The ROYAL MARSDEN
NHS Foundation Trust

Board of Directors Public Meeting

Board Room, Chelsea/Teleconference

15th September 2020, 3.45pm-5pm

Agenda

1.	**Apologies for Absence and Declarations of Interest**	
2.	**Minutes of the Board Meeting held on the 21st July 2020** *Chairman*	Enclosed
3.	**Matters Arising**	Verbal
4.	**Covid-19 Recovery Plan** *Chief Executive*	Enclosed
5.	**Strategic**	
	5.1. RM position within the ICS framework *Chief Executive*	Verbal
6.	**Regulatory**	
	6.1. Freedom to Speak Up Report	Enclosed
	6.2. Mortality Review Q1	Enclosed
	6.3. Medical Workforce Report	Enclosed
	6.4. Emergency Preparedness, Resilience and Response Report *Chief Nurse and Medical Director*	Enclosed
	6.5. Board Self-Assessment Report *Chairman*	Enclosed
7.	**Quality & Performance**	
	7.1. Monthly Quality Account – August (July data) 2020 *Chief Nurse*	Enclosed
	7.2. Key Performance Indicators Q1 *Chief Operating Officer*	Enclosed
	7.3. Financial Performance Report (including capital schemes) *Chief Financial Officer*	Enclosed
8.	**Top Risks and Concerns** *Chief Nurse*	Enclosed
9.	**Risk Appetite** *Company Secretary*	Enclosed
10.	**Board Assurance Framework & DHSC COVID-19 Board Assurance Framework for all NHS Trusts** *Company Secretary and Chief Nurse*	Enclosed
11.	**Medical Appointments –** For Information	Enclosed
12.	**Communications Briefing –** For Information	Enclosed
13.	**Any other business**	

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The ROYAL MARSDEN
NHS Foundation Trust

Minutes of The Royal Marsden Board of Directors Public Meeting

21st July 2020, Board Room, Chelsea and via teleconference

Present

Charles Alexander	Chairman
Ian Farmer	Non-Executive Director
Heather Lawrence	Non-Executive Director
Professor Martin Elliott	Non-Executive Director
Chris Clark	Non-Executive Director
Mark Aedy	Non-Executive Director
William Jackson	Non-Executive Director
Dame Cally Palmer	Chief Executive
Eamonn Sullivan	Chief Nurse
Karl Munslow Ong	Chief Operating Officer
Dr Nick van As	Medical Director
Marcus Thorman	Chief Financial Officer

In Attendance:

Brinda Sittapah	Company Secretary
Tim Nolan	Governor
Fiona Rolls	Governor
Philippa Leslie	Governor
Ellen Mossman	Deputy Director of HR (part)

1/20 Apologies for absence & Declarations of Interest

An apology was received from Professor Paul Workman.

Declarations of Interest

The Chief Executive's position as the National Cancer Director for NHS England was taken as read.

There were no other interests declared other than those already on the register.

2/20 Minutes of the public Board meeting held on the 18th September 2020

The minutes were approved as an accurate record of the meeting.

3/20 Matters Arising

There were no matters arising.

4/20 Covid-19 Recovery Plan

The Chief Executive provided the Board with an overview of the different aspects of the RM recovery plan including the current state of the clinical services and the development of the Cancer Hub to maintain cancer surgery for RM Partners during the recovery period.

The Chief Executive informed the Board that the Trust has seen a significant reduction in the number of inpatients and staff who have tested positive for Covid-19 and also a reduction in the number of staff who are either on sick leave or isolating at home. She added that RM has moved from the emergency response to the pandemic to actively developing recovery plans which support a return to a business as usual state. The Medical Director added that in the last 2 weeks there have been no Covid-19 positive cases reported at the Trust.

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The Chief Executive provided the following highlights to the Board:

- NHS activity is currently averaging between 60 - 80% of pre-Covid levels, however this is continuing to rise month on month
- Referrals are at roughly 70% of pre pandemic levels and are now continuing to rise
- Significant transformation has already taken place in areas such as Outpatients, where over 50% of activity is now via remote consultations and in Radiotherapy and SACT, where changes have been made to treatment protocols to reduce footfall to the Hospital and minimise risk to patients and staff
- There is a continued need to risk stratify patient waiting lists to ensure patients are seen according to clinical priority, including those who have had treatments rescheduled
- Infection Prevention Control standards mean that capacity remains constrained through the majority of patient pathways
- Mobile CT and MRI capacity is being used to support backlog recovery
- The Cancer Hub has now operated on over 1500 patients. At the end of May three additional Independent Sector (IS) providers joined the Hub, which allowed IS capacity to be twinned to particular NHS providers. The IS capacity is currently only guaranteed until the end of August, and there is some ongoing uncertainty regarding whether it will continue, and if so how much capacity will be available.
- The Cancer Hub has been essential in maintaining urgent and essential cancer surgery across West London and there is therefore widespread support for it to continue. Both RM and RMP are playing a key role in the development of system recovery plans and the coordination of IS capacity.
- The Chief Executive informed the Board that NHSE has recently introduced an Adapt and Adopt scheme particularly related to diagnostic procedures and with the success of the Cancer Hub it is looking likely that this will continue to operate in the recovery period. However, it is important to determine its longer-term role, function and funding.
- The next substantial piece of work that RM needs to undertake to support recovery is the adoption of nationally mandated blue / green pathways. Patients following a green pathway will be receiving diagnostic or elective care and will therefore be expected to self-isolate for 14 days prior to attending their appointment, whereas those on a blue pathway will be receiving emergency care.

The Chief Executive pointed out some of the ongoing risks that RM faces with recovery including the reduction in productivity as a result of infection control measures and the continued focus on staff wellbeing, particularly if there is a second peak. The Chief Nurse added that staff continue to wear full PPE and infection control guidance is being reviewed every week. It was noted that a dedicated Covid-19 BAF has been drafted and will be presented to the next QAR and then the Board.

A discussion followed on antibody testing and the research so far on the Corona virus. The Medical Director informed the Board that 22% of our staff have been exposed to the virus but thus far there is insufficient evidence about immunity. It was noted that although generally antibodies can provide immunity, the research on Covid-19 is still ongoing and not conclusive. The Medical Director went on to highlight some of the challenges being faced by the Trust with regards to testing. At the beginning, testing was undertaken only on symptomatic staff but currently asymptomatic staff are also being tested. Around 600 front line staff have to be tested every week. The next step is to undertake asymptomatic patient testing which is due to start at the beginning of August. Discussions are also being had on winter preparation and flu and there is an expectation for a rapid turnaround testing for all viral infections during winter.

The Board congratulated the Executive Team on their hard work during the pandemic and extended their appreciation to all teams and staff.

The Board noted the report and the actions that are being taken by RM to support recovery from the Covid-19 pandemic.

5/20 Strategic

5.1. Children and Young People – Service Review

The Chief Executive reminded the Board of the decision by NHSE/I Board in January 2020 to mandate the colocation of children's cancer services with paediatric intensive care and other specialist children services. She added that NHSE/I London had proposed an option appraisal exercise involving representatives from The Royal Marsden, Guys and St Thomas', King's and St George's to evaluate the benefit and risk of three options as follows:

- Provision of an RM@ model at Evelina
- Provision of an RM@ model at St George's Hospital and
- A Sutton site option as part of the Epsom & St Helier University Hospitals development.

It was noted that a fourth option might be added which is a nuance of the above.

The Chief Executive drew the attention of the Board to the fact that the Trust delivers a safe and high quality service to Children and Young People (CYP) as evidenced in the CQC report which has recognised the service as safe and good with some outstanding areas of practice. It was pointed out that the aim of the option appraisal exercise is to ensure the service meets the requirements of the new specification for these services with a co located PICU and where possible more streamlined pathways for children. The Chief Executive also emphasised that the service has to be properly funded going forward as thus far the service has been operating at a significant loss of c £5-6M per annum. It is additionally supported by RMCC.

The Chairman then invited Professor Martin Elliott who is leading the CYP Task and Finish Group to further update the Board on progress.

Professor Martin Elliott informed the Board that a Strategy Group for CYP had been established to guide the Trust's work and to develop and recommend a way forward to the CYP Task and Finish Group which in turn will provide feedback to the Executive Board and the Trust Board. Professor Martin Elliott explained that there are complex challenges being encountered around the complexity of the service and interfaces and went on to describe the work that will be undertaken over the coming months to develop and prepare for the options appraisal process which is due to commence in September 2020.

The Board recognised that the options appraisal process was initially delayed due to the Covid-19 pandemic.

The Chairman emphasised that the Board is fully supportive of the approach and the Board will make a carefully considered decision to secure the best possible outcome for CYP.

The Board noted the CYP Service review update and extended their thanks to Professor Martin Elliott and all the executives and staff involved in this programme of work.

5.2. Our Patient Experience Commitment

The Chief Nurse presented the Patient Experience Commitment for 2020-2024 to the Board and advised that this is in line with:

- our primary aim to deliver the best cancer treatment through world leading research, operating a bench to bedside strategy with the Institute of Cancer Research (ICR)
- the core themes of our overall Strategic Plan (2019-2024) and, importantly,

- our Trust values.

It was noted that due to the Covid-19 pandemic the date will be reviewed to 2021-2025 given that the programme had to be paused.

The Chief Nurse pointed out that this programme has been co-developed with our patients and carers and its development included three patient and carer workshops hosted by our Patient and Public Involvement/ Engagement Lead (PPI/E) and a review by the Trust Patient Carer Advisory Group (PCAG). The commitment forms the centre piece for Patient Experience across the Trust alongside the newly formed Quality and Patient Experience Strategy Committee.

The Board considered the report and suggested that an action plan is devised to measure the effectiveness of the initiatives. The Chief Nurse advised that this programme will be linked to the national inpatient survey initiatives and will be overseen by the PCAG. The Board also requested that the commitment is reviewed on an annual basis to monitor progress.

The Chairman then invited comments from the Governors present who positively acknowledged the experience and feedback received from this programme.

The Board noted the Patient Experience Commitment for 2021-2025 and agreed that this should be reviewed annually.

6/20 Regulatory

6.1. Equality and Diversity Report

The Deputy Director of HR presented the Equality and Diversity Report to the Board with a view to provide assurance that the Trust is compliant with its responsibilities under the Equality Act 2010 including the public sector equality duties.

The Board was pleased to note the continued positive feedback from CQC and patients on provision of services. It was noted that good progress has been made towards achieving the 2019/2020 equality objectives. The Trust exceeded the WRES Model Employer target for proportional representation at senior level and the gender pay gap has reduced from 8.9% to 5.6% and the bonus pay gap reduced from 33% to 25%.

The Board discussed and approved the workforce priorities for 2020/21 which had been agreed by the ED&I Steering Group in March 2020 as follows:

- Embed the Model Employer strategy and achieve the 2020 targets set for the Trust by the national WRES team
- Identify and implement focused actions to reduce harassment and bullying in the workplace
- Continue to make improvements with regards to employee relations, with a specific focus on WRES indicator 3 - percentage of BAME staff who enter a formal conduct or capability process

Ian Farmer acknowledged the good progress made but questioned the deterioration in some of the WRES indicators from 2018 to 2019. The Deputy Director of HR explained that nationally the WRES stats have worsened and this could be due to the different initiatives the Trust and the NHS overall have implemented such as Freedom to Speak Up Service and the introduction of FTSU champions encouraging more staff to come forward with their concerns. The Chief Nurse added that the BAME Group has also grown from 50 to 70 members recently and with the Black Lives Matter campaign it is likely that more staff will come forward which might impact the data for this year. The Board acknowledged that this could be a sign that the various initiatives are working and agreed that the Trust has to carry on embedding the programme to improve the WRES data whilst at the same time working on initiatives to address unconscious bias by other staff.

The Board noted the summary of the 2020 Equality Report and approved the 2020/21 workforce equality objectives.

6.2. Mortality Review Q4

The Medical Director presented the Mortality review Q4 to the Board and confirmed that the Trust has met all the standards for inpatient deaths. The Medical Director advised that there had been 57 inpatient deaths between 1 January 2020 to 31 March 2020; all of which were reasonably expected. However, the Trust approach is to conduct a Structured Review Judgment (SRJ) for a proportion of deaths which for this period involved 10 deaths. Of the 10 patients for whom the SJR was undertaken one patient had a problem in care identified. One COVID-related death has been reported between the 1st January 2020 to 31st March 2020.

Overall, the Trust is RAG-rated amber for the period between January and March 2020. Although 100% compliance was met for 4 of the 5 standards, 1 of the standards only achieved 90%, this related to a patient who presented with a neurological deterioration, which later was concluded was related due to disease progression (as suggested by Neurosciences MDM) and thus unavoidable even with early CT scan.

The Board noted the Mortality Review for Q4.

6.3. Safer Staffing

The Chief Nurse presented the safer staffing report to the Board and provided an overview of nurse and other clinical staffing capacity and compliance with the National Institute for Clinical Excellence (NICE) Safe Staffing, National Quality Board (NQB) and NHSi standards.

The Chief Nurse explained that by December 2019 there were over 105,000 clinical staff vacancies in the NHS in England. Of this figure Registered Nurse (RN) vacancies were listed at 43,000 - an all-time high for the profession. This figure is set to increase as demand for RNs is set to rise by up to 3% annually to meet essential NHS service needs.

The Chief Nurse pointed out that the Joint Royal Colleges in England (medical, nursing & AHP) have agreed for the first time that stabilising GP and RN vacancies are the two leading workforce priorities for the foreseeable future, as current vacancy rates across these groups are seen as the single biggest threat to delivery of the NHS Long-Term Plan.

The Board acknowledged that the Trust is also facing challenges regarding national nurse recruitment and retention and the COVID-19 pandemic has further impacted upon our recruitment and establishments. The Cancer Hub has been supported by expertise in surgical cancer nursing however changing patient case mix i.e. thoracic surgery has impacted upon the skill mix of nurses required.

The Chief Nurse further provided the following highlights from the report:

- The Trust had seen the overall nursing vacancy factor reduce from 15.4% in April 2017 to 7.1% in April 2019, however this has increased to 9.4% in May 2020. The vacancy figures include newly established posts such as Cavendish Square or Acute Oncology. The ability to continue recruitment internationally has been paused due to travel restrictions during COVID-19. However, the Trust continues to see a positive recruitment picture following programme of recruitment and retention initiatives supported by the RMCC.
- The nursing voluntary turnover rate for 2019/2020 was an average of 15.2%. In particular, the NHS wards/departments have seen a higher turn0ver, with the

London/national demand for experienced nurses across Cancer Services, Critical Care Unit (CCU), Theatres and Children's specialities growing.

The Chief Nurse confirmed to the Board that the Trust is compliant with national staffing guidance and that wards are safely staffed. It was noted that the clinical areas requiring establishment listed in the report require review by Divisions which will be managed via business planning or with immediate effect in the event of a safety risk.

The Chief Nurse advised the Board that the challenges have been recognised but there is a clear plan in place.

The Board noted that the executive team fully support the National Quality Boards recommendation for a Chief Nurse led bi-annual safer staffing reviews to be the primary vehicle for ensuring staffing levels are safe and compliant.

The Board noted the safer staffing report.

6.4. National Surveys update – patient and staff survey

The Chief Nurse provided an overview of the National Inpatient Surveys for 2019 to the Board as follows:

National Inpatient Survey 2019

- With a response rate of 60.74%, well above the national average of 45% the Trust received very positive results and came fifth out of the 143 participating trusts in the question about overall experience with a score of 8.9 out of 10.
- The Trust performed better that other organisations on 49 questions out of 68. There were no areas where the Trust performed worse that other organisations. The Trust's results were about the same as other organisations for 12 questions.
- Overall, the Trust was ranked 75th nationally as compared to 35th in the previous year. The Chief Nurse explained that a deep dive will be undertaken to understand the reasons of the slip. An action plan will be developed and will be collated with other national survey results such as the National Cancer Patient Experience Survey and this will be monitored through the Patient Experience Strategy Committee.

National Cancer Patient Experience Survey

- The 2019 National Cancer Patient Experience survey involved 143 NHS acute trusts in England. The national response rate was 61% (67,858 respondents). The Trust's response rate was 56% (1,604 patients). Both the national and Trust's response rate was slightly lower than last year (national 64%, Trust 60%).
- The Trust performed higher than the national average for 21 out of 61 questions. The Trust performed the same as the national average for 27 out of 61 questions. The Trust performed lower than the national average for 4 questions.
- Overall, the Trust patient experience was rated 5th overall nationally, which is an improvement from 7th in the previous year.

The Board noted the positive results for both the National Inpatient Survey and the National Cancer Patient Experience Survey.

7/20 Quality and Performance

7.1. Monthly Quality Account – June 2020

The Chief Nurse updated the Board on the June Quality Account data. He pointed out to the areas of good performance and advised that due to COVID-19 some Quality indicators have been impacted upon for which actions have already been put in place.

Heather Lawrence in her capacity as Chair of QAR reported that the Quality Report has been presented to QAR and commended the Trust and the Team for the exceptional performance delivered.

The Board noted the Monthly Quality Account for June 2020.

7.2. Key Performance Indicators Q4

The Chief Operating Officer provided the Board with an update on the Trust's performance for quarter 4 2019/20 and highlighted the following:

- Of the 69 RAG-rated metrics, 44 were rated green in Quarter 4 with 8 metrics rated red. This is the highest number of green metrics the Trust has reported for the year. Of particular note is the improvement in the chemotherapy waiting times metrics, which have moved to amber from red for the first time in the year.
- Some of the Red rated metrics are attributed to the on-going COVID-19 situation. Of the Red rated indicators, 2 areas represent a continuation of longer term issues: Cancer Waiting time Performance and Research – Accrual to target. An action plan has been put in place to improve performance.

The Chief Operating Officer informed the Board that the KPIs are currently being reviewed to take into account the Covid-19 KPIs and will be presented to the next QAR and thereafter to the Board.

The Board noted the KPIs for Q4.

7.3. Financial Performance Report

The Chief Financial Officer presented the Financial Performance Report for the YTD June 2020 and highlighted the following:

- The Trust accrued £15.3m top-up to get to a breakeven position at 30th June 2020. £5.9m was accrued in the month, compared to £6m in the prior month. The main driver of this support is much reduced commercial income, notably private patient income, compared to the plan. However, Private patient income improved in the month, but costs as well increased to deliver this. NHS activity and particularly drugs spend also increased in month, which given the block income, drove the top-up back to prior month levels.
- The Trust has a duty to recover back to pre Covid-19 activity levels and reduce the need for this top-up as quickly as possible. There is a risk that top-up funding will be removed before the financial position has recovered, so a number of controls have been put in place to manage spend and recovery plans are being developed in every operational area.
- In addition to the revenue pressures, capital is also constrained for the STP. However, the Trust is within its planned spend YTD with all capital schemes progressing.
- Capital expenditure of £5.5m YTD, which was £4.6m favourable to the Trust's capital plan. The capital plan has not been signed off by NHSI as the Capital Departmental Expenditure Limit (CDEL) for the South West London (SWL) STP is insufficient for all the Provider plans.
- Cash in bank of £149m, a favourable variance of £27m compared to the year-end position as at 31st March 2020. The cash position of the Trust remains strong.

The Board noted the Financial Performance Report.

8/20 **<u>For information</u>**
8.1. Membership Report

The Board noted the Membership Report.

9/20 **<u>Any other business</u>**
No other business was raised.

The Chairman closed the meeting and thanked everyone for attending.

Signed as a true and accurate record

Chaired by:..... Date:.....

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
15 September 2020	4.
Title of Document:	**To be presented by:**
Covid-19 Recovery Plan	Chief Executive

1. Status **For Noting**

2. Purpose:

Relates to:

Strategic Objective(s)	✓
Operational Performance	✓
Governance	✓

3. Summary

In May 2020 RM began seeing significant reductions in the number of inpatients who have tested positive for Covid-19 within the organisation, and the number of staff who are either on sick leave or isolating at home. These factors allowed RM to begin to develop a recovery plan to return our services to a business as usual state. Significant progress has been made against this plan however a number of actions remain necessary to achieve a full recovery.

This paper updates the Board on the governance model for recovery, current priorities for recovery and the support RM continues to provide to West London through the Cancer Hub. It also provides an update on the approach to agile working.

4. Recommendations / Actions

The Board is asked to discuss and note the actions that are being taken to support the Trust's Recovery Programme.

The ROYAL MARSDEN
NHS Foundation Trust

COVID-19 Recovery Plan

1.0 Purpose of paper

This paper provides an update to the Trust Board on the recovery plan which is being developed to support the Trust's response to the COVID-19 pandemic.

2.0 Background

In May 2020 RM began seeing significant reductions in the number of inpatients who have tested positive for Covid-19 within the organisation, and the number of staff who are either on sick leave or isolating at home. These factors allowed RM to begin to develop a recovery plan to return our services to a business as usual state. Significant progress has been made against this plan however a number of actions remain necessary to achieve a full recovery.

3.0 Governance of the Recovery Programme

The Recovery Board, which was established in May 2020 continues to oversee all aspects of the recovery of both RM and RM Partners. The Recovery Board takes account of national and regional updates on recovery, and then ensures that local recovery plans are in line with this guidance. It also approves all spend relating to recovery plans and ensures the compatibility of the different strands of recovery. Finally, in response to the NHSE phase 3 letter, the Recovery Board now meets on a less frequent fortnightly basis and has taken on some of the duties previously undertaken by the Gold Covid-19 group, including the coordination of internal and external communications.

The Recovery Board continues to receive regular reports from all of the following workstreams, and has also begun to receive a progress report from the new Covid-19 testing group:

1. Clinical Workstreams (NHS services and any integrated models with Private Care or R&D)
2. Private Care (non integrated elements)
3. Research and Development (non integrated elements)
4. RM Partners (including the London Cancer Hub)
5. Major Programmes (including Oak, Cavendish Square and Digital Health Record)

4.0 Current priorities for recovery

Across the various workstreams, the following issues are the current priorities which RM is seeking to address:

- Define the future operating model for lung and thoracic surgery undertaken in conjunction with the Royal Brompton
- Utilise the independent sector (IS) theatre and endoscopy capacity which is currently available and ensure further capacity beyond the end of the current NHS/IS agreement which ends on 7th September
- Refine the green / blue pathways (separation of urgent & elective pathways) to best support the actual patient numbers that are being seen
- Agree and implement the required increases in staffing to deal with the anticipated radiotherapy demand over the next 6 months
- Ensure appropriate distancing can be introduced in the Medical Day Units without compromising the level of care that can be provided to patients
- Work through a backlog of bone marrow transplants with support from Imperial and UCLH

- Finalise the future model of delivery in Outpatients including the use of digital solutions such as the Attend Anywhere platform
- Continue to drive private patient growth across all modalities
- Stand up a specific trial which supports the development of a Covid-19 vaccine

5.0 London Cancer Hub

The Cancer Hub was initially established by RM and RMP to create a dedicated regional network for cancer surgery in response to the pandemic. The governance structure of the Hub was amended to a more devolved model in July to reflect the increased amount of IS capacity that had been made available. This revised model has worked well and a further review will be necessary when the long term construct of IS support is known in November.

At present the Hub is playing a key role in helping to provide the evidence for the medium and long term IS requirements. It is also helping to ensure that the current IS capacity is used effectively and that external Trusts are supported through a variety of methods including the coordination of pre-assessment and anaesthetic provision.

6.0 Links to STP / London recovery

In addition to the work undertaken through the LCH, members of the RM and RMP Senior Management Team continue to support the developing recovery plans of Southwest and Northwest London STPs in the following ways:

- Contributing to the STP response to the NHSE phase 3 letter
- Agreement that RM may be commissioned to expand to 19 critical care beds when required
- Helping both sectors to model the level of diagnostic, surgery and inpatient capacity to address the backlog of oncology patients who require treatment
- Working with colleagues at the Royal Brompton to ensure that lung and thoracic cancer diagnostics and treatment can continue while the Royal Brompton Hospital site is being used to treat patients with Covid-19
- Offering to support the planning and development of an elective diagnostic and surgical centre on the Sutton site to support the wider SWL ICS

7.0 Stepping down of Command and Control arrangements

The Command and Control structure which was established to respond to the Covid-19 pandemic has been downgraded. The Strategic Group which oversaw the response to the pandemic has been disestablished, and the Tactical Group now has a reduced frequency of twice a week and a more focussed agenda on the key issues which require ongoing oversight. These issues include daily monitoring of key Covid-19 related metrics, urgent responses to national or regional guidance and operational challenges, such as the ongoing requirement to comply with Infection Prevention Control regulations.

8.0 Agile Working

Since the start of the pandemic in March 2020, RM implemented working from home (WFH) arrangements. These arrangements included a significant proportion of corporate teams working offsite and 133 clinical staff being relocated into alternative space across the Trust.

In June, NHSE/I published guidelines stipulating that NHS organisations should continue to adhere to social distancing of 2 metres, wherever possible in non-clinical areas and that all staff in hospitals should wear face masks. In response to this guidance management teams across RM undertook formal workplace risk assessments including the review of agile working arrangements.

On the 6th August, RM staff who had been shielding began to return to site in line with support from Occupational Health. Following this, a Trust-wide communication was issued on 14th August outlining an expectation that all staff should work with their line manager to plan to return to work to site from 1st September. The communication also set out that agile working arrangements will need to continue for some people, particularly those working in non-clinical functions, to free up the space necessary to allow clinical staff to distance appropriately.

A working group has been established to manage the next phase of this transition and any issues which cannot be addressed satisfactorily will be escalated to the Recovery Board for review.

9.0 Key ongoing risks and concerns

Through the response to Covid-19, six key risks have been highlighted. The latest position on these risks is as follows:

- Ability to obtain enough personal protective equipment to care for patients with Covid-19: Although this issue is monitored daily, no critical stock issues have been reported for a number of weeks. This is currently a low risk.
- Significant number of staff off on sick leave which may threaten RM's ability to maintain services: This issue is also monitored daily however the number of staff who are off sick for Covid-19 related reasons is now down to 1%. This is currently a low risk.
- The need to segregate inpatients who have tested positive for Covid-19 from those who have not, and to restrict the number of visitors to the Trust: The initial separation of inpatient areas has been enhanced by the introduction of green / blue pathways. Although this is being managed well by the operational and clinical teams, as activity levels increase and other winter pressures emerge then it could become more difficult to maintain. Site security arrangements remain in place and have been enhanced by volunteers who are temperature checking all visitors to RM. This is currently a moderate risk.
- The financial position that RM is operating in this year: RM remains subject to the same block contract arrangement that has been in place since April 2020, however this is expected to change in October. The Trust Board has approved some additional funding to support recovery, however this is complicated by the availability of additional external funding for critical care, endoscopy and surgery. This is currently a moderate risk.
- The potential for both ICSs to form recovery plans which do not recognise the role / contribution of RM and RMP: RM and RMP continue to have prominent roles within the SWL recovery plans and are represented within NWL discussions. There is a need to define the role that RM and RMP will take over the next phase of recovery within both sectors. This is currently a moderate risk.

10.0 Summary

The Board is asked to note the actions that are being taken to support the Trust's Recovery Programme.

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NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
15 September 2020	5.
Title of Document:	**To be presented by:**
RM position within the ICS framework	Chief Executive

1. Status **For Noting**

2. Purpose:

Relates to:

Strategic Objective(s)	✓
Governance	✓

3. Summary

Under plans being considered by the new health and social care taskforce, all Integrated Care Systems (ICSs) could become legal entities. They may be given the responsibility for workforce, financial and performance responsibilities by Regions rather than Trusts specifically NHS Foundation Trusts operating as sovereign organisations within the NHS rather than individual trusts.

These changes would clearly affect existing NHS financial and accountability regimes and strategically will involve more integrated delivery models.

The implications for all providers but specialist providers in particular will be significant. The Royal Marsden operates from two sectors of London, is highly research active and will need to consider how best to maintain its global, national and local contribution to improving survival and quality of life for all those affected by cancer in this new integrated NHS system.

4. Recommendations / Actions

The Board is asked to note the update.

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BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
15 September 2020	6.1
Title of Document:	**To be presented by:**
Freedom to Speak Up Report	Chief Nurse

1. Status: **For Noting**

2. Purpose:

Legal / regulatory / audit	*Sir Robert Francis' 'Freedom to Speak Up' Report*

3. Summary

Highlights of the report are as follows:

(a) The National Guardians office FTSU Index 2020 places the Trust in the top 10 trusts nationally for a positive Speak up Culture

(b) The National Guardians office FTSU Index 2020 places the Trust top nationally for 10 trusts national for percentage of staff agreeing that their organisation treats staff who are involved in a near miss, error or an incident fairly

(c) The number of contacts to the service is steadily increasing each year.

4. Recommendations / Actions

The Board is asked to:

- Note the progress and activity of the Freedom to Speak Up service within the Trust
- Note FTSU activity data and whistleblowing activity and Trust response
- Note findings from safety culture indicators taken from the National Guardians Office FTSU Index 2020.

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Freedom to Speak Up Report 2020

1. Introduction

This report provides the Trust Board with an update on the activity of the Freedom to Speak Up (FTSU) service, which was established in 2017 and provides the Board with an overview of the Speak Up culture within the Trust.

2. Background

In response to Sir Robert Francis' 'Freedom to Speak Up' report in 2015, the National Guardian's Office was established as an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes standard practice.

NHS providers were mandated to make provision for the appointment of a Trust Freedom to Speak Up Guardian. A key aim of the Trust Freedom to Speak Up service is to further encourage an open and responsive culture where staff feel safe and confident to speak up before and ultimately if things go wrong.

3. Freedom to Speak Up Team at The Royal Marsden

Anne Howers, Nurse Director for Safeguarding, is the Trust Freedom to Speak Up Guardian and Professor Martin Elliott is the Non-Executive Director lead for raising concerns, and equality and diversity. The Director of Workforce is the Director lead for this service and for whistleblowing. The FTSU Guardian is supported by a team of 9 FTSU Champions who cover all bases and all divisions. The FTSU champions are from a wide range of professions and differing levels of seniority and undertake this role within their work role with agreement and support of their line managers.

The aim of the FTSU Guardian and Champions is to be visible within the Trust and become known so staff can speak to them confidentially for advice and support in relation to raising their concerns or whistleblowing. They have a role in providing information if staff have questions about a public interest concern or have concerns that appear to not be taken seriously or dealt with effectively. They are not directly involved in any investigation of complaints; instead their role is to support staff in getting a timely resolution to any concerns raised.

To raise awareness of the FTSU service, communication resources have been developed. All new starters to the organisation receive information about the Freedom to Speak Up service as part of their induction and there is information in public and staff areas across all Trust sites.

There is a FTSU website page on RM matters which is currently being updated and on RM Matters there is an anonymous reporting link to the FTSU Guardian

4. Activity 2019-20 and learning to date

Concerns raised to the FTSU Guardian and Champions are recorded confidentially, and feedback is provided to the individual raising the concern. Each quarter the National Guardian's office collates activity data and learning in response to our local Freedom to Speak Up service. This feedback requires Trusts to identify if concerns include an element of patient safety/quality, relate to behaviours, including bullying/harassment or identify that a detriment has been suffered as a result of speaking up.

