
- 8 had a return of spontaneous circulation (ROSC)
- There were 5 deaths
- 4 of the cardiac arrest calls were 2 patients ROSC achieved on the ward, then the patient was transferred to CCU where they arrested and sadly died.

Sutton

Total of 5 calls for Cardiac Arrests and 1 for a respiratory arrest:

- 4 were inpatients at the Royal Marsden and 2 were outpatients. 3 cardiac arrests were on the ward. The one respiratory arrest was on the ward and was paediatric. and 1 in step-up and 2 were outpatients.
- Of the cardiac arrests 4 had a return of spontaneous circulation (ROSC)
- There was one death



4.5 Sepsis

4.5.1 The Royal Marsden joined the *Sign up to Safety* campaign in November 2014. Along with a reduction in medication incidents and pressure ulcers, the aim of the campaign was to reduce the number of avoidable deaths from sepsis. The Consultant in Critical Care and Anaesthesia is the medical lead for sepsis and the Sepsis and Acute Kidney Injury (AKI) Nurse is the nursing lead. The team is now part of the wider 'Harm free care' group.

4.5.2 The leads have completed a gap analysis to implement over 150 recommendations following National Institute for Health and Care Excellence (NICE) guideline 51 *Sepsis: recognition, diagnosis and early management* (published July 2016). An adult sepsis policy has been introduced incorporating NICE guidance, UK Sepsis Trust recommendations, NEWS 2 charts and an updated sepsis screening tool. A new sepsis/AKI nurse has been appointed at the Band 8 level who is also leading the Harm Free Care group.

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

4.5.4 **Data collection**

A retrospective audit is conducted of 20 patients per month who have 'sepsis' recorded in their electronic patient records. The audit assesses whether patients have been appropriately screened for sepsis. If they are suspected of having sepsis, then the audited target is for the patient to receive intravenous antimicrobials within the hour. If the target is not met, a root-cause analysis is performed, to generate themes for future quality improvement, as well as feedback to individual departments.

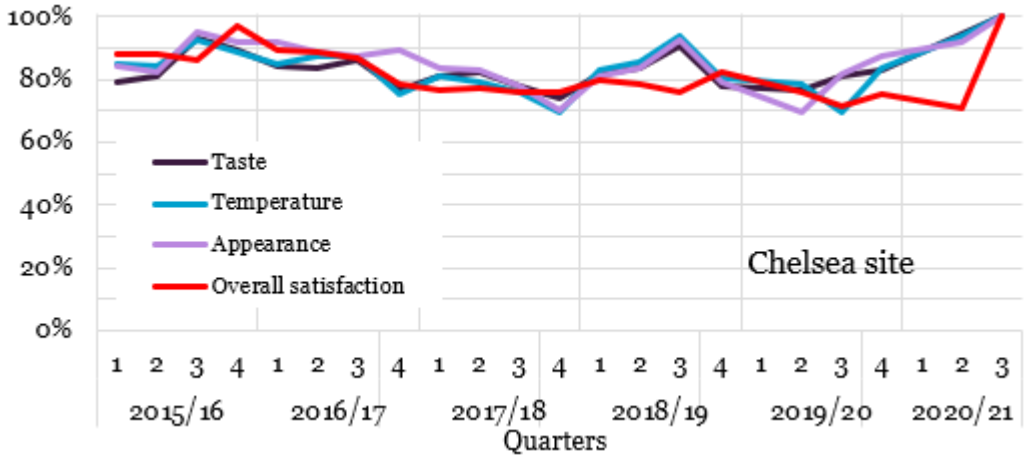
For April-September 2021, the data shows that 99% of patients were appropriately screened for sepsis. One patient was identified that did not meet the target. This data accords with previous quarters and half-years and shows that the recognition of sepsis is being maintained at a high level. Of these patients, 97% met the target of receiving antimicrobials within an hour. For the patients where the target was not achieved, feedback has been provided.

4.5.5 Implementation of action plan

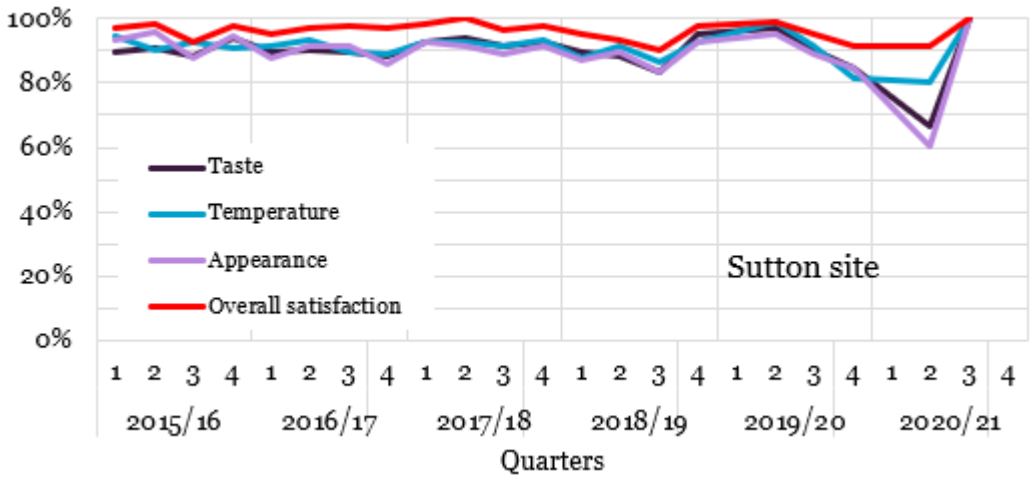
- All patients with a national early warning score 2 (NEWS 2– an early predictor of deterioration) of 5 or above, or 3 in a single parameter with a suspected infection should be referred to CCU Outreach (24/7), a clinical site practitioner or an on-call junior doctor for immediate review. If sepsis is suspected, it must be escalated to a senior clinician for immediate review.
- All patients referred to CCU Outreach teams continue to be assessed for signs of sepsis and the assessments are audited.
- All patients with neutropenic sepsis need a Multinational Association of Supportive Care in Cancer (MASCC) risk score to be recorded, and nurses need to complete a neutropenic sepsis audit which is sent to the Quality Assurance Team.
- The sepsis/acute kidney injury nurses and CCU Outreach teams continue to educate medical and nursing staff on implementation of the *Sepsis Six* bundle. The NEWS 2 charts have been rolled out in the Trust. 'Sepsis champions' are staff trained in the assessment and management of sepsis and their skill mix is incorporated into HealthRoster for safe staffing on the wards.
- Datix reports associated with sepsis have a root cause investigation performed by the sepsis nurse and themes and action plans generated.
- The sepsis team have contributed to a screensaver tool to highlight sepsis screening throughout the Trust.
- Patient Group Directions (PGDs) that permit nursing staff to administer antibiotics rapidly in suspected cases of generalised sepsis have been created and are being implemented. Work is underway to promote their use and plan for their integration into a new digital health record.
- The paper drug chart has been modified to improve rationalisation of antimicrobial therapy.
- A sepsis e-learning tool for adults in the Trust has been developed and has gone live. This is being reviewed, with a view to incorporating into learning across the wider 'Harm-free care' agenda.
- Paediatric screening tools have been created in accordance with NICE and UK Sepsis Trust guidance. This includes changes to the paediatric observation charts. These have fed into a new sepsis policy, amalgamating adult and paediatric guidance.
- The sepsis audit is being enhanced, by separately considering screening for sepsis at admission as well as during inpatient deterioration.

4.6 Nutrition and Catering

4.6.1 Results Chelsea:



4.6.2 Results for Sutton:



4.6.3 The Help with Hydration project is now live on the BRC Cancer Voices platform. This project is to promote good hydration and share ideas about ways to keep hydrated during cancer treatment. Ideas from patients, carers and staff will be shared with the aim of informing patient information on hydration and using ideas to influence the food and drink service within the Trust.

5 Caring

5.1 Paediatric and Teenage Psychological Support Service

5.1.1 Background

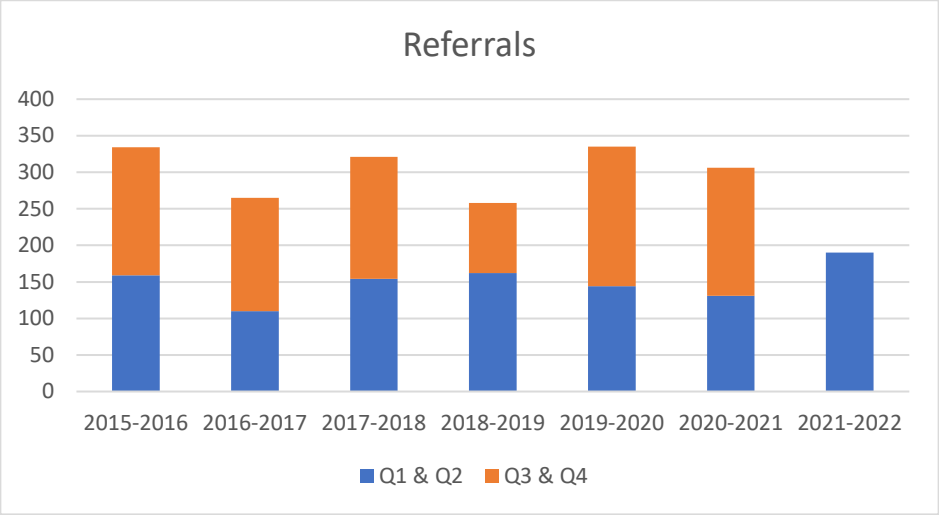
Patients and their families are supported in coping emotionally with their diagnosis, treatment, and late effects by the Paediatric and Teenage Psychological Support Service. The service also provides palliative care support and bereavement support. Staff is trained in evidence-based therapies and are skilled in using psychological models and interventions that have been proven effective in the work with children and families, as well as for health conditions.

In addition to the individual (one-to-one) therapy, the service provides couple and family work, neurocognitive assessments, and group work. The service also provides indirect support to the Paediatric Unit through clinical supervision, reflective staff support groups and consultation through attendance at multidisciplinary meetings.

5.1.2 Clinical Work

5.1.2.1 Referrals

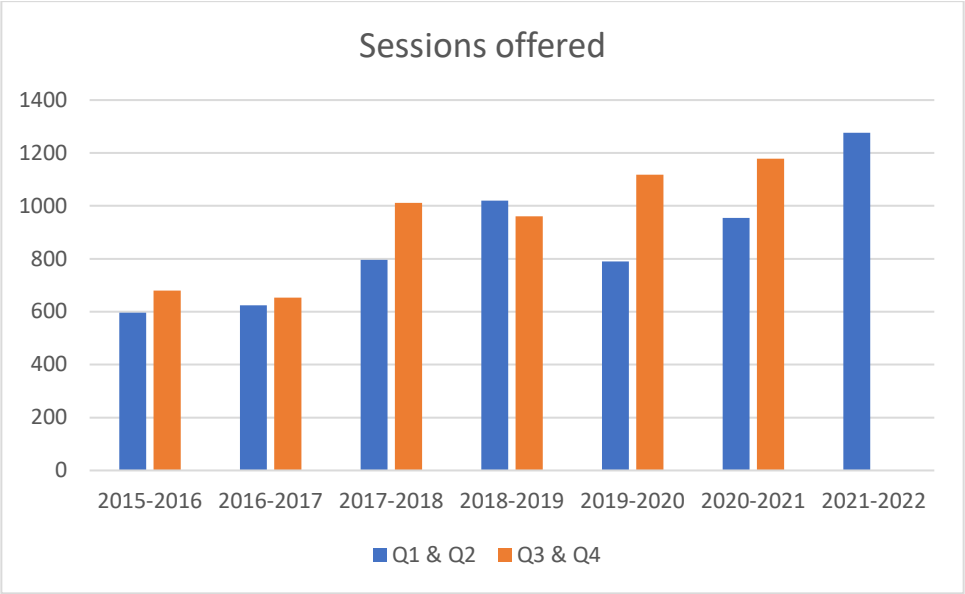
Requests for the service continue to increase. The service received 190 new referrals in Quarters 1 and 2 combined, which is the highest number of referrals in the history of the team and a significant increase from the same period last year (131 referrals) as well as an increase on Quarters 3 and 4 2020/21 (175 referrals). The number of referrals is back up again after a small drop due to the Covid-19 pandemic.



