The ROYAL MARSDEN
NHS Foundation Trust

Board of Directors Public Meeting

Microsoft Teams

28th September 2021, 2.30pm - 4.30pm Public Board

Agenda

1.	**Apologies for Absence and Declarations of Interest**	
2.	**Minutes of the Board Meeting held on 6 July 2021** *Chairman*	Enclosed
3.	**Matters Arising**	Verbal
4.	**Strategic**	
	4.1 Children and Young People Service Review *Medical Director*	Enclosed
	4.2 Digital Health Record *Chief Executive/Chief Financial Officer*	Enclosed
	4.3 Oak Cancer Centre *Chief Executive*	Enclosed
	4.4 Green plan *Chief Operating Officer/ Director of Projects and Estates*	Enclosed
	4.5 RM Partners' 3-year plan *Managing Director RM Partners/Clinical Director*	Presentation
5.	**Operational**	
	5.1 Covid-19 Recovery and Restoration Plan *Medical Director/Chief Operating Officer*	Enclosed
6.	**Quality & Performance**	
	6.1 Monthly Quality Account *Chief Nurse*	Enclosed
	6.2 Key Performance Indicators *Chief Operating Officer*	Enclosed
	6.3 Financial Performance Report *Chief Financial Officer*	Enclosed
7.	**Regulatory**	
	7.1 Medical Workforce Report *Medical Director*	Enclosed
	7.2 Board Self-Assessment Report *Company Secretary*	Enclosed
	7.3 Risk Appetite & Board Assurance Framework *Company Secretary*	Enclosed
8.	**Any other business**	

Date of next public meeting: **8 December (Public Board)**

NHS

The ROYAL MARSDEN
NHS Foundation Trust

Minutes of The Royal Marsden Board of Directors Public Meeting

6 July 2021, via teleconference sections

Present

Charles Alexander	Chairman
Mark Aedy	Non-Executive Director
William Jackson	Non-Executive Director
Ian Farmer	Non-Executive Director
Heather Lawrence	Non-Executive Director
Chris Clark	Non-Executive Director
Professor Paul Workman	Non-Executive Director
Dame Cally Palmer	Chief Executive
Karl Munslow-Ong	Chief Operating Officer
Marcus Thorman	Chief Financial Officer
Nick Van As	Medical Director
Mairead Griffin	Chief Nurse
Andy Dimech	Acting Chief Nurse

Attendance

Brinda Sittapah	Company Secretary
Shams Maladwala	Managing Director of Private Care
Nigel Platt	Governor

1/21 **Apologies for absence & Declarations of Interest**

The Chairman welcomed everyone to the meeting and expressed a warm welcome to Mairead Griffin, Chief Nurse to her first Board meeting at RM.

An apology was received from Professor Martin Elliott.

Members noted that it was Professor Paul Workman's last RM Board meeting. On behalf of the Board, the Chairman thanked Professor Workman for his contribution, dedication, and most importantly for his continuous support on strengthening the ICR/RM relationship.

Professor Workman thanked the Board and assured members that his successor Professor Kristian Helin and newly appointed Chair of the ICR, Professor Julia Buckingham will continue to build this relationship and promote the ICR/RM as a world-leading cancer centre.

Declarations of Interest

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

2/21 **Minutes of the public Board meeting held on the 2 March 2021**

The minutes of the 2nd of March 2021 were approved as an accurate record of the meeting.

3/21 **Matters Arising**

There were no matters arising. All items have been covered on the agenda.

Strategic

4/21 **Financial plan 2021/22**

The CFO reminded the Board that in 2020/21 given the challenges presented by the pandemic, a Covid-19 financial framework was introduced by the NHS. The Board noted that this financial regime will continue into Q1 and Q2 of 2021/22, with NHS Commissioner block income being uplifted for inflation. The CFO added that depending on the impact of Covid-19 through Q1, this extension may be stretched for a further quarter,

or the proposals engaged upon in November could be introduced in Q3 which imply that block contracts would continue for the year, with some cost and volume adjustments built on-top. Given the uncertainty of the NHS Income position for 2021/22, as well as the operational pressures resulting from the ongoing Covid-19 pandemic, a streamlined process was instigated for Business Planning for 2021/22.

The CFO advised that the draft budget of £20m control total deficit that was approved by the Board in March, broadly based on current run rates of activity and spend with Business Cases and Recovery Plans built in, included a number of opportunities to mitigate this deficit. It has been anticipated that for 2021/22, the Trust will deliver a small deficit as a worst-case scenario or a small surplus. It was noted that the capital budgets were also reviewed at the Capital Programme Board for project prioritisation. The CFO informed the Board that the budget has subsequently been submitted to NHSI/E. He added that a further update will be provided mid-year when the NHS Income regime for Q3 and Q4 2021/22 will be announced.