- During the first year 2017-18 of the service 15 concerns were raised
- During the second year 2018-19, 25 concerns were raised
- *These first two years included a community services division*
- During the most recent year 2019-20, 39 concerns were raised

Data collated is based on categories predetermined by the National Guardian's office.

Table 1: Summary of 2019-2020 activity data

Quarter	Number of Cases Raised	Number of cases raised anonymously	Element of patient safety/quality	Element of bullying or harassment	Suffering Detriment:
Quarter 1	5	4	0	5	0
Quarter 2	14	2	0	14	0
Quarter 3	16	2	0	16	0
Quarter 4	4	1	0	4	0

We have seen an increase in contacts this year which may have been as a result of raising the profile of the FTSU service

Locally, data is reviewed and any trends identified at bi-monthly FTSU meetings where the Guardian and champions meet to review cases, to identify emerging themes and any areas for development or improvement and also to consider guidance and reports from the National Guardian's Office. The Non-Executive Director lead for raising concerns, and equality and diversity, attends meetings to support the team and seek assurance of the issues. Concerns raised to the FTSU Champions and Guardian are recorded confidentially and feedback where appropriate or support is provided to the individual raising the concern.

Data from the year 1 April 2019 to March 31st showed we had 39 concerns raised and completed 6 exit interviews. Of the concerns raised, all related to staff attitudes and behaviour, containing elements of bullying and harassment. Nine concerns were raised where staff wished to remain anonymous.

The above theme is in line with the National Guardians Office data and themes.

The data for 2019-2020 does not highlight any trends or themes in relation to a division, staff group or service, but showed trends regarding recruitment processes and a requirement for staff training requirements for team leaders and managers in recruitment. Staff reported that some policies are hard to understand and use and there is a need for simplification and understanding

The activity to date suggests that there is an awareness of the role of the FTSU service and that staff feel able to raise concerns. Staff who have used the FTSU service have reported that as a result of their experience of raising concerns through the FTSU service, they would feel confident and supported to speak up again. We are continuing to monitor this feedback which will provide key information to ensure that staff feel that they are able to speak up effectively and that in

doing so they felt their concerns were listened to and addressed.

5. Freedom to Speak up Strategy

In response to a NHSI requirement in 2018, the Trust published a Speak Up Strategy in December 2018; where we set out our strategic ambition in cultivating an open, transparent and just culture where feedback is encouraged and staff feel confident and safe to raise concerns, and where we learn from our mistakes'. This forms the basis for the FTSU culture and role at The Royal Marsden. The Trust recognises that effective speaking up arrangements help to protect patients and improve staff experience.

6. Link to other services for raising concerns and safety culture indicators

The purpose of the report is to focus on the Freedom to Speak Up service, however there are a variety of ways staff at the trust can raise for raising concerns. These include support from line management, human resources, trade union colleagues, staff support, professional forums, Occupational Health, Health and Safety Manager, Quality and Risk team, and Guardian of Safe Working (for junior doctors). The FTSU service works alongside and complements all these other services.

Staff can also whistle blow directly to the Director of Workforce, however there were no cases reported in 2019-2020

In terms of the culture within the organisation that enables staff to raise concerns, safety culture indicators are shown in the National Guardians Office Freedom to Speak Up Index report 2020. The data for this report is gathered from 4 questions in the annual NHS Staff Survey and allows trusts to compare organisation performance to improve the experience of staff and patients.

Working with NHS England, the National Guardians Office brought together 4 questions from the NHS staff survey into the FTSU Index. These questions relate to whether staff feel knowledgeable, secure, and encouraged to speak up and whether they feel they would be treated fairly after an incident. The FTSU Index seeks to allow trusts to see how an aspect of their FTSU culture compares with other organisations, so learning can be shared, and improvements made.

Nationally The Royal Marsden NHS Foundation Trust was the highest scoring trust for the question - % of staff agreeing that their organisation treats staff who are involved in a near miss, error or an incident fairly- scoring 72.9% against an average score of 59.7% and a lowest score of 40.3%. Furthermore, The Royal Marsden NHS Foundation Trust is in the top 10 trusts for all four FTSU index questions with a score of 84.3% overall

7. National Legislation 2019 regarding Freedom to Speak Up

NHS England/NHSI issued new guidance in August 2019, which includes the requirement for the Trust Board to receive an annual report on the FTSU service in the public section of a Trust Board meeting. The Board is also expected to review FTSU activity and consider wider issues relating to Speaking Up every six months.

The National Guardian's office was also published updated guidance on FTSU training. The guidance suggests that FTSU awareness training should be treated with parity with all other forms of mandatory training. The previous Director of Workforce was aware and assured that the Trust is compliant.

8. Raising the profile of FTSU within the Trust in 2019-2020

The Freedom to Speak Up team attended Health and Wellbeing Events in Chelsea, Sutton and Wallington in summer 2019 to raise the FTSU profile and spoke to over 75 staff members. Staff from many departments talked to the team indicating that they knew about the service and would use it if needed, a smaller proportion were not aware of the service.

Nationally October 2019 was Speak Up Month and the Freedom to Speak Up team had visited over 25 departments and spoken to several hundred staff during October with positive feedback from staff being received about FTSU service.

In January 2020 the Freedom to Speak Up team again attended the Health and Wellbeing Events in Chelsea, Sutton and Carew House Wallington to further raise the FTSU profile and spoke to over 140 staff members. Staff were asked what they know about FTSU and the service and also invited to assist the FTSU in designing a new poster information leaflet to advertise the service.

Over 100 staff completed a questionnaire to express their thoughts and views so that we can have a poster and leaflet for staff designed by staff. Staff gave some excellent ideas and feedback. Staff from many departments talked to the team indicating that they knew about the service and would use it if needed, a very few were not aware of the service. This information is being analysed in order to design and new poster and website information for next year.

9. Work plan for 2020-2021

- To further increase the visibility and awareness of the champions and embed their roles into the organisation through improved marketing and communication.
- Regular updates to staff about the service and access to FTSU
- Triangulation of data - The Freedom to Speak Up team will be looking to understand the low numbers of incidences relating to patient care such as Trust-wide patient data, datix reports, and complaints. As concerns can also be raised outside of the FTSU service, the team will develop a process for triangulating the information from other sources so that there is a shared view within the organisation about areas of concern and the actions required to address these. The team will ensure trends from triangulation of the above are reviewed and appropriate actions taken in line with findings to strengthen our current practice and governance in the trust
- Utilise the Speak Up Champion role in the exit interview process. The aim is to develop the exit process so staff leaving the organisation or thinking about leaving the organisation have someone they can talk to about their experiences of working with the Trust or raise concerns confidentially. This information will then be utilised to inform the organisation's approach to retention and to address any recurring themes or issues.
- Explore ways in which the learning from FTSU can be connected to other organisational interventions such as those relating to Equality, Diversity and Inclusion , workforce retention and wellbeing.

- Participation in the **National October is Speak Up month** using this as a base for a Trust-wide promotion and events regarding Speaking Up.

10. Conclusion

Freedom to Speak Up at the Royal Marsden has a strong foundation to build on.
This report aims to provide assurance that the Trust takes speaking up very seriously and wants to embed Speaking Up as good practice within the Trust.
Our aim to ensure that staff know that the culture of speaking up is part of delivering high quality care to patients; that it is welcomed, acted upon and outcomes and changes taken as appropriate and required, and that we have a culture that makes speaking up business as usual.

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BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
15 September 2020	6.2
Title of Document:	**To be presented by:**
Mortality Review Quarter 1	Medical Director

1. Status **For Noting / Information**

2. Purpose:

Legal / regulatory / audit	*Audit*

3. Summary

The Trust has been reviewing all inpatient deaths each quarter since 2015. The aim of this audit is to review all patient deaths occurring in The Royal Marsden in this three-month period to determine the reasons for these deaths occurring in the hospital and the patient's preferred place of death.

All 4 standards were achieved, and any actions identified as a result of this audit are disseminated to staff across the Trust.

4. Recommendations / Actions

The Board is asked to note the Mortality Review for quarter 1.

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Quarterly Hospital Mortality Review Audit,
1st April 2020 to 30th June 2020

1.0. Background

1.1 The trust has been reviewing all inpatient deaths each quarter since 2015. The aim of this audit is to review all patient deaths occurring in The Royal Marsden in this three-month period to determine the reasons for these deaths occurring in the hospital and the patient's preferred place of death.

1.2 The National Mortality Case Record Review Programme from the Royal College of Physicians (RCP) outlines use of the 'Structured Judgement Review' to conduct in depth 'case record review' of certain deaths. The consultants undertaking the reviews have attended training on how to conduct a 'Structured Judgement Review'.

1.3 The audit evaluates if the patient's death was reasonably to be expected given their clinical condition, whether the referral to the Palliative Care team was timely and whether there were any problems in care identified following the full Structured Judgement Review in accordance with guidelines from the Royal College of Physicians.

1.4 The audit results have been presented in a quarterly report to the Integrated Governance and Risk Management and Quality, Assurance and Risk committees each quarter by the Medical Director.

2.0 Audit methodology

The data was reviewed at a meeting on 11th August 2020 with Dr Halley, Dr Tatham, Dr Benson, Dr Tweddle, Ms Sanderson, Mr Kramer, Ms Curtis, Ms Bracey and Ms Marcus to agree the findings as outlined in this report.

3.0 Conclusions

3.1 Standard 1: 100% of in-hospital deaths should either be expected given the patient's overall clinical condition, or should have a clear identifiable irreversible reason for death that could not have been prevented by clinical intervention

There were 73 inpatient deaths between 1st April and 30th June 2020.

Conclusion: 73 inpatient deaths were reasonably expected therefore 73 out of 73 patients met the standard. 100% - standard achieved.

3.2 Standard 2: 100% of patients who died in hospital with a documented preferred place of death that was not "hospital" should have a clear, identifiable reason outside the control of RM as to why their preferred place of death was not achievable

Conclusion: Of the 73 deaths, 7 patients had indicated a preferred place of death other than "hospital" with a clear, identifiable reason outside the control of RM. 7 of the patient's experienced either a rapid deterioration or an acute event. Therefore seven out of 7 patients met the standard. 100% - standard achieved.

3.3 Standard 3: A discussion with the Symptom Control and Palliative Care team takes place in 80% of the admissions which resulted in patient death in hospital, where the death was reasonably expected as per standard 1

Conclusion: Of the 73 deaths, 59 patients were discussed with the Symptom Control and Palliative Care team before their death, 81% - this standard was achieved.

3.4 Standard 4: 100% of patients for whom the Structured Judgement Review (SJR) is undertaken have no problems in care identified

A total of 24 inpatient deaths had a 'Structured Judgement Review' (SJR).
No problem in care was identified. – this standard was achieved for Q1.

4.0 The Learning Disabilities Mortality Review (LeDeR)

Of the 73 inpatient deaths in Q1 2020-21, there were no patients with learning disabilities according to information recorded in the electronic patient records (EPR).

5.0. Children's cases

Of the 73 deaths in this quarter, there were no paediatric deaths.

6.0. Serious Incidents

Of the 73 deaths in this quarter, there was no deaths investigated as a Serious Incident.

7.0. Complaints

There were 24 deaths in this quarter that had a 'Structured Judgement Review' (SJR) conducted.
The 24 deaths were selected for SJR's for the following reasons:

Reasons for SJR	April	May	June	Total No of Deaths
Concerns raised from relatives after death	**2**	**2**	**2**	**6**
Deprivation of liberty safeguards in place	**0**	**1**	**1**	**2**
Complaint	**1**	**0**	**0**	**1**
E.Coli Bacteraemia	**1**	**0**	**1**	**2**
Unexpected death	**1**	**1**	**2**	**4**
Post-surgical death	**0**	**4**	**2**	**6**
Sudden deterioration	**0**	**1**	**0**	**1**
Fall on ward and intracranial bleed	**0**	**1**	**0**	**1**
Staff concern	**0**	**1**	**0**	**1**
				24

8.0. Numbers of deaths caused by problems in care

For all 73 patients which had an SJR , it was assessed that no problems in care were identified.

9.0. Number of COVID-19 related deaths reported

21 COVID-related deaths were reported between the 1st April 2020 to 31st June 2020. Of those deaths 13 were metastatic solid tumours and 8 were haematological malignancy.

A retrospective review of end of life care for patients who died with confirmed or a high clinical suspicion of COVID- 19 was undertaken to determine whether there was any learning for the Trust and that the management of these patients was appropriate. The outcome of this review was that medical management at the end-of-life was generally uncomplicated, however, suggesting many cancer patients dying with COVID-19 could be appropriately managed by non-specialist physicians supported using ward-based teaching, comprehensive guidelines and specialist input for more complex cases. High levels of family anxiety were also observed and in the event of a potential future surge, the recommendation was for increased focus on family support and communication about end-of-life wishes and priorities.

No patients with Learning Disabilities died of COVID-19 and the Trust is assured that from the end of March 2020 all patients transferred to a Nursing Home were COVID-19 screened prior to discharge.

10.0. Themes, trends and learning points

10.1 The review found that of the 73 inpatient deaths, 43 had metastatic or progressive diseases, 15 were haematological malignances.

10.2 In this quarter, reviews of care in the SJRs provided the following learning points:

- Clinical documentation on EPR should be concise and relevant to that consultation- avoid copying and pasting identical information from day to day during inpatient admissions.
- Visiting Anaesthetists and Surgeons should be made aware of, and encouraged to engage in training and use the electronic clinical documentation methods at RM
- Treatment escalation plans should be recorded for all non-elective admissions and if a day case patient is admitted unexpectedly
- During the current visiting restrictions, communication of clinical information between patients, their families (if consent is given) and the clinical team should be prioritised and recorded on EPR.

10.3 Points of good care that was noted:

- Despite the challenges of the pandemic excellent, compassionate end of life care was recorded for deaths across the trust.

11.0. Summary

11.1 The Trust Board is asked to note that overall, from the review of the data the Trust is RAG-rated green for the period between April to June 2020. The table below shows the RAG ratings from previous quarters:

Quarter	RAG rating
Q12020-2021	Green
Q4 2019-2020	Amber
Q3 2019-2020	Green
Q2 2019-2020	Amber

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BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
15 September 2020	6.3
Title of Document:	**To be presented by:**
Medical Workforce Report	Medical Director

1. Status: For Noting

2. Purpose:

Relates to:

Strategic Objective(s)	*Workforce*

3. Summary

- Medical revalidation –the Report aims to provide assurance that there is a system in place that meets General Medical Council (GMC) requirements for the appraisal and revalidation of all medical staff.
- Guardian of Safe Working report –a summary of exception reports (ER) in 2019-20.
- Update on the status of the GMC survey of trainees

4. Recommendations / Actions

The Board is asked to:

a) Note progress with medical appraisal and revalidation and approve the Chief Executive and Chair to sign off a statement of compliance Guidance from NHSE/I is awaited as to when this will be required.

b) Note the report from Guardian of Safe Working for 2019-20

c) Note the current status of the GMC survey of trainees 2020

The ROYAL MARSDEN
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Medical Workforce Report 2019-20

1. Introduction

This report provides the Board with an update on three medical workforce regulatory matters: medical revalidation, a summary report from the Guardian of Safe Working (GSW) and summary of GMC survey results. The report aims to:

a) Provide assurance that there is a system in place that meets General Medical Council (GMC) requirements for the appraisal and revalidation of all medical staff. The type of information required to provide assurance and the format of the report is prescribed by NHS England.

b) Provide summary activity information from the Guardian of Safe Working in relation to junior doctors in training.

c) Provide an update on the GMC survey results 2020. This survey relates to the educational experience of junior doctors in training and is mandatory for all doctors in a designated training role.

The reference period for this report is 1 April 2019 to 31 March 2020.

2. Medical Revalidation

2.1. The Framework of Quality Assurance for Responsible Officers and Revalidation (2014) requires organisations employing doctors (Designated Bodies) to present an annual report to the Board on the implementation of medical revalidation and submit an annual statement of compliance to their higher level responsible officers, which in the case of London Trusts is NHS England South Region.

2.2. Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety, and increasing public trust and confidence in the medical system. Each NHS provider is required to have a Responsible Officer, who leads on appraisal and revalidation and makes recommendation to the GMC. This role is undertaken by the Medical Director on behalf of The Royal Marsden and the Institute of Cancer Research.

2.3. NHS provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that Trust Boards will oversee compliance by:

a) monitoring the frequency and quality of medical appraisals in their organisations;

b) checking there are effective systems in place for monitoring the conduct and performance of their doctors;

c) confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and

d) ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Governance Arrangements

2.4 The Medical Director is the designated Executive Lead for medical appraisals and revalidation and is supported in this role by the Appraisal and Revalidation Lead, Dr

Jonathan Handy, Consultant Intensivist. The focus for this clinical leadership role is to support the Trust to maintain a high level of compliance (90%+) with appraisals and more importantly, improve the quality of appraisals.

2.5 The Medical Workforce Committee, led by the Medical Director, is responsible for tracking compliance with appraisal and revalidation. Monitoring is tracked through monthly and quarterly reports to NHS England South Region, Annual Organisational Audit to NHS England South Region and monthly reporting to the Performance Review Group.

2.6 The Trust has a policy on medical appraisals and revalidation in line with NHS requirements, which is reviewed annually. The policy also covers doctors that are employed by the ICR and hold an honorary contract with The Royal Marsden.

Appraisal and Revalidation Performance Data

2.7 The appraisal completion was 98% in 2019-20, exceeding the Trust target of 90% as shown in table 1. There are 320 doctors who have a prescribed connection to the Trust; 297 had an appraisal meeting on time – 9 appraisals were deferred for a valid reason e.g. maternity or sick leave and 14 doctors who completed their appraisal but not within the deadline for a non-valid reason.

2.8 The non-valid deferral rate has been problematic in previous years and the Trust was a negative outlier in London. This has now been addressed and the non-valid deferral rate reduced significantly from 24% in 2016-17 to 6% (9) in 2018-19 to now 4.5% (14) in 2019-20.

2.9 Due to the impact of Covid-19, appraisals due in March 2020 were postponed to September 2020. The GMC also postponed revalidations due in March 2020 by 12 months.

2.10 Table 2 shows that 92 doctors were due to revalidate during 2019-20 (compared to 63 in 2018-19). The level of revalidation activity has increased significantly and is scheduled to remain at this new level during 2019-20. Of the 92 doctors, 81 received a positive recommendation for revalidation, three assessments were deferred by the GMC due to COVID-19 and eight assessments were deferred by the Trust. The reasons for deferral are set out in table 3.

Table 1 shows *appraisal performance data 2019-20*

Doctors with a prescribed connection	**Trust**	**Honorary**	**Total**	**Valid Deferrals**	**Number of appraisals due 2019-20**	**Number of completed appraisals**	**Non-valid Deferrals**
Cancer Services	154	22	176	5	176	165	6
Clinical Services	91	1	92	2	92	85	5
Clinical Research	37	8	45	2	45	40	3
Private Care	7	0	7	0	7	7	0
TOTAL	**289**	**31**	**320**	**9**	**320**	**297**	**14**

Table 2 shows revalidation data for 2019-20

Number of positive recommendations to the GMC for revalidation between 1/04/2019 - 31/03/2020 i.e. these are doctors who have met all the requirements and have	**81**

actually been revalidated by the GMC	
Number of deferrals between 1/04/2019 - 31/03/2020 i.e. these are doctors who were due to be assessed for revalidation but the assessment has been deferred by the Trust	**8**
Number of deferrals from GMC due to COVID-19	**3**

Table 3 shows the reasons for revalidation deferral 2019-20

Reasons for deferrals	**Total**
Long term sickness/personal reasons	1
Maternity leave	1
New starter	2
Incomplete appraisal/360	4
Ongoing investigation	1

2.11 There are currently 74 trained consultant appraisers in the Trust. This figure is reviewed annually as part of the appraisal audit process to ensure there is sufficient capacity to deliver a high completion rate for appraisals.

2.12 There are a number of mechanisms in place to ensure that medical appraisals are of a high quality. These include:

- An audit review process led by the Medical Appraisal and Revalidation Lead. Appraisal portfolios are reviewed prior to submission to the Responsible Officer to ensure documentation is complete and up to date;
- Monthly review of the appraisal completion rate is undertaken by the Medical Workforce Committee and Performance Review Group;
- A process to link complaint information to the appraisal process;
- A process to link significant clinical events to appraisals. There is a positive reporting mechanism to confirm if there have been significant events.

2.13 To further improve medical appraisals in 2020-21 we will:

- Utilise an external training provider to run appraiser refresher courses to improve the quality of medical appraisals (Sessions were run in Jul-20 and Aug-20)
- Run an appraiser training course for 20 new Consultants to become trained appraisers, making it easier for appraisees to find a suitable appraiser (booked for Nov-20).
- Use the appraisal auditing, feedback, support and training for appraisers to continue to improve the quality of medical appraisals within the Trust;
- Liaise monthly with department managers and the Appraisal and Revalidation Lead to highlight any non-valid deferrals so that Doctors can be supported to complete their appraisal within one month of their due date

2.14 Concerns about conduct and performance are managed formally under the Maintaining High Professional Standards framework. Information about the number and type of concerns raised about individual clinical practitioners during 2019/20 are shown at appendix 1.

3. Guardian of Safe Working (GSW) – annual activity report 2019-20

3.1 The Trust has approximately 116 junior doctors in training posts. There is a mandatory requirement for organisations that employ junior doctors in training to appoint a GSW. The GSW is a senior consultant within the Trust who is independent of the management

structure and responsible for protecting the safeguards outlined in the 2016 terms and conditions of service for junior doctors. The safeguards relate to maintaining safe hours of work ensuring service commitments do not compromise the educational experience of trainees and the support available to trainees during service commitments.

3.2 The Trust, in partnership with Junior Doctor Forum representatives, appointed Dr Andrew McLeod, Consultant Anaesthetist as the GSW in March 2019 replacing Dr Nathan Kasivisvanathan.

3.3 Exception reporting (ER) is the mechanism used by doctors in training to inform the Trust when their day-to-day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be:

- Hours/rest – differences in total hours, breaks or pattern of hours;
- Education – differences in opportunities and support available, including during service commitments.

3.4 The purpose of exception reports is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained. The purpose of work schedule reviews is to ensure that a work schedule remains fit for purpose in circumstances where earlier discussions have failed to resolve concerns.

3.5 Financial penalties (fines) can be issued by the GSW, if a problem is not resolved through the ER system. No financial penalties were levied against the Trust during 2019-20.

Exception Reports

3.6 There have been 33 ERs during 2019-20 as shown in table 4 below, which is a 32% reduction from 2018-19 when the Trust had 70 ERs. Only specialties where ERs have been reported are shown in table 4 e.g. all surgical specialties, Histopathology and Anaesthesia/Critical Care continue to have zero ERs and are therefore not listed in table 4. The General Medicine rota on the Sutton site had the most ERs in 2019-20.

3.7

Table 4: 2019-20 ER activity

Rota	ERs Q1	ERs Q2	ERs Q3	ERs Q4	Total
General Medicine Sutton	0	0	8	2	10
General Medicine Chelsea	2	0	2	1	5
Radiotherapy	2	3	2	1	8
Paediatrics	1	7	0	0	8
Haematology	1	0	0	1	2
Total	6	10	12	5	33

3.8 Actions taken to reduce ERs during the reference period included reviewing timings of ward rounds, and clinics to minimise delays in starting and finishing handover on a timely basis. To address compliance issues within the various rotas, the Trust has begun implementing a specific eRostering package for medics, providing greater compliance and rostering solutions for doctors throughout the organisation.

3.9 The feedback from the GSW and also from the BMA has been that exception reporting appears to be working as envisaged in identifying issues with working patterns and addressing problem areas. When the GSW has benchmarked ER activity against similar sized trusts with a similar number of trainees the Trust compares favourable in terms of the number of ERs.

3.10 To further support all junior doctors in training work within agreed rota patterns, a review of the Hospital at Night model is also being undertaken. Hospital at Night aims to ensure that staffing out of hours remains safe and the operational infrastructure is effective.

3.11 The resolutions to ERs during 2019-20 are shown in table 5 below:

Table 5: Breakdown of resolution to ERs

Resolution method	Number of times resolution was used	% of total
Time off in lieu	15/33	45
Payment for extra hours work	14/33	43
Exceptions not agreed (submitted over 14 days after the event)	0	0
Review of work schedule	0	0
Exceptions not resolved	0	0
Fines incurred	0	0
No Action Required	4	12
Total	**33**	**100%**

3.12 During 2019-20 there was a significant reduction in the number of exception reports, which reflects the changes that have been put in place to respond to the issues raised by ERs. Data on exception reporting has been shared with representatives from the Junior Doctor Forum, British Medical Association and Medical Workforce Committee.

4.0 GMC survey results 2020

4.1 The national training surveys are a core part of the work the GMC carries out to monitor and report on the quality of postgraduate medical education and training in the UK. Every year all doctors in training and trainers are surveyed for their views. There are two distinct reporting groups: the experience of trainees, and the experience of trainers who act as educational supervisors.

4.2 The training survey due to be run in March 2020 was postponed. Instead a survey was carried out in July 2020. This focused on experiences relating to Covid and results are expected towards the end of 2020.

5. Pension tax allowances and the consultant workforce

5.1 Following discussion about the impact of annual and lifetime pension tax allowances on high earners during 2018/19, particularly the consultant workforce, the Department of Health and Social Care launched a consultation on changes to the NHS Pension Scheme in September 2019.

5.2 As a result of this, new flexibilities were introduced to allow healthcare professionals to manage pension growth that would apply from 2020/21. In order to support our staff, the Trust introduced an alternative shared payment scheme during the tax year 2019/20 as operational alternative to the provisions of NHS pension contributions to employees who could demonstrate that they would have been adversely affected.

6 The Board is asked to:

a) Note progress with medical appraisal and revalidation and approve the Chief Executive and Chair to sign off a statement of compliance Guidance from NHSE/I is awaited as to when this will be required.

b) Note the report from Guardian of Safe Working for 2019-20

c) Note the current status of the GMC survey of trainees 2020

Appendix 1 - Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	1	5	3	9
Capability concerns (as the primary category) in the last 12 months		1		1
Conduct concerns (as the primary category) in the last 12 months	1	3		4
Health concerns (as the primary category) in the last 12 months		1	3	4
Remediation/Reskilling/Retraining/Rehabilitation				0
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2019 who have undergone formal remediation between 1 April 2018 and 31 March 2019 Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				2
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				4
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				1
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				1
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All DBs				1
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All DBs				0
TOTALS				9

Other Actions/Interventions	0
Local Actions:	0
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	1
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	6-12 months
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	1
GMC Actions: Number of doctors who:	
Were referred to the GMC between 1 April and 31 March	1
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	0
Number of doctors about whom NCAS has been contacted between 1 April and 31 March:	2
For advice	2
For investigation	0
For assessment	0
Number of NCAS investigations performed	0
Number of NCAS assessments performed	0

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 15 September 2020	**Agenda item:** 6.4
Title of Document: Emergency Preparedness Resilience and Response Assurance Report	**To be presented by:** Chief Nurse

1. Status **For Noting**

2. Purpose:

Relates to:

Legal / regulatory / audit	✓

3. Summary

The purpose of the annual Emergency Preparedness, Resilience and Response (EPRR) Assurance Process is to provide evidence to NHS England that the Trust maintains comprehensive, robust arrangements in order to respond in the event of an incident or emergency.

4. Recommendations / Actions

The Board is asked to note the results of the 2019 Emergency Preparedness Resilience and Response Assurance process and support the ongoing work of the Trust to maintain and improve its resilience capabilities.

The ROYAL MARSDEN
NHS Foundation Trust

Emergency Preparedness, Resilience and Response Assurance

1. Introduction

The Chief Nurse is the responsible Executive for the Trusts Emergency Preparedness. The purpose of the annual Emergency Preparedness, Resilience and Response (EPRR) Assurance Process is to provide evidence to NHS England that the Trust maintains comprehensive, robust arrangements in order to respond in the event of an incident or emergency.

As a Specialist Trust, the Department for Health and NHS England expect the Trust to plan for and respond to emergencies and incidents in a manner which is relevant, necessary and proportionate to the scale and services provided. By definition RMH is a Specialist Trust and a Category Two responder, however due to our location and our clearly identifiable NHS status; we are required to prepare readiness in line with the duties placed on Category One acute responders under the Civil Contingencies Act 2004.

2. Process

Providers of NHS funded care are assessed against the NHS England EPRR Core Standards, which set out the minimum standards of preparedness that an organisation must adhere to. The Core Standards cover a broad range of issues and seek to ensure that Providers have sufficient plans and arrangements in place. The Trust must demonstrate resilience in ability to provide continuous, safe standards of patient care. Each year a different detailed review topic is posed and investigated. The focus of the 2019 deep dive was Severe Weather.

The initial stage of the process is a RAG rated self-assessment of preparedness arrangements in response to 69 specific topics and a further 20 deep dive themes, which is then submitted to NHS England (London), alongside supporting evidence.

These documents are assessed, and further evidence of assurance is obtained at a review meeting attended by representatives from NHS England (London), an NHS Peer Reviewer, the Trust Accountable Emergency Officer (Eamonn Sullivan) and the Trust Risk & Resilience Manager (Diane Lee).

3. Results of the 2019 EPRR Assurance process

The Marsden completed the annual EPRR assurance process for 2019 and is pleased to report that the organisation's overall compliance rating was deemed to be 'substantially compliant' with the NHS England Core Standards – this is the same rating that the Trust has achieved for the past five years.

The assessment report concluded that the Trust has maintained its standards over the last 12 months and continues to make progress in consolidating this position.

The panel identified 6 Amber ratings for the following core standards (with actions in place to address each):

- CS14 Cold Weather.
- CS25 Trained on call staff.
- CS27 EPRR Exercising and Testing Programme.
- CS28 Strategic and Tactical Responder Training.
- CS66 Training Programme.
- CS68 Staff Training – Decontamination.

Amber (partially compliant) with the core standard recognises that the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.

There were no Red ratings.

Key priorities identified for the subsequent twelve months include:

- Training programme.
- Live Exercise.
- CBRN / Hazmat exercise/ walkthrough.
- Development of a Trust Cold or Adverse Weather Plan.
- Review the version control on all documentation.
- Work with Chelsea partners to ensure plans are consistent.

These recommendations will be taken forward and implemented ahead of the 2020 EPRR Assurance process.

4. COVID 19 EPRR Response

During wave one of the COVID Pandemic, the Trust enacted a full EPRR Command and Control response with a positive effect to maintain clinical operations, including patient and staff safety. This 'tactical/strategic' Command & Control structure remains in place at the time of writing. The Trusts focus following wave one is now on 'Recovery' with the CEO chairing a Recovery Board twice a month.

The Trust will be holding a COVID/Flu/BREXIT table-top exercise in September 2020 to prepare the organisation for forthcoming challenges.