The increase in number of referrals in combination with the backlog of work that built up during the first Covid-19 lockdown has led to a waiting list of up to three months for therapy patients and up to six months for neurocognitive assessments.

5.1.2.2 Sessions

1,276 sessions were offered in the service in Quarters 1 and 2. This is a significant increase compared to the same period last year (955 sessions) as well as an increase from the last two quarters of 2020/21 (1,178). The increase in number of sessions offered is believed to reflect an increased complexity in problems families are referred for, with some families generating multiple individual referrals, requiring more intensive input, and for longer duration.



A combination of face-to-face, video sessions (Attend Anywhere) and telephone sessions are offered, with face-to-face appointments being limited due to a lack of room space for the team.

5.1.2.3 Neurocognitive assessments

27 neurocognitive assessments were conducted in Quarters 1 and 2. These are predominantly for children with brain tumours and assesses their cognitive function and learning, resulting in a report for families and schools.

5.1.2.4 Family clinic

Cancer treatment puts a lot of strain on family relationships. The family clinic is a new initiative which aims to address this and where family members are seen together for up to six sessions. Four families were seen in the Family Clinic in Quarter 1 and 2 combined and two additional families were offered the clinic but were unable to attend.

5.1.2.5 Groups/workshops for patients

The team normally holds twice-a-year meetings with Young Lives Vs Cancer, the TCT Youth Worker and other people within the paediatric unit who run groups in order to plan groups that can address needs or patients. These have not happened due to Covid-19 and Young Lives Vs Cancer being absent from the hospital. Ward groups had still not restarted at the time of writing this report.

The following groups/workshops have been running in Quarter 1 and 2.

Bereaved parents' group – this is a face-to-face closed group running monthly in the evenings. The group is run jointly with a social worker from Young Lives Vs Cancer and the clinical psychologist at the Maggie's Centre. The group started in April 2021 and will run until October 2021 with a follow-up session in January 2022

End of Treatment Day – a day for parents whose children have recently completed treatment. The team used technology to adapt the format to an online event. This was run together with Young Lives Vs Cancer.

Parent support group – a closed group for parents with children who are currently on active treatment. A weekly group run using Microsoft Teams. This group was set up during the Covid-19 pandemic to support parents as it was recognised that Covid-19 caused additional stress for parents. This is a collaboration with the Maggie's Centre.

TYA Beads of Life Workshop – an online day for patients (16-25) who were on treatment or had recently completed treatment, strength and resilience-based intervention within the framework of peer support (sharing wisdom/knowledge/ experiences).

5.1.3 Indirect work

5.1.3.1 Staff Support

The demand for staff supervision and support has continued to be high. Some requests for individual supervision are seen by the team whereas others are referred to Staff Support Services. Some groups are run jointly with Staff Support.

Quarter 1 and Quarter 2 2021-2022	
Clinical Supervision Groups	36
Staff Support Groups	13
1:1 Supervision	179
Debriefs	3
Complex Case Discussions	6
Child safeguarding meetings	6

5.1.3.2 Consultation

The team provides consultation regarding psychological/mental health/child development issues to the MDT, 1:1 as and when required, and as part of attending multidisciplinary meetings. The following meetings are attended: Multidisciplinary Ward Round (chairing), Palliative Care meeting, Late Effects meeting, Teenage and Young Adults Multidisciplinary Meeting, and Neuro Oncology meeting.

5.1.4 Training/Teaching

The team provides regular teaching and training, both internally, externally, and internationally.

5.1.4.1 Internal teaching

- ‘Psychological Support for Paediatric Patients’ – for Junior Doctors
- ‘The Impact of Cancer on Children and Families’ – Nurses Foundation Training (x 2)

5.1.4.2 External teaching

- ‘Role of Effective Communication in Paediatric Oncology – for MDT in Pakistan (x 2)
- ‘Adapting to COVID-19: The work of the Paediatric Psychology team at the RMH’ – for the Paediatric Psychology National Special Interest Group
- ‘Working with children with cancer’ – for Croydon Hospital Play/Drama Therapy Team

5.1.5 Research and service evaluations

The team is involved with a number of projects aiming to improve the care for patients.

5.1.5.1 Research

The team conducts research within the Trust, jointly with other organisations/Trusts and supports the drug development team with the neurocognitive/psychological evaluations of drug trials.

5.1.5.2 Internal research projects

- The effects of COVID-19 on children and young people with cancer – study is going through the R&D process

5.1.5.3 Collaborations with other Trusts/Organisations

- Collaborating on and providing external supervision for a Trainee Clinical Psychologist from University of Surrey completing her Doctoral thesis: 'Exploring parent experiences when childhood brain tumour survivors enter adolescence and young adulthood'. The viva was passed in June, and this will be written up for publication.
- Setting up a research project with the Royal Alexandra Hospital in Brighton evaluating data received through the Holistic Needs Assessment
- Joint project with St George's Hospital, looking at the effect of Invasive Fungal Infections on parents. A research proposal is currently being drafted but has been put on hold due to maternity leave.
- Working with the International Late Effects of Childhood Cancer Guideline Harmonization Group (IGHG) reviewing research related to psychosocial late effects and developing international guidelines:
  - Employment and education outcomes – accepted for publication in *Cancer*
  - Neuropsychological outcomes – evidence tables completed.

5.1.5.4 Paediatric Drug Development studies

- SIOPE Ependymoma Trial (one assessment conducted in Quarter 1 and 2 combined)
- Entrectinib Trial (no assessments conducted these quarters)
- NANT201502 Lorlatinib Trial (eight assessments conducted in Quarter 1 and 2 combined)

5.1.6 Service evaluations

The service is running an ongoing internal evaluation of patients' view of the service they receive from the team. 46 questionnaires were sent out in Quarter 1 and 2 and 12 were returned. The team is keen to make electronic versions available to increase return rates but due to information governance issues, this has not yet been possible.

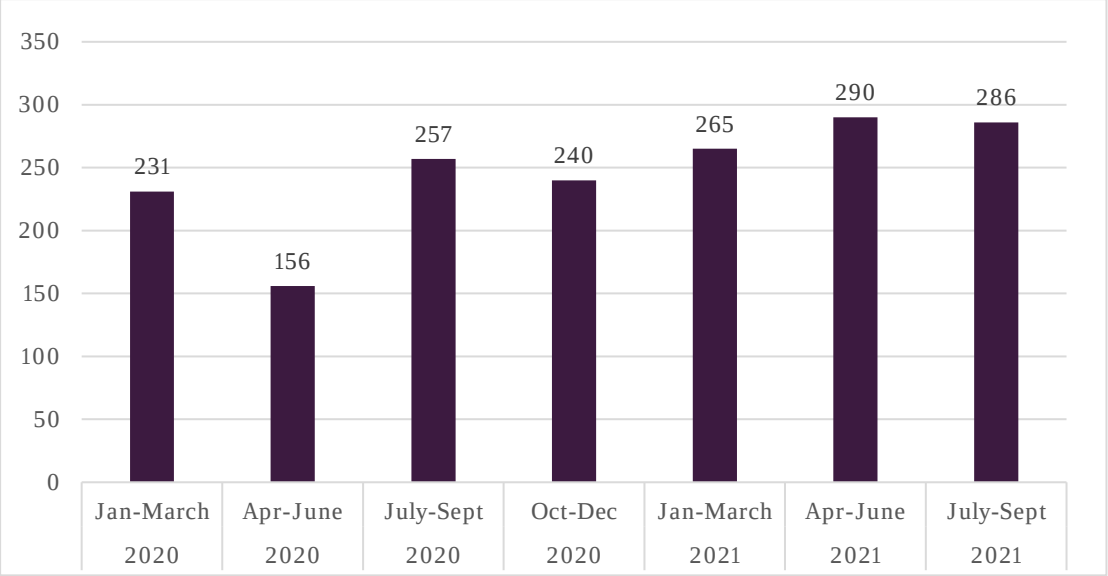
5.2 Adult Psychological Support Service (APSS)

The Trust provides a confidential psychological support service for patients treated at the hospital, to help them adjust to the emotional impact of a cancer diagnosis and its treatment. APSS has several pathways: art therapy, counselling/ psychology, family therapy, liaison psychiatry, psychosexual therapy.

5.2.1 Adult Counselling/ Psychology Pathway - Outpatient

During the reporting period, 576 referrals for NHS patients were made to the Counselling/ Psychology pathway of APSS. Of these 514 met eligibility criteria and were offered a triage appointment.

For those that were not offered a triage appointment the majority were already under the care of APSS, or the referral did not meet the eligibility criteria (i.e., <2 years post treatment, cancer related concerns).



Referral numbers have continued to increase and because of this The Royal Marsden Cancer Charity kindly funded an additional 2.0 whole-time equivalent Band 7 posts to meet this demand (these posts have just been recruited to). Referrals are estimated to be higher in the current financial year than before the COVID-19 pandemic.

During the first two quarters of 2021/22, the service has run two remote Mindfulness Groups:

Quarter 1 (6 sessions) attended by six people
Quarter 2 (6 sessions) attended by eight people

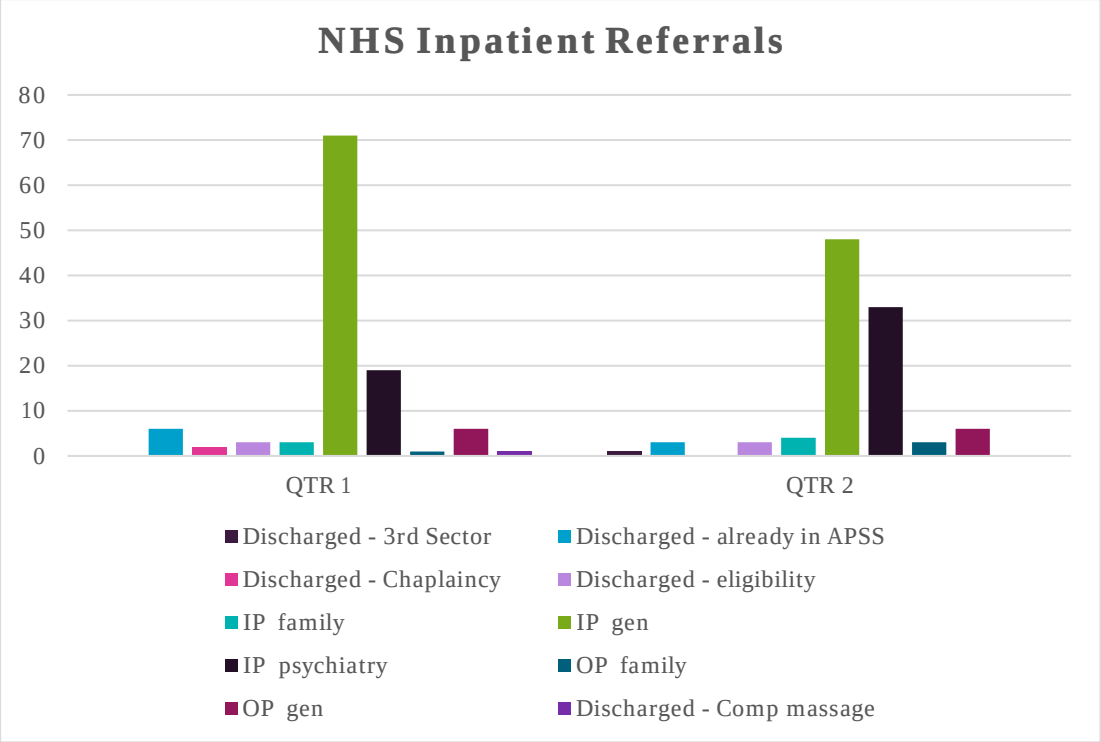
There are currently 17 patients on the waiting list to attend future sessions and this programme will become a regular aspect of our service delivery.

The service is working with Anaesthetics and Rehabilitation on the Royal MILE Prehabilitation project. Due to the Covid-19 pandemic the intervention has been adapted to be remotely delivered, so that patients have a 1:1 appointment with a clinician who directs them to psycho-education videos and worksheets to help them prepare for their surgery. Following patient and public involvement, the videos are being re-recorded and will soon go live.