Ian Farmer highlighted that the budget was discussed at the Audit and Finance Committee, and it was agreed that it was the best plan the Trust could put forward given the uncertainty around revenue and private care income due to international travel. The CE reported that the NHS is looking to recover and get back to a normal regime not before 2022/23 but it was agreed that cancer is a priority hence there is a strong likelihood that income will increase. The CE added that given the available information, it is a satisfactory holding position for the Trust to achieve at least a break-even position.

It was agreed that a further discussion will be had on private care income in the latter part of the agenda when the Managing Director of Private Care will join the meeting to provide an update on Cavendish Square.

The Board noted the revised position on the opportunities available to close the control total deficit of £20m to a breakeven position recognising that a revision will be brought back to the Board, mid-year, once the financial framework for the second half of the year and the level of income is notified.

5/21 **Outline proposals:**

5.1 Digital Health Record

The CE noted that as part of the Trust's Digital Programme, work has been ongoing to explore the options for procuring a new Digital Health Record (DHR) which will provide the opportunity to radically transform and future-proof how care is delivered to meet the needs of our patients. The CE reminded members that a Full Business Case (FBC) is being prepared for both a standalone EPR solution and an Epic Connect model with GOSH for approval by the Board in July.

The CFO briefed the Board on the governance arrangements in place to approve the FBC. Currently the FBC is being reviewed by the Programme Assurance Group (PAG), a committee chaired by Chris Clark, and the Digital Health Record (DHR) Steering group. The next stage of approval will be through the Executive Board on 13 July and the Audit and Finance Committee on 14 July with a view to have final Board approval on 27 July. The CFO advised that PwC's services were also sought as external advisor to review the FBC.

On a question from Mark Aedy as to whether the Christie had been considered as an organisation to partner with, the CFO advised that the Christie was considered at an earlier stage of the procurement process. The Christie has a different EPR model and is not digitally mature enough to partner with as compared to other organisations such as GOSH.

Chris Clark explained that the partnership with GOSH is a less risky option and will provide the opportunity to harness the digital excellence, technologies and learning that they have achieved and offer the opportunity for both organisations to create a sustainable

platform. He added that the partnership model will accelerate the benefits for both Trusts, both in financial and qualitative terms and will improve efficiencies.

On a question from the Chair as to whether RMH were content with Epic as a partner, the CFO advised that RMH's due diligence exercise and feedback from national and international organisations that had contracted with Epic had shown a positive response. Counterparts in Australia and Canada who have similar partnership arrangements in place with Epic confirmed they were pleased with the service provided, the benefits realised and demonstrated that it worked well.

Heather Lawrence emphasised the importance of evidencing interoperability in the business case. The Board noted that Epic had a number of tools which facilitated interoperability: organisations that have already implemented Epic can share records and Trusts that do not have Epic as their EPR solution can also share records subject to data sharing agreements. This provides RMH the opportunity to share information with the wider SWL ICS and nationally irrespective of organisations' EPR solution.

The Board noted the update.

5.2 Cavendish Square Progress Report

The Managing Director of Private Care provided an update to the Board on Cavendish Square private care facility which opened on 28 April 2021.

The Managing Director of Private Care assured the Board that as a new model of private care delivery, Cavendish Square is a step change for patient experience, will enable further revenue growth through targeting a wider catchment, controlling patient pathways and improving consultant loyalty and succession. He explained that the reduced market demand is due to delayed UK access for international patients, but commercial actions are in place to mitigate this risk and NHS patients are accessing Cavendish Square diagnostics to support trust recovery.

The Managing Director of Private Care reported that Month 1 performance has been on plan with income exceeding target. Feedback from consultants and staff has been hugely positive and 98% of patients rated their experience as "Excellent". However, the main risk remains reduced international demand due to limited access. The Managing Director of Private Care advised that the relationship with international embassies is very strong, and he remains confident that demand will increase. There is evidence showing new patients coming via sponsor referral, via BUPA and direct referral. Being part of an integrated model, a lot of lessons are also being learnt on the mechanisms by which patients access the RM. The Managing Director of Private confirmed that the plan will be phased and flexed depending on the market and from September a greater level of growth is expected.