5. Summary

The Board is asked to note the results of the 2019 Emergency Preparedness Resilience and Response Assurance process and support the ongoing work of the Trust to maintain and improve its resilience capabilities.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
15th September 2020	6.5.
Title of Document:	**To be presented by:**
Board self-assessment report	Chairman

1. Status: For Approval

2. Purpose:

Relates to:

Strategic Objective(s)	
Operational Performance	
Legal / regulatory / audit	
Accreditation / inspection	
NHS policy / consultation	
Governance	*Board development*
Other	

3. Summary

The NHS Well-Led guidance, issued by the healthcare regulator NHS Improvement, recommends that an annual self-assessment exercise is carried out by NHS Boards of Directors.

In line with this guidance, the Trust Board has completed its review and the results are enclosed for Board discussion.

4. Recommendations / Actions

The Board is asked to review the findings and approve the proposed action plan arising from the Board self-assessment.

The ROYAL MARSDEN
NHS Foundation Trust

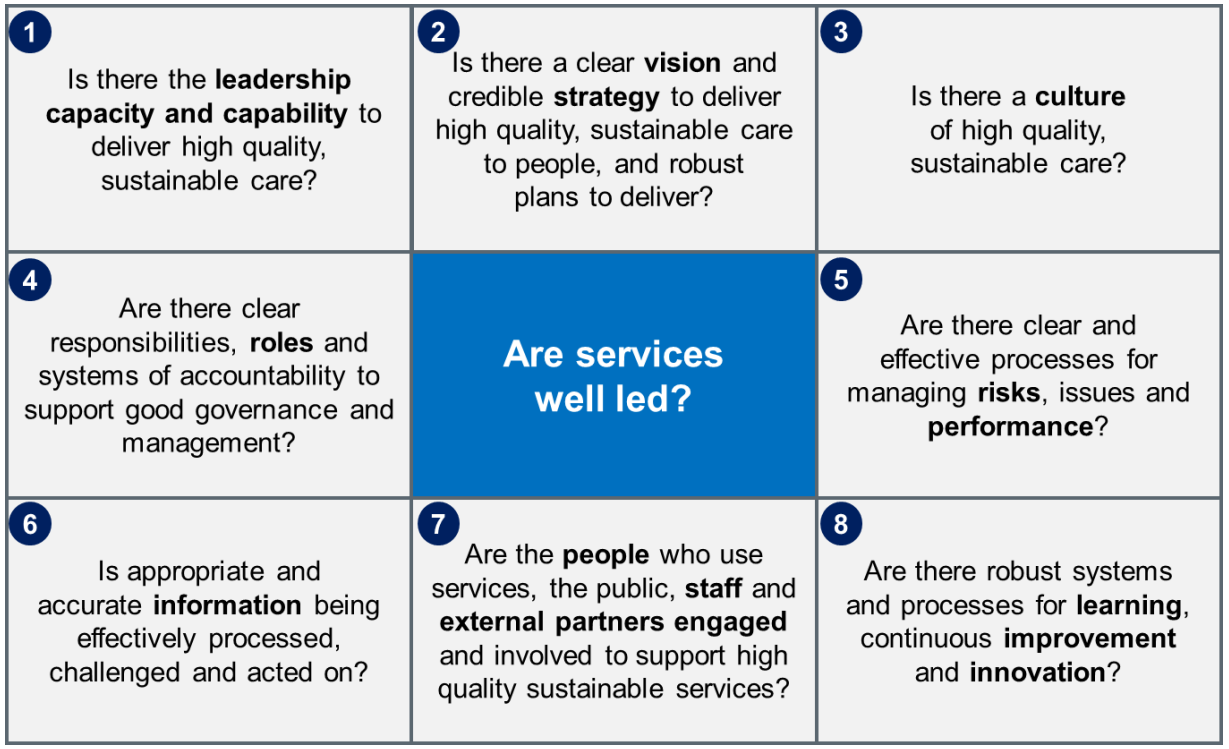
Board Self-Assessment: Results Report 2020

Contents

1. Introduction

The NHS Well-Led guidance, issued by the healthcare regulator NHS Improvement, recommends that an annual self-assessment exercise is carried out by Boards of Directors of NHS Organisations. In line with this guidance, the Trust Board has completed its review and the results are enclosed for Board discussion.

The well-led framework is structured around eight key lines of enquiry (KLOEs) and Board members have been asked to undertake a self-assessment around these KLOE. As Board members will see, recommendations have been made to continue to improve the Board's effectiveness and performance.



2. Summary of Board Responses

Board members were asked to provide a rating between 1 to 5 for each question (1 = strongly disagree, 5 = strongly agree). The results have been analysed by averaging the scores for each KLOE and cross referenced with the NHSI well led rating framework. Overall, the rating and comments received from Board members demonstrated a positive response to the Board's function and performance.

All Board members agreed that the Chairman encourages a range of views and constructive challenge. Furthermore, Board decision making includes active participation and members views are taken into account. There was widespread agreement amongst the Board members that the current Board composition has suitable and skilled representatives and has improved markedly in the last two years with the addition of new NEDs. However, it was felt strongly that diversity in terms of ethnicity and gender balance should be considered in any future Board appointments and at senior management level as well. The new members of the Board commented that they felt the induction programme was excellent and provided good oversight of the key areas of the Trust.

Board members felt that there is a strong feeling of purpose and collegiate spirit on the Board. All Board members felt passionate about their work for the Trust and take pride in the excellent personal relationships between the Non-Executive Directors and the Executive Directors to function as a unitary Board. Our CQC ratings around leadership also speak to the effectiveness of decision making and the use of the Board for oversight and debate. Non-Executive Board members agreed that the Executive Team is responding extremely well during the Covid-19 pandemic. The recent 12 months has been astonishingly difficult and Board members felt that the support from each other has been phenomenal. Board members referred to the excellent work by the internal communication team during this challenging time.

With regards the vision and strategy, Board members agreed that the vision is clear but recognised that the landscape is changing due to STPs/ICS and impending legislation and the strategy and ambitions of the Trust should be reviewed. Two Board strategy sessions have already taken place during the pandemic to discuss the future of the Trust and couple of more sessions have been organised to finalise the Trust position. Board members agreed that the executive do consider staff engagement in development of the strategy but believe that the Board could consider doing more and should have more opportunity to hear the voice of staff.

Board members strongly believe that there is a strong culture of high quality and sustainable care. It was agreed that much of the decision making the Board undertakes has absolute direct impact on this area/promise and the QAR reporting and oversight also helps with this in keeping the board vigilant. With regards the Equality and Diversity agenda it was noted that since Covid-19 and Black Lives Matter this has become even more pressing and visible inside the organisation. It was noted that the Equality and Diversity should be progressed even further and monitored via the Board or its committees.

The Board members agreed that the Board has positive and collaborative working relationships with relevant external partners and bodies and noted the significant progress made with the Institute of Cancer Research (ICR) but recognised that the relationship with the ICR should be further strengthened. With regards internal relationships, Board members felt that there is effective communication with the Governors even more so recently and Governors have expressed satisfaction at Covid-19 communication updates. The attendance of Non-Executive and Executive Director at Council of Governors meetings has also helped form good working relationships with the Governors. Board members recognised the importance of the Governors and the valuable contribution they make to the Trust. Board members felt that active engagement with Governors could be improved.

With regards to Risk and Performance Management, the Board acknowledged that there is a sound risk based approach underpinning most of the work of the Trust. The Board believes the Risk Register and Board Assurance framework are effective in monitoring risks that could impact the Trust and is made aware of any potential issues which may affect key outcomes, targets or financial performance. The Board felt that the existing range of performance measures and financial information provided is broad enough to enable the Board to monitor operational management performance. The Board also commented that the quality of care and services remained a key focus and priority and dominates the Board's thinking and strategic development.

Board members' views were sought about Board operation although this is not a KLOE. It was felt that the frequency and format of the Board meetings and agenda items were appropriate however, Board members noted that lately especially during the Covid crisis the agendas remained very full and the Board was often pressed for time. The Chair and CEO have prioritised the agenda well and while time has been tight the ability to use the time well and stay focused on the issues was very good and the discussions were succinct.

There was widespread agreement that the format of reports, particularly dashboards, are clear and informative. The Board agreed that it is adequately briefed on the business of its committees, including the key risks. There were suggestions to consider additional sessions for strategy or extended meetings while the 5-10 year sustainability strategy is being assessed. Further thought could also be given as to whether any Board committee needs to take some oversight responsibility for some of the new emerging developments such as RM Medicines and the rapidly changing external environment of ICS/STPs.

The table below shows a summary of the Trust's view against the Well-Led Framework based on the self-assessment conducted.

Key Line of Enquiry (KLOE)		**Board's View (Average scoring)**	**Risk Rating**
KLOE 1	Is there the leadership capacity and capability to deliver high quality, sustainable care?	4.8	
KLOE 2	Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	4.6	
KLOE 3	Is there a culture of high quality, sustainable care?	4.7	
KLOE 4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?	4.7	
KLOE 5	Are there clear and effective processes for managing risks, issues and performance	4.4	
KLOE 6	Is appropriate and accurate information being effectively processed, challenged and acted on?	4.5	
KLOE 7	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	4.3	
KLOE 8	Are there robust systems and processes for learning, continuous improvement and innovation:	4.2	
Additional question	Board operation/administration/governance	4.5	

Key:

4-5 score – Green

3-4 score - Amber Green

2-3 score - Amber Red

1-2 score - Red

Risk rating	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and no major omissions.
Amber-green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, some minor omissions and robust action plans to address perceived gaps with proven track record of delivery.
Amber-red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery.
Red	Does not meet expectations	Major omission in governance identified. Significant volume of action plans required with concerns regarding management's capacity to deliver.

3. Proposed Action Plan

The following action plan has been developed based on the feedback provided by Board members.

Area of Board Self-Assessment	Action
KLOE 1: Leadership, capacity and capability	• Diversity (gender balance and ethnicity) to be a key focus in the next Board appointment (Chairman/Company Secretary) • Patient Story to be explored for public Board meeting (Chief Nurse) • Staff Story to be explored for private Board meeting and other initiatives to hear the voice of staff (Chief Executive)
KLOE 2: Vision & Strategy	• Strategy to be reviewed in line with changing landscape. This is currently in progress; several discussions have already taken place at the Board strategy sessions and more sessions have been scheduled to finalise the Strategy, ambitions and the Trust's positioning (Chief Executive)
KLOE 3: Culture	• More time allocated on the Board or sub-committee agenda re the Equality and Diversity Strategy (Chief Nurse)
KLOE 4: Clear responsibilities/accountability	• Provide more understanding and clarity to the Board on accountability framework below the Executive Team level. Deep dives into areas may be considered for the future. (Chief Executive)
KLOE 5: Risk and Performance Management	• Further development of the Board Assurance Framework and Risk Appetite can be considered (Company Secretary)
KLOE 6: Quality of information	• Feedback can be sought at the end of each meeting rather than this being taken for granted. Review of Board/Committee meeting to be added to agenda and views of Board/Committees sought at each meeting (Company Secretary)
KLOE 7: Stakeholder awareness and engagement	• Relationship with ICS requires further impetus and there is also a need to enhance the

	relationship with other specialist Trusts (Chairman/Chief Executive)
KLOE 8: Robust systems, processes and continuous improvement and learning	• Topics for Board Development to be sought and Board Development Framework to be embedded (Chairman and Company Secretary)
Board Operation	• Ensure adequate time is allocated for all agenda items at Board meetings (Chairman/Chief Executive and Company Secretary)

4. Conclusion

Board members are asked to review the findings from the Board self-assessment and approve the proposed action plan.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
15 September 2020	7.1
Title of Document:	**To be presented by:**
Monthly Quality Account – August (July data) 2020	Chief Nurse

1. Status Discussion

2. Purpose:

Operational Performance	✓

3. Summary

In the July QA Dashboard we have introduced additional Infection Prevention and Control reporting under 'safe care' which includes:

- COVID-19 positive tests for staff and patients
- Personal Protective Equipment (PPE) audit results
- Hand Hygiene

Good Performance:

- Reduction in attributable E.coli and overall C.Diff
- No moderate falls
- No Category 4 HAPU since May 2019 and reduction in DTI's
- Overall Trust VTE compliance met
- Increased FFT responses
- Trust sickness rate decreased 3.5% to 3.1% and Nurse from 3.7% to 3.6%

Area for Improvement / Note:

- Unexpected death following a fall. Currently under investigation, cause of fall/arrest as yet unknown.
- An increased number of PU's including cat 3. Panels underway to determine learning and attributability. Deep dive into areas with increased PU's and additional training and support on wards
- An increased number of overall falls with Trust wide environment review undertaken
- Sutton Chemotherapy waiting time due to reporting change and further investigation underway
- Nurse vacancy rate increased from 10.4% to 10.6% and nurse turnover rate increased from 13.0% to 13.5%

4. Recommendations / Actions

The Board is asked to note the monthly Quality Accounts.

The Royal Marsden NHS Foundation Trust

Monthly Quality Account

AUGUST 2020 (July Data)

A report by the Chief Nurse: Eamonn Sullivan

Monthly Quality Account – Table of Contents

Quality Account Dashboard 2020-21

Indicator		Annual Target	Aim	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	2019/20
Safe care																	
Hospital Standardised Mortality Rate (rolling 12 months, NHS and PP)		80	Below	85.97 (Q4 19/20)			(Q1 20/21)			(Q2 20/21)			(Q3 20/21)				N/A
Mortality audit		Green		G (Q1 20/21)			(Q2 20/21)			(Q3 20/21)			(Q4 20/21)				N/A
SIs: Number of SIs (including PU cat 4)		7	Below	0	1	0	2									3	7
Number of diagnoses of Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia		0	Below	0	0	0	0									0	1
Number of diagnoses of Methicillin-sensitive *Staphylococcus aureus* (MSSA) (Attributable)		6	Below	0	0	1	1									2	6
Clostridium difficile (C. Diff)	Number of reportable cases - Community Onset Hospital Associated and Hosptial Onset Hospital Associated	67		6	4	7	3									20	58
E-Coli	Total number of E-Coli Bacterium	65		7	4	6	6									23	72
	Number of Attributable E-Coli Bacterium	No target		2	3	4	2									11	35
Covid-19 positive tests (shadow reporting until Q3)	Patients (P)	No target		357 (P=76; S=281)			5 (P=1; S=4)									362 (P=77; S=285)	N/A
	Staff (S)																
PPE audit results	Chelsea	95%		N/A	N/A	N/A	100.0%									100.0%	N/A
	Sutton	95%		N/A	N/A	N/A	95.2%									95.2%	N/A
Hand hygiene	Trust	95%		N/A	N/A	N/A	98.5%									98.5%	N/A
Sepsis	% of inpatients screened for sepsis	90%	Above	100.0%												100.0%	98.9%
	% of those screened positive who received IV abx within 1 hour	90%	Above	100.0%												100.0%	98.9%
Falls	Attributable Moderate Harm Incidents while patient under RMH care	5	Below	1	0	1	0									2	5
	Attributable Major Harm Incidents while patient under RMH care	0	Below	0	0	0	0									0	0
	Attributable Death Incidents	0	Below	0	0	0	1									1	0
Number of patients with attributable pressure ulcers	Number of patients	No target		11	12	14	17									54	101
	Category 1	No target		2	2	3	4									11	21
	DTI	No target		1	1	4	1									7	14
	Category 2	No target		5	5	7	8									25	55
	Category 3	No target		0	3	0	2									5	3
	Unstageable	No target		3	1	0	2									6	6
	Category 4	0	Below	0	0	0	0									0	2
Number of attributable medication incidents with moderate harm and above		9	Below	0	0	0	0									0	4
Number of cardiac arrests		No target	Below	1	5	2	3									11	20
Failure to recognise deterioration in a patient leading to death		0	Below	0	0	0	0									0	1
VTE risk assessment		95%	Above	96.2%	96.2%	95.7%	95.4%									95.8%	96.8%
Effective Care																	
Chemotherapy waiting times: % chemo patients starting treatment within 1 hr of appointment time	Chelsea	85%	Above	84.9%	88.0%	88.5%	84.2%									86.3%	76.4%
	Sutton	85%	Above	82.4%	79.4%	79.7%	71.8%									78.1%	78.2%
	Kingston	85%	Above	95.4%	96.3%	92.7%	94.2%									94.6%	87.4%
Chemotherapy waiting times: % chemo patients starting treatment within 3 hrs of first appointment of day	Chelsea	85%	Above	76.4%	75.3%	73.6%	78.1%									76.0%	72.8%
	Sutton	85%	Above	83.3%	82.1%	85.7%	84.9%									84.1%	81.7%
	Kingston	85%	Above	95.8%	95.4%	97.8%	98.2%									96.9%	94.3%
Caring																	
RMH Inpatient Friends and Family Test: % Recommended		95%	Above	98.6%	100.0%	99.2%	99.3%									99.3%	97.4%
RMH Inpatient Friends and Family Test: Number of responses		No target		73	78	126	144									421	3005
Responsive																	
% of complaints responded to in required timescale		81%	Above	100.0%	100.0%	100.0%	100.0%									100.0%	79.0%
Number of complaints		No target		3	8	3	8									22	103
Number of complaints per 1000 inpatient discharges		10.04	Below	4.58	9.82	3.42	9.13									6.82	10.04
Number of concerns received		No target		10	10	27	16									63	369
Number of compliments received		No target		32	124	79	60									295	1,338
Well-led																	
Number of Freedom To Speak Up (FTSU) alerts		No target		15												15	56
Trust vacancy rate		7%	Below	11.0%	10.9%	10.9%	10.9%									10.9%	10.7%
Trust sickness rate		3%	Below	6.7%	6.9%	3.5%	3.1%									5.0%	3.5%
Nurse vacancy rate		8%	Below	9.6%	9.4%	10.4%	10.6%									10.0%	9.4%
Nurse sickness rate		3%	Below	7.1%	8.4%	3.7%	3.6%									5.7%	3.6%
Nurse turnover rate		12%	Below	14.5%	13.4%	13.0%	13.5%									13.6%	15.2%

Cancer Services Divisional Dashboard 2020-21

Indicator		*Annual Target - Trust Level*	Aim	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD
Safe care																
SIs: Number of SIs (including PU cat 4)		7	Below	0	0	0	2									2
Number of diagnoses of Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia		*0*	Below	0	0	0	0									0
E-Coli	Total number of E-Coli Bacterium	*65*		4	2	3	3									12
	Number of Attributable E-Coli Bacterium	*No target*		2	2	3	2									9
Falls	Attributable Moderate Harm Incidents while patient under RMH care	5	Below	0	0	0	0									0
	Attributable Major Harm Incidents while patient under RMH care	0	Below	0	0	0	0									0
	Attributable Death Incidents	0	Below	0	0	0	1									1
Number of patients with attributable pressure ulcers	Number of patients	*No target*		4	6	4	7									21
	Category 1	*No target*		1	0	0	0									1
	DTI	*No target*		0	1	0	0									1
	Category 2	*No target*		0	3	4	5									12
	Category 3	*No target*		0	2	0	1									3
	Unstageable	*No target*		3	0	0	1									4
	Category 4	*0*		0	0	0	0									0
Number of attributable medication incidents with moderate harm and above		9	Below	0	0	0	0									0
Number of cardiac arrests		No target	Below	0	0	1	2									3
Failure to recognise deterioration in a patient leading to death		0	Below	0	0	0	0									0
VTE risk assessment		*95%*	Above	96.3%	95.4%	95.8%	95.9%									95.8%
Caring																
RMH Inpatient Friends and Family Test: % Recommended		95%	Above	98.6%	100.0%	100.0%	98.9%									99.3%
RMH Inpatient Friends and Family Test: Number of responses		*No target*		73	73	66	95									307
Responsive																
% of complaints responded to in required timescale		81%	Above	100.0%	NA	100.0%	100.0%									100.0%
Number of complaints				2	3	1	6									12
Number of concerns received				5	8	19	12									44
Number of compliments received				9	124	75	50									258
Well-led metrics are Trust wide and included in Trust QA																

Clinical Services Divisional Dashboard 2020-21

Indicator		*Annual Target - Trust Level*	Aim	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD
Safe care																
SIs: Number of SIs (including PU cat 4)		7	Below	0	0	0	0									0
Number of diagnoses of Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia		*0*	Below	0	0	0	0									0
E-Coli	Total number of E-Coli Bacterium	*65*		1	0	2	2									5
	Number of Attributable E-Coli Bacterium	*No target*		0	0	0	0									0
Falls	Attributable Moderate Harm Incidents while patient under RMH care	5	Below	0	0	0	0									0
	Attributable Major Harm Incidents while patient under RMH care	0	Below	0	0	0	0									0
	Attributable Death Incidents	0	Below	0	0	0	0									0
Number of patients with attributable pressure ulcers	Number of patients	*No target*		4	3	8	4									19
	Category 1	*No target*		1	1	2	2									6
	DTI	*No target*		1	0	3	1									5
	Category 2	*No target*		2	1	3	1									7
	Category 3	*No target*		0	0	0	0									0
	Unstageable	*No target*		0	1	0	0									1
	Category 4	*0*		0	0	0	0									0
Number of attributable medication incidents with moderate harm and above		9	Below	0	0	0	0									0
Number of cardiac arrests		No target	Below	1	5	1	0									7
Failure to recognise deterioration in a patient leading to death		0	Below	0	0	0	0									0
VTE risk assessment		*95%*	Above	97.4%	96.3%	100.0%	93.1%									96.7%
Caring																
RMH Inpatient Friends and Family Test: % Recommended		95%	Above	NA	100.0%	98.3%	100.0%									NA
RMH Inpatient Friends and Family Test: Number of responses		*No target*		0	5	60	49									114
Responsive																
% of complaints responded to in required timescale		81%	Above	NA	100.0%	NA	100.0%									NA
Number of complaints				1	3	0	1									5
Number of concerns received				2	2	4	2									10
Number of compliments received				4	0	1	1									6
Well-led metrics are Trust wide and included in Trust QA																

Private Patients Divisional Dashboard 2020-21

Indicator		Annual Target - Trust Level	Aim	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD
Safe care																
SIs: Number of SIs (including PU cat 4)		7	Below	0	1	0	0									1
Number of diagnoses of Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia		*0*	Below	0	0	0	0									0
E-Coli	Total number of E-Coli Bacterium	*65*		2	2	1	1									6
	Number of Attributable E-Coli Bacterium	*No target*		0	1	1	0									2
Falls	Attributable Moderate Harm Incidents while patient under RMH care	5	Below	1	0	1	0									2
	Attributable Major Harm Incidents while patient under RMH care	0	Below	0	0	0	0									0
	Attributable Death Incidents	0	Below	0	0	0	0									0
Number of patients with attributable pressure ulcers	Number of patients	*No target*		3	3	2	6									14
	Category 1	*No target*		0	1	1	2									4
	DTI	*No target*		0	0	1	0									1
	Category 2	*No target*		3	1	0	2									6
	Category 3	*No target*		0	1	0	1									2
	Unstageable	*No target*		0	0	0	1									1
	Category 4	*0*		0	0	0	0									0
Number of attributable medication incidents with moderate harm and above		9	Below	0	0	0	0									0
Number of cardiac arrests		No target	Below	0	0	0	1									1
Failure to recognise deterioration in a patient leading to death		0	Below	0	0	0	0									0
VTE risk assessment		*95%*	Above	95.3%	98.6%	84.3%	92.8%									92.9%
Caring																
RMH Inpatient Friends and Family Test: % Recommended		95%	Above	No data	No data	No data	No data									
RMH Inpatient Friends and Family Test: Number of responses		*No target*														
Responsive																
% of complaints responded to in required timescale		81%	Above	NA	NA	NA	NA									NA
Number of complaints				0	2	1	1									4
Number of concerns received				3	0	4	0									7
Number of compliments received				19	0	2	9									30
Well-led metrics are Trust wide and included in Trust QA																

Healthcare Associated Infections & Hand Hygiene

Data Owner: Pat Cattini – Lead Nurse & Deputy Director of Infection Prevention and Control.

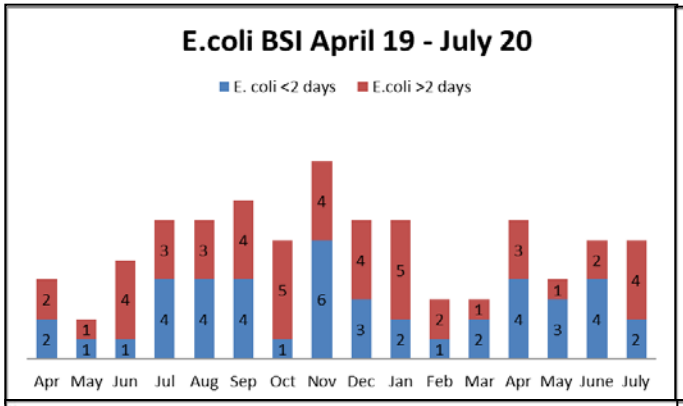
A review of all cases of reportable infections is in place to identify learning and opportunities for improvement through a healthcare infection review learning panel.

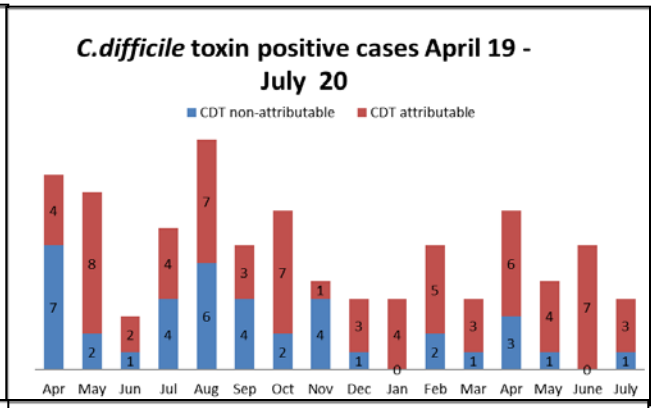
E.coli numbers are steady and on trajectory.

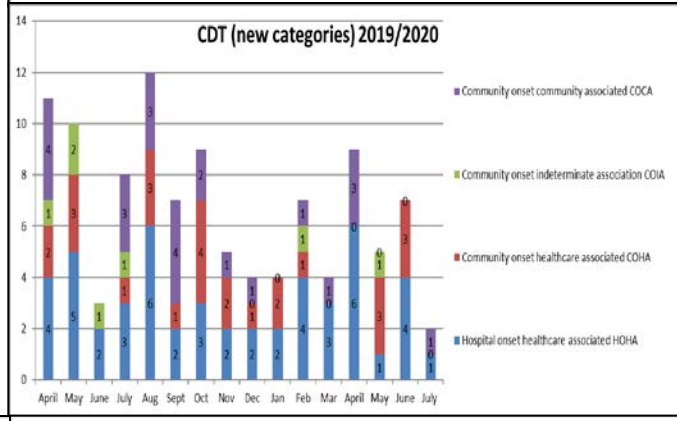
C.difficile numbers remained within trajectory.

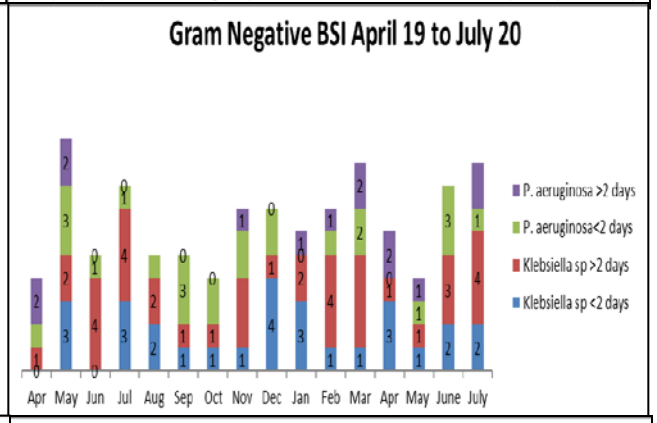
Hand hygiene & commode cleaning compliance is overall very good. We continue to work with the matrons to ensure this is maintained using the new *Perfect Ward* app.

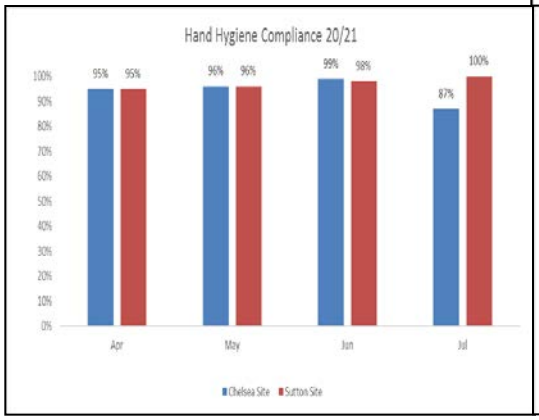
The IPC and Micro Teams continue to support the C-19 effort. There remains a focus on face mask fit testing and donning and doffing of PPE. Advice also includes patient flows, assessment of working environments and continued staff support.