5.2.2 **Adult Psychological Support Service (APSS) - Inpatient**

At the beginning of 2020 a Duty Clinician function was created to enhance the psychological care of inpatients. This role is shared across Counsellors and Psychologists, who work closely with our Mental Health Advanced Nurse Practitioners. Referrals are screened and triaged and followed up by a clinician from the post appropriate APSS pathway(s).

During the reporting period, 213 NHS inpatient referrals were received.



5.2.3 **Family Therapy**

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

During Quarters 1 and 2 of 2021/22, a total of 37 families were referred to the service:

Eight families as inpatients

29 families as outpatients

During this period two Trainee Clinical Psychologists (University of Surrey, University of East London) were on clinical placement as part of their clinical psychology doctoral training.

As a part of the service's move toward a stepped care model, the Family Pathway is in the process of producing a series of short, animated films (3-5 minutes in length), with the FruitFly Collective. Themes are

- Why and How to Talk to Your Child about Cancer
- How to support a child whose parent has cancer
- Dilemmas faced by young adults with cancer and their families
- Dilemmas faced by young adults whose parents have cancer
- Young Carers.

Our aim is to put these on the Royal Marsden Hospital website, where they can serve as a Level 2 intervention for patients, their families, and the general public. We would also put them on the trust's intranet, so that our colleagues around the hospital can easily access them.

For patients who have further questions and would like to discuss these animations 'live', we offer the Talking to Children About Cancer online workshop as a Level 3 intervention.

There will remain some families who will still need to discuss their questions and dilemmas in this regard, or who won't feel comfortable sharing these in a workshop. For these families, we continue to provide single family consultations with qualified and

trainee psychologists, which sometimes also lead to further therapeutic work, tailored to the family's specific circumstances (Level 3-4).

The service has piloted a Beads of Life full-day workshop for teenage and young adult patients with cancer, in collaboration with a Clinical Psychologist and Youth Support Coordinator in the Teenage Cancer Trust. The 'Beads of Life' is an approach which helps people to tell their stories in ways that make them stronger. Young people were invited to tell stories about the cancer and different aspects of their life using beads. Four young people attended this pilot workshop and have provided encouraging and positive feedback. They have said that they would recommend this workshop to other young people who have cancer. One of them also made the following comment: "I think it is a really fun and easy way to reflect on your whole cancer journey and to meet others who have had similar experiences and just get it!" The service is currently in the process of considering introducing a similar workshop to other adult patients with cancer.

5.2.4 Chaplaincy services

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

Religion	QUARTER 1			QUARTER 2		
	APR	MAY	JUNE	JULY	AUG	SEPT
Church of England	61	50	37	19	45	40
Roman Catholic	61	56	42	38	58	44
Christian (other)	31	43	31	25	28	35
Muslim	32	22	16	3	1	6
Hindu	3	1	4	1	1	2
Buddhist	1	0	1	1	1	0
Jewish	1	2	3	0	0	1
Sikh	1	1	0	0	0	1
Religion not known	16	6	10	6	4	10
Not Religious	14	15	11	7	8	5
Agnostic	0	0	0	0	0	1
Atheist	1	0	0	0	1	0
Jehovah's Witness	0	1	1	0	0	0

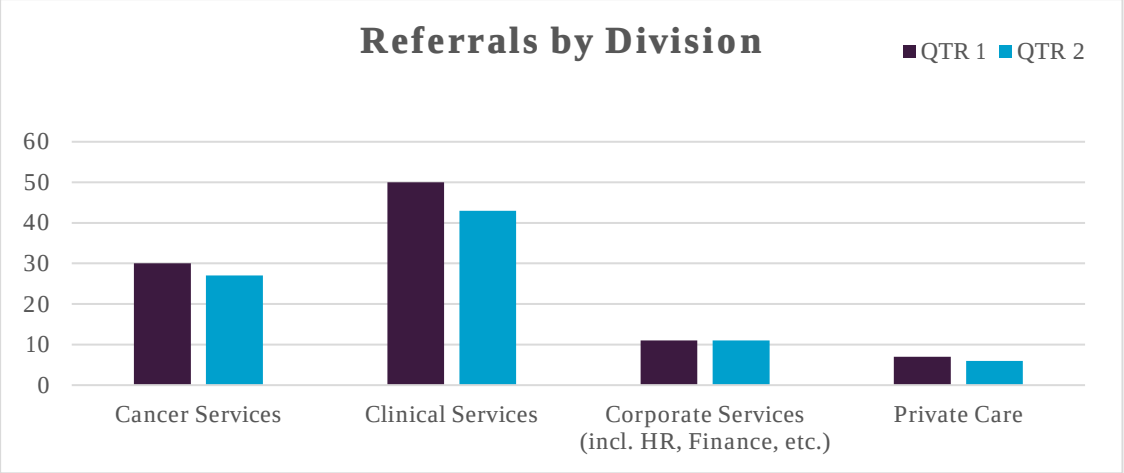
There is a weekly service in the chapels on each site of the hospital open to all. The chapels are open day and night for prayer or quiet reflection. There are also separate prayer rooms on each site for Muslim patients.

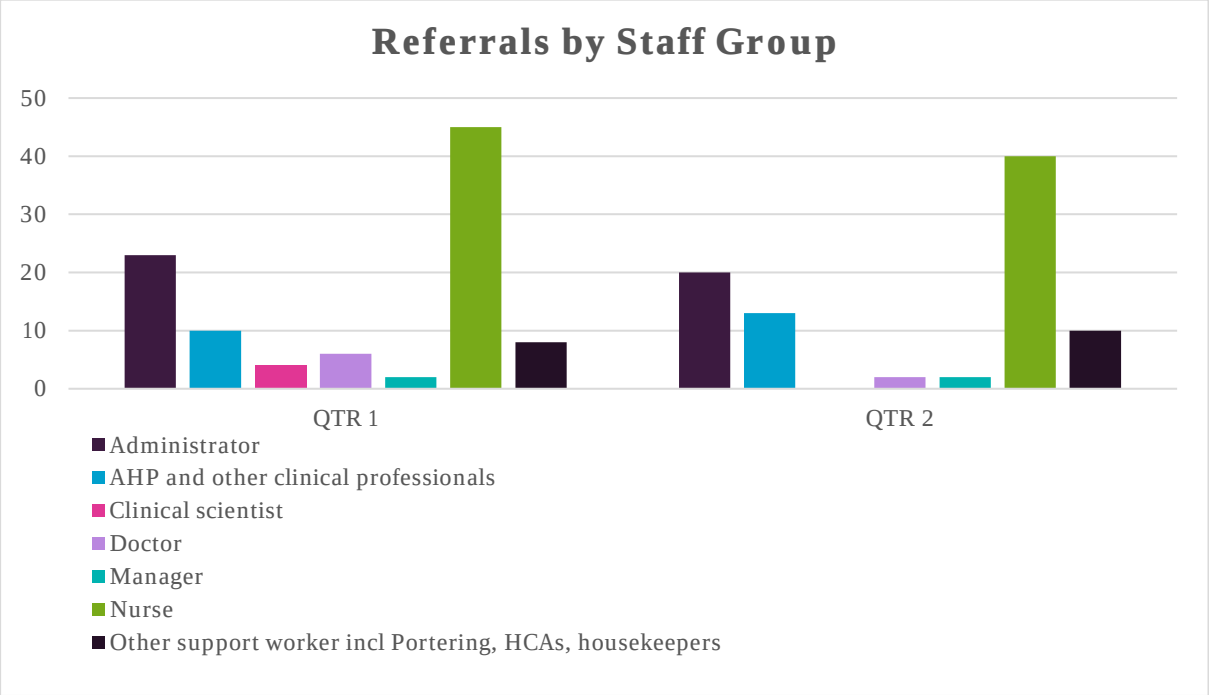
During the first two quarters of the year, the chaplaincy team made 1688 visits to 967 patients. Of these 1688 visits, 945 were made on the Chelsea site and 743 visits were made on the Sutton site.

5.2.5 Staff Support, Psychotherapy and Counselling Service (SSPCS)

All members of SSPCS are qualified and accredited mental health professionals with considerable experience of delivering workplace psychological interventions. As well as offering psychotherapy/counselling and supervision, they facilitate both preventative and reactive group clinical interventions to staff across both hospital sites.

During the period April – September 2021, the service received a total of 185 referrals: 95 referrals for Chelsea and 90 referrals for Sutton.





The most common reason for referral was work-related stress which accounted for almost half of the referrals.

5.3 Symptom Control and Palliative Care

5.3.1 Policies and procedures relating to end-of-life care and symptom control

We continue to ensure that our guidance on compassionate visiting at the End of Life and policies relating to care after death are kept up to date with national guidance and as community prevalence of Covid-19 changes.

The integrated palliative care outcome scale (IPOS), a patient outcome measure, continues to be used for patients referred to the Symptom Control and Palliative Care Team and has now been rolled out electronically (eIPOS).

The use of the Treatment Escalation Plan (TEP) is now well embedded into routine practice for non-elective and elective adult patients. An audit of its initial implementation along with staff feedback shaped the development of a second version of the TEP with improved clarity on ceilings of care and appropriate treatments. The team are now overseeing ongoing teaching and training related to the use of the TEP which continues to be well received as an initiative to improve the quality of patient care.

Data has been submitted for the 2021 National Audit of Care at the end of life (NACEL). The National Audit of Care at the End of Life (NACEL) is a national clinical audit commissioned by the Healthcare Quality Improvement Partnership (HQIP) and run by the NHS Benchmarking Network in partnership with the Patients Association. It has been designed to ensure that the priorities for care of the dying person outlined in the document 'One Chance to Get it Right' are monitored at a national level. NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute, community and mental health inpatient providers in England, Wales and Northern Ireland. Data submitted includes organisational level data, case note reviews of in-patient deaths, bereaved relative survey and staff survey.

The Learning from deaths policy has been updated and reviewed to include amendments including involvement of the Medical Examiners in the review process.

5.3.2 Education and mandatory training

The service delivers mandatory training (MT) on end-of-life care to medical and nursing staff. Annual updates to other clinical and non-clinical areas have been delivered and continue to be scheduled. An online video is now available for MT in End-of-Life Care and will be updated annually.

Our National Palliative Care Update Day is scheduled for two webinars in November this year. We are currently working towards creating further in house virtual study days surrounding issues relating to palliative and end of life care.

5.3.3 Strategic developments

The End-of-Life Care Steering Group chaired by the Chief Nurse (Executive Lead for EoLC) continues to meet on a quarterly basis. The End-of-Life Care Steering Group for adults and children provides a forum for a multi-professional group to meet and share their specialist knowledge, clinical experience, and skills.

The Symptom Control and Palliative Care team has been reaccredited as an ESMO Designated Centre of Integrated Oncology and Palliative Care for 2022-2024. The Royal Marsden is one of only eight centres in the UK with this designation and has been a centre since 2009. Our work in early integrated symptom control and palliative care at the Royal Marsden continues with both our 'Triggers' service and Enhanced Supportive Care. We are keen that this work continues to expand and flourish particularly within the Covid-19 recovery phase and beyond.

5.4 Friends and Family Test

Between March 2020 and December 2020, due to the Covid-19 pandemic, national data uploads for the Friends and Family Test were paused. These have now been reinstated and a new question set launched. Rather than asking if patients and visitors would recommend the Hospital to their friends and family, they are now asked to rate and comment on their overall experience.

In Quarter 1, the Friends and Family Test showed that

- 99% of Royal Marsden inpatients who responded rated their experience as very good or good. This is above the national average of 95%.
- 97% of Royal Marsden outpatients who responded rated their experience as very good or good. This is also above the national average of 93%.

At the time of writing this report, the national data for Quarter 2 is not yet available.

6 Responsive

6.1 Concerns and complaints

All expressions of dissatisfaction are classed as concerns or complaints according to the issues raised and the level of investigation required.

6.1.1 Concerns

Concerns are expressions of dissatisfaction that can be resolved by Patient, Advice and Liaison Service (PALS) Officers or the Complaints Team and do not require a written response.