The Board was pleased to note that Cavendish Square has had good PR coverage nationally, in trade titles Langbuisson News, Building Better Healthcare, Healthcare Markets, Independent Practitioner (which goes to over 14,000 GPs and Consultants) and Prognosis Magazine, the Financial Times, and internationally in embassies.

The Acting Chief Nurse confirmed that the Cavendish Square facility has been assessed and accredited by the CQC and overall staffing level are safe and appropriate. He added that Cavendish Square will be added as a site in the QA metrics with the activity in the PP dashboard.

Heather Lawrence sought assurance that the consultants will be in the right place at the right time. The Medical Director advised that the team has worked thoroughly on the job planning and the transition between sites has been incorporated in consultant job plans.

The Board congratulated the team for the progress made.

The Board noted the update.

5.3 Specialist Emergency Hospital, Sutton

The CE reminded the Board that in 2019, as part of the first phase of the Health Infrastructure Programme, Epsom & St. Helier (ESH) were granted provisional government funding towards a new build subject hospital to a business case. After an options appraisal and consultation, they settled on a plan to build a non-elective hospital at their retained Sutton site (as well as requiring some of RM's existing land). An outline business case (OBC) was submitted by ESH to the regulators in late 2020. The OBC included a core bid and two variants; variant 1 involved moving the Renal services out of SECH into a new combined unit at St. Georges to merge the two main services in South West London. Variant 2 involved the development of the RM cancer surgical centre within the new SECH building in the proposed space vacated by renal services.

The CE provided an update to the Board on the progress of the SECH following the outline business case that was submitted to the Joint Investment Committee (JIC) of NHS England and NHS Improvement for approval in May. It was noted that there was enough evidence to support both variants 1 & 2 but variant 1 (renal) required a formal public consultation. It was noted that subject to the consultation the core OBC and variants should be incorporated into one refreshed OBC to go back to JIC in October 2021. Once the revised OBC receives approval from JIC in October, ESH is expected to take back a more detailed Full Business Case (FBC) to JIC in June 2022.

The CE advised that the net additional cost of the surgical variant bid is estimated at £36m and pointed out that clarity is still awaited on how cancer surgery would fit within the Treasury's delegated capital spending limit for South West London. In principle the RM Board has made a commitment of £20m cash funding and the transfer of the required land has a value of £8m. The CE expressed her concern about the funding gap of £8m that is planned to be found through SWL capital allocation and the CDEL limit issue that still needs to be addressed given that the Treasury has confirmed that no further central funding would be made available.

The Board discussed the importance to continuously promote the importance of cancer surgery in the new built and it was noted that the CE and the Chairman will keep on voicing this concern at the SWL ICS and emphasise this option as an opportunity.

The Board noted the update.

6/21 Development of Integrated Care Systems

The CE informed the Board that NHSE/I has now published the ICS design framework which sets out in more detail the way in which NHS organisations should respond to the establishment of ICS NHS bodies from April 2022. The CE summarised the principles outlined in the ICS design framework and discussed the approach that RM should be taking in working collaboratively with the NW and SW London ICSs. It was noted that it was crucial to establish the role of RM and RM Partners in the ICS framework. The CE added that the framework does not undermine the concept and operation of foundation trusts and therefore RM will remain a separate legal entity.

The CE summarised the risks and opportunities this reform will bring for RM as a specialist cancer centre and how RM will fit within the new national strategy. The CE pointed out that the key and agreed position is that Cancer Alliances lead whole system planning for cancer for their constituent ICSs. They may also have responsibility for strategic commissioning for cancer, and delegated authority for their ICS for planning, transformation, and delivery of cancer services for their local communities.

It was noted that SW London ICS draft operating arrangements includes Royal Marsden Partners, our Cancer Alliance, as a provider collaborative. RM Partners/RM as host will have a seat on the key decision making ICS Board and includes all acute providers as stakeholders. The CE reported that that discussion is ongoing with NW London regarding the role of RM and RM Partners in the system.

The Board noted the update.

7/21 **Covid-19 Recovery Plan**

The COO provided an update on progress with the Trust's recovery and restoration plan including an overview of activity and projected performance against the Elective Recovery Plan (ERF) incentive scheme. Overall, the Trust has been performing very well and is amongst the top performing trusts on elective recovery in London.

The COO advised that activity plans had been submitted to the SWL ICS in April 2021 which will inform ICS and London planning. The Elective Recovery Fund (ERF) provides the opportunity to receive financial top-ups above block and the Trust is in a strong position to exceed thresholds in all affected modalities in most months although overall payments will be determined on an ICS footprint. Work is now underway to explore additional capacity options that can be delivered within the likely ERF funding to drive further throughput in some surgical specialities.