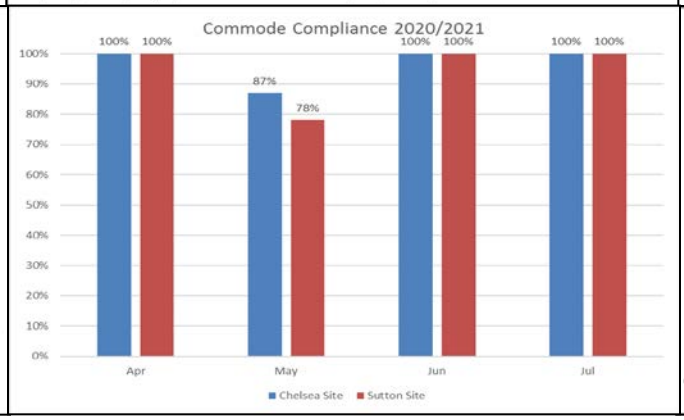


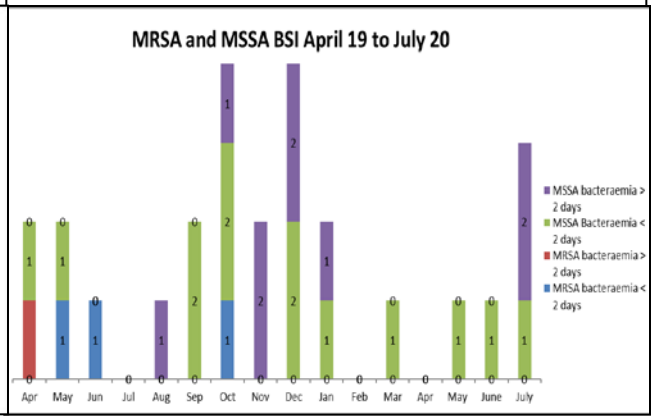




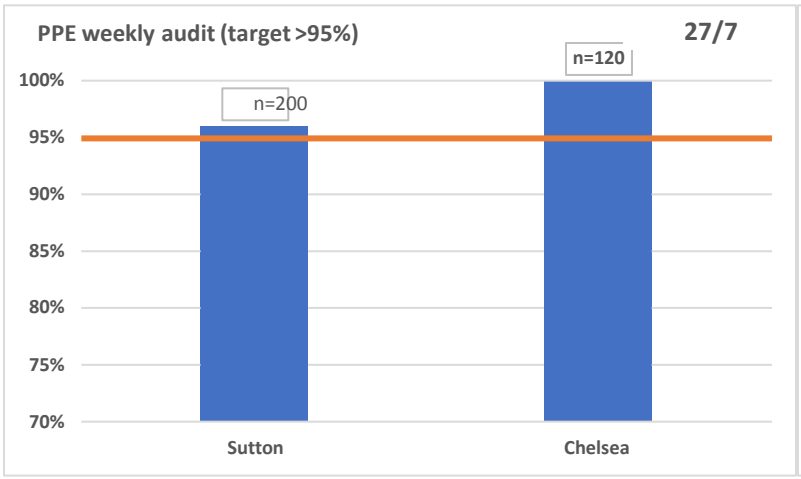


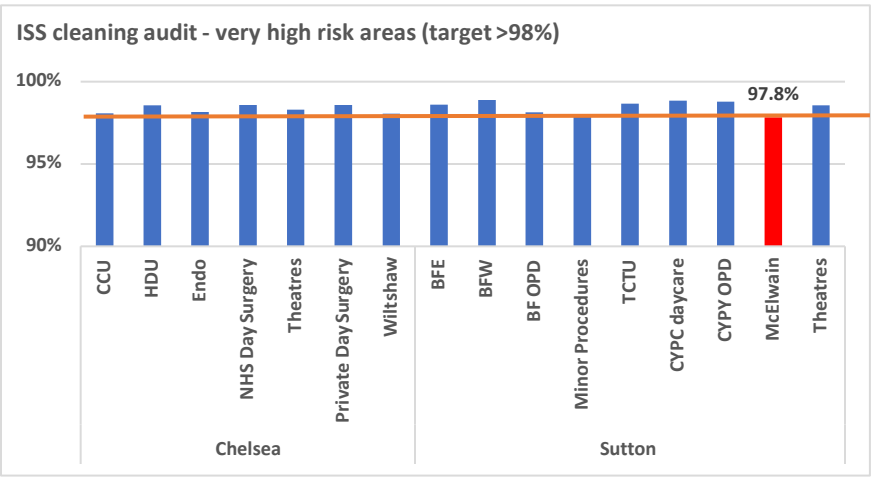


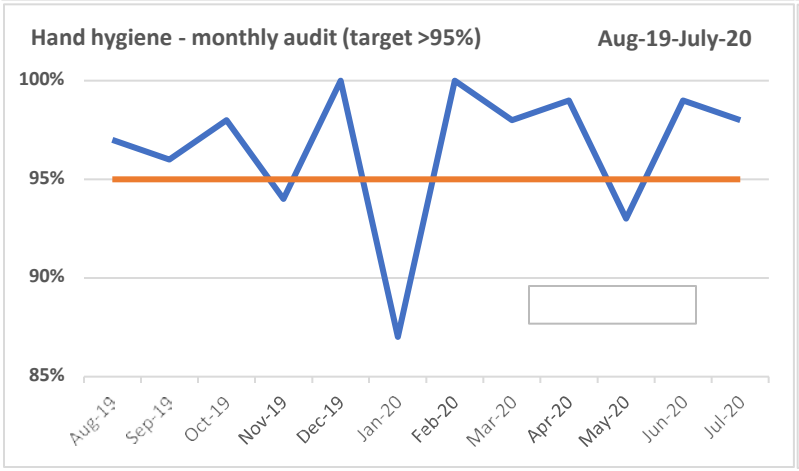


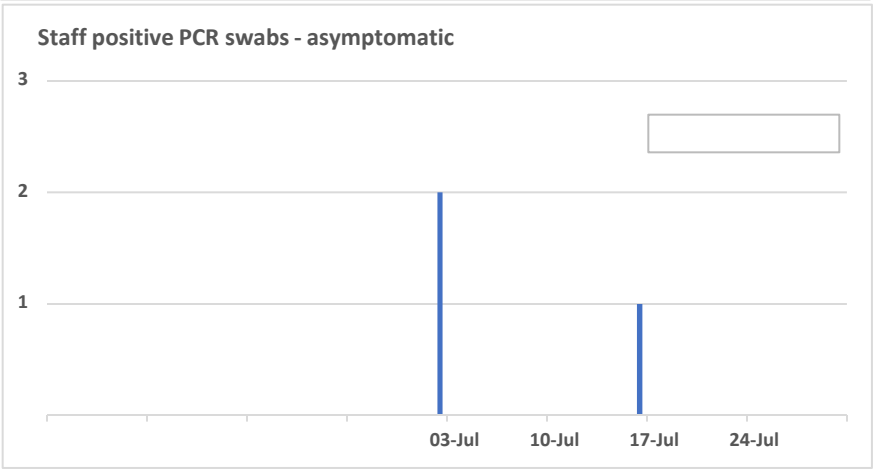


Infection Prevention & Control - COVID-19









This is a new slide detailing key assurance information relating to COVID 19. The Trust now undertakes fortnightly PPE compliance audits – compliance is generally excellent in the clinical areas, with slightly lower compliance in corridors/transit areas, where staff or visitors very occasionally forget to wear, or wear facemasks incorrectly. This slide also details ISS cleaning compliance across clinical areas, and new staff or patient positive COVID-19 cases. In the case of a new staff or patient positive COVID result (which can come via RM screening or externally via NHS Track/Trace) – the result prompts a same day Executive level root cause analysis – seven days per week. To date four of these reviews have occurred and in all cases the positive cases were deemed low risk community transmissions, with no cross infection/outbreaks occurring.

Patient Fall Incidents

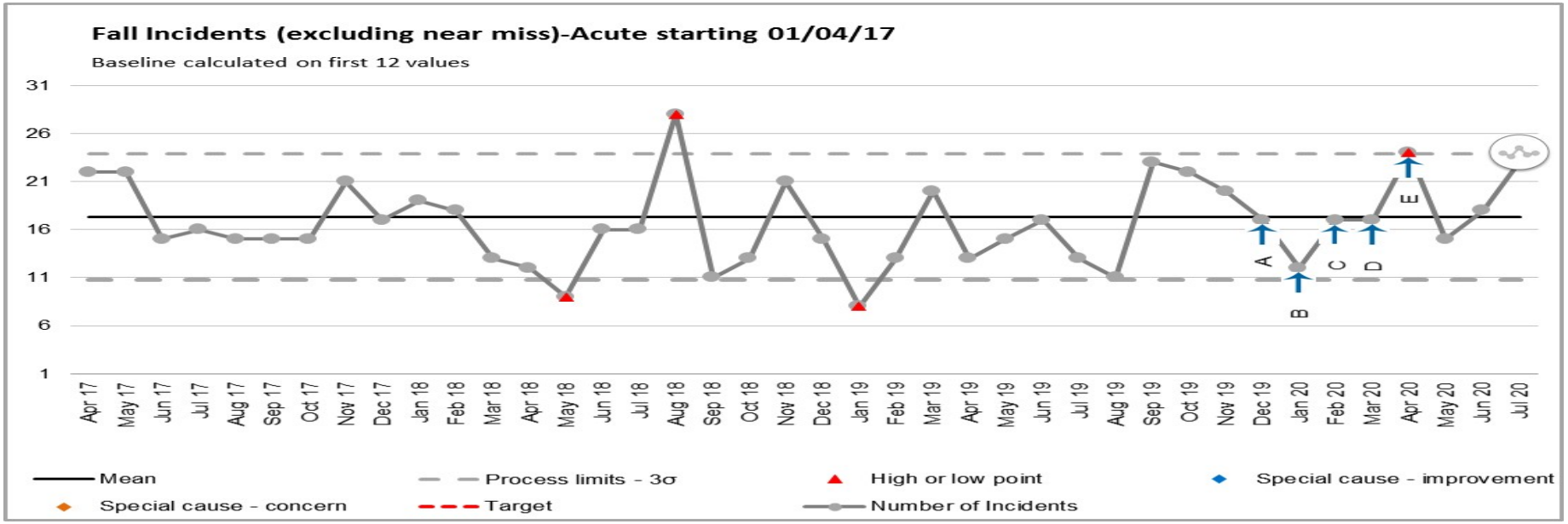
Target: <0.7 falls with moderate or above harm

Data Owner : Teresa Deakin Matron The Graph below details falls (no and low harm) overlaid with critical improvement interventions over the past 12 months. Importantly Moderate and above harm events (a falls related fracture or significant head injury).

Trends: There have been 0 falls with moderate harm in the month of July however there has been an increase in the number of falls.

Themes: Areas with side rooms have an increase number of falls

Actions: Cross site ward reviews continue in order to identify any reasoning behind the increase in reported falls this month. Learning opportunities being identified such as a falls e-learning package, falls champions and appropriate study days. New patient 'call don't fall' placements and signage ordered.



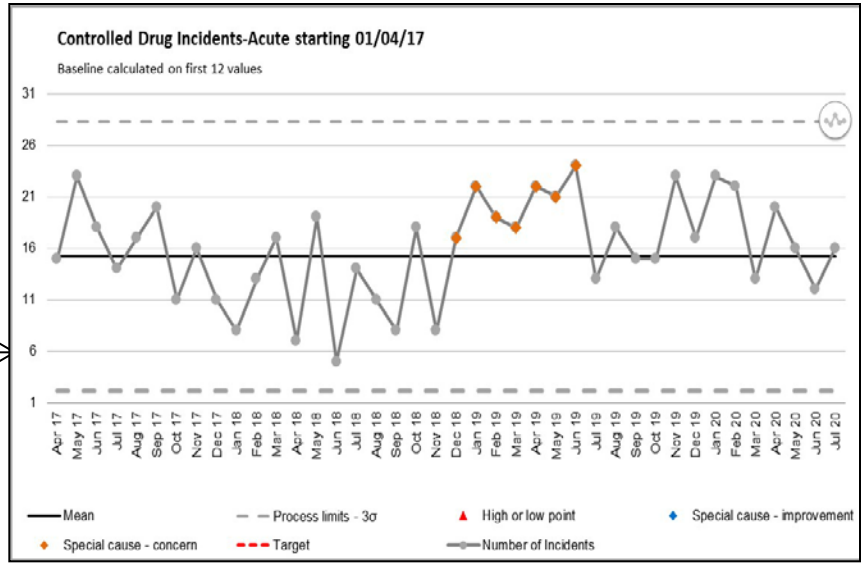
Key Interventions

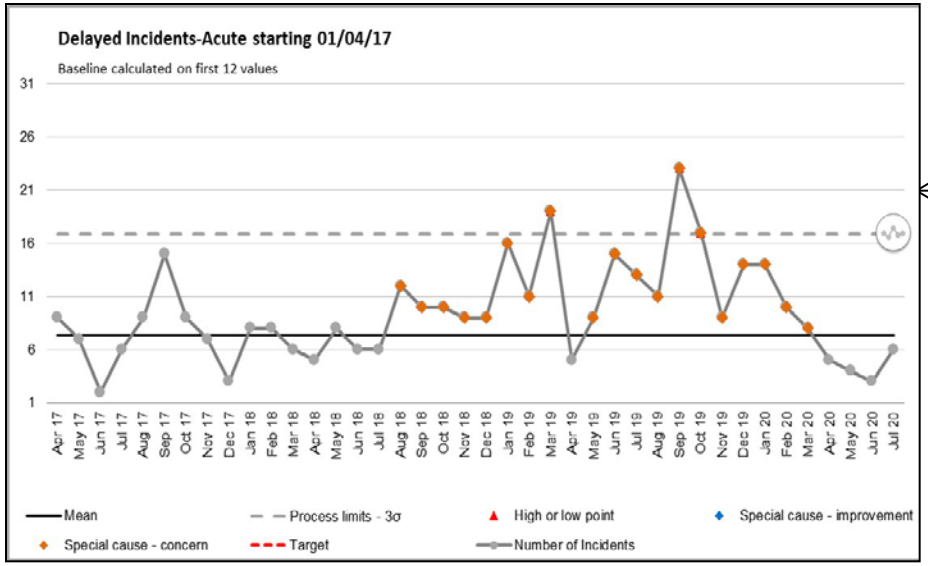
A	Introduction of Harm Free Care documentation
B	Lying and Standing BP added to NEWS charts
C	Falls CQUIN interventions awareness event
D	Improvement of Sutton entrance and outside areas
E	Equipment review

Medication Incidents

Data Owner: Suraya Quadir, Medication Safety Officer.
There were 148 medication incidents this month, of which 30% were due to chemotherapy reactions when used as intended. The majority of this month's incidents were no harm (84%) and low harm (16%).

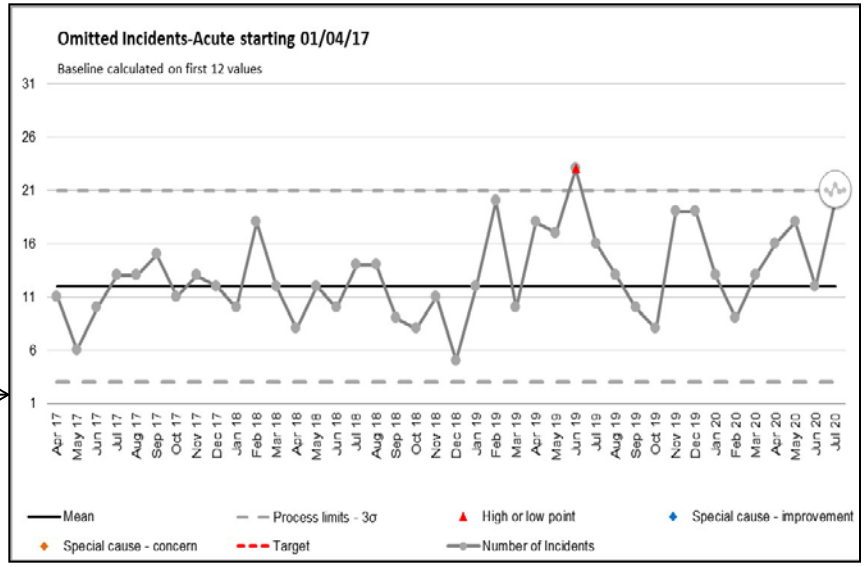
CD Incidents (14) : The main themes this month were *administration incidents* (4) due to delayed medication, wrong dose, wrong formulation and *accounted for losses* from liquid discrepancies through measurement and spillage (4).





Delayed medicines (6) : All incidents referred to critical medicines. The main group was delay in chemotherapy administration (3) due to delay in chemo preparation, syringe fault and first course treatment not administered out of hours.

Omissions (20): Of these incidents 55% referred to critical medicines. The main group was chemotherapy (6) which were not administered as according to the chemotherapy proforma. Follow up actions included ensuring appropriate skill mix to administer and updating the proforma to ensure clarity.



Hospital Pressure Ulcers* – excluding category 1

Target: Zero grade 4 pressure ulcers

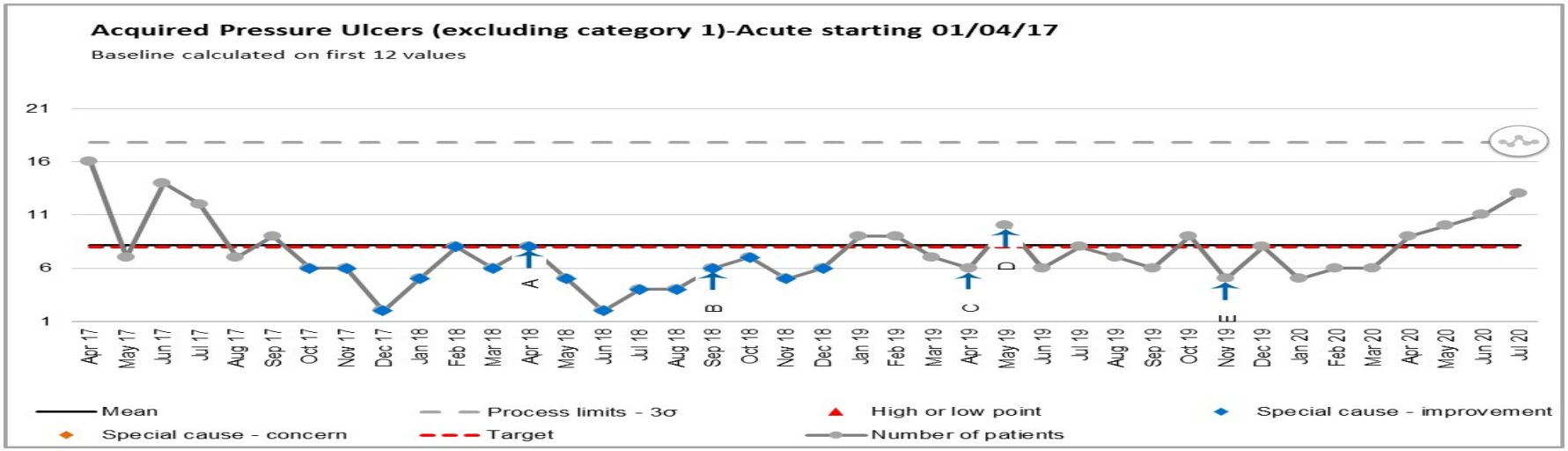
Data owner: Carla Nunes CNS Tissue Viability

In July we had n=13 Hospital Acquired Pressure Ulcers (HAPU) excluding category 1: Eight category 2, two category 3, two Unstageable and two Suspected Deep Tissue Injury (SDTI). There is an increase in the total of HAPU and level of harm with two Moderate Harm PU under panel review.

Trends: n=3 in Wilson, n=2 in CCU and n=2 in Robert Tiffany; n=7 in Chelsea and n=5 in Sutton wards.

Themes: n=2 patient at EoL, n=2 HAPU related to incontinence, n=5 HAPU caused by medical devices (n=1 anti-embolic socks, n=2 NGT, n=2 tracheostomy cannula). n=1 category 3 HAPU resulted from deterioration from a category 2 in a patient transferred between wards. n=1 moderate harm unstageable PU and n=1 moderate harm category 3 may have been imported from home/another hospital however there was inaccurate skin inspection/Nursing documentation and delay in obtaining Medical Photography.

Actions: Deep dive into areas with increased PU's. Focused training and trials in Theatres and in Chelsea Wards with regards to NGT fixation technique and tape ongoing; spike in HAPU highlighted to Wards Managers/Matrons and TV Champions; extra support/training sessions delivered to TV Champions during monthly/extra weekly meetings focusing on PU prevention, however with poor attendance. TVS planning ASSKING bundle training drop-in sessions across sites.



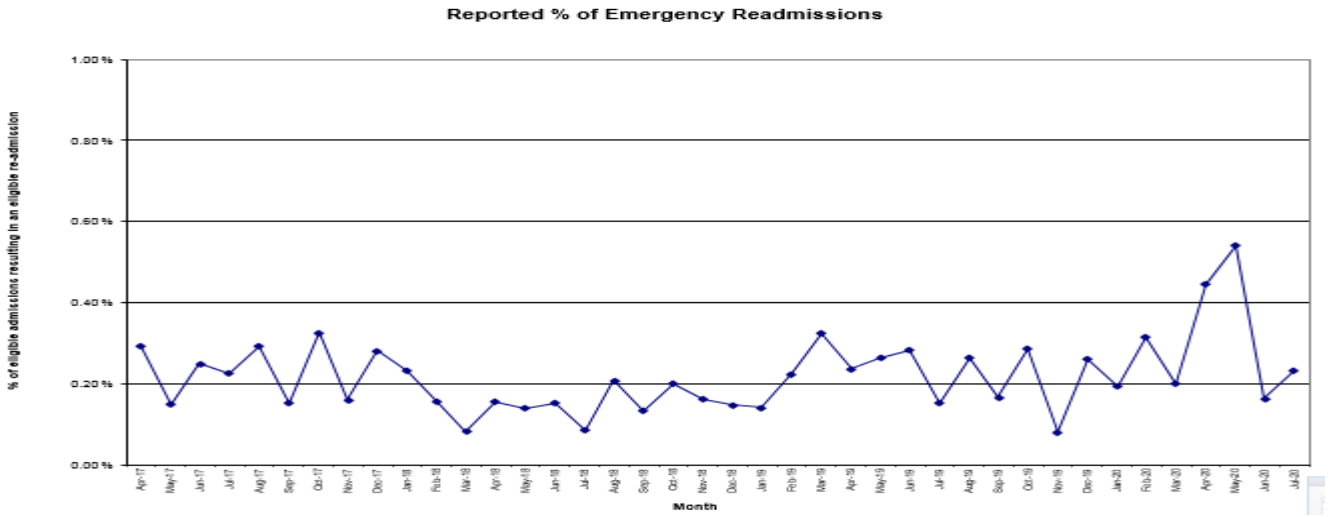
Key Interventions

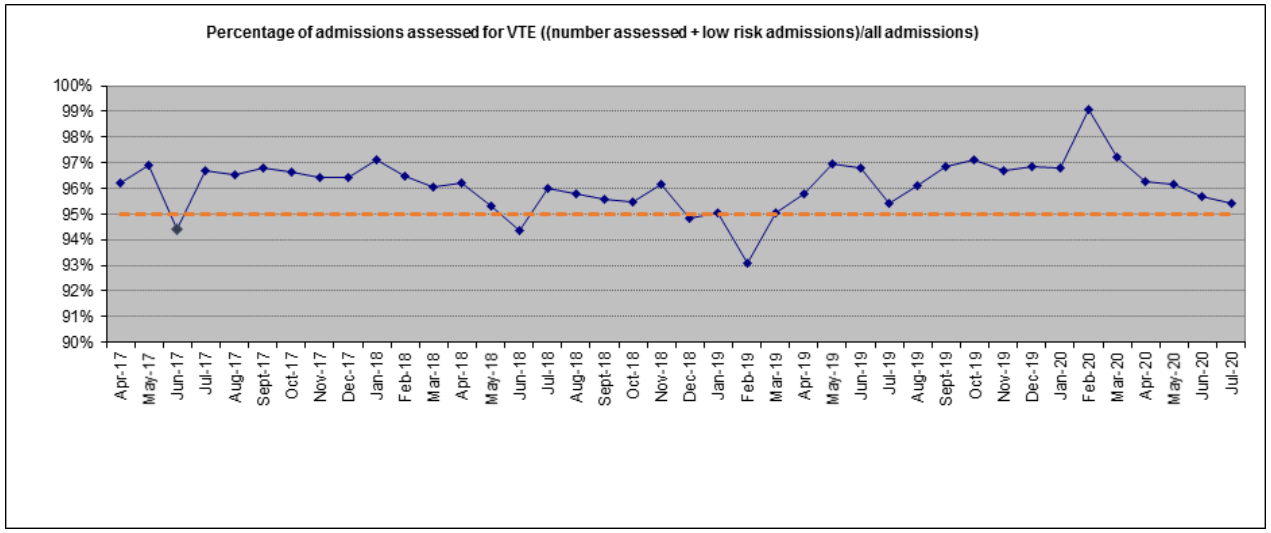
A	Introduction of Mini Root Cause Analysis & Prevalence & Quality Audit
B	Launch of Tissue Viability Champions Training
C	Launch of aSSKINg Bundle
D	Prevalence & Quality Audit
E	Launch of Harm Free Care Bundle & Wound Assessment Plan

Readmission Performance / Hospital VTE Screening

(July 2020 Data)

Table 7.0 Hospital Readmissions Summary





Readmissions Summary Data July 2020: Joanna Waller DND

There were 11 readmissions in July, 6 of which related to symptom control. Review of these readmissions showed none were admitted with COVID related symptoms. The remaining readmissions showed no other clusters.

VTE data July 2020: Joanna Waller DND

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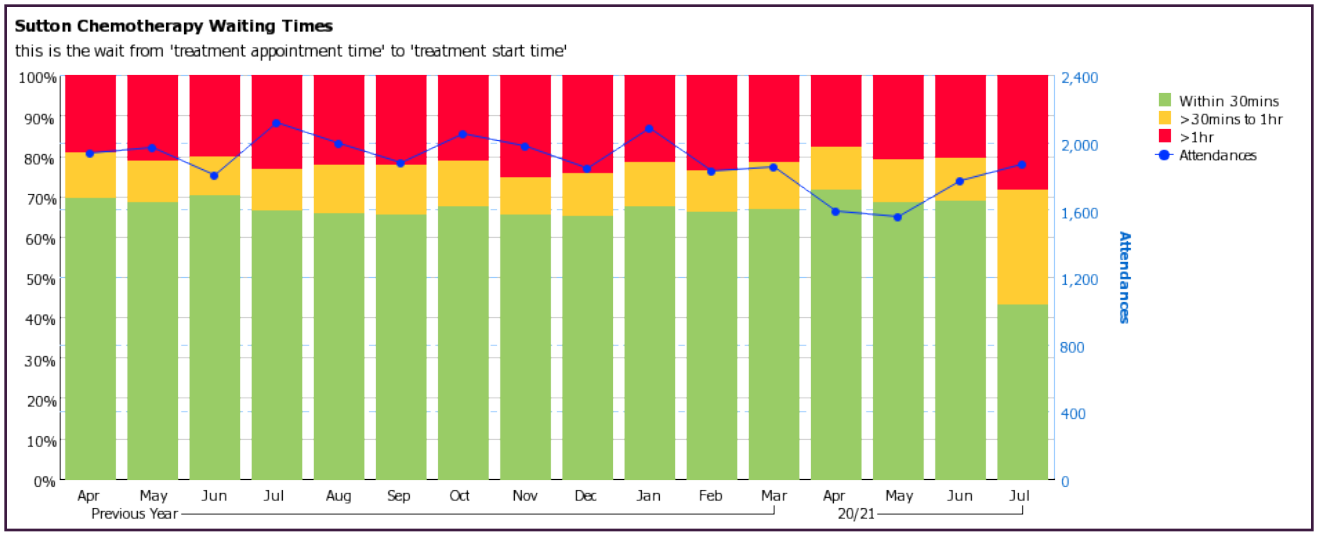
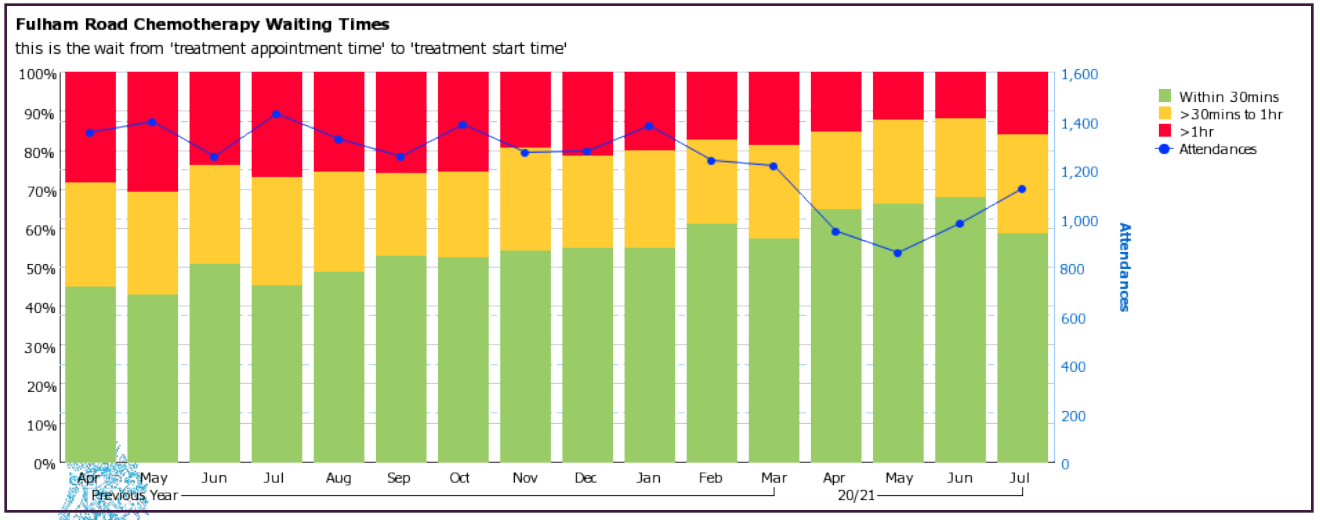
VTE passed in July – 95.4%. Slight decline (0.3%) attributable to patients moving between wards within 24 hours of admission. A further drive has been made to encourage electronic reporting.

Chemotherapy Waiting Times & Prescribing





Data Owner: Helen Benson, Chief Pharmacist

Chemotherapy attendances are continuing to grow following the COVID-19 pandemic.

Unfortunately, we have seen patient waiting times increase during the month of July, particularly on the Sutton site. This may be due to changing the way chemotherapy wait times are being recorded (to standardise approach across both sites) at the beginning of the month. This is currently being investigated and an update will be provided by the end of August.

Validation of the new pharmacy aseptic suite on the Chelsea site is underway and opening is scheduled for the end of September 2020.

Patient Experience

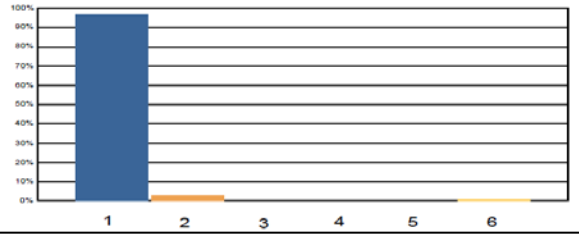
Service

Clinical Services

Star Rating

Positive	Negative
99.28%	0.00%

Overall Scores



Response Option	Responses	Percentage
1 - Very good	133	96.38%
2 - Good	4	2.90%
3 - Neither good nor poor	0	0.00%
4 - Poor	0	0.00%
5 - Very poor	0	0.00%
6 - Don't know	1	0.72%

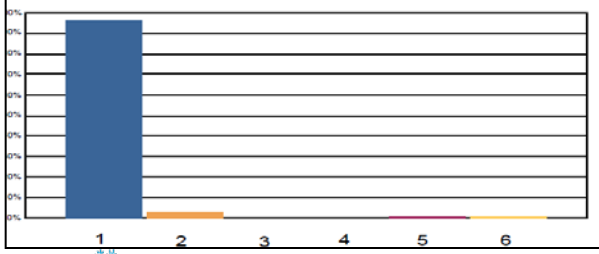
Service

Cancer Services

Star Rating

Positive	Negative
98.86%	0.57%

Overall Scores



Response Option	Responses	Percentage
1 - Very good	169	96.02%
2 - Good	5	2.84%
3 - Neither good nor poor	0	0.00%
4 - Poor	0	0.00%
5 - Very poor	1	0.57%
6 - Don't know	1	0.57%

Patient Experience Feedback Summary

The numbers of responses has increased in July however remains impacted upon due to the COVID-19 pandemic.

The submission of friends and family test has been temporarily suspended due to the COVID-19 pandemic. However, the Trust is continuing to collect responses and collate the data locally.

The launch of the new Friends and Family Test put on hold, however it is anticipated that this will launch in October 2020. Face to face training for staff on the applications and patient experience dashboard has also been put on hold, however we are working with our provider to send out webinar training to staff

The Patient Experience Commitment is now in place and the first Quality and Patient Experience Committee was held in July 2020. Recruitment of chairs for the Sutton, CYP and Chelsea patient experience groups is underway with the first meetings to be held in September 2020.

Patient Experience

The patient comments below are captured via our paper FFT comments cards in July 2020. Information is fed back directly to ward teams. Ward Sisters and Matrons review the data as it arrives and action appropriately. The information is also reviewed at the CBU Performance Review meetings.