6.1.2 Number of concerns received in Quarters 1 and 2

	Chelsea	Sutton	Total
Concerns relating to NHS patients	59	67	126
Concerns relating to private care patients	6	3	9
Total	**65**	**70**	**135**

6.1.3 Complaints

Complaints are expressions of dissatisfaction that require investigation and a written response or a meeting. The following sections give details of the complaints received and completed.

Each complaint is categorised by its main subject. A letter of complaint may contain more than one subject and relate to more than one service area.

6.1.4 Standard

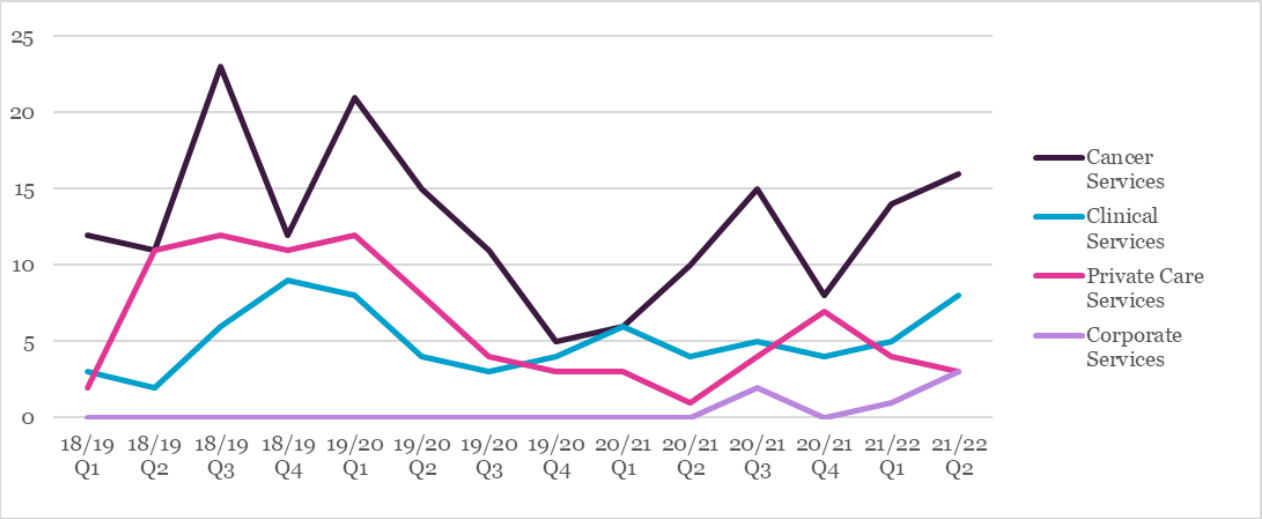
It is a Trust standard that all complainants receive

- A personal acknowledgement within three working days
- A full response with a deadline agreed with the complainant (25 working days is considered best practice for written responses)
- Regular/frequent progress reports
- Information about their right to further redress if not satisfied.

6.1.5 Number of complaints received in Quarter 1 and 2

	NHS			Private Patients		
	Chelsea	Sutton	Total	Chelsea	Sutton	Total
Complaints received	13	34	**47**	**5**	**2**	**7**
Acknowledged within 3 working days	13	34	**47 (100%)**	**5**	**2**	**7 (100%)**

6.1.6 Number of complaints received by quarter



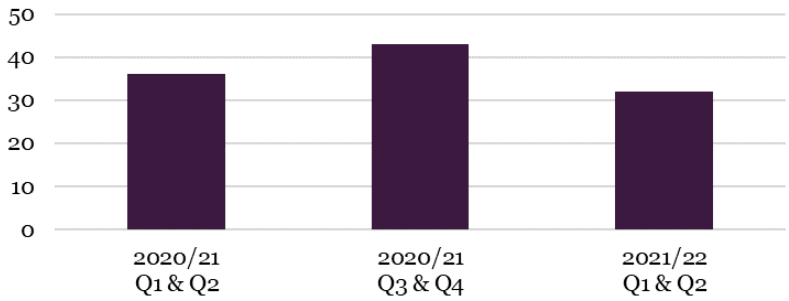
Analysis of the data shows a varied fluctuation for each of the Divisions from month to month. There has been a steady increase in Cancer Services and Clinical Services and Corporate Services complaints in recent months; however, this is more in line with pre Covid-19 expectations. Private Care has seen a decrease recently. All complaints have been reviewed and no themes have been identified.

Any Covid-19 specific complaints were triaged and actioned and responded to as a matter of priority.

6.1.7 Number of complaints completed in Quarter 1 and 2

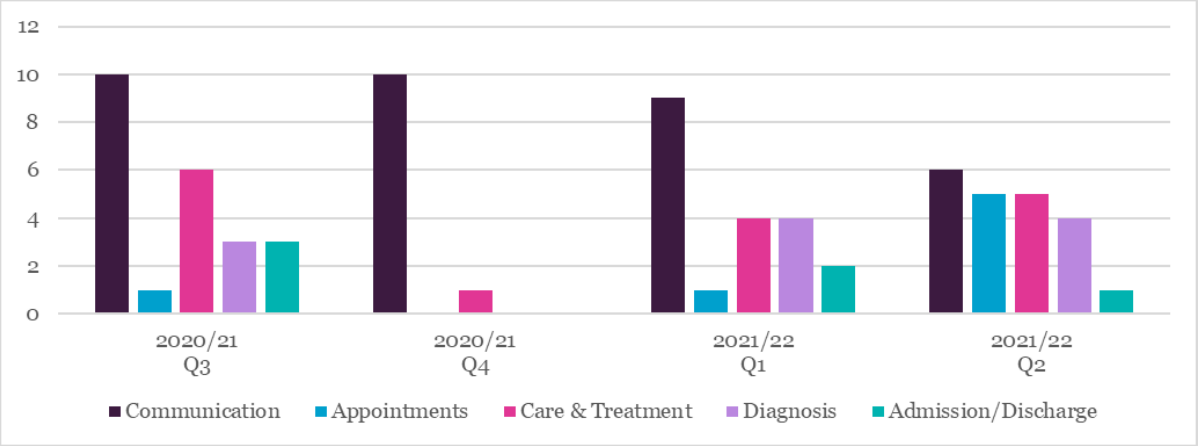
	NHS			Private Patients		
	Chelsea	Sutton	Total	Chelsea	Sutton	Total
Complaints completed	13	28	**41**	**7**	**1**	**8**
Responded to within the agreed deadline	7 (54%)	19 (68%)	**26 (63%)**	7	**1**	**8 (100%)**

6.1.8 Average response time by number of days



The average response time in Quarters 1 and 2 was 32 working days. This is a decrease from the previous few quarters and more in line with expectations pre Covid-19. The complexity of the investigation and/or time taken to receive a draft response and/or statements from the staff can affect the time taken to respond. The Complaints team continue to agree timescales with complainants as well as inform of any delays and agree extensions where required.

6.1.9 Complaint themes review



Communication has been the most frequently complained about issue. More recently, care and treatment, appointment and diagnosis issues followed closely. Any trends (recurrent themes) in particular service areas that are identified are reported to the appropriate senior manager for service-level review and remedy.

6.1.10 Ethnicity of complainants for complaints received

The Royal Marsden collects ethnicity data for all complainants to ensure that all users of the Trust are able to access the Complaints Service. Together with other data, it will help the service to understand who is using the complaints process. The increased knowledge will help in continually improving the service. The table below shows the ethnicity of either the patient or, the numbers in brackets give the numbers within the category for where the complainant is not the patient.

Ethnic origin of complainant	Number of complaints
Asian Bangladeshi	0
Asian Indian	o
Asian Pakistani	2
Asian (other)	0
Black African	0
Black Caribbean	(1) 1
Black (other)	0
Chinese	0
Indian	1
Mixed White and Asian	0
Mixed White and Black African	0
Mixed White and Black Caribbean	1
Mixed (other)	0
White British	(6) 9
White Irish	0
White (other)	(2) 2
Other	1
Not disclosed	0
Not stated	(1) 1
Unknown	(1) 1
Total	**30**

6.1.11 Examples of complaints completed in Quarter 1 and 2 where actions were identified

Chelsea

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Gastro intestinal	Very low	Care & Treatment	Patient suffered hernia following surgery. Communication around hernias.	Review how to communicate more clearly at consent stage that hernias are a known complication of a laparotomy.	Closed - Not upheld
Private patients	Very low	Communication	Concerns around unrestricted use of mobile phones by other patients.	Apologies for experience. Staff reminded of escalation process and given guidance on how to address such issues to empower them to speak up.	Closed - Partly upheld
Transport	Low	Transport/ Transfer	Delay in transport following appointment. Pain levels affected whilst sitting in a chair for 6+ hours.	Review possible ward area, where possible, should there be a delay in stretcher vehicle availability. Transport Operational Manager to review the dispatch and management policy to align available resources and escalation process for extra resource allocation.	Closed - Upheld
Private patients	Very low	Admission/ Discharge	No room for private patient on private ward. Unhappy with cleanliness on ward and noise levels.	Apology for lack of bed and cleaning standard on ward. Enhanced daily cleaning checks with the cleaning supervisor and an infection control action plan. Nursing staff have also been encouraged to do regular checks of the facilities and the ward in general and to report any cleaning issues promptly.	Closed - Upheld
Gynaecology	Very low	Diagnosis	Delay in diagnosis and possible treatment.	Review of blood sample labelling procedures and instructions to staff who undertake labelling samples to take extreme care. Instructions will be placed in clinical hub rooms as reminders.	Closed - Partly upheld
Facilities	Very low	Communication	Unhappy with treatment from Security.	The meet and greet team will no longer ask patients for appointment letters unless offered by the patient. All staff will receive further training on escalation to a manager if there is a concern or complaint at the entrances.	Closed - Partly upheld
Private patients	Very low	Appointments	Unhappy with wait for MRI scans.	Apology that patient was not informed of delay sooner. Appointment letters to be reviewed to explain processes more clearly	Closed - Upheld
Interventional Radiology	Mod	Procedure	Concerns around time to diagnose surgical complications which resulted in return to theatre. Poor pain management.	Pain controlled appropriately. Apologies and acknowledgement that earlier imaging would have identified surgical complication.	Closed - Partly upheld

Sutton

Service area	Risk grade	Subject	Concern	Action taken	Outcome
Diagnostic radiology	Very low	Care & Treatment	Covid-19 Concerns around correct usage of masks on staff.	Retraining for staff. Review of alternatives for face mask.	Closed - Partly upheld
Diagnostic radiology	Very low	Appointments	Delay in appointment.	Apology that temporary staff omitted to check patient in on arrival. Experienced staff to work alongside new members of staff	Closed - Upheld
Endoscopy	Very low	Communication	Contradicting information whether an overnight stay after a procedure is needed.	Review of the Endoscopy booking system to align appointments with EPR.	Closed - Upheld
Breast	Very low	Admission/ Discharge	Covid-19 Patient refused entry as unwilling to wear face mask or visor due to anxiety.	Reviewed policies and guidance related to face covering and improving communication to facilitate quicker alternative appointments during quieter periods for those who are exempt.	Closed - Partly upheld
Haemato-oncology	Very low	Care & Treatment	Delay in treatment. Shortage of ward staff. Poor management of appointments.	Recruited into vacant nursing and healthcare assistant posts. Review of communication and escalation to ensure there is a robust process in place in which patients are kept informed. Review of the current scheduling process. Additional training for administrative team to ensure they understand the importance of scheduling blood sampling appointments in advance to avoid unnecessary delays in the process.	Closed - Upheld
Skin and melanoma unit	Very low	Appointments	Unhappy with appointment booking process	Apology for experience and explanation that unit has been short staffed. Recruitment underway for new staff and new management role. New text message reminders in place.	Closed - Upheld
Gastrointestinal	Very low	Appointments	No apology for delay in telephone consultation Delay in treatment	Explanations given and apologies given. Staff reminded that chemotherapy confirmed after 16:00 is processed the following day. The new Clinic Coordinator has been asked to ensure that telephone appointments to patients who are due to have chemotherapy the next day are to be given priority in the clinic listing.	Closed - Upheld

6.1.12 NHS Digital data – benchmarking

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

The results for Quarter 4 2020/21 (the latest available) are shown in the table below for selected service providers. More recent quarters are not yet available.

	Total New	Total Resolved	Upheld	Partially Upheld	Not Upheld
NHS England	23,103	21,050	5,181	7,794	8,075
NHS England London	4,598	4,120	880	1,607	1,633
The Royal Marsden	19	26	8	16	2
Christie NHS Foundation Trust	33	20	3	4	13
Clatterbridge Cancer Centre	13	4	-	3	1
Royal National Orthopaedic Hospital NHS Trust	9	18	3	9	6
Royal Brompton and Harefield NHS Foundation Trust	23,103	21,050	5,181	7,794	8,075

From webpage:

https://digital.nhs.uk/data-and-information/publications/statistical/data-on-written-complaints-in-the-nhs/2020-21-quarter-3-and-quarter-4

6.1.13 Parliamentary & Health Service Ombudsman Referrals

There were no new referrals to the Parliamentary and Health Service Ombudsman in Quarter 1 or 2.

6.2 Letters of Praise

6.2.1 Staff are encouraged to send any letter of praise they receive to the Head of Assurance for noting in this report and to help identify any members of staff who should receive personal thanks for their work from the Chief Executive.

6.2.2 In Quarter 1, 158 letters of praise were received and 179 were received in Quarter 2. Some examples of the comments made in letters of praise follow.

Chelsea

As we embark on one year since dad's passing, we wanted to send a small note and token of gratitude, for the endless support and hope you provided to dad while he was in your care. While his treatment was tough and at times gruelling, all the nurses who played a part in his care left a hugely positive mark. He knew most of you by name and enjoyed countless hours chatting and getting to know you. We want to thank you for making his cancer journey manageable and trips to the hospital relaxed, we will be forever grateful for your support

I wanted to email to say thank you to you and your team for supporting me through my cyberknife treatment back at the end of March, and indeed for offering me the opportunity for targeted treatment when my own Trust did not. A recent Brain MRI has shown a complete response to the treatment... and I wanted to express my thanks as I simply would not be in this position if it wasn't for you guys at the Marsden. Heroes!

Please pass on our gratitude and love to all of the RMH team that looked after him, particularly the ward team on Marcus ward. I am personally very grateful for the care and attention he received in what ended up being his final few weeks. Keep up the amazing work you all do and the attention to detail that Dad and I witnessed, which he was particularly so impressed with.

I really don't have the words that adequately express my thanks to you and the team for your humanity, commitment, sensitivity, and professionalism. I have heard so many times that you and all "were just doing our jobs" but it felt so much more than that to me- I would not have managed without it. When I am better and able to I would very much like to put something back and would love to hear of any ideas!

Thank you for your kindness, care, and all you do. You make a difference.

Sutton

To everyone working at the Robert Tiffany ward – a massive sincere thank you for all your wonderful care. With much love & gratitude.

Unfortunately, we lost our dear father on Wednesday. We wish to take this opportunity to thank you for all your support you gave throughout our painful journey. Really don't have the words to show our gratitude.

I had a mammogram in the RDAC followed by a consultation. My mammogram was at 2.00pm and I just wanted to say how impressed I was with the radiographer. Every other mammogram that I've had has been excruciatingly painful but [name] took her time to apply the compression gradually and that made all the difference. Yes, it was still painful but not the usual agony. I would be grateful if you could please pass on my thanks to [name] and to the head of the diagnostic radiology service

I wanted to take this opportunity to express my gratitude and amazement for your staff at the Royal Marsden, Sutton... In addition to the marvellous people named above, every single person working at The Marsden has the same attitude, always friendly, welcoming, and genuinely wanting to help. Whether that be the volunteers greeting you at the door or the nurses taking your bloods, each one of them makes the experience the best it can be. You stand on the shoulders of giants and should be extremely proud of all your staff at the hospital. I will be forever grateful for the outstanding service I received and never forget the kindness they showed.

6.3 Patient Information Service

Type	New title/ new edition	Revision	Total
Booklets	0	3	**3**
Factsheets	0	7	**7**
Leaflets	0	2	**2**
Total	**0**	**12**	**12**

Booklets revised this quarter include:
Welcome to the West Wing Clinical Research Centre
Donating stem cells for your own use

Factsheets revised this quarter include:
Bone palliation therapy
Having gynaecological brachytherapy after a hysterectomy

6.4 Freedom of Information

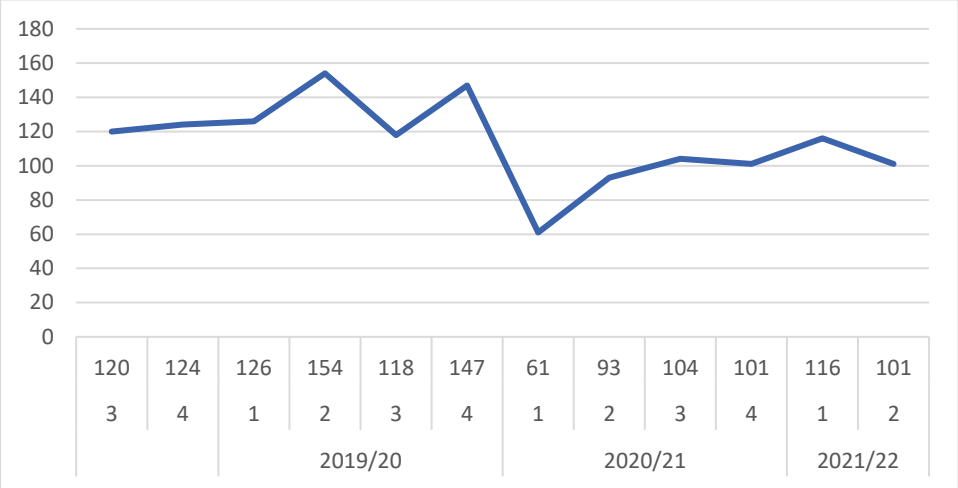
The Freedom of Information Act 2000 gives the public a right of access to information held by public authorities about their activities. The Act sets out that public authorities must respond to such requests within 20 working days. In the context of the Covid pandemic, achieving the 20-working day deadline has been challenging and all current requests are acknowledged referencing the potential delays.

6.4.1 Requests received under the Freedom of Information Act 2000

The Trust received 217 requests during Quarters 1 & 2 of 2021/22, compared to 154 in the first two quarters of 2020/21. Of the 217 requests received, 102 were answered within the 20 working days (47%), 113 were answered outside of the 20 working days (52%) and 2 (1%) remain incomplete. Compliance for this period is in line with the same period last year (46.7%) and is mainly attributable to a combination of pandemic challenges and an increase in the number and complexity of the requests received by the Trust.

In the period under review, the Trust received 77 requests for information from commercial sources compared to 32 commercial requests from the last two quarters of 2020/21. The Trust also received 77 requests from members of the public in the same period however, upon a closer look, a high number of these member of the public requests could also be classed as commercial. The commercial requests are increasing in complexity with some requiring the Trust to fill in 6-page tables of data.

6.4.2 **Number of requests received by quarter**



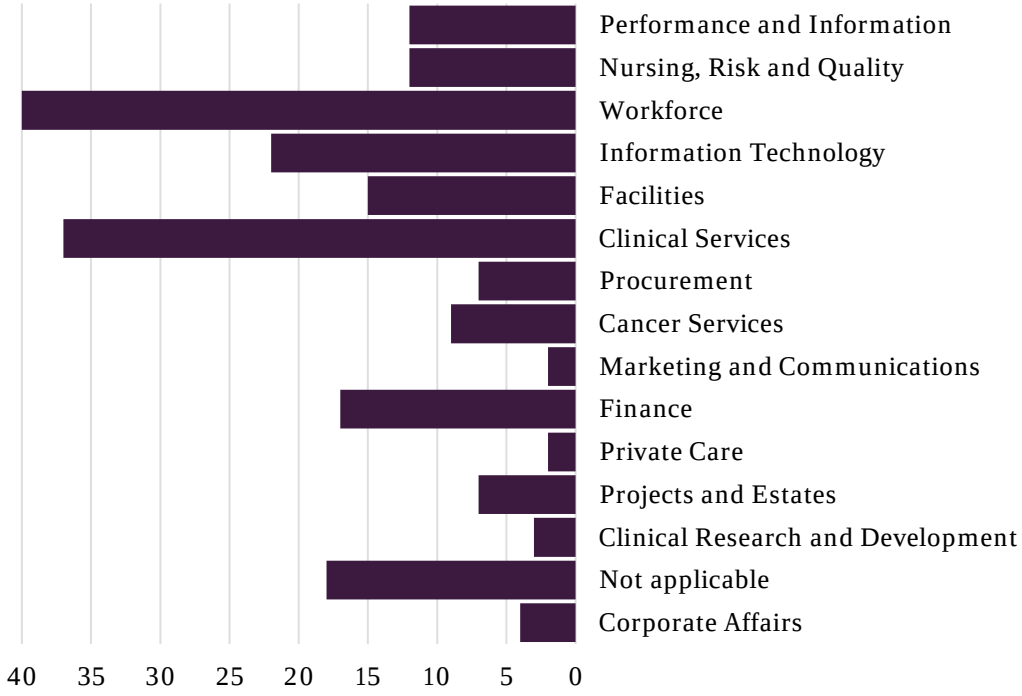
The requests in the first two quarters of the year had the following outcomes:

Disclosed	171
Not applicable to The Royal Marsden	21
Partial	18
Information not held or clarification sought	0
Refused – exemption or too expensive to answer	2
Advice and Assistance given	3
Still open	2
Total	**217**

The requests in the first two quarters came from the following sources:

Charity	1
Commercial	77
Journalist	36
Member of parliament	5
Member of the Public	77
NHS Public sector	10
Researcher	9
Staff	1-5
Trade Union	1-5
Total	**217**

6.4.3 Number of requests by directorate and division



6.5 Clinical Legal Services

6.5.1 **Claims received**

The Trust received fourteen requests for medical records, ten Inquest notifications and six claims reported to NHS Resolution NHSR from Quarters 1 and 2.

Of the six new claims, five were clinical negligence claims and one was a personal injury claim involving a member of staff.

6.5.2 **Claims opened**

The table below shows the number of claims at each stage of the litigation process as at the end of Quarter 2, September 2021.

Stage	Sub-stage	Total	Description of sub-stage
Pre-action			
	Request for medical records	**14**	Request where claim intimated against the Trust
	Letter before action/claim/ notification of claim	**1**	Pre-action letter detailing allegations likely to be subject to court proceedings
	Letter of Claim	**1**	Response to the allegations as set out in the Letter of Claim
	Letter of Response	**18**	Response to the allegations as set out in the letter before action/claim
	Negotiating settlement	**10**	Attempts to reach settlement without recourse to the court
Issued claims			
	Claim form served	**0**	Formal court proceedings sent to the Trust

Defence served	**4**	Trust provides formal response to allegations denying all or some of the allegations made
Negotiating Settlement	**0**	Attempts to reach settlement without recourse to the court
Trial	**0**	Case listed for trial subsequent to proceedings
Structured payment	**1**	Claim settled and annual payments made to Claimant
Discontinued	**0**	Claimant withdrew claim. Legal costs to be confirmed.
Total	**49**	

Open live files reported to the NHSR

Of the 49 claims, 35 are "live" claims (i.e., reported to NHSR); 25 claims relate to clinical negligence claims and 10 are personal injury claims.

6.5.3 **Claims closed**

Claim withdrawn	**0**	**Claimant notifies Trust that they no longer intend to proceed with claim or length of time since last contact suggests claim withdrawn.**
Claim Repudiated	**0**	**Claims repudiated by the NHSR**
Settled pre-action	**0**	**Damages were paid (with, or without an admission of liability) before court proceedings**
Settled out of court	**4**	**Damages were paid (with, or without an admission of liability) after court proceedings have been issued**
Judgment for Trust	**0**	**Trust wins claim at court**
Judgment for Claimant	**0**	**Claimant wins claim at court**
Total	**4**	

6.5.4 Four of the settled claims were clinical negligence claims.

6.5.5 **Inquest notifications received**

The Trust received notification of ten inquests for Quarter 1 and Quarter 2, 2021/22.