Examples of positive comments this period

Attentive, prompt, courteous, friendly and professional constantly. I cannot imagine how it could be improved. Clinical Assessment Unit

Amazing compassion and professionalism. Comfortable beds and very attentive staff. Bravo! Critical Care Unit

The care I have received has been fantastic - all staff are so attentive and have made me feel that I am so important to them. Staff cannot do enough and once all has been done on each visit they all ask Is There Anything I Can Do For You?! The food is brilliant. Wards, actually are not enough. I think we all miss hugs at this weird time of C19. Virtual hugs. Ellis Ward

Nurse looked after me well, she kept me informed about my treatment at each stage. Nurse responded well to any questions I had, I was treated promptly and efficiently. MDU

Everyone so kind and helpful, I felt comfortable and confident that I was in good hands. PP Surgical Unit

So attentive and supportive and friendly. Explained everything clearly and followed up additional question effectively and quickly. Very caring and gentle. Never seemed rushed and always listened. Took time with you. Nothing ever seemed like too much trouble. Fun and made me laugh. Reassurance. Made me feel very safe. Thank you so much - you made a difficult time seem like a breeze.
Smithers Ward

Comments where care can be improved this period

Lovely team, great care and kindness, medical expertise. Noisy bells at night, food is repetitive if you are here a long time and portions are too big for me. **BudFlanagan East Ward**

Good, superb, supportive manner of all staff. Friendly faces, prepared to share a joke, helpful in providing requested items; sensitive to patients needs and concerns. Food quality and selection available, room kept spotlessly clean and tidy. All staff happy to engage in uplifting banter to help keep positive mood in tough circumstances. Bad, but important- did not change the bathroom soap dispenser despite being asked 4 times as we are told so often TV wash our hands, this is a central nor trivial matter.
Kennaway Ward

Good: Friendliness of all staff on ward. Food and choice. Constant attention of staff. Clinical care confidence. Improvement: Lack of aural privacy and confidentiality between patients caused by small space for wards. Accurate advance information on appointment timings, etc. No room for staff to do their job, battling around curtains. Oak Day unit

Left waiting in outpatients clinic for three hours. No communication. Everyone I asked told me You Are Next. Don't give unrealistic appointment times. Outpatients Chelsea

The care from all the staff from reception, doctors and radiation. The good humor of the staff in the hospital. The punctuality of appointments and when there were delays, they were for genuine reasons and with apologies. The phone response is very bad! The Pharmacy is very slow! Radiotherapy - Chelsea

Patient Experience

National Friends & Family Test Data (RM data as of May 2020 – Against February 2020 National data. Due to COVID19, national uploads are on hold therefore data from March 2020 is not available)

Inpatient data was collected for 177 Acute NHS trusts and independent sector providers. Nationally, the overall average percentage for those who would recommend the service to friends and family was 96% in February 2020. **The trust is above this with a score of 98 %.**

Outpatient data was collected for 238 Acute NHS trusts and independent sector providers. Nationally the overall average percentage for those who would recommend outpatients to friends and family was 94% in February 2020, **The trust is above with a score of 96 %**

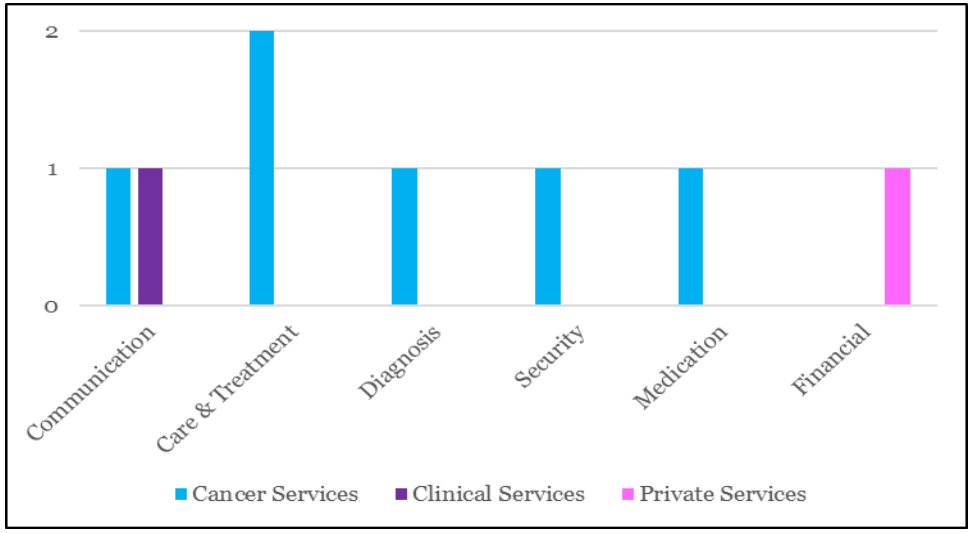
INPATIENTS FFT	Q2 19/20	Q3 19/20	Q4 19/20	April 20	May20	June 20	July 20
The Royal Marsden inpatients who would recommend	97%	97%	National upload suspended due to COVID-19	National upload suspended due to COVID-19	National upload suspended due to COVID-19	National upload suspended due to COVID-19	National upload suspended due to COVID-19
National average	96%	96%	National upload suspended due to COVID-19	National upload suspended due to COVID-19	National upload suspended due to COVID-19	National upload suspended due to COVID-19	National upload suspended due to COVID-19
Response number	**805**	**707**	**National upload suspended due to COVID-19**	**National upload suspended due to COVID-19**	**National upload suspended due to COVID-19**	**National upload suspended due to COVID-19**	**National upload suspended due to COVID-19**

OUTPATIENTS FFT	Q2 19/20	Q3 19/20	Q4 19/20	April 20	May 20	June 20	July 20
The Royal Marsden outpatients who would recommend	94%	96%	National upload suspended due to COVID-19	National upload suspended due to COVID-19	National upload suspended due to COVID-19	National upload suspended due to COVID-19	National upload suspended due to COVID-19
National average	94%	94%	National upload suspended due to COVID-19	National upload suspended due to COVID-19	National upload suspended due to COVID-19	National upload suspended due to COVID-19	National upload suspended due to COVID-19
Response number	**1814**	**1271**	**National upload suspended due to COVID-19**	**National upload suspended due to COVID-19**	**National upload suspended due to COVID-19**	**National upload suspended due to COVID-19**	**National upload suspended due to COVID-19**

Patient – Complaints

Complaints Summary: 8 new complaints were opened in July 2020. 6 complaints were for Cancer Services, 1 complaint for Clinical Services and 1 complaint for Private Services. No complaints were reopened and in total, 16 complaints remain open at the beginning of August 2020. The subject matters were varied and no trends were identified.

July received Complaints – Grouped by subjects



Subject narrative :

Out of the 8 complaints received in July, the subjects were:

- Communication breakdown (2)
- Care and Treatment issues (2)
- Diagnosis concerns (1)
- Security issues (1)
- Medication concerns (1)
- Financial concerns (1)

Closed Complaints

Complaints	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July
Number per month (aim <12)	10	8	9	7	12	1	8	8	1	2	5	6
PHSO - Upheld	0	0	0	0	0	0	0	0	0	0	0	0
PHSO – Not upheld	0	0	0	0	0	0	0	0	0	0	0	0

Safer Staffing - Nurse Recruitment

Nurse Recruitment

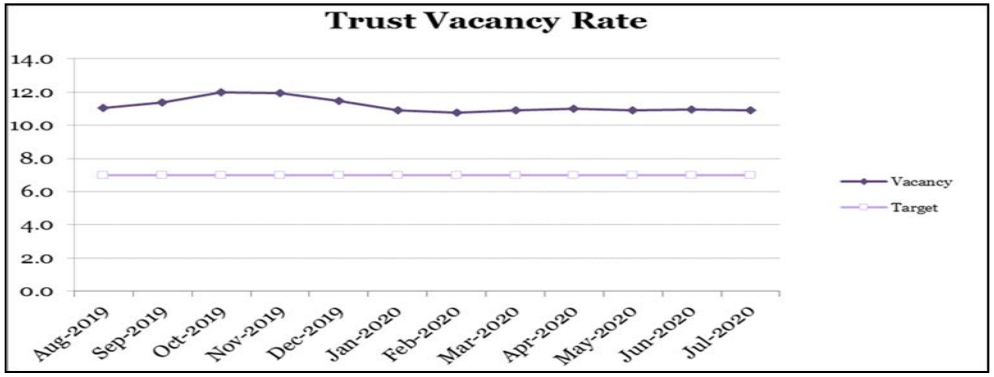
Nurse recruitment and retention remains a Trust priority and the nursing recruitment and retention group continues to meet to ensure a sustained focus on our objectives is maintained. The Trust nurse vacancy rate increased marginally to 10.6%. There were 7 wte nursing new joiners all of which were recruited to band 5 and 6 posts. There are 68.6 wte nurses in the domestic recruitment pipeline of which 33.5 wte have a agreed the start date. We continue to interview for international nurses and there are currently 5 nurses in the international recruitment pipeline however international travel restrictions have delayed their deployment .

August 2020 Nurse Recruitment Activity:

1) Continue to undertake a range of recruitment activities, monthly virtual recruitment days targeting both qualified and newly qualified nurses, rolling advertisements in social media and NHS jobs. The main focus areas are Critical Care, Outpatients and paediatrics

2) We are currently working with our international recruitment agency to reinstate international nurse deployments from the Philippines, as the visa offices begin to re-open. The nurse recruitment team are also planning how they can support the candidates when they arrive as they will be required to quarantine for two weeks. International recruitment continue with monthly virtual interviews and there are 5 candidates in the recruitment pipeline.

3) A nursing careers pathway has been developed which showcase possibilities of a career in nursing to staff. It clearly sets out the possible route's nurses can pursue at each level, with a view to aid retention and support staff with ambitions to progress.



Nursing Joiners - Band 5-6													
Month	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Total
Starters (fte)	12.0	20.5	20.0	9.5	9.8	12.6	6.0	13.0	4.0	12.3	11.0	7.0	137.7

Safer Staffing: Nurse Turnover & Retention

Turnover & Retention

The Trust Nursing voluntary turnover rate increased marginally decreased by 0.5% to 13.5% and remains average for London. The voluntary band 5 nursing turnover rate increased by 2.6% to 25.3% whilst the band 6 turnover rate decreased further from 13.4% to 12.6% There were 8.3 wte band 5&6 nurse leavers in July and the reason given are set in the table below. A retention action plan is in place and includes a review of career pathways, stay conversations, staff engagement and learning from others and recruitment is underway for a Retention HR Business Partner; this role will lead on the retention strategy and will proactively work with the Divisional Nurse Directors and Deputy Chief Nurse to identify the retention drivers across the sites and roles within nursing.

Nurse 'Leavers' cumulative position

Nursing Voluntary Leavers - Band 5-6													
Month	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Total
Leavers (fte)	9.0	10.4	7.6	9.6	12.6	11.3	7.2	6.8	5.6	2.0	5.6	8.3	95.9

Reasons for leaving

Voluntary Nurse leavers Bands 5&6	FTE
Relocation	4.0
Work Life Balance	0.9
To undertake further education or training	0.0
Child dependent	1.0
Other/Unknown	2.4
Total	8.3

Safe Staffing

Ward name	Fill% RN Days	Fill % NA Days	Fill % HCA Days	Fill % RN Nights	Fill % NA Nights	Fill % HCA Nights	RN CHPPD	NA CHPPD	HCA CHPPD	Total CHPPD	Red Flags	Comments
Burdett Coutts	102.0%		97.0%	94.0%			7.0		1.6	8.6		Staffed for acuity /Additional staffing rostered as required - Cancer Hub Pt specialled: Confusion/Cognitive impairment
Critical Care Unit	99.0%		81.0%	105.0%		97.0%	26.2		2.1	28.3		Staffed for activity - increased Bed no's - Cancer Hub activity
Ellis Ward	101.0%		135.0%	99.0%			7.5		2.1	9.6		Staffed for acuity - Staffing based on newly approved following quality and safety reviews Pt specialled: DOLS/Safeguarding/Required RMN
Granard House 1	100.0%	100.0%	119.0%	102.0%	160.0%	82.0%	9.9	1.1	3.2	14.2		High acuity - Cancer hub Pt specialled - Nurse Escort
Granard House 2	96.0%	100.0%	93.0%	100.0%	100.0%	86.0%	9.5	1.0	3.1	13.6		Ward closed for wk during month staff redeployed.
Granard House 3	96.0%	114.0%	111.0%	100.0%	101.0%	100.0%	9.8	1.1	3.0	13.9		
Horder Ward	98.0%	98.0%	193.0%	95.0%	100.0%	153.0%	11.2	0.8	5.4	17.4		Staffed for acuity/activity - cancer hub Pt specialled
Markus Ward	96.0%		100.0%	102.0%		129.0%	10.2		4.6	14.8	3	RED FLAGS: Omissions of elements of care 1 RN on shift/2 clinical staff short
Wilson Ward	94.0%		101.0%	100.0%			7.7		1.7	9.4		
Wiltshaw Ward	101.0%		114.0%	97.0%		135.0%	9.7		3.1	12.8		
Bud Flanagan East Ward	91.0%		112.0%	93.0%		122.0%	9.1		2.8	11.9		Staffed for acuity/Unable to cover all unfilled shifts Pt specialled: DOLS/Safeguarding
Bud Flanagan West Ward	92.0%		84.0%	90.0%		123.0%	8.9		2.4	11.3		RN redeployed to train to support Apheresis service in case of future Covid shortfall New starters supranumary shifts left unfilled Pt specialled - Risk of falls
McElwain Ward	98.0%		63.0%	100.0%		102.0%	8.9		1.2	10.1		Reduced bed numbers Ward not fed back
Kennaway Ward	111.0%		97.0%	106.0%		334.0%	9.5		3.1	12.0		Pt specialled: Escort: Confusion/cognitive impairment
Oak Ward	91.0%	100.0%	0.0%	101.0%			14.9		0.3	6.0		HCA LT absence not covered
Robert Tiffany Ward	89.0%		104.0%	95.0%		103.0%	11.5		3.1	14.6	4	High acuity Staff redeployed when acuity allowed RED FLAGS: Delay/omissions of elements of care: Missed breaks: 1 RN on shift/2 clinical staff short
Smithers Ward	104.0%	100.0%	82.0%	148.0%	100.0%	107.0%	7.5		1.6	9.0		Increased bed numbers staffed as covid cost pressure Ward not fed back Pt specialled: prolonged surg/Comp post op care
Teenage and Young Adult Unit	91.0%		90.0%	98.0%		93.0%	7.7		2.6	10.3	1	Staffed for acuity RED FLAGS:Delay / omissions of element of care

Ward name	Fill% RN Days	Fill % NA	Fill % HCA Days	Red Flags	Comments
Bud Flanagan AC	97.70%		120.00%		
APU C	97.00%		71%		
APU S	117.00%				Additional weekend activity - Cancer hub
CAU L	102.00%	84.00%	126.00%		
CAU S	96%				
Childrens Day unit	93.50%	94.90%	93.00%	2	RED FLAG: 1 RN on shift/2clinical staff short
DSU	100.70%		89.90%		
Endoscopy	100.00%		84.00%		
MDU C	98%		61.80%		High HCA unavailability
MDU Kingston	93.60%		94.20%		
MDU Sutton	95.00%		92.40%		
Oak Day unit	94.00%		99.70%		
PPMDU C	88.30%		107.00%		Staffed for activity - vacancies not covered
PPMDU S	91.20%		103%		
PPOPD C	98.10%				Additional weekend activity - Cancer hub
PPOPD S	93.20%		90.40%		
PPDSU	109.40%				Additional weekend activity
Outpatients C	91.10%		93.20%		
Outpatients S	93.60%	85.90%	90.60%		
RDAC C	92.00%		83%		
RDAC S	89.30%		93.00%		
Theatres C	96%		98.80%		
Theatres S	93.00%	94.30%	89.00%		
West Wing	94.00%		57%		High HCA unavailability

Notes:

- The fill % was higher this month across some units due increased acuity and activity with the Cancer Hub.
- High acuity on all wards and high use of specials required staff redeployed where able too.

Safer Staffing: Guidance

Safe staffing

NHSi released Developing Workforce safeguards building on NQB2016 guidance indicates that Trusts should be able to monitor from Ward to board.

- Since 2014 the Trust has been required to publish the fill % for all inpatient wards, and in addition have been reporting on Care Hours Per Patient Day (CHPPD) since May 16. From April 2019 this has been extended to include all staff groups.
- Note: Bud Flanagan West, Kennaway, and Smithers run day areas within their establishments both staff and patients have been excluded from fill% however CHPPD will reflect the total establishment.

Care Hours Per Patient Day (CHPPD)

- CHPPD is designed to be used on inpatient wards only and currently there is no evidence based tool to be used in day areas
- CHPPD is calculated by:

$$\frac{\text{Number of nursing + Healthcare support workers}}{\text{Number of patients on the ward at Midnight}}$$

- CPPPD for Oak Ward does appear too high in relation to other wards this is due to a low patient number on the ward at 2400 hrs. as patients are often discharged late in the evening following post treatment tests being completed.
- Smaller Wards also result in higher CHPPD – including GH1, GH2, GH3, Horder, Markus, and TCT

Red Flags

- NICE recommended the introduction of Red Flags as a tool to record those occasions where staffing may impact on the ability to care for patients with the right staff, right skills and at the right time. These should be reported by Staff on Datix.
- We have seen some improvement in the reporting of red flags however overall reporting remains low particularly in Day areas.

Red Flags include:

- 1 RN on shift/2 RN and/or HCSW on shift
- Unplanned omission in providing patient medications
- Delay of more than 30mins in providing pain relief
- Patients' vital signs not assess or recorded as outlined in care plan
- Missed Breaks
- Missing essential skills on shift (i.e. Head and Neck Trained RN/Chemotherapy competent RN
- Delay or omission of intentional rounding including
  - Pain: Asking patients to describe pain using a local pain assessment tool
  - Personal needs: i.e. hydration, assisting patient to toilet/bathroom
  - Placement: making sure patient has easy access to items that they may need
  - Positioning: making sure patient is comfortable and risk of pressure ulcers is assessed and minimised

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 15 September 2020	**Agenda item:** 7.2
Title of Document: Key Performance Indicators – Q1 2020/21	**To be presented by:** Chief Operating Officer

1. Status **Information / Discussion**

2. Purpose:

Relates to:

Strategic Objective(s)	✓
Operational Performance	✓

3. Summary

The paper provides an update on the Trust's performance for quarter 1 2020/21.

4. Recommendations / Actions

The Board is asked to note and discuss the Quarter 1 position.

The ROYAL MARSDEN
NHS Foundation Trust

KEY PERFORMANCE INDICATORS

QUARTER 1 2020/21

1. Purpose

This paper provides the Board with an update on the Trust's performance for quarter 1 2020/21. The scorecard and narrative are also submitted to the Council of Governors.

This report refers to the balanced scorecard for the Trust and provides a commentary on the red-rated indicators identified in the quarter 1 report, including actions underway to improve performance.

2. Scorecard review

The Board scorecard including the KPIs and thresholds was reviewed for 2020/21 to ensure it remains consistent with any national changes and Trust priorities. The scorecard has been updated to include KPIs relating to the COVID-19 pandemic.

A paper detailing the changes for 2020/21 has been shared with The Executive Board and Quality Assurance and Risk Committee for review and discussion in September 2020. The paper sets out the Trust's approach, given the context of COVID-19, in ensuring KPIs are included to reflect the changing priorities of the pandemic but also to ensure that the scorecard accurately reflects any risks. Therefore, only a brief summary of the key changes has been provided in this paper.

2.1 Key scorecard changes

In addition to the updating of thresholds to reflect any changes in national guidance the following KPIs have been removed from the scorecard as they are no longer monitored nationally:

- Cancer Waiting times - 62 day Screening referral (pre-allocations)
- Harm Free Care
- Single Oversight framework rating
- CQUIN: RMH has 20-21 block contract and therefore there are no CQUINs for 20/21
- Staff Friends and Family Test (suspended for Q1 and Q2)
- Clinical research metrics – date site selected to first participant recruited and accrual to target (suspended for Q1)

The following definitions of metrics have been amended:

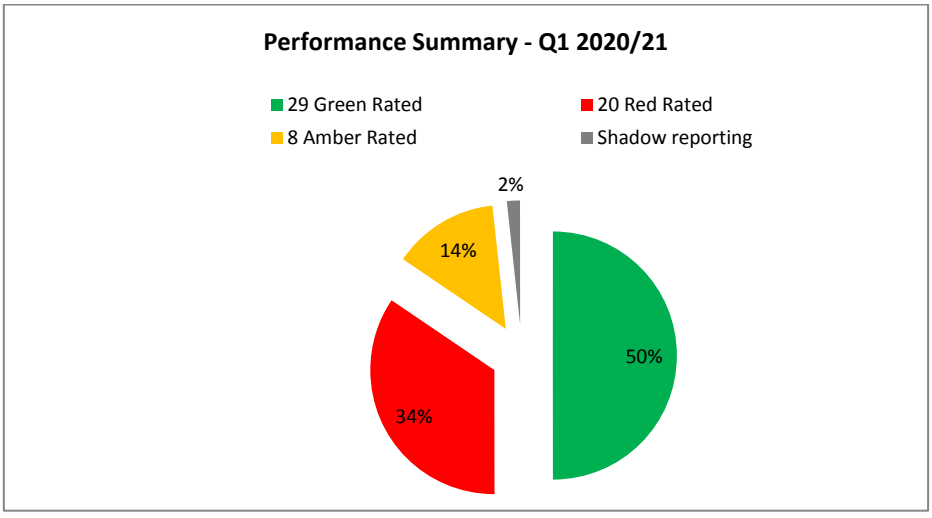
- Theatre utilisation hours and thresholds have been amended to reflect the recovery programme
- MDU Patients per Chair KPI has been updated to reflect additional units not previously included namely the MCU, Oak Day Unit and Bud Flanagan Ambulatory Care Unit
- Complaints KPI definition has been amended to be based on inpatient discharges to be better aligned with the national dataset

Due to COVID-19 and the related recovery workstreams, a suite of new KPIs have been developed to better reflect the current issues facing the Trust and up to date guidance. This includes:

- Finance indicators: many of the 19-20 KPIs for finance are no longer relevant for 20-21 due to the introduction of a block contract. The finance directorate has revised the indicators to ensure they remain relevant and appropriate.
- Infection Prevention and Control (IPC) metrics: a suite of metrics are being introduced to reflect testing and a range of IPC audits:
    - Positive PCR tests (staff and patients) – shadow reporting from Q1, target from Q3
    - PPE audit results (from Q2)
    - Hand hygiene audit (from Q2)
    - Flu vaccine uptake (Q3 &Q4)
- Recovery metrics: In line with national requirements as part of the third phase of the NHS response to COVID-19 the following recovery metrics will be included in the scorecard from Q2.
    - Elective admissions
    - Outpatient appointments
    - % of outpatient appointments carried out virtually (Q3)
    - Diagnostic activity (includes MRI/CT and endoscopy)
    - Bone Marrow Transplants
    - SACT and radiotherapy activity
    - % bed occupation of the CCU at Chelsea has been included from Q1
    - % bed occupation of blue wards (from Q2 in line with implementation of green and blue area guidance)

In addition, the 28 day Faster Diagnosis Standard will be included in the scorecard from quarter 2 (shadow reporting) in line with national guidance. The national target is 75% of GP referrals on the suspected cancer pathway either have cancer ruled out or diagnosed (and communicated with the patient) within 28 days.

3. Performance for Quarter 1 2020/21



Of the 57 RAG-rated metrics, 29 were rated green in Quarter 1 with 20 metrics rated red. This is the highest number of red metrics the Trust has reported in a quarter. However, this is to be expected given the impact of the pandemic. In addition, while the Trust has included new measures to reflect the COVID-19 pandemic and recovery, the approach has not been to adjust targets for the shorter-term impact. This is to ensure the position and risks are accurately reflected and to measure recovery. The narrative provided in this paper provides the context and actions being taken to recover performance.

The scorecard shows an improvement in the 2-week wait from referral to date first seen, which has moved to green from red in quarter 4 2019/20. Additionally, percentage of Chemotherapy patients seen within 3 hours of arrival and percentage of chemotherapy patients seen within 1 hour of appointment time remained amber for second quarter in row, continually improving performance each quarter. It is important to note these improvements are in the context of lower than usual attendances and referrals.

The following section of the report provides a commentary on the red-rated indicators identified in quarter 1 reporting, including actions underway to improve performance. It also provides a commentary on positive COVID-19 tests for quarter 1, which is reported in shadow form this quarter.

4.1 Patient Safety, Quality and Experience

Q1 20/21	COVID-19 testing – Positive tests: patients, staff	
	Actual: 357	N/A - shadow reporting

A total of 357 positive PCR tests were reported for quarter 1, including 76 patient tests and 281 staff tests. Quarter 1 included the first peak of the COVID-19 pandemic and since May the number of positive tests has significantly reduced. A comprehensive programme to reduce the risk of transmission has been introduced at the hospital including:

- Symptomatic testing for staff and patients
- Asymptomatic testing for patient facing staff
- Asymptomatic testing for patients in place for surgery, elective medical inpatients and radiotherapy. SACT testing is going live in a phased approach across all sites.
- Track and trace for positive results
- Implementation of separate Blue and Green pathways for urgent and planned care within the hospital during quarter 2. Blue (COVID-risk managed) and Green (COVID-protected) pathways include separation of physical areas and staff within the Trust as much as possible.
- PPE for all staff including non-patient facing staff, with audits in place (results will be included within the Q2 board scorecard)
- Enhanced cleaning, with audits in place.

A target has been implemented at the end of August of 26 a quarter. This is based on an operational working threshold of two positive tests a week triggering a review of processes including track and trace and PPE. As such the target will come into effect in quarter 3, with quarter 1 and 2 reported in shadow form. This target will be kept under review as processes are further embedded.

Q1 20/21	30 day mortality post surgery		
	Actual: 1.49%	Target: ≤0.8%	Forecast: Green

Surgical mortality within 30 days increased in quarter 1 20/21 to 1.49%, which is above the threshold. In line with NHSE Guidance the Trust prioritised urgent surgery during the first wave of the COVID-19 pandemic, meaning the denominator was significantly lower than usual (please see table 1 below). There was also an increase in the number of deaths in quarter 1, compared to previous quarters.

The percentage calculation is volatile due to the small numbers involved. In addition, since the Cancer hub was introduced the Trust has been carrying out procedures that before COVID-19 would not have been carried out at RMH and are not performed by RMH surgeons.

Five of the deaths in the quarter followed palliative thoracic procedures. These interventions alleviate distressing symptoms in patients with very limited life expectancy. In the past these types of cases were transferred to RBH and so would not feature in the Trust's post-surgery mortality figures. If thoracic procedures are removed then the mortality rate reduces to 0.9% (just above threshold at amber). The remaining deaths for the quarter were significantly represented by procedures also performed for palliative purposes.

The quarter 1 mortality audit carried out at the Trust reported as green, meaning all standards of care were achieved and no problems in care were identified.

The performance team will review the impact thoracic work is likely to have on the surgical mortality and amend the thresholds accordingly if it becomes a longer-term arrangement.

Table 1: 30 day mortality post surgery

Quarter	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21
% 30 day mortality post surgery	0.43%	0.66%	0.72%	0.47%	1.49%
Deaths within 30 days post surgery	6	10	11	7	12
Total	1,400	1,519	1,518	1,476	805

4.2 Effective Care: National Waiting times

Q1 20/21	31 day wait from diagnosis to first treatment		
	Actual: 91.0%	Target: ≥96%	Forecast: Green

The Trust did not meet the 31 day wait from diagnosis to first treatment for quarter 4 2020/21 with performance at 91.0% against a target of 96%. This is largely as a result of surgeries that were delayed due to COVID-19 with, 37 of the 48 breaches falling into this category.

Q1 20/21	31 day wait for subsequent treatment: Surgery		
	Actual: 83.9%	Target: ≥94%	Forecast: Green

The Trust did not meet the 31 day subsequent surgery standard for quarter 1 2020/21 with performance at 83.9% against a target of 94%. As with the delays incurred with the first treatment target the majority of these breaches were the result of surgeries cancelled due to

the pandemic. The trust incurred 38 subsequent surgery breaches during Q1, of these 29 were patients who had their surgeries delayed due to the pandemic.

Q1 20/21	62 day wait for first treatment – GP referral to treatment (post reallocated)		
	Actual: 68.9%	**Target: 85%**	**Forecast: Red**

The Trust did not meet the 62 day standard for quarter 1 2020/21 with reallocated performance at 68.9% against a target of 85%. The major contributor to the drop in performance in Q1 were issues that arose from the COVID-19 pandemic. Of the breaches incurred during Q1, 61.4% were as a direct result of COVID-19 related reduction in services. In addition, RMH also experienced changes in the ratios of patients referred via GP and tertiary trusts that further impacted performance. In Q1 2019/20 51.7% of RMH's 62 day activity originated from GP referrals direct to the Trust. In 2020/21 this figure dropped to 44.2%. As internal performance outstrips shared performance significantly this shift in referral pattern further negatively impacted performance

In quarter 1, there were 57.0 accountable breaches following reallocation.

- 18.0 (31.5%) were GP breaches,
- 20.0 (35.2%) were referred early (defined as by day 38) but not treated within 62 days.
- 19.0 (33.3%) were referred late (defined as after day 38) and not treated within 24 days.

Review of quarter 1 breaches indicates that 41.5 of the 57.0 accountable breaches (72.8%) were unavoidable, resulting from patient-initiated delay, patient fitness and complex pathways. Accountable breaches occurred for the reasons set out in table 2:

Table 2: Breakdown of breaches

		GP Breach	Early referral (not treated within 62 days)	Late referral (not treated within 24 days)
Unavoidable breaches	Patient initiated	1.0		1.0
	Patient fitness	1.0		
	Complex pathway	1.0	1.0	7.0
	Delay for genetic testing			
	Delay for fertility treatment			0.5
	COVID delays to diagnostic services	1.0	2.0	1.0
	COVID delays to treatment planning	11.0	9.0	5.0
	Other			
Total unavoidable breaches = 41.5				
Avoidable breaches	Outpatient capacity	2.0	3.0	2.0
	Elective capacity		1.0	2.0
	Pathway Management			
	Admin		1.0	0.5
	Delay to diagnostic testing	1.0	3.0	
	Equipment breakdown			
Total avoidable breaches = 15.5				

In quarter 1, Trust internal compliance (GP referrals direct to the Trust) was measured at 76.8%. In addition, 33 patients were referred late but treated within 24 days and the breaches were therefore reallocated to the referring organisation.

On December 13th, 2019 the Trust agreed a performance trajectory supported by a comprehensive workplan to support recovery of the cancer waiting times targets. Following the implementation of this workplan the Trust met all the improvement milestones each month during quarter 4, including the trust recording its highest monthly performance for the year in March. Recovery workstreams have been set up to address the backlogs due to the COVID-19 pandemic, which covers all impacted services.

Q1 20/21	**62 day wait for first treatment – Screening referral to treatment (reallocated)**		
	Actual: 46.9%	**Target: 90%**	**Forecast: Green**

The Trust did not meet the 62 day standard for quarter 1 2020/21 with reallocated performance at 46.9% against a target of 90%. The major contributor to the drop in performance in Q1 were issues that arose from the pandemic. Of the breaches incurred during Q1 53.6% were as a direct result of COVID-19 related reduction in services.

Q1 20/21	**18 wks from Referral to Treatment: Incomplete Pathways under 18 weeks**		
	Actual: 89.7%	**Target: ≥92%**	**Forecast: Green**

The trust did not meet the RTT incomplete pathway target for quarter 1 20/21 with performance of 89.7% against a target of 92%. This deterioration in performance is unprecedented for the Trust and is COVID-19 related. Specific areas which were particularly impacted were radiotherapy pathways for non-urgent skin patients as the service was temporarily suspended; non urgent plastic surgery cases; and Lower GI, which suffered as a service from the closure of the endoscopy unit. These departments have now all reopened and the backlog is being cleared.

4.3 Effective Care: Finance, Productivity and Efficiency

Q1 20/21	**PP activity Income Variance YTD (£000)**		
	Actual: 12,890	**Target: B/even or > plan**	**Forecast: Red**

In quarter 1 the PP activity income was under plan for the quarter. This is due to reduced PP activity volumes as a result of the COVID-19 pandemic. Please see section 4.5 below relating to PP referrals which provides detail around the trends. Operational and commercial recovery workstreams were set-up in PP to drive recovery and some weekly referral volumes have now achieved pre-COVID volumes in July.

Q1 20/21	**PP Aged debt at >6months**		
	Actual: 34.1%	**Target: ≤23%**	**Forecast: Red**

PP aged debt over 6 months increased to 34% in quarter 1, from 17% in quarter 4 19/20. The increase in debt is due to reduced payments from embassies largely due to their offices closing during the COVID-19 pandemic. The PP credit control teams are pursuing all sponsor groups, in particular embassies, for catch-up payments in Q2 now that most offices have opened again.

Q1 20/21	Non NHS/Non-PP Debtors over 90 days (% of total non NHS/non PP-debtors)		
	Actual: 42%	Target: ≤25%	Forecast: Red

Quarter 1 saw an increase in the amount of non-NHS and Non-PP debt over the COVID-19 first wave. Work being done with commercial R&D sponsors, in particular, to receive moderators on site so payments can be approved.

Q1 20/21	Capital Expenditure Variance YTD (% of plan)		
	Actual: 55%	Target: 85%-115% of plan	Forecast: Amber

Capital expenditure is reported at 55% of plan in quarter 1 20/21. This is due to a delay in capital projects due to COVID-19. Recovery work is underway to meet project deadlines.

4.4 Effective Care: Productivity & Asset Utilisation

Q1 20/21	Bed occupancy - Chelsea		
	Actual: 70.5%	Target: ≥82% ≤87%	Forecast: Amber
	Bed occupancy - Sutton		
	Actual: 76.8%	Target: ≥82% ≤87%	Forecast: Amber

There was a consistent decrease in bed occupancy in quarter 1 across both sites. Bed occupancy at Chelsea decreased across all wards. The biggest drop was recorded by Horder Ward with bed occupancy 54.6%. The ward was designated a COVID-19 positive ward and as such there was a period where it was closed and at times had very few patients.

In Sutton, a drop in bed occupancy was also seen across all wards. Kennaway Ward noted the biggest decrease during quarter 1 (60.9% from 88.9% in previous quarter). The ward became a COVID-19 positive ward in April and as such was only able to admit COVID positive patients. After the discharge of the last positive patient, the ward become a yellow-zoned ward where all patients had to be nursed separately reducing the number of patients that could be accommodated. Bed occupancy on Oak remains low however, there was a slight increase to 50.2% from 49.8% in previous quarter. Occupation of wards across both sites is expected to increase over the following two quarters as recovery plans are implemented and referrals start to increase.

Q1 20/21	Bed occupancy - Critical Care Chelsea		
	Actual: 59.8%	Target: ≥82% ≤87%	Forecast: Amber

CCU bed occupancy increased slightly in Q1 to 59.8% from 58.4% in Q4. However, it is lower than Q1 2019/20 (69.5%) due to the reduction in theatre activity at the start of COVID in March/April 2020. Theatre activity has since increased due to the development of the cancer hub and recovery plans. CCU occupancy has been increasing since May 2020, with June and July reporting 76.0% and 70.3% respectively. Q2 CCU occupancy is therefore expected to be higher than Q1. CCU has increased its bed base from 16 beds to 19 beds from 1st April 2020.

Q1 20/21	**Theatre utilisation - Chelsea**		
	Actual: 58.5%	**Target: ≥85%**	**Forecast: Amber**
	Theatre utilisation - Sutton		
	Actual: 42.9%	**Target: ≥70%**	**Forecast: Amber**

The theatre utilisation KPI has been amended in 20/21 to reflect the work being carried out by the Surgery recovery workstream. The key change is the increased occupation target for Sutton (60% to 70%) and the rebasing of the hours to 80 a week for Sutton and 352 hours a week in Chelsea. There was a marked reduction in theatre utilisation in quarter 1 across both sites. This was due to the change in patient pathway management in line with COVID-19 risk stratification. This includes the cancellation of nonurgent surgery during the peak of the pandemic and significant time gaps between cases to support safe PPE donning and doffing (as part of the PHE Infection Control and AASGB guidance). Therefore, the significant drop in utilisation was expected during quarter 1. Utilisation is now improving during the recovery phase with better COVID-19 screening and clearer strategy in managing the infection risk.

4.5 Effective Care: Clinical and Research Strategy

Q1 20/21	**Total NHS referrals**		
	Actual: 3707	**Target: ≥5992 ≤6164**	**Forecast: Amber**
	Total PP referrals		
	Actual: 919	**Target: ≥1526 ≤1618**	**Forecast: Amber**

The number of referrals the Trust received reduced significantly during the height of the COVID-19 pandemic for both NHS and private care.

The National lockdown and government emphasis on 'Protecting the NHS' by staying at home meant that patients were not attending GP practices from the end of March and throughout Quarter 1. As a result, there was a significant reduction in the numbers of referrals from GPs being received by Hospitals, including RMH. Table 2 below shows the split of referrals received compared to quarter 1 2019/20. For GP referrals the Trust received 53% (NHS) and 82% (PP) of the referrals it received in Q1 2019/20.

In addition, Acute Trusts were required to prioritise capacity for COVID-19 positive patients during this period and therefore tertiary referrals were also lower than usual levels. The lack of International travel during the period further impacted PP referrals. The Trust received 73% (NHS) and 60% (PP) of the tertiary referrals it received in Q1 2019/20.

The significant reduction in referrals in quarter 1, has effectively created an unknown backlog where the Trust expects to receive increased referrals later in the year. A recovery programme was set up towards the end of quarter 1, with workstreams for each of the modalities to develop plans to prepare for an increase in referrals. Referrals are now steadily increasing across quarter 2 for both PPP and NHS and across tertiary and GP.

Table 2: Referrals in Q1 20/21 compared to Q1 19/20

NHS	**GP**	**Tertiary**	**Total**
20/21 Q1	1,749	1,958	3,707
19/20 Q1	3,327	2,685	6,012
PP			
20/21 Q1	129	790	919

19/20 Q1	157	1,323	1,480

4.6 Well Led: Workforce productivity

Q1 20/21	Sickness rate		
	Actual: 5.7%	**Target: ≤3%**	**Forecast: Amber**

The quarter 1 sickness rate was high due to the number of staff who had to take seven days off if they got a temperature or a cough during the COVID-19 pandemic. In June the sickness rate reduced back down to the Trust's normal levels.

4.7 Well Led: Quality and Development

Q1 20/21	Appraisal & PDP rate		
	Actual: 78.2%	**Target: ≥90%**	**Forecast: Amber**

The appraisal and PDP rate decreased in quarter 1 to 78.2%, from 86.7% in quarter 4. There was an informal moratorium applied to appraisals at the height of pandemic at the Trust, with the appraisal season extending to 31st of July. Monthly performance dashboards have been reinstated and are now circulated to divisional managers highlighting local hotspots in relation to training and appraisal non-compliance to support the improvement in performance.

Q1 20/21	Completed induction		
	Actual: 69.2%	**Target: ≥85%**	**Forecast: Amber**

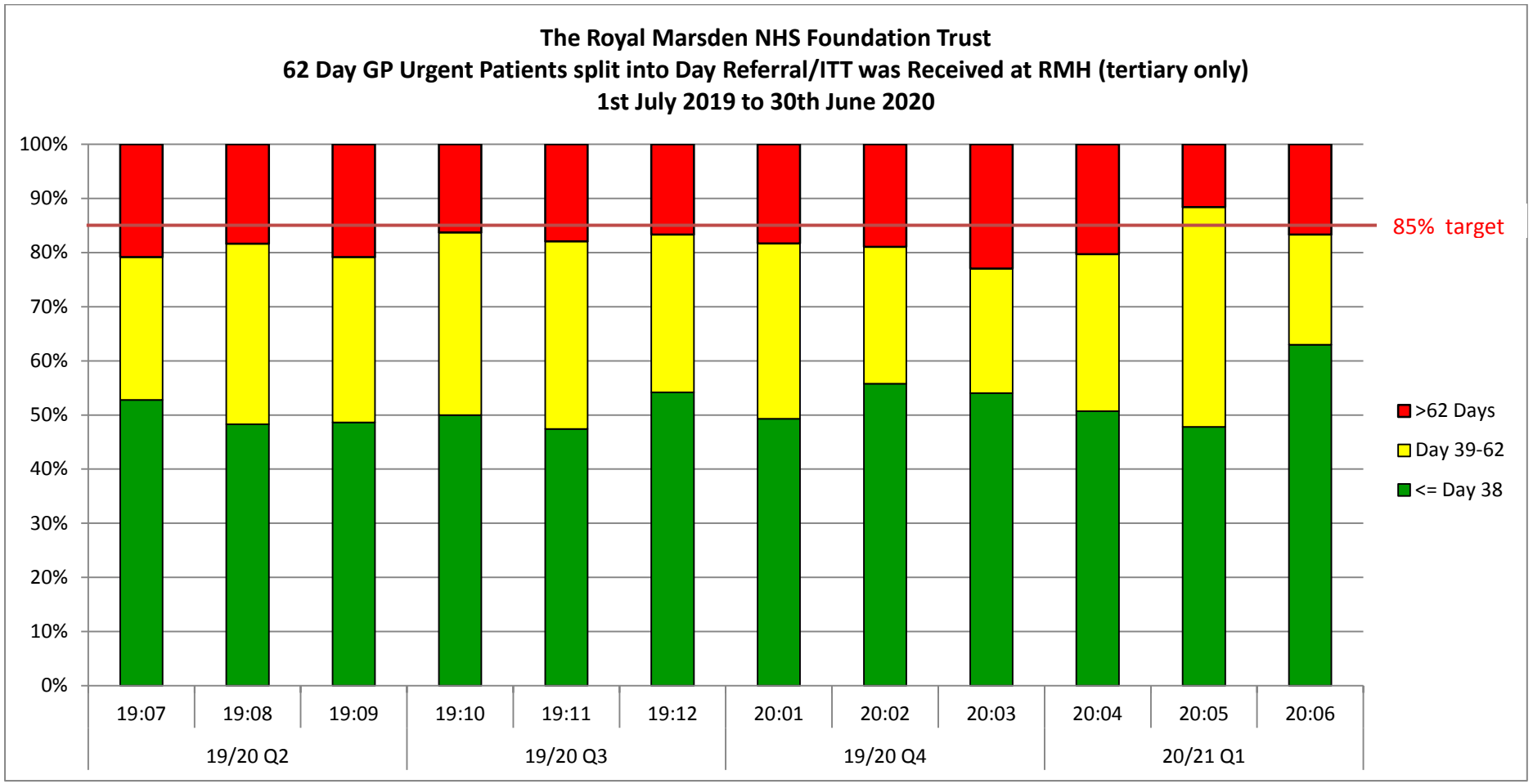
Completed inductions decreased in quarter 1 to 69.2% (down from 82.9% in Q4). In response to the requirement for social distancing all corporate inductions were cancelled. A new digital corporate welcome programme was launched in May 2020 and follow up with staff who have yet to complete the digital version of the induction is underway. Local induction completion confirmation has moved from a paper-based system to an on online form and the Trust is working with staff and managers to embed the new online process. Compliance has since improved.

5.0 Conclusion

The Board are asked to note the Trust's balanced scorecard and commentary for quarter 1 2020/21 and are invited to discuss the position.

APPENDIX B

62 Day GP Urgent Referrals by Category



APPENDIX C

62 Day Wait for First Treatment (GP Urgent). Performance by Tumour Type

Please note that the RAG ratings below are designed to be used at Trust level rather than tumour level and are only shown below as a guide. Open Exeter (pre-allocation) is no longer monitored nationally. The position is submitted via the National Cancer Waiting Times database.

Tumour site	Number of Reallocated Patients % Compliance
Breast	83.05%
Gynaecological	66.67%
Haematological (excl. Acute Leukaemia)	84.21%
Head & Neck	57.89%
Lower GI	45.00%
Lung	62.50%
Sarcoma	60.87%
Skin	75.00%
Upper GI	86.67%
Urological	32.61%
Unknown Primary / Other diagnosis	100.00%

The Royal Marsden NHS Foundation Trust
Balanced Scorecard 20/21

Denotes different targets applied for 2019/20 performance
NHSi *Denotes NHS Improvement standard*

1. Safe Care

Patient Safety and Quality		Target in 2020/21	Q1 (Apr- Jun 20/21)	Q4 (Jan-Mar 19/20)	Q3 (Oct-Dec 19/20)	Q2 (Jul-Sep 19/20)	Q1 (Apr - Jun 19/20)
Covid-19 testing/IPC metrics	**Positive tests - Patients**	≤26	357 (76 patients; 281 staff)	**New measure for 2020/21**			
	- Staff			**New measure for 2020/21**			
Quality Account indicators	**MRSA positive cultures (cumulative)**	0	**0**	**0**	**1**	**0**	**0**
	Total number of E-Coli Bacterium	≤65 per annum	**17**	**16**	**23**	**22**	**11**
	C Diff - Number of Reportable Cases (COHA/HOHA)	≤67 per annum	**17**	**12**	**14**	**16**	**16**
	VTE risk assessment	≥95%	**96.0%**	**97.7%**	**96.9%**	**96.1%**	**96.5%**
Serious incidents (Including Level 4 Pressure Ulcers)		≤7 /year	**1**	**3**	**1**	**1**	**2**
Mortality							
Hospital Standardised Mortality Ratio *(rolling 12 month - qtr in arrears - NHS & Private patients)*		≤80	**85.97**	**93.88**	**91.73**	**85.47**	**91.49**
Mortality audit		G	**G**	**A**	**G**	**A**	**G**
30 day mortality post surgery		≤0.8%	**1.49%**	**0.47%**	**0.72%**	**0.66%**	**0.43%**
30 day mortality post chemotherapy		≤2.2%	**1.94%**	**2.08%**	**1.78%**	**1.85%**	**1.40%**
100 day SCT mortality (Deaths related to SCT)		≤5%	**0.00%**	**3.45%**	**8.20%**	**4.00%**	**4.08%**
100 day SCT mortality (All deaths)		≤5%	**0.00%**	**5.17%**	**11.48%**	**6.00%**	**4.08%**
Medicines Management							
% Medicines reconciliation on admission		≥90%	**96%**	**92%**	**90%**	**99%**	**94%**
Unintended omitted critical medicines (Quarterly ratio)		0	**1.5**	**2.0**	**6.7**	**2.7**	**1.0**
Cancer staging							
Staging data completeness sent to Thames Cancer Registry (1 qtr in arrears)		≥70%	**75.7%**	**73.3%**	**70.5%**	**70.3%**	**73.6%**

2. Effective Care

	National waiting times targets		Target in 2020/21	Q1 (Apr- Jun 20/21)	Q4 (Jan-Mar 19/20)	Q3 (Oct-Dec 19/20)	Q2 (Jul-Sep 19/20)	Q1 (Apr - Jun 19/20)
NHSi	**2 wk wait from referral to date first seen:**	All Cancers	≥93%	**96.1%**	**91.5%**	**93.1%**	**88.5%**	**82.1%**
NHSi		Symptomatic Breast Patients	≥93%	**97.4%**	**96.8%**	**95.4%**	**94.7%**	**90.3%**
NHSi	**31 day wait from diagnosis to first treatment**	All Treatments	≥96%	**91.0%**	**97.9%**	**97.7%**	**97.3%**	**98.1%**
NHSi	**31 day wait for subsequent treatment:**	Surgery	≥94%	**83.9%**	**96.3%**	**96.4%**	**94.5%**	**94.8%**
NHSi		Drug treatment	≥98%	**98.9%**	**98.8%**	**99.8%**	**99.2%**	**98.7%**
NHSi		Radiotherapy	≥94%	**96.6%**	**92.8%**	**97.2%**	**95.1%**	**96.7%**
NHSi	**62 day wait for first treatment:**	**GP referral to treatment (Reallocated)**	≥85%	**68.9%**	**83.1%**	**82.6%**	**80.6%**	**81.5%**
NHSi		**Screening referral to treatment (Reallocated)**	≥90%	**46.9%**	**95.6%**	**95.9%**	**96.3%**	**82.3%**
NHSi	**18 wks from Referral to Treatment**	**Incomplete Pathways under 18 weeks**	≥92%	**89.7%**	**95.4%**	**95.9%**	**95.9%**	**95.9%**
NHSi	**18 wks pathways - patients waiting > 52 wks. (distinct patients across the quarter)**		≤6 a quarter	**5**	**0**	**1**	**2**	**1**

Finance, Productivity & Efficiency	Target in 2020/21	Q1 (Apr- Jun 20/21)	Q4 (Jan-Mar 19/20)	Q3 (Oct-Dec 19/20)	Q2 (Jul-Sep 19/20)	Q1 (Apr - Jun 19/20)
Cash (£m)	On or > plan	**149.0**	**121.5**	**113.7**	**124.6**	**79.3**
Delivery against recovery plan	On or >deficit plan of £17m FY	**(£0.2m)**	**New measure for Q1 20/21 onwards**			
PP activity Income Variance YTD (£000)	B/even or > plan	12,890	**3,059**	**4,197**	**4,312**	**2,975**
PP Aged debt at >6months	≤23%	**34%**	***17%***	***15%***	***21%***	***21%***
Non NHS/Non-PP Debtors over 90 days (% of total non NHS/non PP-debtors)	≤25%	**42%**	**New measure for Q1 20/21 onwards**			
Capital Expenditure Variance YTD (%)	85% - 115% of Plan	**55%**	-11,724	-20,114	-10,656	-4,707

Contract performance (QUARTER IN ARREARS)		Target in 2020/21	Q4 (Jan - Mar 19/20)	Q3 (Oct-Dec 19/20)	Q2 (Jul-Sep 19/20)	Q1 (Apr-Jun 19/20)	Q4 (Jan-Mar 18/19)
Contractual Sanctions incurred (£000)	Trust	0	**0**	**0**	**0**	**0**	**0**

Productivity & Asset Utilisation	Target in 2020/21	Q1 (Apr - Jun 20/21)	Q4 (Jan-Mar 19/20)	Q3 (Oct-Dec 19/20)	Q2 (Jul-Sep 19/20)	Q1 (Apr - Jun 19/20)
Bed occupancy - Chelsea	≥82% ≤87%	**70.5%**	**80.8%**	**81.7%**	**83.5%**	**79.9%**
Bed occupancy - Sutton	≥82% ≤87%	**76.8%**	**82.3%**	**82.7%**	**84.3%**	**81.0%**
Bed occupancy - Critical care Chelsea	≥82% ≤87%	**59.8%**	**New measure for Q1 20/21 onwards**			
Care Hours per Patient Day Total Ratio	≥11.7	**14.0**	***12.3***	***12.4***	***12.3***	***12.3***
Theatre utilisation - Chelsea	≥85%	**58.5%**	***77.5%***	***80.4%***	***82.3%***	***80.7%***
Theatre utilisation - Sutton	≥70%	**42.9%**	***62.1%***	***58.8%***	***55.1%***	***55.7%***
MDU Patients per Chair	≥1.3	**1.11**	**1.48**	**1.47**	**1.44**	**1.48**

The Royal Marsden NHS Foundation Trust
Balanced Scorecard 20/21

Denotes different targets applied for 2019/20 performance
NHSi *Denotes NHS Improvement standard*

Clinical and Research Strategy		**Target in 2020/21**	**Q1** (Apr - Jun 20/21)	**Q4** (Jan-Mar 19/20)	**Q3** (Oct-Dec 19/20)	**Q2** (Jul-Sep 19/20)	**Q1** (Apr - Jun 19/20)
Total NHS Referrals		≥5992 ≤6164	**3707**	***5859***	***6034***	***6059***	***6012***
Total PP Referrals		≥1526≤1618	**919**	***1503***	***1577***	***1542***	***1480***
Research (1 QUARTER IN ARREARS)		**Target in 2020/21**	**Q4** (Jan - Mar 19/20)	**Q3** (Oct-Dec 19/20)	**Q2** (Jul-Sep 19/20)	**Q1** (Apr-Jun 19/20)	**Q4** (Jan-Mar 18/19)
Date site selected to first participant recruited	Mean number of days between date site selected and date of first participant recruited	≤90 days	Suspend	***87.8***	95.8	96.1	***89.7***
Accrual to target (1Q arrears) - National definition	% of closed commercial interventional trials meeting contracted recruitment target (excluding trials that had no set target)	≥85%	Suspend	72.5%	72.1%	67.6%	58.8%
No. of 1st patients recruited in previous 12 months	No. of 1st UK patients	1	**14**	**13**	**13**	**11**	**8**
	No. of 1st European patients	1	**1**	**1**	**1**	**2**	**2**
	No. of 1st Global patients	1	**6**	**6**	**5**	**7**	**3**
Trials led by RMH	As percentage of commercial interventional trials with RMH involvement which opened in the last 12 months	≥20%	**50.0%**	**45.7%**	**44.0%**	**47.6%**	**48.8%**

3. Caring

Patient Satisfaction	**Target in 2020/21**	**Q1** (Apr- Jun 20/21)	**Q4** (Jan-Mar 19/20)	**Q3** (Oct-Dec 19/20)	**Q2** (Jul-Sep 19/20)	**Q1** (Apr - Jun 19/20)
Friends and Family Test (Inpatient and Day Care)	≥95%	**99.3%**	**98.8%**	**98.6%**	**97.0%**	**96.5%**
Friends and Family Test (Outpatients)	≥95%	**97.4%**	**96.9%**	**96.1%**	**96.6%**	**95.7%**
Percentage of Chemotherapy patients seen within 3 hours of arrival	≥85%	**82.0%**	**80.6%**	**79.4%**	**79.5%**	**78.1%**
Percentage of Chemotherapy patients seen within 1 hour of appointment time	≥85%	**83.9%**	**80.4%**	**78.2%**	**77.1%**	**77.5%**
Mixed sex accommodation breaches	0	**0**	**0**	**0**	**0**	**0**

4. Responsive

Experience	**Target in 2020/21**	**Q1** (Apr- Jun 20/21)	**Q4** (Jan-Mar 19/20)	**Q3** (Oct-Dec 19/20)	**Q2** (Jul-Sep 19/20)	**Q1** (Apr - Jun 19/20)
Complaints per 1,000 inpatient stays	≤10.04	5.96	**New measure for Q1 20/21 onwards**			
Staff Friends and Family Test: Recommend – Care	≥96%	Suspend	97%	N/A	97%	96%
Staff Friends and Family Test: Not recommend – Care	≤1%	Suspend	1%	N/A	2%	2%

5. Well Led

Workforce productivity	**Target in 2020/21**	**Q1** (Apr- Jun 20/21)	**Q4** (Jan-Mar 19/20)	**Q3** (Oct-Dec 19/20)	**Q2** (Jul-Sep 19/20)	**Q1** (Apr-Jun 19/20)
Vacancy rate	≤7%	**10.9%**	**11.1%**	**11.8%**	**10.8%**	**9.1%**
Voluntary staff turnover rate	≤12%	**12.8%**	**14.1%**	**14.2%**	**13.8%**	**13.6%**
Sickness rate	≤3%	**5.7%**	**3.9%**	**3.7%**	**3.3%**	**3.2%**
Quality and Development	**Target in 2020/21**	**Q1** (Apr- Jun 20/21)	**Q4** (Jan-Mar 19/20)	**Q3** (Oct-Dec 19/20)	**Q2** (Jul-Sep 19/20)	**Q1** (Apr-Jun 19/20)
Consultant appraisal (number with current appraisal)	≥95%	**98.3%**	**98.0%**	**97.2%**	**97.0%**	**97.6%**
Appraisal & PDP rate	≥90%	**78.2%**	**86.7%**	**89.7%**	**88.5%**	**86.1%**
Completed induction	≥85%	**69.2%**	**82.9%**	**81.9%**	**86.5%**	**80.8%**
Statutory and Mandatory Staff Training	≥90%	**86.8%**	**91.6%**	**90.7%**	**91.0%**	**89.8%**

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
15 September 2020	7.3
Title of Document:	**To be presented by:**
Financial Performance Report	Chief Financial Officer

1. Status **For Information**

2. Purpose:

Relates to:

Operational Performance	✓

3. Summary

For the YTD July 2020, the key headlines are as follows:

- The Trust accrued **£19.2m top-up** to get to a breakeven position. £3.9m was accrued in month, compared to £5.9m in the prior month. The reduction in top-up was due to the continuing improvement of private patient income as well as the resumption of BRC income recognition. Additionally, lower pay costs were seen in July as more were capitalised to projects.
- Capital expenditure of **£9.1m** YTD, which was £7.7m favourable to the Trust's capital plan.
- Cash in bank of **£153m**, a favourable variance of £31m compared to the year-end position as at 31st March 2020.

4. Recommendations / Actions

The Board is asked to note the position at 31st July 2020.

Financial Performance Report
31st July 2020

The ROYAL MARSDEN
NHS Foundation Trust

1. Introduction

The paper provides a summary of the financial position at 31st July 2020.

Currently, a Covid-19 financial framework is in place in the NHS. All trusts receive a block income contract, calculated based on the NHS income received to month 9 2019/20, uplifted for inflation. In addition, a retrospective top-up is being provided to adjust provider positions for additional costs and/or loss of revenue where the block payment does not equal the actual costs of genuine and reasonable additional marginal costs due to Covid-19. This framework is in place until 30th September 2020 whereupon it is expected there will be further revisions to it, including the removal of the top-up value. The plan discussed below is as calculated by NHS Improvement (NHSI), reflecting the NHS income as stated above, with non-NHS income and costs based on M8 to M10 2019/20 average run rates uplifted for inflation.

2. Summary Financial Position

Key headlines

For the YTD July 2020, the key headlines are as follows:

- The Trust accrued **£19.2m top-up** to get to a breakeven position. £3.9m was accrued in month, compared to £5.9m in the prior month. The reduction in top-up was due to the continuing improvement of private patient income as well as the resumption of BRC income recognition. Additionally, lower pay costs were seen in July as more were capitalised to projects.
- Capital expenditure of **£9.1m** YTD, which was £7.7m favourable to the Trust's capital plan.
- Cash in bank of **£153m**, a favourable variance of £31m compared to the year-end position as at 31st March 2020.

YTD July 2020	NHSI Plan £'000	Actual £'000	Variance £'000
Income			
NHS Block Payments	76,284	76,284	0
Other NHS Acute Income	2,168	299	(1,869)
Private Patient Income	44,036	30,158	(13,878)
Research and Development	11,148	4,522	(6,626)
Education & Training Income	1,720	1,196	(524)
Charitable contributions to expenditure	3,804	3,368	(436)
Other income	11,840	4,686	(7,154)
Donated Asset Income	0	2,195	2,195
Top up	0	19,193	19,193
Total Operating Income	**151,000**	**141,900**	**(9,100)**
Expenditure			
Employee Expenses			
Substantive	(71,060)	(73,622)	(2,562)
Bank	(3,712)	(3,688)	24
Agency	(1,668)	(2,050)	(382)
Capitalised costs	0	676	676
Employee Expenses	**(76,440)**	**(78,684)**	**(2,244)**
Non Pay Expenses			
Drug costs	(28,760)	(26,884)	1,876
Purchase of healthcare	(7,884)	(4,608)	3,276
Supplies and services-clinical	(10,588)	(10,035)	553
Supplies and services-general	(2,952)	(2,855)	97
Premises	(5,096)	(6,544)	(1,448)
Other	(8,968)	(5,281)	3,687
Depreciation & Amortisation	(3,632)	(5,328)	(1,696)
Total Operating Expenditure	**(144,320)**	**(140,219)**	**4,101**
Net Finance Costs	**(1,204)**	**(1,435)**	**(231)**
Retained Surplus / (Deficit)	**5,476**	**247**	**(5,229)**
Control Total basis (excl. top up funding)	**5,476**	**(19,193)**	**(24,669)**

The Trust reports the percentage of income for the provision of goods and services for the purpose of the health service as set out within the NHS Act 2006 and amended by the Health and Social Care Act 2012.

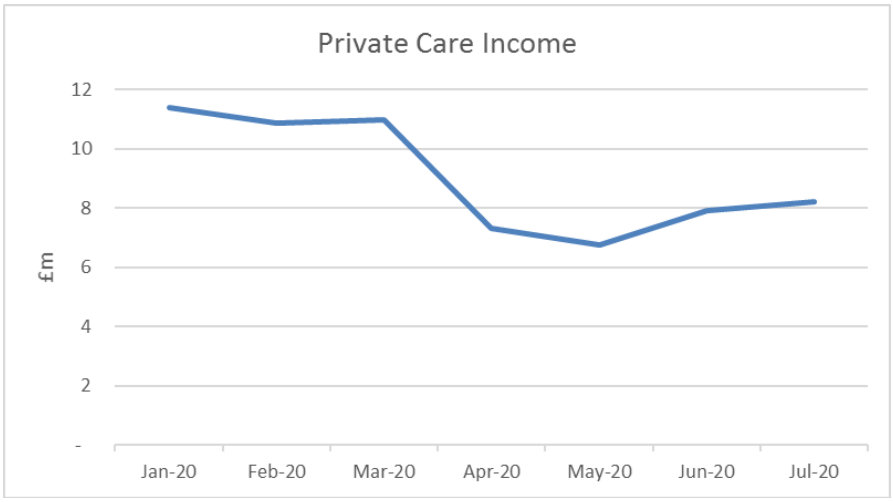
As a ratio the Trust is required to have more income as NHS than non-NHS and for month 4 YTD the position was 73% of income was from NHS sources.

3. Income and Expenditure

Income – The income position was £9.1m adverse to plan YTD.

Other NHS Acute Income was £1.9m adverse to plan YTD reflecting a reduction in non-England activity and some non-recurrent income in the plan.

Activity reduced in Q1 for Private Care due to Covid-19 as can be seen below, but is recovering well in the insurer and self-pay markets. Income in July was £0.3m higher than in June.