Stage	Chelsea	Sutton	Community Services	Kingston
Request for documents	6	4	0	0
Inquests listed for hearing	0	0	0	0

In accordance with our obligations to the Coroner's Court, witness statements (reports) and medical notes were submitted when requested to assist the coroner's investigations. With one of the Inquest notifications, the Trust also attended a Pre-Inquest Hearing and a second Pre-Inquest Hearing is to be confirmed before the Inquest date is listed.

6.5.6 **Inquests concluded**

Three Inquests were closed during Quarter 1 and 2 of 2021/22. The first Inquest was discontinued after a statement was submitted to the coroner. As for the second Inquest, the Trust was not called to give evidence. The conclusion of this inquest was mesothelioma. The final Inquest was a request for medical notes only and the conclusion was natural causes.

6.5.7 **The pandemic**

The Trust has been notified of an Inquest notification relating to COVID-19 death and the Trust is assisting the coroner with the investigation.

6.6 Clinic waiting times

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

Waiting times

	Quarter 1 2021/22	Quarter 2 2021/22
Less than 30 minutes	96.8%	96.8%
Between 30 and 60 minutes	2.6%	2.7%
More than 60 minutes	0.6%	0.5%

6.7 Outpatient non-attendances

Non-attendance at first and subsequent appointment

	Quarter 1 2021/22	Quarter 2 2021/22
Non-attendance at first appointment	5.3%	4.9%
Non-attendance at subsequent appointment	4.5%	5.0%

7 Well-led

7.1 Key Performance Indicators

The metrics below represent the National NHS performance indicators. Where applicable, the targets shown are set nationally and performance against these targets will be monitored by External organisations as well as through internal performance groups.

NATIONAL TARGETS

National Cancer Plan Targets					
Indicator	**Target**	**2021/22** (projected)†	**2021/22 YTD**	**2020/21**	**2021/22 Cumulative Month**
2 Weeks:					
% of patients seen within 2 weeks of urgent GP referral	93.0%	91.7%	91.7%	94.6%	Sep
% of patients seen within 2 weeks for Breast Symptoms	93.0%	94.9%	94.9%	98.6%	Sep
31 Days:					
1st Treatment - % treated within 31 days of decision to treat	96.0%	95.9%	95.9%	96.1%	Sep
Subsequent Drugs - % treated within 31 days of decision to treat	98.0%	99.3%	99.3%	99.1%	Sep
Subsequent Surgery - % treated within 31 days of decision to treat	94.0%	88.6%	88.6%	90.8%	Sep
Subsequent Treatment RT - % treated within 31 days of decision to treat	94.0%	96.6%	96.6%	97.5%	Sep
62 Days:					
All cancers - % treated within 62 days of urgent GP referral	85.0%	74.5%	74.5%	74.8%	Sep
All cancers - % treated within 62 days of urgent GP referral (Post Reallocation)	85.0%	80.9%	80.9%	81.7%	Sep
Referral from Screening - % treated within 62 days of urgent GP referral	90.0%	82.1%	82.1%	81.9%	Sep
Referral from Screening - % treated within 62 days of urgent GP referral (Post Reallocation)	90.0%	90.1%	90.1%	84.6%	Sep
Consultant Upgrade - % treated within 62 days of urgent GP referral	N/A	63.0%	63.0%	76.8%	Sep

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

National Access Targets					
Indicator	**Target***	**2021/22** (projected)†	**2021/22 YTD**	**2020/21**	**2021/22 Cumulative Month**
Cancelled Ops:					
**Number of last minute cancelled operations for non-clinical reasons not admitted within 28 days	0	0	0	1	Sep
RTT:					
RTT % Incomplete Pathways within 18 weeks	92.0%	94.2%	94.2%	92.8%	Sep

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

Other National Indicators - Data Quality					
Indicator	**Target***	**2021/22** (projected)†	**2021/22 YTD**	**2020/21**	**2021/22 Cumulative Month**
% of valid NHS Number submitted to SUS, as defined in Contract Technical Guidance	99.0%	99.9%	99.9%	99.9%	Sep

Other National Indicators					
Indicator	**Target***	**2021/22 (projected)†**	**2021/22 YTD**	**2020/21**	**2021/22 Cumulative Month**
Number of occurrences of patients in breach of sleeping accommodation guidelines	0	0	0	0	Sep
VTE risk assessment	95.0%	97.2%	97.2%	95.6%	Sep

Activity Data					
Indicator	**Target***	**2021/22 (projected)†**	**2021/22 YTD**	**2020/21**	**2021/22 Cumulative Month**
Number of NHS Elective Inpatient FCEs	-	5,233	2,606	4,911	Sep
Number of NHS Daycase FCEs	-	13,371	6,659	10,575	Sep
Total NHS Elective FCEs	-	*18,604*	*9,265*	*15,486*	*Sep*
Number of NHS Non-Elective Inpatient FCEs	-	1,847	920	2,202	Sep
Number of NHS Outpatient Attendances	-	242,074	120,555	215,330	Sep

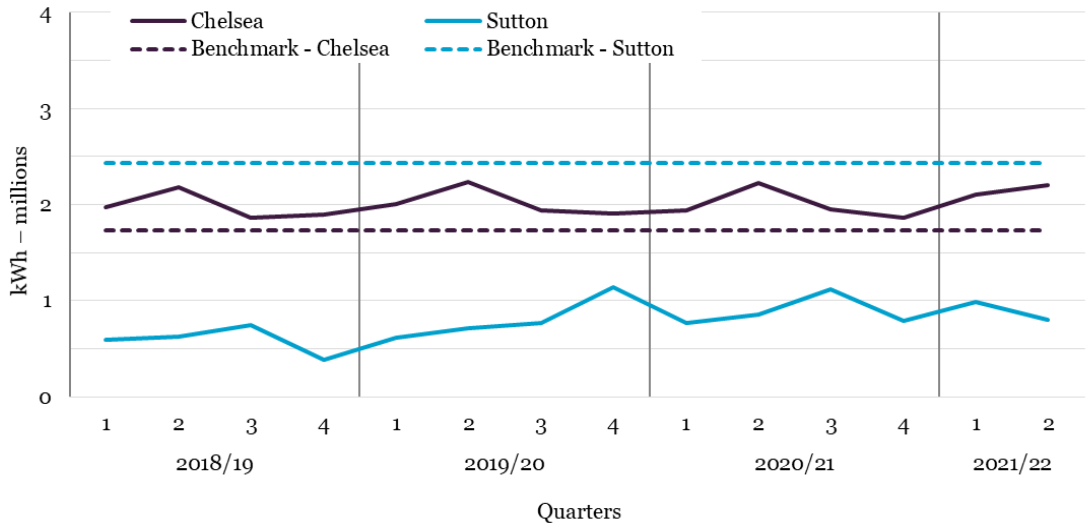
* Target is based on NHS England targets where published
† 2021/22 figures show the year-to-date position seasonally projected to year-end.

7.2 Energy use

7.2.1 Electricity consumption – Chelsea and Sutton

Electricity consumption in the first half of the current financial year at Chelsea increased by three percent in the same period last year and increased by 13 percent in the combined Quarters 3 and 4 in 2020/21. The main contributors for the increase are additional electrical load due to cooling in summer months, additional site load in Cavendish square clinic and newly installed ventilation and air conditioning systems.

Electricity grid consumption in Quarters 1 and 2 in 2021/22 at Sutton increased by 11 percent in the same period last year and reduced by seven percent in the second half of the year in 2020/21. The main contributors to the increased import figures are believed to be increased load due to cooling in summer months, additional energy demand associated with newly installed air conditioning and ventilation systems, and new loads in catering. Improved reliability of the onsite power generation is the main contributor to reduced electricity imported figure.

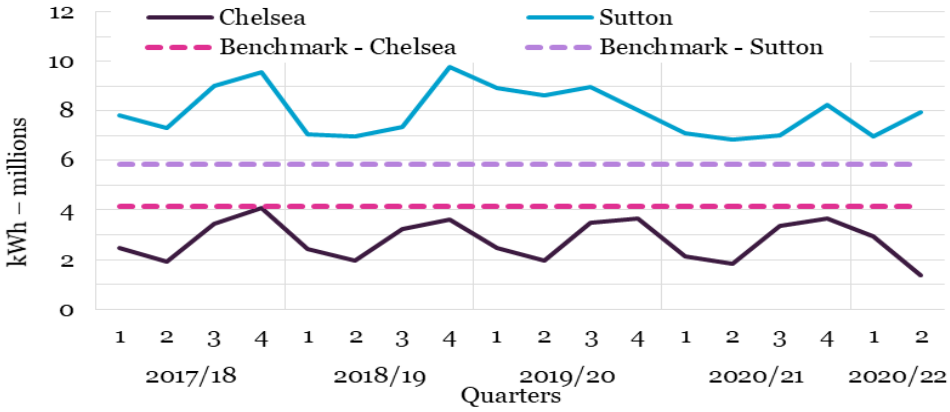


The benchmark used is an average of consumption of five acute trusts in London. The Royal Marsden's electricity consumption at the Chelsea site is slightly above the benchmark line but the consumption at Sutton is below the benchmark line. The Trust is preparing a feasibility study for on-site generation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

7.2.2 Gas consumption – Chelsea and Sutton

Gas consumption in the first half of the current financial year at Chelsea increased by nine percent in the same period last year and reduced by 39 percent in the combined Quarters 3 and 4 in 2020/21. The main contributors for the increase are a longer heating season (due to colder climate) compared to the previous year, and the new heating system testing and commissioning in June, which resulted on running the boilers which are usually stayed off in the summer months. The additional load at Cavendish square clinic is also another factor that affected the site consumption.

Gas grid consumption in Quarters 1 and 2 in 2021/22 at Sutton increased by seven percent compared to the same period last year and reduced by two percent compared to the second half of the year in 2020/21. The main contributors for the increase are longer heating season (due to colder climate) compared to the previous year.

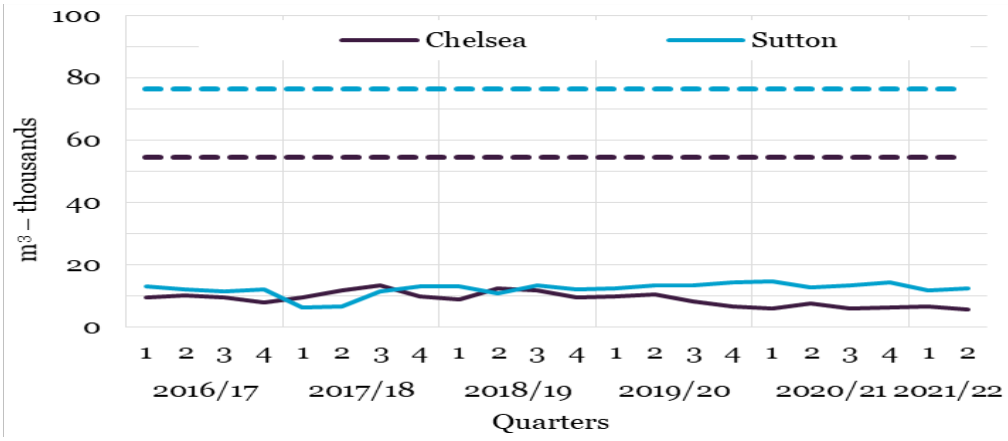


7.2.3 Water consumption – Chelsea and Sutton

Water usage in the first half of the current financial year at Chelsea reduced by nine percent in the same period last year and one percent in the combined Quarters 3 and 4 in 2020/21.

At the Sutton site, water usage in Quarters 1 and 2 in 2021/22 reduced by 12 percent compared to the same period last year and reduced by 13 percent compared to the second half of the year in 2020/21.

Improved metering and reduced number of leakage incidents are believed to be the main contributors to reduced water usage at both sites.



7.3 Waste Management

7.3.1 Clinical waste

❖ *Chelsea*

External – issues with late or failed clinical waste collections continue to impact service and the Trust's ability to meet its legal waste Duty of Care on occasion. To mitigate, securing daily clinical waste collections to increase bin availability and speed of disposal off site is being considered.
Internal – the current twice-daily waste collections from internal areas and waste holds are often insufficient for the volume of waste generated, leading to a build-up of waste, poor segregation, and customer dissatisfaction. This is compounded by the small-sized holds unsuitable for a modern-day waste management service previously reported. Please see 'Service improvement' section below.