Research and Development income was £6.6m adverse to plan YTD due to lower levels of commercial income and activity in Q1 as well as BRC monies not being recognised. BRC income recognition has now resumed so July income was £0.8m higher than June.

Other income was £7.2m adverse to plan YTD although this is mostly presentational as RM Partner (RMP) income and Genomics income budgeted in "other income" now form part of block income. In addition, there were significant reductions in catering, car parking and provider-to-provider income.

A top-up payment of £19.2m was calculated to return the Trust to breakeven. £12.9m has already been received on account for this.

Pay expenditure – Pay expenditure was £2.2m adverse to plan YTD.

Pay overspends were driven by Covid-19 spend (£2m), which consisted primarily of backfill for sickness and some additional capacity for resilience. Additionally, new posts have been recruited to since month 10 last year before new Covid controls were introduced. Some additional positions have been approved for strategic business cases but all recruitment to positions not in the month 10 position are challenged and escalated to Executive Director level for approval.

The pay trend shown in the chart below shows pay costs falling over the last quarter. Agency spend was £2.1m YTD and although over budget, has been reducing and is now below month 10 levels. Bank spend has also reduced to month 10 levels. The fall in substantive costs in July was due to more staff being capitalised to projects as well as some research and development recharges being reclassified from pay to non-pay costs.

Non-pay expenditure – Non-pay expenditure was £6.3m favourable to plan YTD.

Drugs costs were £1.9m below plan YTD but increased by £0.5 in July as activity began to recover. The purchase of healthcare, supplies and services were £3.9m reduced also due to lower activity levels as well as minimal RMP activity. Premises costs have begun to increase as RM Digital costs increase for strategic projects such as Windows 10 and Office 365. Business Case investment reserves were unutilised as the focus has been on Covid-19 action plans.

4. Capital Expenditure

On 25 March 2020 the Board approved a draft capital plan for 2020/21 of £76.1m, consisting of £51.2m Trust funded schemes and £24.9m Royal Marsden Cancer Charity funded schemes. After consolidation into SWL STP, the group saw a c£71m shortfall against their allocated CDEL. Plans were revised acknowledging slippage due to Covid-19 and the Trust proposed a new capital plan of £66.8m, with grant funded schemes unchanged, Trust funded schemes reduced and an additional £0.6m of Covid-19 related schemes.

Capital expenditure was £9.1m YTD in July against a revised draft plan of £16.8m. Slippage was mostly seen on grant funded schemes including the Oak Centre, Sutton MRI replacement and medical equipment purchases as well as the Private Care Diagnostic Facility. All schemes have been impacted by Covid-19 but recovery plans are being developed to ensure the timelines for project completion can be met. Appendix A shows a further breakdown of these schemes.

Capital Plan - Summary by Directorate (Total)						
£000	Year to Date Budget	Year to date Spend	Year to Date Variance	Initial Plan	Forecast	Forecast Variance
ICT	1,242	551	(691)	12,664	10,298	(2,366)
Estates	5,880	4,012	(1,868)	16,472	15,711	(761)
Oak and Sutton Site Development	3,612	1,424	(2,189)	15,850	15,850	0
Space Planning	33	100	66	100	136	36
Private Care	2,590	761	(1,829)	10,273	9,807	(466)
Medical Equipment	2,801	1,870	(931)	10,808	10,686	(123)
COVID-19	587	343	(244)	587	587	0
	16,746	9,059	(7,686)	66,754	63,074	(3,680)

5. Cash and Debt

Cash – The Trust had £153m in cash at the end of July, an increase in £31m from the year-end. This is driven by a reduction in NHS debtors as NHSE cleared its debts and paid a top-up income sum in advance to ensure liquidity in the NHS.

Debt – Overall trade receivables have reduced by £17m year to date, to £50.4m as at 31st July 2020. This is driven by NHS debt which has reduced by £9.4m in the last four months. However, the reduction in NHS debt has been primarily NHSE current debt, with aged debt over 90 days remaining stable. A number of debts have been escalated for resolution, particularly those in our South West London STP. Private Care debt has also reduced in year, by £4.3m, although aging has also worsened as debts are being paid more slowly and activity is reduced so there is less current debt.

6. Conclusion and Recommendation

The Trust accrued £19.2m top-up to get to a break-even position at 31st July 2020. The Trust has a duty to recover back to pre Covid-19 activity levels and to reduce the need for this top-up as quickly as possible. There is a strong risk that top-up funding will be removed before the financial position has fully recovered so a number of controls have been put in place to manage spend and recovery plans are being developed in every operational area.

In addition to the revenue pressures, capital is also constrained for the STP. However, the Trust is within its planned spend YTD with all capital schemes progressing.

The cash position of the Trust remains strong.

The Board are asked to note the position as set out in the paper above.

Financial Performance Report
31st July 2020

The ROYAL MARSDEN NHS Foundation Trust

Appendix 1 – Capital Report

	Year to Date Plan	Year to date Spend	Year to Date Variance	Initial Plan	Full Year Forecast	Forecast Variance
	£000	£000	£000	£000	£000	£000
IT - Trust funded						
IT Strategy - EPR RMH	109	62	(48)	7,635	7,682	46
IT Strategy - LIMS RMH	222	1	(221)	2,323	1	(2,322)
IT Strategy - Infrastructure RMH	240	99	(142)	876	937	61
New Bloodtracking Product Approved by FSG	178	15	(163)	279	216	(63)
2nd Opinion Implementation	50	0	(50)	250	245	(5)
Genomics IT investment (Gardant)	0	0	0	250	0	(250)
EDM Phase 2	55	0	(55)	231	223	(8)
Stem Cell	53	50	(3)	211	211	1
Enhancements to legacy EPR	50	104	54	200	210	10
IT Strategy - Research RMH	76	0	(76)	178	148	(30)
Genomics ICT Works RMH	40	69	29	131	172	41
McElwain - systems moving from ICR to Trust	0	0	0	100	100	0
Other schemes	169	152	(17)	0	152	152
IT Total	**1,242**	**550**	**(692)**	**12,664**	**10,297**	**(2,367)**
Estates - Trust funded						
LTHW system upgrade and CHP installation at Chelsea site	565	834	268	4,178	4,237	58
Pharmacy Expansion Chelsea RMH	332	36	(296)	1,848	1,375	(474)
3rd MRI Chelsea - RMH	800	534	(266)	1,530	1,522	(8)
McElwain Feasibility work - RMH	800	828	28	1,156	1,220	64
Chelsea site design fees	333	0	(333)	1,000	1,000	0
Carlyle Linac Infrastructure Chelsea - RMH	357	95	(262)	797	767	(30)
Backlog Maintenance 2020/21- Chelsea	254	38	(215)	750	388	(362)
Backlog Maintenance 2020/21- Sutton	254	559	306	750	959	209
Stem Cell Lab Rebuild RMH	103	(30)	(133)	540	524	(16)
Radiopharmacy Office Space Sutton - RMH	250	28	(222)	291	299	9
AMBIN Expansion RMH	190	186	(4)	238	249	11
X-Ray Carestream Dr7500 (Room 3) Chelsea	10	1	(9)	100	101	1
Minor Works 2020/21 - Chelsea	20	16	(4)	100	96	(4)
Minor Works 2020/21 - Sutton	20	2	(18)	100	103	3
X-Ray Carestream Dr7500 (Room B) Sutton	60	64	4	99	125	26
Pharmacy Expansion Sutton RMH	0	30	30	91	121	30
PP refurbishment	0	0	0	63	63	0
Brightview Gamma Camera	50	62	12	58	94	36
CyberKnife Infrastructure - RMCC	40	33	(7)	50	61	11
MAMMOGRAPHY DIGITAL SENOGRAPHE DS - Sutton	29	2	(27)	43	36	(7)
MAMMOGRAPHY DIGITAL SENOGRAPHE DS - Chelsea	42	27	(15)	42	38	(4)
Mobile MRI Chelsea works - RMH	0	2	2	25	25	0
Other	0	150	150	0	209	209
	4,509	3,496	(1,012)	13,849	13,612	(237)
Estates - Charity funded						
MRI Scanner Replacement Sutton Feasibility RMCC	1,136	486	(650)	1,488	1,636	148
Replacement MRI Sutton - RMCC	196	28	(168)	1,055	442	(613)
CMP Molecular Lab Genomics	40	2	(38)	80	22	(58)
	1,371	516	(856)	2,623	2,100	(523)
Estates Total	**5,880**	**4,012**	**(1,868)**	**16,472**	**15,712**	**(760)**

Financial Performance Report
31st July 2020

The ROYAL MARSDEN NHS Foundation Trust

	Year to Date Plan	Year to date Spend	Year to Date Variance	Initial Plan	Full Year Forecast	Forecast Variance
	£000	£000	£000	£000	£000	£000
Oak and Sutton Site Development - Trust funded	574	1,346	772	2,828	2,828	0
Oak and Sutton Site Development - Charity funded	3,038	78	(2,961)	13,022	13,022	0
Oak and Sutton Site Development Total	**3,612**	**1,424**	**(2,189)**	**15,850**	**15,850**	**0**
Private Care - Trust funded						
Cavendish Square Private Patient OP Facility	1,049	741	(308)	5,650	5,691	41
Cavendish Square Equipment	1,541	20	(1,521)	4,623	4,116	(507)
	2,590	**761**	**(1,829)**	**10,273**	**9,807**	**(466)**
Space Planning - Trust funded	33	100	66	100	136	36
	33	**100**	**66**	**100**	**136**	**36**
Medical Equipment - Trust funded						
3rd MRI - Chelsea Basement (Additional)	424	0	(424)	1,270	1,058	(212)
Carlyle Linac Server Upgrade Chelsea - RMH	65	84	19	277	277	0
MRI ACHIEVA 3T - PDC funded	0	0	0	0	1,530	1,530
Other	0	302	302	0	387	387
	491	387	(104)	1,547	3,252	1,705
Medical Equipment - Charity funded						
CT Flash Dual Source (Including Chiller replacement)	541	0	(541)	2,000	0	(2,000)
MRI ACHIEVA 3T (Plan)	541	0	(541)	2,000	150	(1,850)
Additional 4th Growth MRI 3T	420	0	(420)	1,800	1,800	0
Replacement MRI Avanto (including £30k Chiller)	373	0	(373)	1,600	1,036	(564)
Patient Monitoring - Phase 1 of 2	138	0	(138)	590	685	95
Minor Equipment 20/21	117	115	(2)	500	500	0
EUS System & Scopes	72	0	(72)	310	370	60
X-Ray Carestream Dr7500 (Room 3)	72	0	(72)	310	150	(160)
Koelis Trinity MR/US fusion prostate biopsy system	35	0	(35)	151	182	31
Theatre Endoscopy Stack and Scopes (Chelsea Theatres)	0	818	818	0	998	998
Other Equipment	0	551	551	0	1,563	1,563
	2,310	1,484	(826)	9,261	7,434	(1,827)
Medical Equipment - Total	**2,801**	**1,871**	**(931)**	**10,808**	**10,686**	**(122)**
COVID-19 - Trust funded	587	343	(244)	587	587	0
	587	**343**	**(244)**	**587**	**587**	**0**
TOTAL	**16,746**	**9,059**	**(7,686)**	**66,754**	**63,074**	**(3,680)**

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
15 September 2020	8.
Title of Document:	**To be presented by:**
Top Risks and Concerns	Chief Nurse

1. Status **For Approval**

2. Purpose:

Relates to:

Strategic Objective(s)	*X*
Operational Performance	*X*
Legal / regulatory / audit	*X*

3. Summary

This is the fifth annual 'Top risks and concerns paper' taken to the Board. Since 2015 the Risk/Assurance Team has compiled this paper through analysis of the Risk Register/Board Assurance Framework and from staff feedback.

4. Recommendations / Actions

The Board is asked to discuss, comment and agree the final 'top-three' risks for 2020/2021.

The ROYAL MARSDEN
NHS Foundation Trust

The Annual Top Risks and Concerns Summary Paper

1.0. Top 3 Risks

Following a review of the Corporate Risk Register and discussions with staff, the following top 3 risks have been identified:

2019/20 'Top Three Risks' presented to QAR/AFC Sept 2019:

1. IT resilience and infrastructure (including replacement of EHR).
2. Finance: potential structural changes to payment systems as part of the 2019/20 tariff and planning cycle. Delivery of research strategy, given the risk of reduced BRC grants. New.
3. Clinical capacity – particularly in surgery, diagnostics and interventional radiology to enable RM to meet key national targets.

2020/2021 – suggested:

1. Failure to achieve financial plan; due to the financial implications of the pandemic.
2. Recovery/clinical capacity post wave one of the pandemic including clinical and non-clinical space constraints as a result of 2m distancing requirements.
3. Impact of Brexit implementation on workforce, supplies and research output.

2.0. Other risks (above 12 on the Risk Register)

- **Failure to achieve required performance for national cancer waiting times targets**, (62 days from urgent GP referral to first treatment, and 62 days from screening referral to treatment). COVID-19 had impacted the volume of GP referrals for cancer as well as diagnosis and treatment rates across the country. Referral to treatment backlogs had increased.
- **IT infrastructure**- Cyber-attacks due to ageing and legacy infrastructure. Impact of the pandemic on HER procurement, including financial stability.
- **RM/ICR** receives £8m per annum for 5 years (2017 – 2022) to support translational research. Competitive bids for retaining BRC status will open in 2021. An unsuccessful bid could lead to significantly reduced or lost funding.

3.0. Top Concerns from RM Staff

Trust frontline clinical and administration staff at all levels were asked what their top 5 concerns were which are themed and summarised below (not in any priority order):

1. Staffing – recruitment & retention of clinical and technical staff in nationally recognised shortage areas: Children's, Critical Care Services, Specialist Radiologists, Interventional Radiology Nursing and Radiographers (Diagnostic and therapeutic)
2. IT infrastructure – modernising our infrastructure to support effective care and reducing the administration/paper burden on frontline staff.
3. Workload Pressure/stress – exacerbated by the pandemic and in line with the wider NHS – increases in patient numbers and acuity.
4. Patient and staff environment and space – particularly referenced on the Sutton site, but with a new trend of office environments emerging.

While the concerns raised by staff are broadly aligned with the strategic and operational risks found within the BAF and Corporate Risk Register, there are understandably some differences for example, staff identify workload pressures as a risk but would not necessarily identify the delivery of the research strategy and BRC grant as a key risk.

4.0. Conclusion

Board members are invited to discuss this paper and to confirm that the top 3 risks to the Trust have been accurately identified. The Chief Nurse will also provide thematic feedback from staff debriefings on Covid-19 for information.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
15 September 2020	9.
Title of Document:	**To be presented by:**
Risk Appetite	Company Secretary

1. Status **For Noting**

2. Purpose:

Relates to:

Governance	✓

3. Summary

The Risk Appetite Statement was recommended by KPMG as part of the deep dive exercise on Risk Management and presented to the Audit and Finance Committee on 25th November 2019. The Executive Team and the Company Secretary have since worked on the statement and the attached is for discussion and approval.

4. Recommendations / Actions

The Trust Board is asked to discuss and approve the Risk Appetite Statement.

Risk Appetite Statement 2020

Headline Risk Appetite Statement

The Trust seeks to employ a risk framework to reduce risk as far as possible and to within agreed tolerances. This risk appetite statement sets out the amount of risk the Trust is willing to accept, tolerate or justify when delivering its healthcare, education, training and research. It is recognised that delivering healthcare carries inherent risks that can never result in an absence of risk. The Trust will not accept risk that materially impacts on patient safety, the viability of the Trust (through the capacity and capability for the work), the health and safety of its built environment or its responsibility to safeguard public funds, but has a higher appetite to take risks in pursuit of other strategic objectives.

The Board will review its Risk Appetite at least annually, to ensure that the risk tolerance levels are acceptable and to ensure that the Board and staff consistently undertake Trust activity. The risk appetite will also be reviewed if there are actual or proposed significant changes to the local healthcare environment.

Risk appetites have been divided into the following areas based on the current classification of strategic objectives:

- Research and innovation.
- Treatment and care.
- Modernising infrastructure.
- Financial sustainability and best value.

The risk appetite is made up of a statement about the Board's view of risks in the above areas and its appetite to take those risks and then linked to a risk tolerance based on a scale identified by the Good Governance Institute (GGI) (see Appendix 1) .

The risk appetite can therefore be summarised as:

Objective / Risk Appetite	Risk Tolerance
Research and innovation: Seamless, systematic and rapid transition from scientific research to translational clinical research, developing smarter kinder treatments and embedding innovative treatments in the clinic.	
The risk appetite for research and innovation is broad, depending on the nature of the research or innovation being proposed. It has a flexible view of innovation that supports quality, patient safety and operational effectiveness. This means that it will support the adoption of innovative solutions that change the way care is delivered as well as supporting implementation of approaches that have been tried and tested elsewhere, which challenge current working practices and involve systems/technology developments as enablers of operational delivery. Research will be supported which is operated in a controlled way and has appropriate ethical and supervisory oversight and is delivered with regards to the appropriate safety protocols.	**Significant tolerance** (across all aspects of research and innovation)
Treatment and care: Developing and leading new models of care; Leading Royal Marsden Partners; Address capacity constraints; Deliver cancer waiting times targets.	
For those activities which impact the three domains of quality – safety, effectiveness and patient experience. It includes those risks which have the ability to affect patient care and may cause harm to the patient. This covers anything related to the diagnosis, treatment and outcome of each patient. Psychological harm or distress is also included.	**Low tolerance** (in respect of risks associated with patient safety, including non-compliance with safeguarding and patient experience or clinical outcomes).
The approach to systems leadership, through initiatives such as Royal Marsden Partners, is to be an agent for convening relevant stakeholders but without putting patients or the Trust and its reputation at risk.	**High tolerance** (in respect of promoting new models of care and systems leadership).
Those risks that threaten the achievement of the Trust's principal objectives and the viability of the organisation through the capacity and capability of the workforce.	**Low tolerance** (in respect of risks associated with workforce safety and workforce management).
Modernising infrastructure: Modernisation of estate and facilities, including IT, to maximise opportunities for research and manage capacity (NHS & Private Care).	
The development of IT and other facilities that support modernisation of services can never be done without risk, but will be managed with decision making at a high level.	**Moderate tolerance** (across all aspects of modernisation of IT and estates)
Health and safety risks include risks that affect the environment of care and risks that could cause injury or ill health to any person in connection with the Trust's activities. This includes fire, security, environmental and health and safety issues.	**Low tolerance** (in respect of risks associated with patient and staff safety).

Objective / Risk Appetite	Risk Tolerance
Financial sustainability and best value: Improve productivity and efficiency; Manage capital programme; Maximise commercial opportunities.	
Those risks which have the ability to affect the financial well-being of the Trust. Financial decisions impacting on quality and patient safety will be subject to rigorous quality impact assessments. The Board has a balanced view of commercial and capital risk. It will support low-risk opportunities in established business areas and markets and in areas where it has significant commercial strength over its competitors and/or wishes to secure continuity to the benefits and outcomes to the Trust's patients and the wider community it operates in. More novel or contentious propositions need a cautious approach to the commitment of Trust resources.	**Low tolerance** (to financial risks to safeguard public funds). **High tolerance** (to commercial or capital risks in areas of proven operation) and **moderate tolerance** (to novel commercial or capital propositions).

Appendix 1

RISK APPETITE FOR NHS ORGANISATIONS
A MATRIX TO SUPPORT BETTER RISK SENSITIVITY IN DECISION TAKING

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 - 6

Risk levels / Key elements	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal (ALARP)** (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
15 September 2020	10.
Title of Document:	**To be presented by:**
Board Assurance Framework & DHSC COVID-19 Board Assurance Framework for all NHS Trusts.	Company Secretary & Chief Nurse & Director of Infection Prevention Control.

1. Status **For Approval**

2. Purpose:

Strategic Objective(s)	*Monitoring strategic risks against objectives*
Governance	✓

3. Summary

The purpose of the Board Assurance Framework (BAF) is to present the Trust's risk assurance framework in the context of the strategic objectives based on the core and cross-cutting themes set out in the Strategic Plan 2018/19 – 2023/24.

The largest single risk to population health in 2020 has been the COVID-19 Pandemic. As a result of this, the Department of Health & Social Care (DHSC) has produced a dedicated COVID-19 BAF with the expectation by the DHSC and the CQC that all NHS Board of Directors have sight of and discuss the risks and mitigations of the pandemic on the areas that the Board is responsible for.

The Royal Marsden takes Infection Prevention extremely seriously. Prior to the pandemic (June 2019) on the recommendation of the Chief Nurse & Medical Director the Trust invested significantly in the Infection Control and Microbiology Teams, adding an additional 1.0 WTE Consultant Microbiologist, 1.0 WTE Infection Prevention Matron and 0.5 WTE Specialist Infection Prevention Pharmacist to the team. This capability was fully recruited to prior to the pandemic and further augmented in March 2020 with an additional 2.0 WTE Infection Prevention Nurses.

This enhanced Infection Prevention provision was important in supporting the Trust to design and deliver England's first Cancer Hub at the height of the first wave of the pandemic, and continues to this day to advise on all matters related to Infection Prevention, not just related to the Pandemic, but also common opportunistic infections related to specialist cancer care, such as E-coli and Clostridium Difficile.

4. Recommendations / Actions

The Board is asked to note the changes highlighted in red and the risk tolerance scores that are currently exceeding the risk tolerance threshold and to note the actions taken to mitigate risks of COVID-19 infection to patients, staff and visitors.

The joint Quality Assurance and Risk Committee and Audit and Finance Committee is also reviewing these documents at its meeting on 9 September and comments will be incorporated.

The ROYAL MARSDEN
NHS Foundation Trust

Board Assurance Framework: August 2020

1.0. Purpose

The purpose of the Board Assurance Framework (BAF) is to present the Trust's risk assurance framework in the context of the strategic objectives based on the core and cross-cutting themes set out in the Strategic Plan 2018/19 – 2023/24.

The Board is asked to note the changes highlighted in red and in particular the risks exceeding the Board tolerance scores as shown in the table below.

2.0. Summary of current position

Strategic Objective	Initial Risk Score	Residual Risk Score	Risk Tolerance	Risk exceeding tolerance?	Change in risk score
Increasing capacity constraints and meeting cancer waiting times targets	25	16	Moderate (11-15)	✓	None
Ensure a sustainable paediatric model	16	12	Low (6-10)	✓	None
Achievement of key national infection control targets – Ecoli & CDI	16	12	Low (6-10)	✓	None
Developing a sustainable consultant medical model	16	9	Low (6-10)	-	None
Delivery of IT Strategy	20	15	Moderate (11-15)	-	None
To work collaboratively with RBH	15	12	Moderate (11-15)	-	None
RM Partners to rollout best practice	12	12	High (16-24)	-	None
Ensure BCP in the event of a 'no-deal' Brexit	12	12	Moderate (11-15)	-	None
To support the national policy direction setting out much greater emphasis on system decision making	12	12	High (16-24)	-	None
Achieving Optimal Scale & Transformation through collaborations with partners	16	9	High (16-24)	-	None
Complete the development of the new diagnostic facility for PP (Cav Sq)	12	8	Moderate (11-15)	-	None
Maximise opportunities for Sutton via LCH&ESH	8	8	High (16-24)	-	None
Delivery of PP Strategy	12	8	Moderate (11-15)	-	None
Successful delivery of BRC grant	15	6	Significant (25+)	-	None

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
	Research and innovation: Seamless, systematic and rapid transition from scientific research to translational clinical research, developing smarter kinder treatments and embedding innovative treatments in the clinic.							
1.	Successful delivery of the NIHR BRC grant 2016-2021 based on reduced funding award of £42.5m in December 2016 and preparation for renewal of the grant in 2022. Director of Clinical Research / COO <u>RM Board of Directors</u>	Reduced BRC funding poses a risk to the delivery of the research strategy launched in July 2016 as well as maintaining research output.	15 14/11 /18	All themes were allocated a reduced budget in 2017-18 and 2018-19. Each theme lead has been instructed to prioritise research and seek alternative sources of funding where possible. Grant manager appointed to facilitate increase in grant submissions. Performance management systems have been implemented to monitor output and efficiencies via quarterly Performance Review Groups Continuation of RMCC grant for further five years from 2017 (£15m) Oversight of progress at weekly Clinical Research Executive (CRE), chaired by Director of Clinical Research and BRC Steering Board. There has been no drop off in research activity and output. Interim BRC Digital Theme Champion has been appointed. Planning for next competition has commenced. BRC planning is standing item for new RM/ICR Joint Exec Group and Joint Research Strategy Board. BRC competition standing item on Joint RM/ICR Research Ops Meeting and RM/ICR Research Strategy Board.	Small working group meetings to identify theme structure and major research priorities have been completed with the outputs used to help inform preparation for the next renewal grant. Mid-term independent review of BRC progress scheduled for Q1 2020 Discussions will take place with the ICR regarding our preparation for the renewal as part of our new joint working arrangements – ongoing The latest BRC recruitment plan was reviewed at the Joint Research Strategy Board in September Ongoing discussions with Imperial to agree relationship between RM/ICR application and Imperial BRC	6	25+	Mid-term review completed and report received, scheduled for discussion at Joint Research Strategy Board. Discussions with Imperial ongoing. BRC Competition delayed by minimum of 6 months with steady state funding expected for that time.

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
				Mid term review has been completed.				
2.	Achieving optimal scale and transformation of care through strengthening and developing collaborations with partners. *RM / ICR CEOs* <u>RM Board of Directors</u>		16 14/11/ 18	Imperial Academic Health Science Centre partnership. The Royal Marsden and the Royal Brompton joined the extended AHSC in 2016. Contract was agreed by the Board. Oversight of progress through the Board. IPA and supporting agreements have now been approved by both the RM and ICR Board as of March 2019 ICR/RM JEG and Joint Strategy Boards are now well established.	RM currently working with RBH colleagues to formalise the joint lung oncology service model. A proposal will be brought to EB for consideration in Q1 20/21. In response to the COVID-19 pandemic RM have taken on the provision of RBH's thoracic surgery for oncology patients and is also looking to support delivery of different elements of the diagnostic pathway. Proposal for formal consolidation of the joint service model to be brought to a joint Executive meeting in September 2020 RM/ICR Joint Board strategy session planned fo Autumn 2020	9	16-24	Decision on formalisation of joint thoracic oncology service with RBH to be made by Oct 20 Board meeting

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
	Treatment and care: Developing and leading new models of care; Leading Royal Marsden Partners; Address capacity constraints; Deliver cancer waiting times targets.							
3.	Leading RM Partners to oversee the rollout of best practice across healthcare systems to reduce variation in outcomes for patients. *Managing Director, RM Partners* <u>RM Board of Directors</u>	Funding risks: RM Partners funding beyond 2019/20 will be granted on a population share. This will reduce the funding available to RMP after that time. Reputational risk – reputational risk to RMH if RMP is not successful as an entity or does not deliver projects and milestones.	12 14/11/ 18	Monthly RMP Exec Board comprising of CEOs established for NW & SW London. Monthly RMP Delivery Group and bi-monthly Clinical Oversight Group across RM Partners. Now in place a Patient Advisory Group (PAG) – provision of patient opinion on RMP activities/projects including work streams arising from pathway groups. RM Partners as West London Cancer Alliance is accountable to National Cancer Programme via London NHSE and NHSI regional teams for delivery of the cancer transformation plan. Aligns with STP/ICS and pan London plans. Robust PMO plan in place to map projects to resource. Underlying costs are within financial allocations for next five years. Oversight of progress and management of risk through the RM Executive Board up to the RM Board. RM and RMP have jointly developed the Cancer Hub model that has been rolled out for West London and has now been adopted as national policy in response to the COVID-19 pandemic.	RMP to clarify funding arrangements for 20-21	12 18/01/19	16-24	

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
				RMP have agreed and signed off a 20-21 work plan incorporating its roll coordinating the cancer recovery plans for NW and SW London				
4.	To support the national policy direction setting out much greater emphasis on system decision making, and by definition, an erosion of autonomy for individual institutions, particularly FTs. RM Board of Directors	Trust Board to consider the potential risk to some loss of control on capital expenditure limits and use of surpluses for reinvestment	12 16/04/19	Active engagement in both SWL and NWL STP and Integrated Care System planning Feedback via NHS Providers on the proposed policy changes Active engagements with other specialist hospitals in ensuring our collective interests are represented at both a regional and national level. Fully funded and endorsed RMP business plan which is aligned to the NHS Long Term Plan RM/RMP are leading the cancer response and recovery plan to the COVID-19 pandemic on behalf of the NWL and SWL STP/ICS	Continue to support the developments in SWL to find a sustainable long-term solution to the configuration of acute hospitals PM decision to fund redevelopment of ESHT. RM to support ESHT in the development of OBC by end of 2020 Work with NWL and SWL STPs to align the ICS and RMP plans for integrated care	12 16/04/19	16-24	
5.	Increasing capacity constraints and meeting Cancer Waiting times targets RM Board of Directors	Capacity constraints in ambulatory care, diagnostics (prior to completion of Cavendish Square), inpatients and surgical capacity. Risk relates to meeting service demand, impact on performance and	25 14/11/18	Weekly Patient Tracking List and monthly Performance Review Joint RHM/RMP 62 day CWT action plan in place and being implemented and monitored through RMP and the Systems Leadership Forum Delivery of internal transformation projects to address capacity constraints and deliver service improvements	Day care improvement programme priorities agreed and focussed on reducing waiting times. West Wing will go live with electronic scheduling in April 2020. Work is in progress to improve pre-prescribing rates and aseptics	16 9/04/2019	11-15	Recovery plan trajectories will be monitored as part of the revised Board scorecard

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
		meeting cancer targets and failure to deliver private income targets. Reputational risk also.		Fortnightly Recovery Board meetings with oversight of projects. Work programme includes: • Inpatients • Outpatients • Surgery • Administration • Daycare Mobile MRI commissioned on the Chelsea site as interim measure until additional permanent capacity opens in autumn 2020 Trust has accessed NHSE funded mobile CT to support backlog recovery Ongoing use of Independent Sector capacity to support Covid recovery	workflow. This is delayed due to COVID-19 Plan to extend working days in theatres to support surgical recovery (subject to agreed commissioner funding) – Sept 20			
6.	Development of a sustainable Consultant medical model MD, DoW, DME, COO <u>QAR</u>	Workforce risk as there are gaps in Academic Paediatrics, Academic Haematology (ICR appointments).	16 14/11/18	Development of a sustainable and compliant junior medical model to support excellence in training is underway (rota review); ward based medical model; support roles) as part of transformation work plan. Cavendish Square Delivery Group has been largely established and consultant workforce is now in place ready for opening in Feb. Lung business case for Cav square being finalised The Trust has developed consultant workforce	Further discussions are underway in haematology to address service workload issues. Temporary plan to outsource some transplant work until December 2020	9 18/01/19	6-10	