❖ *Sutton*

External – road markings, signage and secure fixings have been introduced in the external storage area to enhance the management of clinical waste. Improvements are starting to be seen.
Internal – the same concerns as Chelsea above.

❖ *Cavendish Square*

No other issues have been reported with the waste management at Cavendish Square; the on-site team is working well.

7.3.2 General and Recycling waste

Incorrect segregation in the external waste compactors at Chelsea and Sutton remains an issue; recycling is going in the general waste stream and vice versa. This continues to impact the robustness of waste data reporting.
There are insufficient internal recycling bins in place with some areas still reliant on small under-desk bins and unable to recycle waste. Additional bins are being purchased to address this.

7.3.3 Food waste

Failed collections and un-washed bins were highlighted as an issue during the summer months at Chelsea and Sutton. Teams are working hard to ensure these issues do not return.

7.3.4 Confidential waste

Chelsea and Sutton no longer use a bagged service and confidential wheelie bins are now available on the ground floor of all areas. Cavendish Square does not have a conventional confidential waste service; paper is shredded on site and disposed of as recycling.

7.3.5 **Audits**

An audit tool to formally assess and monitor the Trust's waste management service for continued improvement is being developed for implementation across sites for roll-out in November.
The annual external assessor Dangerous Goods and Waste Pre-Acceptance audits will be taking place in October – the reports will be circulated in the next quarter.

7.3.6 **Environmental initiatives**

Coffee cups - due to the different materials used in their manufacture, coffee cups cannot be recycled unless segregated from other waste streams. We have sourced a supplier who can recycle these if segregated and therefore put dedicated 'cup bins' in areas of heavy usage to capture these.

Water cooler cups - plastic cups cannot be recycled with RMH's current external waste contractors so we have replaced these with paper alternatives which can be discarded in our regular green recycling bins.

Re-use – we have signed up to join Globechain, a re-use marketplace, to re-use items we cannot use internally such as chairs, tables, couches. This quarter RMH has donated 167 items to charities and community groups, diverting approximately two tonnes from landfill.

Increasing recycling – we are currently researching options to provide dual general/recycling bins at RMH's main entrances/areas of heavy usage to capture all recycling.

7.3.7 **Service improvement**

The following proposals will be reviewed internally to further improve the waste management service and increase compliance with the Trust's legal Duty of Care:

1. Increase external clinical waste collections to daily frequency at Chelsea.
2. Increase internal waste collections of all waste streams at Chelsea and Sutton.
3. Increase number of waste holds at Chelsea & Sutton and ensure these are sized appropriately (and/or remove the storage of wheelie bins stored in Sutton corridors)

7.4 Information Governance

7.4.1 **Data Security and Protection Toolkit**

The Data Security and Protection Toolkit encompasses the National Data Guardian's review and 10 data security standards and considers compliance with data protection legislation. The Toolkit submission is a self-assessment of compliance against relevant assertions.

NHS Digital requires NHS organisations to submit in two stages during the year:

– baseline and performance update (28 February 2022)
– final submission (end June 2022).

The Trusts' IG Toolkit position submitted in June 2021 be made available to the public and to regulatory bodies such as:

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

Due to the Coronavirus pandemic the Trust's final submission for 2020-21 for March 2021 was deferred to June 30th, 2021. This was to ensure the focus was on managing the

pandemic work. Compliance with the National Data Opt-out has been deferred again from September 30th, 2021, to March 31st, 2022. In addition, the deadline to have cyber essentials external assessment has been withdrawn with no new deadline date at this time. The Trust's final submission was "Standards Met", which means that all mandatory assertions were met, by the revised deadline. Furthermore, as part of the national Toolkit submission, the Trust is required to achieve a target of 95% for IG training. The Trust's year-end total for IG training was 95%.

7.4.2 Information governance training

All staff must complete Information Governance training as part of their induction as well as annual refresher training. These training requirements are stipulated by NHS Digital (NHSD) as an essential requirement for Trusts to demonstrate compliance with information governance standards. This training is for all staff with an IT account and is delivered via the bespoke Trust information governance e-learning module. The current compliance is 92.3% as of September 2021.

7.4.3 Policy review

In line with the requirement to review policies annually, all IG policies have now been reviewed and have been approved by the IG Committee.

7.4.4 Information Governance Committee

The Information Governance (IG) Committee functions across a range of IG related matters such as IG incidents, policies, data quality, records management, subject access requests, freedom of information requests, and compliance against the Data Security and Protection Toolkit. The Committee is chaired by the Caldicott Guardian who is the Chief Nurse, with the Senior Information Risk Owner who is the Chief Operating Officer as Deputy Chair and Member. The Trust's Data Protection Officer (DPO) is also a member of this Committee and provides an annual DPO report. Over the last six months the following items have been discussed.

- Office365 Security work programme.
- One London Data Sharing Framework.
- IG Training Needs Analysis for code IG staff.

7.4.5 Information governance incidents

The Information Commissioner's Office has had the powers to fine organisations since 2010 and The Royal Marsden to date has not incurred any fines.
In addition, the UK has implemented the EU Directive on the Security of Networks and Information Systems (known as the NIS Directive), this also carries a maximum fine of €20,000,000 or 4% of gross global turnover. Under the new legislation, organisations are required to report breaches within 72 hours of the incident discovery.

The Information Commissioner's Office also has the power to issue undertakings, which commit an organisation to a particular course of action in order to improve its compliance and enforcement notices. Enforcement notices are issued to organisations in breach of legislation, requiring them to take specified steps to ensure that they comply with the law.

Since the introduction of GDPR and the Data Protection Act 2018, incident-reporting requirements have changed. There are now three types of breaches reportable under the new regime, these are: Confidentiality, Integrity, and Availability.

There has been one incident that met the requirement to report externally in the last 6 months. This was in relation to inappropriate sharing of a staff letter containing sensitive information. This incident was reported to the ICO via the DSPT. The ICO has concluded its investigation and decided that no further action by the ICO is necessary therefore this incident has been closed.

To date, The Royal Marsden has not been levied a fine, enforcement notice or undertaking for breaching data protection legislation or regulatory requirements.

7.4.6 General Data Protection Regulation (GDPR)

Following on from the introduction of the 'General Data Protection Legislation (GDPR)' the Trust continues to work towards full compliance.

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

The Information Governance Committee monitors overall compliance with the GDPR.

7.4.7 Caldicott Guardian

Caldicott Guardians derive their name from the Government Review of Patient-Identifiable Information, which recommended that "a senior person, preferably a health professional, should be nominated in each health organisation to act as a guardian, responsible for safeguarding the confidentiality of patient information." The Trust's Caldicott Guardian is the Chief Nurse.

The Caldicott Guardian shares a common function, which is to make wise decisions about the use of people's information. They balance the need to protect people's confidentiality with the need to protect their welfare by ensuring that information is safely communicated among the various professional teams caring for an individual, sometimes across organisational boundaries. They bring to bear ethical as well as legal considerations, making judgements about real life human situations that could not be done by a machine.

The role includes:

- Oversee access to patient-identifiable and personal information in the NHS/Social Care
- Oversee development, agree, and review local protocols governing the disclosure of personal identifiable data
- Review and justify the use of personal information across organisation boundaries.

A regular report of Caldicott issues is presented at the Information Governance Committee.

7.4.8 Senior Information Risk Owner

The Data Security and Protection Toolkit define the SIRO role as an Executive Director who understands the strategic business goals of the organisation in terms of information risk.

Key responsibilities of the SIRO include overseeing the management of information risk within the existing Information Governance framework and taking ownership of the risk assessment process and actions for information and cyber security risk while ensuring all information assets have an assigned Information Asset Owner.

The Trust's SIRO is Chief Operating Officer, Karl Munslow Ong, with Chief Information Officer, Lisa Emery, as the Deputy SIRO.

As part of the DSPT work plan for 2021/22 the following actions will be carried out:

- ❖Carry out full review of data flow mapping returns and complete the Trusts Record of Processing activity in line with GDPR requirements,
- ❖A review of the Trust's Information Asset Register to ensure all areas have completed their register for their areas. Ensure registers have been reviewed and signed off by each Information Asset Owners.

The above key actions will be monitored by the Information Governance Committee.

7.5 Non-clinical Training and Development

All personal effectiveness, management and leadership development courses and programmes continue to be delivered through virtual platforms.

This period saw the launch of three flagship leadership programmes:

- ❖ Leading Excellence is aimed at consultants and those in bands 8b – 8d leadership roles and has been designed and delivered in conjunction with Henley Business School. There are 34 participants on the first cohort.
- ❖ Leading for Change is a clinical leadership programme for managers in bands 7 and 8b and has been designed and delivered by The Royal Marsden School. There are 12 participants in the first cohort.
- ❖ Operations Manager Programme. A 15-month level 5 apprenticeship for all managers, designed and delivered by Hult Ashridge Business School has attracted 12 participants on cohort 1.

During the period, we also continued to roll-out our Management Essentials programme for new managers. 32 workshops were delivered to a total of 472 participants.

Our one-day introduction to Supervisory Skills course was delivered three times throughout the period to 45 staff, and our Enhanced Leadership Programme was delivered to three cohorts across the period, a total of 42 staff.

Our Coaching, Mentoring and Leadership Team Shadowing programmes continued to offer staff the opportunity to learn on the job, and throughout the period we attracted 14 applicants for mentoring, 27 for coaching and 16 for leadership team shadowing.

7.6 Estate Improvements

7.6.1 Sutton:

7.6.1.1 Stem Cell (Phase 2) Offices

Following the works to provide cellular therapies facilities with increased capacity, work was undertaken to provide office accommodation for 12 people, a 2-person office and staff team room. All works were completed in April 2021.

7.6.1.2 Radiopharmacy

Refurbishment and alterations took place to four separate adjoining areas within Radiopharmacy/Nuclear Medicine to create additional treatment rooms and office accommodation. These were the reconfiguration of the Scanner Room, refurbishment of 2 offices, refurbishment of a corridor and conversion of the Radiopharmacy area to offices to include a corridor. All works were completed in May 2021.

7.6.1.3 MRI Avanto (1st)

Replacement of the Avanto MRI took place as part of the MRI programme at Sutton and included works to the Recovery room. Additional works were also carried out for a new

Treatment room, a Paediatrics room and refurbishment of a section of a corridor. Minor alterations were carried out to Control Room 1. Works were completed August 2021.

7.6.2 **Chelsea:**

7.6.2.1 Pharmacy Expansion

Work was carried out to redesign and refurbish the existing Pharmacy in Chelsea by upgrading the current aseptic suit and provide the necessary space to meet regulatory requirements for safely managing and preparing aseptic products and the increasing clinical trial workload. Additionally, works were also carried out to re-configure the department to provide more office space. Works were completed in April 2021.

7.7 Fire Service Attendance

		2021				
	2020	Q1	Q2	Q3	Q4	Total
Chelsea	14	7	2	1	3	13
Sutton	16	4	1	4	3	12

There was a small drop in the number of times the fire service attended. One of the Chelsea attendances was to a fire incident. There are no discernible patterns or trends in these occurrences, although the higher figure in Quarter 1 at Chelsea was as a result of some weekend building work in June, which fortunately was not in a patient area.

The fire incident was a minor explosion in the electrical sub-station located in the basement plantroom. The incident was very well managed by our fire response team and caused little disruption to our service.

For fire alarm systems of the Trust's size, the number of call outs is relatively low.

7.7.1 **Fire Safety Training**

Fire Safety training has still been affected by the pandemic. There are two new online fire safety packages available which are specific to the Trust.
Some face-to-face fire warden training has taken place in the last months. In addition, there will be fire evacuation training in departments where the training will concentrate on specifics relating to that area as well as giving staff the opportunity to have some practical training using ski sheets and evacuation chairs.

The current compliance rates for mandatory fire safety training are:

	Compliant	Non-compliant	% Target = 90
Fire Safety – Clinical	2262	206	91.65%
Fire Safety – Non-Clinical	1422	82	94.55%

Following the success of the multi-agency exercises held last year at both Sutton and Chelsea a further exercise was planned at Sutton for this October. This exercise has had to be postponed due to the effect of the fuel supply crisis on the emergency services. The exercise will now take place in February 2022.