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
				strategy, which details development or investment required to support ambition set out in the Five Year Strategy Task and Finish Group (chaired by CEO) meeting bi-monthly established for Cavendish Square				
7.	To ensure a sustainable paediatric service model at RM. CEO/MD <u>RM Board of Directors</u>	Primary Treatment Centre is decommissioned from RM as a result of NHSE mandating co-location with a PICU	16 14/11/18	CQC inspection gave Paediatrics a rating of "Good" and Trust overall rating of Outstanding Service deemed safe. Internal service evaluation of the Paediatric Service complete and validated by KPMG. The review has confirmed that the Principal Treatment Centre provides a comprehensive, high-quality, safe service to children. Comprehensive governance arrangements in place with St Georges that have ensured that there have been no SIs in relation to the joint service model 2019 Picker Service ranked RM paediatric services as one of top 6 providers for patient experience Joint statement developed by RM and StG committing to develop a SWL option for the retention of the PTC in line with commissioning requirements	Continuing to working with St George's Hospital to optimally manage PTC beds. Centre of Excellence collaboration with ICR and GOSH being developed. Funding to be sought to progress this model that will embed a tripartite of clinical, research and academic leadership roles in RMH/ICR with the addition of research fellow posts to progress academic ambitions and gain further R&D funding – Q4 19/20. Staff, patient and families comms and engagement plan to be enacted Q4 19/20 Work plan to be developed setting out the Sutton case for a consolidated PTC as part of	12 18/08/20	6-10	

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
					an NHSE led option appraisal Q2 20/21			
8.	To continue to work collaboratively with The Royal Brompton RM Board of Directors	Service risk as the Royal Brompton plans to move services to Guy's and St Thomas' Hospital site; risk to lung cancer pathways and loss of local lung cancer diagnostics and surgery.	15 14/11/18	A joint public commitment from both RBH and RMH Boards to developing the existing joint thoracic lung service as a preferred option for the long term (June 2019) RBH and RMH project Board established to oversee the development of the future joint service model.	In response to the COVID-19 pandemic RM have taken on the provision of RBH's thoracic surgery for oncology patients and is also looking to support delivery of different elements of the diagnostic pathway. Proposal for formal consolidation of the joint service model to be brought to a joint Executive meeting in September 2020	12 09/04/19	11-15	
9.	To ensure business continuity in the event of the EU Exit CN, DoW and COO QAR	Potential risk to business continuity and possible financial risk across eight key areas: 1) Medicines supply 2) Medical devices & consumables 3) EU workforce 4) Professional regulation 5) Reciprocal healthcare 6) 6. Research & clinical trials	12 14/11/18	EU Exit lead (Jatinder Harchowal) is holding weekly local EU Exit meetings to oversee and manage any risks in the key areas, particularly if there is a 'no-deal' exit from the EU. A table-top exercise was held in October 2019 to test EU Exit related scenarios. Following the table-top exercise, all departments and clinical areas have been asked to complete their EU-Exit Business Continuity Plans and EU-Exit Risk assessments. These will be reviewed in January 2020. The Trust will continue working closely with the regional EU Exit teams to keep aware of any issues and planning taking place nationally to support the impact of exit from the EU.	At this current time NHS Trusts have been advised that they should not be considering any local action for medicine or other consumables supply and therefore should not be stockpiling additional medicines or writing longer prescriptions. EU Exit planning committee will meet weekly from January 2020 and the Trust will be submitting a daily EU Exit submission report as requested by NHS England to identify any EU Exit related	12 18/01/19	11-15	

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
		7) Data sharing 8) Access to Radioisotopes		The Department of Health and Social Care (DHSC), has undertaken a detailed analysis of the supply chain for medicines, including radioisotopes and vaccines. The DHSC has set up a Medicines Supply Contingency Planning Programme and expects pharmaceutical companies to have a minimum of six weeks additional supply in the UK, over and above their business as usual operational buffer stocks, in case of a no-deal Brexit. The Trust has been continually monitoring its workforce supply over the last 12 months and the number of staff from the EU has remained steady at 12%. An update will be presented to the Executive Board in February 2020.	risks. DHSC expected to issue further guidance, pending the outcome of the next phase of BREXIT negotiations. The current date for withdrawal from the EU has now been set at 31 January 2020. The EU Exit lead attends the regional EU Exit preparation meetings. This is on hold due to COVID-19.			
10.	Achievement of key national infection control targets – Ecoli & CDI Chief Nurse Director of Infection Control (DIPC) <u>RM Board of Directors</u>	Failure to achieve key national infection control targets as set by NHSI and Commissioners. Quality risk, reputational risk, financial risk (as per contracting)	16	Assurance to the Board and QAR via the monthly Quality Account. Assurance to Board & QAR via dedicated IPC updates. Levels of both infections are not demonstrating outbreaks or deterioration in performance. External review of CDI cases by CCG quarterly as part of CCG contract.	Ecoli – initiated collaboration with The Christie, Clatterbridge & NHSi. Darzi fellow for Ecoli improvement work completed Dedicated Ecoli action plan. CDI – dedicated CDI action plan. Weekly DIPC CDI improvement meetings. Review of CDI at RMH by	12 28/03/19	6-10	

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
					national leaders in the field (via NHSi).			
11. New (April 2020)	COVID-19 pandemic RM Board of Directors	Failure to deliver a safe, effective and responsive service following COVID-19 (Coronavirus) outbreak. Quality risk, reputational risk, financial risk	20	Twice weekly COVID-19 Tactical Group Meeting Service continuity plans have been reviewed and are ready to enact Surge plans have been tested and can be re-enacted as required CAS alerts pathway Participations in NHS England system wide stress test exercise COVID-19 inbox in use, particularly to receive messages from the National Track and Trace scheme Daily Site rep COVID-19 escalation 'surge plan' in place Implementation of blue / green pathways for patients which separates elective patients from urgent ones. Where appropriate, reintroduction of previous clinical pathways, procedures and interventions Digital solutions minimise clinical face to face contacts and MDT's Social distancing in place where possible – separation of 2 meters and face masks to be worn in all Trust buildings. Workforce group in place (volunteers, welfare) HR workforce hotline in place. Group in place to implement on site staff and patient Covid testing. Logistics and critical care infrastructure (Digital and PPE provision)	Actions reviewed at twice weekly Tactical meetings. GOLD meetings in place (weekly) Timely response to guidance and updates from NHSE/I and PHE. Development and delivery of our recovery plan including work with the cancer alliance and STP/ICS. To be completed by March 2021.	12	16-20	

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
				Digital solutions to enable working from home being rolled out. Records of competencies outside of existing role Reinstating medical trainee rotations Reinstating nurse mandatory training, multi-disciplinary and HCA sessions.				
12. New (April 2020)	The Trust and RM Partners have jointly developed and set up a Cancer Hub for surgical pathways with RM as the host for West London. The model has since been adopted as national policy in response to the COVID-19 pandemic. RM Board of Directors	Risk that the Trust as host will be responsible for the consequences of all decisions made to enable Cancer Hub to be set up (& during its operation) and start receiving patients. [Clinical decision of 'decision to treat' made by MDTs external to Trust and not being reviewed by RM]. Quality risk, reputational risk, financial risk	16	The Trust and RMP are leading the cancer response to the Covid pandemic on behalf of the NWL and SWL STPs/ICS Reports to GOLD meetings, IGRM committee to monitor governance processes are followed. Develop SOPs for all trust to follow. Pathways for patients going through the Clinical Prioritisation Group (CPG).	Trust risk register for the Cancer Hub contains 23 separate risks. To be completed by 5 May 2020. Cancer Hub CPG meeting chaired by Medical Director. RM Partners working closely with the Trust to ensure work follows Trust's governance processes. Review if other clinical treatment pathways (Radiotherapy and SACT) and Diagnostics would be appropriate to be delivered through the Cancer Hub as part of the Recovery Plan. Develop SLAs for other trusts involved.	12	16-20	
	Modernising infrastructure: Modernisation of estate and facilities, including IT, to maximise opportunities for research, and manage capacity (NHS & Private Care).							

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
13.	Maximise opportunities for Sutton site through the London Cancer Hub (LCH) proposal alongside plans for a new Epsom and St Helier (ESH) site to the north of RM Sutton site. COO <u>AFC</u>	Risk that external projects may have an impact on RM plans for site development and / or that RM may not realise the full benefits of these developments	8 14/11/18	RM planning contribution to new Sutton Hospital, London Cancer Hub and potential SWL elective cancer centre. LCH Development Framework and implications for future planning of the Sutton site. RM continues to engage with LCH and ESH plans to ensure the developments fit with the future site direction for RM. Planning permission granted for the Oak Cancer Centre.	LCH procurement exercise to find a development partner has stopped. The LBS plan to take forward the LCH vision in a step by step manner starting with a smaller Knowledge Centre, which will be funded by an external grant. The SWL Committees in Common have approved Sutton as the preferred site for the ESH build. RM is engaging with ESH to explore where there may be opportunities to collaborate between ESH and RM. A proposal for a SWL elective cancer centre has arisen. RM is engaging with this proposal to explore whether it is viable and to clarify what role RM would wish to plan in it.	8 18/01/19	16-24	
14.	Complete the development of new diagnostic facilities for private patients in Cavendish Square due October 2020. CEO; MD Private Care; <u>RM Board of Directors</u>	Clinical and Governance risks for a new off-site model of care delivery which relies on consultant capacity and commitment, completion of the build on time, and financial risk	12 14/11/18	KPMG Governance and estates procurement review on Cav Sq completed in December. Green/Amber rating achieved with a plan of recommendations agreed. Programme Board (chaired by CEO, now meets monthly) and Project team (meeting fortnightly) established. Workstream leads identified and established.	Recommendations from Dec 2019 KPMG audit agreed and implemented. Final Business case being prepared for Board approval in March. Site handover took place in June (access delayed by 3 months due to landlord works	8 18/01/19	11-15	FBC to be reviewed by EBs and the Board in March 2020 Build commenced following site access in June. Site

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		regarding management of the budget in line with the business case.		New Clinical Director for Cavendish Square appointed Programme assurance report created and updated monthly at Programme Board Assessment of key risks and contingencies undertaken and regularly reviewed by Programme Steering Board and Capital Programme Board. Budget phased in accordance with programme delivery milestones Workstream milestones under review by the Programme Board. Clinical Advisory Group (CAG) regularly review consultant participation and key clinical risk and mitigation.	over running). Build has commenced. Opening date set at November 2020. Workforce gap assessment completed in September 2017. Mitigation actions in progress to address gaps. Preliminary Commercial strategy completed in June 2019 to identify sources of demand and detail plans to build revenue in line with budget forecast.			opening scheduled for November 2020. This is delayed due to COVID-19 Workforce gaps assessed and mitigation actions in place.
15.	Deliver the Information and IT Strategy including upgrades to the network and WiFi, creation of the digital workplace, new LIMS and data warehouse, and replacement of the Electronic Patient Record and Clinical Research System. CFO/CIO	Financial risk: inability to support productivity and efficiency gains through use of technology. Potential loss of income. Cyber-security risk: risk of a cyber-attack which poses a risk to patient safety, loss of	20 14/11/18	The IT strategy has been finalised and agreed by the Board in June 2016. There is a Board approved Joint Venture with Chelsea & Westminster Trust that oversees and runs the technical aspects of the IT infrastructure. The CFO and COO are on the Board of the JV (Sphere). A review of the current EPR and options for replacement is currently being scoped. Oversight of the programme is through the IT Strategy Group (ITSG)	The CCIO and CNIO have been appointed and commenced their roles in October and September 2019 respectively. Revised governance to include a clinically-led Design Authority was ratified by the IT Strategy Programme Board in March 2019. New governance structures are in place, with SROs appointed.	15 18/09/19	11-15	Board approved OBC for EPR in December 2018. The formal EPR procurement process commenced in October 2019 and is

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
	AFC / RM Board of Directors	income, reputational damage. Workforce risk: inability to attract and retain staff with poor IT systems.		Monthly tracking against capital plan at IT Programme Board (ITPB) The ITSG assesses the risk of the lack of investment and manages this within the resources available. Cyber risk has been added to Risk Register and monitored. It was agreed on 21 Feb 2018 that the AFC will receive an annual progress report on the IT Strategy. The Board received a report on Cyber-Security at its meeting in November 2017 and held a Board Seminar on this subject in Feb 2018. CIO appointed from August 2018. Programme Assurance Group has received external (PWC) assurance report.	A non-executive director led Programme Assurance Group commenced formally in September 2019. LIMS procurement remains in progress, FBC was due September 2019 but has been delayed whilst hosting arrangements are clarified. External gateway governance in place to assure procurement. EPR programme resources are in post to support procurement process. External gateway governance in place to provide assurance. Digital Council members to be appointed January 2020 to provide clinical leadership of the programme. Windows 10, single sign on and device replacement full business case now approved, procurement has commenced Procurement process for data warehouse and business intelligence tools has completed. Evaluation taking place January 2020 to select			due to complete in April 2020 via an accelerated framework. Infrastructure improvements have commenced. This includes the rollout of Office 365 across the organisation. Network replacement FBC approved October 2019. Work commences November 2019 and will address key cyber security risks and improve staff experience.

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
					preferred supplier(s). Full business case is being presented to FPC and EB in March 2020.			This is delayed due to COVID-19
	Financial sustainability and best value: Improve productivity and efficiency; Manage capital programme; Maximise commercial opportunities.							
16.	Successful delivery of the Private Care Strategy which requires short and medium term initiatives to enable profitable growth <u>AFC / RM Board of Directors</u>	Lack of Private Capacity (and shared service resource) impacts ability to meet revenue targets and meet service expectations. Risk of over-dependency on volatile embassy business impacts debt and profitability. Lack of system integration (Compucare vs HIS) presents risks to efficiency and accuracy of billing information. Rate of business growth increasing pressure on staffing models resulting in	12 14/11/18	Private care KPIs for financial, operational and clinical performance have been created. Reporting of these KPIs happen quarterly to the Private Care Board. Wider strategic initiatives taken to Private Care Board / EB for approval to implement. Monthly performance review of Private care delivery as part of the PRG review. Monthly meetings to track income scheme delivery with action plans developed. Major business cases supported, signed off and post implementation evaluated by FSG. All Private Care risks are monitored and reviewed across all areas and are reported into the monthly Quality and Safety meetings. Debt management position is reviewed and monitored at AFC, Board and Council of Governor meetings. Staff metrics monitored monthly in partnership with HR Business Partner. Improved stability within Billing and Credit Control teams and improved debt recovery and data quality performance. Risk remains around recruitment and retention of key staff and reliance on other	Audit recommendations on-going. Outpatient and diagnostic capacity provided through the RDAC centre (shared with the NHS). New capacity options being assessed as part of a Trust wide review of estate and 6 day working. Due for presentation in November 2019. This is delayed due to COVID-19 Cavendish Square due for delivery in October 2020. Staff engagement plan developed in September 2019 and being rolled out. Programme of new market development underway. GP strategy approved in June 2019. Clinical Advisory Group (CAG)	8 18/01/19	11-15	Reporting of Private Care KPIs occur quarterly to the Private Care Board. Wider strategic initiatives, capacity cases and updates are taken to the Board / EB for approval.

No.	Strategic objective, Lead Director and Board ownership	Strategic Risk(s)	Initial risk score	Key controls and assurances	Action plan and timescales for completion	Residual risk score	Risk tolerance	Board update
		increased turnover and rates of sickness. Competition risk		departments to deliver benefits of the Profitability and Automation projects. Cavendish Sq facility Business Case approved to add further Outpatient, Diagnostic and chemotherapy capacity. Updated FBC to be presented to the Board in March 2020 Performance is reviewed against income/contribution targets. Risks are held on the Trust risk register including action and improvement plans across each team. Direct links with Gulf Referral institutions being formed to improve patient flow. New markets identified to diversify risk.	regularly review consultant participation, key clinical risks and mitigation. New Clinical Director appointed for Cavendish Square.			

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Infection prevention and control board assurance framework

22 May 2020, Version 1.2

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19-related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assess measures taken, in line with the current guidance, and assure directors of infection prevention and control, medical directors and directors of nursing. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can be used to assure trust boards.

Using this framework is not compulsory; however, its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May

Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, service users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful to directors of infection prevention and control, medical directors and directors of nursing, rather than imposing an additional burden. This is a decision that will be taken locally, but organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk, and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection prevention and control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission • compliance with the national guidance around discharge or transfer of COVID- 19 positive patients • **all staff (clinical and non-clinical)** are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Copies of documentation on Standard Operating Procedure (SOP) and policy including zoning / surge plan, PPE use and de-isolation. Staff fit testing records. Staff donning and doffing records Staff records for deployment / re-deployment during the COVID-19. Documents available on Intranet available for all staff. Silver tactical notes, agendas and daily sit-reps. Email staff communications. Updated risk registers Records of patients discharged to nursing or care homes. Records of ventilation review / changes. Risk register and BAF updated and presented to the board Quality account review during COVID-19.	Risk of COVID-19 outbreak amongst patients or staff, notably as community cases increase, and visitor restrictions are relaxed.	The trust has closely adhered to PHE guidance since the start of the pandemic. Patient assessments in place at all levels of entry to trust. Assessment of patients initially through telephone consultations and then through testing in a designated hub. Policies adjusted as guidance and circumstances changed. COVID-19 zones identified to minimise movements and keep symptomatic patients away from non-symptomatic risks. Extensive PPE training undertaken. Extra staff transferred in to work with IPC Team. IPC guidance used to formulate

• risks are reflected in risk registers and the board assurance framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens			operational policies. Staff intranet and WhatsApp broadcast groups used to communicate information daily to staff along with signage. Bi Weekly review of COVID-19 related risks via Silver meeting. Weekly Chief Nurse IPC Huddle (July 2020 onwards). Twice weekly tactical Silver command meeting attended by an IPC Nurse and relevant items brought forward for discussion and decision making. Environmental risk assessments completed.

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas • designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance • attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	Zoning areas / surge plan Training records for donning and doffing. Training records for fit testing Extra IPC staff records. Records of UV light and Bioquell SOP & Policies. ISS audit records for training and enhanced cleaning. Stock level records including cleaning products and linen. Staff in COVID-19 areas using scrub uniforms. Non-uniform staff including execs asked to wear washable clothes and change daily (i.e. no suits, ties or dry clean only clothing).	Elderly estate in some areas, notably Chelsea site.	Minimal backlog maintenance, including elderly estate. Experienced IPC team, well staffed. Trust Silver tactical apprised of changes where necessary. Lead IPC nurse in regular dialogue with NHSE/I lead and consulted on documents to enhance cleaning. Recommended cleaning part of our business as usual and all fell within current standards Difficulty with supply of regular products was mitigated by use of suitable alternatives. Information was given to staff to ensure correct use of products. Highlighted guidance was all part of SOP and with UVC and Bioquell was done to a higher standard, Records from stores and ISS of items purchased. Emails and documentation re ventilation Communications team engaged to produce user friendly posters and information to guide staff in correct procedures. Weekly cleanliness audits. Fortnightly cleanliness audits presented to Silver meeting.

• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is erective against enveloped viruses. • Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance. • 'frequently touched' surfaces, e.g door handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluid • Electronic equipment, e.g mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) • Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken			

• single use items are used where possible and according to single use policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance • review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Twice weekly antimicrobial stewardship ward rounds have continued to take place on both sites of the Trust. The Antifungal Stewardship and Start Smart, then Focus audits have continued.	None. Adherence to the Start Smart, then Focus principles has continued to be audited twice a week. There has been no change to adherence to these principles during the pandemic.	The Pharmacy Department has prioritised providing pharmacy support to the Antimicrobial Stewardship team during the pandemic to ensure antimicrobials continued to be used appropriately in the Trust.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access • information and guidance on COVID-19 is available on all trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Visitor signage / no visitors. Patient information posters. Signage for patients and staff Security at entrances. Closure of most entrances to limit traffic. Only designated people allowed to enter the hospital. Communication via the website, using telephone messages and letters. Radio Marsden broadcast by IPC Lead.	Risk that rapidly changing guidance is missed, or implementation is delayed.	Silver tactical meetings twice weekly to determine actions as pandemic evolved. Weekly CN IPC Huddle. Visitors restricted, footfall reduced, but visitors supported for children, patients at end of life or patients with cognitive or learning issues (a senior nurse designated to triage visitor requests daily). Guidance document produced for facilitating compassionate care of dying patients. Communications team engaged to produce user friendly posters and information to guide staff and patients

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance • mask usage is emphasized for suspected individuals • ideally segregation should be with separate spaces, but there is potential to use screens, e.g to protect reception staff • for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible • patients with suspected COVID-19 are tested promptly • patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	Security records. SOPs detailing actions training records. IPC staffing increase to provide support to clinical areas. Posters on mask usage Purchase of screens for reception desks. Protocols for screening. Use of Hubs to segregate patients Use of zoned wards. Early testing of staff and patients. Appropriate isolation protocols. Records of staff sickness. Records of staff risk assessments and redeployment.	Risk of staff or visitor cross infection.	Closure of most entrances to limit footfall and unnecessary visitors. Security at entrances. Security given lists of permitted visitors with only designated people allowed to enter the hospital sites. Reception staff primed early on to question people on arrival re travel history, symptoms etc. Initial screening of suspicious cases was undertaken by site managers or IPC Nurses. Moved to zoning systems as cases increased. Introduced staff screening in early March Patient testing turnaround time improved by utilizing Francis Crick Institute Daily monitoring of staff sickness /isolating. Temperature checking & screening by volunteers at main entrances.

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it • a record of staff training is maintained • appropriate arrangements are in place so that any reuse of PPE in line with the CAS alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited	Training records for use of PPE inc donning and doffing Posters to support staff. SOPs on intranet. Videos on intranet. Regular IPC presence on wards to support staff and ensure PPE being worn correctly and appropriately. Extra IPC staff employed. Silver tactical meeting notes including CAS alert response. Responsive stores management to monitor and manage supplies of PPE and ensure we never ran out of PPE. Never ran out of PPE. Charity work to obtain extra supplies of PPE. Continuation of hand hygiene auditing and environmental monitoring.	Risk of national supply chain issues with PPE are compromised due to a significant second wave of COVID-19. Risk of interruption of supply of RMH standard FFP3 masks (that the majority of staff are fit-tested on) leading to a requirement to mass re-fit-test staff.	Twice weekly review of PPE stock levels at Silver meeting. Extra support for stores for management of PPE. Extra IPC support to ensure very visible presence in clinical areas across site. Extra input from RM Charity to support additional procurement of PPE. Fortnightly PPE fit-testing update reported at tactical meeting.

• staff regularly undertake hand hygiene and observe standard infection control precautions • hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance • guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas • staff understand the requirements for uniform laundering where this is not provided on site • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of the symptoms	Hand towels used in clinical area. Hand hygiene guidance displayed. Increased dispersal of alcohol handrub. Staff in Covid areas wearing scrubs. Uniform guidance given and laundry bags supplied for those taking uniform home. Regular messaging via screen savers o what to do if unwell and how to report		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with possible or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Use of isolation rooms as appropriate. Zoning of wards with an escalation plan. IPC input in all clinical areas to ensure correct standards met. Continue to maintain IPC standards and monitor infection.	During second wave – risk that demand outstrips side room or ICU capacity.	Zoning adapted as pandemic unfolded, with excellent effect. Training of additional staff to support Critical Care in the event of a second wave. Focus remains on other infections which may place patients and staff at risk – norovirus, CDT, Ecoli and Flu.
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • screening for other potential infections takes place	Only accredited labs utilised, including those with mature business continuity plans. Trust Testing (staff/patients) Committee Chaired by the Medical Director weekly.	Risk of interruption to testing facilities due to increased demand, staff sickness, reagent supply issue or device failure. Risk of false positive or false negative results.	The Trust has a variety of different lab solutions available, including an enhanced internal solution with a rapid turnaround which went live in August 2020. Accreditation of equipment and facilities according to national standards.

9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance • PPE stock is appropriately stored and accessible to staff who require it	Extensive suite of SOPs and guidelines developed as pandemic developed. All guidance available on intranet after approval at Silver tactical and Gold Communications team ensured messages were clear, appropriate and user friendly Waste manager involved in all waste decisions. PPE managed carefully through stores with records kept and systems for monitoring where low.	None identified	Extensive use of the Communications team to ensure clear and consistent messaging.
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance	Risk assessment process identified and actioned. Staff enabled to shield or work from home where necessary and appropriate Occupational health team engaged with staff screening and risk assessments.	Risk of staff cross-infection with COVID-19.	Extensive PPE training undertaken with all levels of staff. Internal gatherings (ie study-days) limited, with staff required to wear masks. All clinical staff catering (ie buffets) restricted.

and a record of this training is maintained • Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance. • All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a face mask, and in a non- clinical area. • Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas • Staff absence and wellbeing are monitored and staff who are self- isolating are supported and able to access testing • Staff who test positive have adequate information and support to aid their recovery and return to work	Efforts made not to move staff wherever possible to reduce cross over from COVID to non COVID areas. Staff given guidance on social distancing. Staff advised re staggering breaks, use of FRSM for sessional use etc. Masks available for all staff as required. Monitoring records kept of staff absence and presented in a daily sitrep. Staff at home supported by managers staff testing in place. Extensive psychological services available for all staff. Regular staff communication through email, bulletins and through WhatsApp		

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
15 September 2020	11.

Title of Document:

Senior Medical Appointments

1. Status **For Information**

2. Purpose:

Other	Board Briefing

3. Summary

The Trust has appointed two new senior medical appointments between June and August 2020. Dr Neil Dev Raju Soneji was appointed to the post of Consultant Radiologist with an interest in Breast Imaging and Dr Adam Sharp to the post of Leader of Translational Therapeutics Team, which is a joint appointment between the Institute of Cancer Research and The Royal Marsden NHS Foundation Trust. The background of these appointments is shown in the attached paper.

4. Recommendations / Actions

The Board is asked to note the appointments.

The ROYAL MARSDEN
NHS Foundation Trust

Senior Medical Appointments – June to August 2020

Dr Neil Dev Raju Soneji – Consultant Radiologist with an interest in Breast Imaging

Dr Neil Dev Raju Soneji was appointed to the post of Consultant Radiologist with an interest in Breast Imaging by an AAC panel on 16th June 2020. He commenced his substantive role on 1st July 2020.

Dr Soneji obtained his primary medical qualification from Imperial College London in 2010. He subsequently embarked on a training programme and has since worked at several NHS Trusts in the UK. In 2015 he became a Fellow of the Royal College of Radiologists, followed by specialist registration in Clinical Radiology awarded by the GMC in 2017.

Dr Soneji was previously contracted for 8 sessions as a Consultant radiologist at Imperial College London and 2 sessions as Locum Consultant at the Royal Marsden. Additionally, he is an Educational and Clinical supervisor to registrars and fellows. He has demonstrated his commitment to education by co-authoring several publications, presentations and has an active lecture and tutor role on various radiology courses.

Dr Adam Sharp – Leader of Translational Therapeutics Team, Clinical Consultant ICR and Honorary Consultant at The Royal Marsden NHS Foundation Trust

Dr Adam Sharp was appointed to the post of Leader of Translational Therapeutics Team by an AAC panel on 2nd September 2020. This is a joint appointment between the Institute of Cancer Research and the Royal Marsden NHS Foundation Trust.

Dr Sharp obtained his primary medical qualification from the University of Southampton in 2009. He subsequently embarked on a training programme and has since worked in several NHS Trusts in the UK and has been an Academic Clinical Lecturer with the Institute of Cancer Research since 2015.

He was awarded the very prestigious Wellcome Clinician Scientist grant in 2019, which has allowed him to pursue his commitment to research and transition into the Clinical and Honorary Consultant role.

Dr Sharp was previously granted the opportunity to act up as a Locum Consultant Medical Oncologist (Gynaecology Unit) at the Royal Marsden NHS Foundation Trust from April 2020 to July 2020, post CCT. Additionally, he is an associate supervisor to five PHD students and continues his commitment to his professional development by being active in several research committees, first author for 33 peer review articles, has conducted 19 oral presentations and has featured in 18 poster presentations.

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BOARD PAPER SUMMARY SHEET

Date of Meeting: 15 September 2020	**Agenda item:** 12.
Title of Document: Communications Briefing	**To be presented by:** For information

1. Status: For Information

2. Purpose:

Other	Board Briefing

3. Summary

The enclosed report updates the Board on relevant communications and PR coverage.

4. Recommendations / Actions

The Board is asked to note the enclosed communications briefing for information.

The ROYAL MARSDEN
NHS Foundation Trust

Communications Briefing – September 2020

Recent highlights

Corona communications
We have been supporting NHS England on highlighting the cancer services that have been available throughout the pandemic. This has included working with BBC Panorama to show that celebrity cancer patient Deborah James' treatment has continued, and various stories to highlight the work of the Cancer Hub for example sharing stories of people who accessed surgery via the Hub. We also secured a story on ITV's national evening news of a patient who had bene diagnosed and treated throughout the pandemic.

Marsden Marathon
We have engaged with some of our patients who are influencers on social media, including Deborah James and Emma Campbell, and have bene using other runner stories to spread the word about this accessible virtual running event. We secured coverage on BBC Radio London, followed by BBC Breakfast on the back of the London Marathon being cancelled, and are expecting to be mentioned in a Sunday Express interview with Deborah James in the coming weeks. The story has also been covered by local media and third sector media.

Jack Whitehall – NHS Superstars
On the back of a book compiled by celebrity doctor Adam Kay in which celebrities thanked the NHS, we featured on a spin-off TV documentary 'Dear NHS Superstars'. Comedian Jack Whitehall was filmed talking about the time he visited our Oak Centre for Children and Young People and played football with a young patient. The book and TV programme were widely reported in national print and online media, with Jack talking about the incredible work of the centre.

Future highlights

Paediatric documentary
Last year a camera crew followed three patients, their families and staff for six months, resulting in a powerful and emotional portrayal of paediatric cancer. Whilst the transmission date was delayed due to COVID-19, we understand Channel4 is airing the programme on 9th of September. The hour-long documentary provides a unique insight into our Oak Centre for Children and Young People, and along with the Channel we will be using the opportunity to maximise publicity of the unit, including referencing Charity support. We are expecting this to air on 9 September 2020.

CyberKnife installed in Sutton
The second CyberKnife is now fully installed in Sutton and began treating patients at the end of July, following a short delay due to the COVID-19 pandemic. We have worked with the radiotherapy team to identify a suitable case study who will be one of the first patients to be treated on the new machine, and we are planning to pitch this story to media. We have photos and time lapse footage of the installation which will be featured across our website and social media channels. Part of the new CyberKnife due to be in operation from September onwards (an MLC head) will make it the first of its kind in the UK, so we'll be pitching this angle to national media, alongside the impact of COVID-19 as the machine results in fewer, shorter visits to hospital for patients.

Oak Cancer Centre public appeal
The appeal is due to launch at the ground breaking event, which is potentially in October. We are developing a PR approach for this event, as well as the ongoing appeal including engagement with celebrities and patient case studies.

ESMO
We are working with a number of researchers to generate media coverage and content for our own digital channels around trials and new data which is being presented at the European Society for Medical Oncology Virtual Congress in mid September. Particular highlights so far include promising results from the Checkmate trial which is being led by Professor James Larkin around long-term survival rates for patients with stage 4 melanoma, also due to be published in the Lancet, and research from Professor Stephen Johnston around advances in breast cancer treatment.