7.7.2 **Fire Safety Works**

At Chelsea a major upgrade of the fire alarm system has been partially completed. The second phase of the works has been delayed by supply issues. It is still expected that the works will be completed by the end of the year.
Fire compartmentation works are also underway.

At Sutton we will be commissioning a fire compartmentation survey at the beginning of the next financial year. Maintenance work will be carried out on the fire dampers at Sutton before the end of the financial year.

We have also had some input on the projects at Sutton in the MRI department and the new Oak Cancer Centre; ensuring the fire safety measures provided are up to date, meeting requirements.

7.8 Reports to NHS England and NHS Improvement

7.8.1 NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHS Improvement regulates foundation trusts to ensure they comply with the NHS provider licence. This is a detailed set of requirements covering how foundation trusts must operate.

7.8.2 Since April 2019 NHS England and NHS Improvement have worked together as a single organisation.

7.8.3 For Quarters 1 and 2, 2021/22 the Trust submitted the following finance and governance reports as part of the requirements:

Months one to six 2021/22 Finance performance returns and commentary

Months two to six 2021/22 Workforce returns

Forecast capital and revenue returns for 2021/22

Weekly agency returns on compliance with price caps and frameworks

7.9 Research governance

7.9.1 Research sponsor

Trust sponsorship was awarded to the following 16 projects:

Reference number	Title	Single or multiple centre
CCR5459	IDT - Improving Diagnosis and Treatment of advanced prostate cancer through better imaging with whole-body magnetic resonance imaging with diffusion weighted imaging	Single
CCR5242	FUNQOLR - FUNctional and QOL changes with Recurrent oropharyngeal cancer	Single
CCR5214	FAIM - Phase II study of induction Fulvestrant and CDK4/6 inhibition with the Addition of Ipatasertib in Metastatic ER+/HER2- breast cancer patients with PI3 Kinase pathway activation without ctDNA suppression	Multiple
CCR5502	AI SONAR - AI & radiomics for Stratification Of lung Nodules After Radically treated cancer	Multiple

7.9.2 Suspected unexpected serious adverse drug reactions

The following is a breakdown by study of the seven suspected unexpected serious adverse drug reactions (SUSARs) that occurred in the quarters, of which so far no further action has been required.

Study code	Total number of SUSARs	Number of SUSARs which required no further action	Number of SUSARS which required further monitoring	Number of SUSARs requiring flagging to a REC
CCR 4731	4	4	0	4
CCR 5112	1	1	0	0
CCR 5184	1	1	0	0
CCR 3972	1	1	0	1

8 Glossary

AHP - Allied health professional.

Alfentanil - An opioid analgesic drug, used for anaesthesia in surgery.

ASD - Autism spectrum disorder.

Bacteraemia - The presence of bacteria in the blood.

BacT/Alert - An automated microbial detection system.

Bedsores - See *pressure ulcers*.

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

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

Care pathway - The route a person takes through healthcare services.

Care Quality Commission (CQC) - The independent regulator of health and adult social care in England. Its role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and to publish its findings, including performance ratings.

CAR-T therapy - Chimeric antigen receptor T-cell therapy. It is specifically developed for each individual patient and involves reprogramming the patient's own immune system cells which are then used to target their cancer. It is a highly complex and potentially risky treatment, but it has been shown in trials to cure some patients, even those with quite advanced cancers and where other available treatments have failed.

CCG - See *clinical commissioning group (CCG)*.

CDI - See Clostridium difficile *infection (CDI)*.

Cerebra - A charity for children with neurological conditions.

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

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

Ciprofloxacin - An antibiotic.

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

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

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

CNS - Clinical nurse specialist *or* Central nervous system.

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

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

Computed tomography (CT) - A medical imaging system that produces cross-sectional X-ray images.

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

CQC - See *Care Quality Commission (CQC)*.

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

CT - See *Computed tomography (CT)*.

Customer Service Excellence standard - The government's customer service standard. It replaced the Charter Mark.

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

Data Security and Protection Toolkit (DSPT) - An online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. This system is subject to ongoing development. Previous versions of the DSPT were known as the Information Governance Toolkit.

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

DNA - Patient non-attendance – 'did not attend'.

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

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

EPR - Electronic patient record.

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

ESMO - The European Society for Medical Oncology.

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

FCE - See *full consultant episode (FCE)*.

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

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

GCP - See *Good Clinical Practice (GCP)*.

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

Haematopoietic stem cell (HSC) - Haematopoietic stem cells are progenitor cells that have the ability to both generate all types of blood cells, including those of the myeloid and lymphoid lineages, and to replace themselves. In adults they are mostly found in bone marrow.

HCA - Healthcare assistant.

HCAI - See *Healthcare-associated infection*.

Healthcare-associated infection (HCAI) - Infection that occurs as a result of contact with the healthcare system.

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

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

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

Hospital2Home - An initiative developed by The Royal Marsden that supports patients' end-of-life choices. The scheme gives patients under palliative care more confidence about choosing to be cared for at home by improving communication between hospital and community services. The scheme is supported by a specialist team funded by The Royal Marsden Cancer Charity.

HPC - Haematopoietic progenitor cell.

HSC - See *haematopoietic stem cell (HSC)*

ICR - See *Institute of Cancer Research (ICR).*

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

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

Information Governance Toolkit - See *Data Security and Protection Toolkit (DSPT).*

Institute of Cancer Research (ICR) - A public research institute and a constituent college of the University of London specialising in oncology. The partnership of The Royal Marsden and the ICR is the largest comprehensive cancer centre in Europe.

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

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

Integrated Governance and Risk Management Committee (IGRM) - An internal committee of The Royal Marsden that meets monthly to oversee patient safety.

Integrated Governance Monitoring Report - This report. A six-monthly publication that reviews the governance of care, research and infrastructure at The Royal Marsden. The report is published on the Royal Marsden's website.

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

ISAS - see *Imaging Services Accreditation Scheme (ISAS).*

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

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

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

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

Joint Accreditation Committee of the International Society for Cellular Therapy (ISCT) and the European Group for Blood and Marrow Transplantation (EBMT) (JACIE) - A non-profit body established in 1998 for the purposes of assessment and accreditation in the field of haematopoietic stem cell (HSC) transplantation.

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

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

Linac - Linear accelerator.

LocSSIPs - Local Safety Standards for Invasive Procedures.

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

Medical devices - Any instrument, apparatus, appliance, software, implant, reagent, material or other article intended by the manufacturer to be used, alone or in combination, for human beings for one or more of the following specific medical purposes:

- diagnosis, prevention, monitoring, prediction, prognosis, treatment or alleviation of disease,
- diagnosis, monitoring, treatment, alleviation of, or compensation for, an injury or disability,
- investigation, replacement or modification of the anatomy or of a physiological or pathological process or state,
- providing information by means of *in vitro* examination of specimens derived from the human body, including organ, blood and tissue donations,

and which does not achieve its principal intended action by pharmacological, immunological, or metabolic means, in or on the human body, but which may be assisted in its function by such means.

The following products shall also be deemed to be medical devices:

- devices for the control or support of conception.
- products specifically intended for the cleaning, disinfection, or sterilisation of medical devices.

Meticillin-resistant *Staphylococcus aureus* (MRSA) - A type of bacteria that is resistant to a number of widely used antibiotics, making it more difficult to treat than other bacterial infections.

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

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

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

MRI - See *magnetic resonance imaging (MRI).*

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

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

National Institute for Health and Care Excellence (NICE) - A non-departmental public body accountable to the Department of Health with responsibility for providing guidance and advice to improve health and social care in England.

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

NEWS - See *National Early Warning Scores (NEWS).*

NEWS 2 - The latest version of the National Early Warning Scores (NEWS) system, updated in December 2017. See *National Early Warning Scores (NEWS).*

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

NHS Litigation Authority (NHS LA) - See *NHS Resolution***.**

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

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

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

NMC - See *Nursing and Midwifery Council (NMC).*

Nursing and Midwifery Council (NMC) - The professional regulatory body for nurses and midwives in the UK.

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

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

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

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

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

Patient and Carer Advisory Group (PCAG) - A group of current and former Royal Marsden patients and carers that works with the Trust on projects where the views of patients and carers help make the hospital a better place for patients.

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

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

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

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

PET - See *Positron emission tomography (PET).*

PGD - See *Patient Group Direction (PGD).*

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

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

Pilot study - A small-scale trial run of a particular approach.

POS - See *Palliative care Outcome Scale (POS).*

Positron emission tomography (PET) - A medical imaging technique that uses a very small amount of radioactive drug to show how body tissues are working.

Pressure ulcers - Injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. Also known as pressure sores or bedsores.

They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time.

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

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

QMS - See *Quality management system (QMS).*

Q-Pulse - Proprietary quality management system software.

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

R^2 - A statistical measure that shows how closely the trend line fits the data in a chart. The value is between zero and one – the higher the value the closer the fit.

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

RAG rating - Red/amber/green rating**.**

RCN - The Royal College of Nursing.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) - Regulations that put duties on employers, the self-employed and people in control of work premises to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses).

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

RIG - Radiologically-inserted gastroscopy.

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

SALT - Speech and language therapy.

Schwartz rounds - Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of Rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care.

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

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

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

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

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

SOP - Standard operating procedure**.**

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

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

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

TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981.

TYA - Teenage and young adult.

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

UKAS - See *United Kingdom Accreditation Service (UKAS).*

Venous thromboembolism (VTE) - Blood clot typically occurring in the leg but which can occur in any blood vessel.

VTE - See *venous thromboembolism (VTE).*

WHO - See *World Health Organization (WHO).*

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

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

World Health Organization (WHO) - A specialised agency of the United Nations that is concerned with international public health.

This glossary is appended to each edition of the Integrated Governance Monitoring Report. The terms described are not found in all editions of the report.

9 Care Quality Commission inspection framework for cancer services

9.1 Safe

How do systems, processes and practices keep people safe and safeguarded from abuse?

- Mandatory training
- Safeguarding
- Cleanliness, infection control and hygiene

How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?

- Assessing and responding to patient risk
- Nurse staffing
- Medical staffing

Do staff have all the information they need to deliver safe care and treatment to people?

- Medicines

What is the track record on safety?

Are lessons learned and improvement made when things go wrong?

- Incidents
- Safety thermometer

9.2 Effective care

Do people's care, treatment and support achieve good outcomes, promote a good quality of life and are based on the best available evidence?

- Evidence-based care and treatment
- Nutrition and hydration
- Pain and relief

How are people's care and treatment outcomes monitored and how do they compare with other similar services?

- Patient outcomes

How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?

- Competent staff

How well do staff, teams and services within and across organisations work together to deliver effective care and treatment?

- Multidisciplinary working
- Seven day services

How are people supported to live healthier lives and where the service is responsible, how does it improve the health of its population?
Is consent to care and treatment always sought in line with legislation and guidance?

- Consent, Mental Capacity Act and DOLs

9.3 Caring

How does the service ensure that people are treated with kindness, dignity, respect and compassion, and that they are given emotional support when needed?
How does the service support people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible?
How is people's privacy and dignity respected and promoted?

- Compassionate care
- Emotional support
- Understanding and involvement of patients and those close to them

9.4 Responsive

How do people receive personalised care that is responsive to their needs?
Do services take account of the particular needs and choices of different people?

- Service delivery to meet the needs of local people
- Meeting people's individual needs

Can people access care and treatment in a timely way?

- Access and flow

How are people's concerns and complaints listened and responded to and used to improve the quality of care?

9.5 Well-led

Is there the leadership capacity and capability to deliver high-quality, sustainable care?

- Leadership

Is there a clear vision and credible strategy to deliver high-quality sustainable care to people who use services, and robust plans to deliver?

- Vision and strategy

Is there a culture of high-quality, sustainable care?

- Culture

Are there clear responsibilities, roles and systems of accountability to support good governance and management?

- Governance

Are there clear and effective processes for managing risks, issues and performance?

- Managing risks, issues and performance

Is appropriate and accurate information being effectively processed, challenged and acted upon?

- Managing information

Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

- Engagement

Are there robust systems and processes for learning, continuous improvement and innovation?

- Learning, continuous improvement and innovation

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

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