The COO noted that the Trust was looking to focus on addressing expected increases in demand for cancer services from September onwards, for NHS patients and potentially private practice when international travel reopens. Preparations are under way for the second half of the year to ensure the right capacity is in place to continue to deliver timely care to our patients.

The COO provided an update to the Board on staff returning to site in line with the national easing of lockdown. From 19th July (subject to any national changes) the aim is to have staff on-site for the majority of their working time and a hybrid model has been proposed which has been positively received by staff who want to reconnect with the organisation and their team.

The Medical Director reported that the Trust currently has one COVID positive inpatient at the hospital and 30 members of staff are isolating. It was noted that the figures nationally were going up and is predicted to continue to rise until mid-late August. However, pressures on hospitals have not risen at the same rate as in the second wave. The Medical Director advised that although covid restrictions will be lifted in the UK, it is most likely that Public Health England's infection prevention control guidelines and hospital visiting guidance will remain in place for all staff and visitors. It is expected that staff, patients and visitors will also be expected to continue to follow social distancing rules when visiting any care setting as well as using face coverings, mask and other personal protection equipment.

The Medical Director stated that the vaccine programme closed on 21 May 2021 and the Trust was expecting to run a vaccine booster programme in line with the flu programme for staff in the autumn, details are still to be provided.

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

8/21 **Monthly Quality Account – May (April data)**

The Acting Chief Nurse updated the Board on the May (April data) Quality Account data. He drew the attention of members to the areas of good performance which included a significant reduction in the numbers of Covid-19 cases in the Trust, reduction in falls from 25 to 17, reduction in pressure ulcers and improvement in chemotherapy waiting times in BFAC. The

Acting Chief Nurse informed the Board that RM has scored 100% in inpatient and 96% in outpatients in the national inpatient survey, the national average is 95%. It was noted that over 85% of staff (including volunteers) have received their first COVID-19 vaccination. Second vaccinations is in progress, with a view to finish on 21st May 2021. Thereafter, patients and staff will use other established local services.

The Acting Chief Nurse reported on the areas for improvement. C.difficile numbers were up slightly, and further work is being undertaken to identify any trends and ensure there are no lapses. Chemotherapy waiting times is red/amber in Sutton; however, this is attributable to patient preference for 1 stop treatment vs 2 stop, which is more popular in Chelsea and Kingston. Patients are being encouraged to undergo 2 stop and staff are being encouraged to pre prescribe. The Trust nurse vacancy rate increased to 8.7%, slightly above the Trust target of 8.0%. However, there are 70 WTE nurses (19 newly qualified nurses) in the recruitment pipeline of which 21 WTE have an agreed start date.

Heather Lawrence, Non-Executive Director and Chair of Quality Assurance and Risk Committee commended the nursing staff for their continuous commitment to provide high quality services to patients throughout the pandemic.

The Executive Board noted the monthly Quality Account.

9/21 Key Performance Indicators Q4

The COO presented the Key Performance Indicators for Q4, advising that the overall performance of the Trust is generally good given the challenging circumstances.

The COO explained how the 70 metrics reported on the scorecard have changed across the year and how the number of green metrics have increased steadily each quarter. It was noted that for Q4, 60% of the metrics were green and there was a slight increase in the number of reds (10 in total) which was due to a pandemic dominant theme emerging and driving these. Areas where improvements were noted related to bed occupancy in Sutton and Theatre utilisation in Chelsea. It was noted that 85% of frontline staff have been vaccinated, a significant improvement on the same quarter the previous year where 73% of frontline staff members received the vaccine.

The COO summarised the red areas and improvements required. It was noted that the number of referrals had declined compared to the previous quarter and this was due to the impact of the lockdown and restriction of travel for international patients. The COO highlighted that although flu uptake has turned red in quarter 4, it should be noted that performance was significantly higher than the previous year.

The Board noted the Trust's balanced scorecard for quarter 4 2020/21.

10/21 Financial Performance Report

The CFO reminded the Board that a Covid-19 financial framework is in place in the NHS for the first half of 2021/22. All trusts will receive block income contracts, calculated based on the NHS income received to month 9 2019/20, uplifted for inflation. High cost drugs remain outside of blocks and are pass-through in nature. In addition, a top-up payment has been awarded to each Trust, via their Integrated Care System (ICS) to help fund the additional costs associated with Covid-19 and to target bringing each provider to a breakeven financial position. The CFO informed the Board that Department of Health negotiations with Treasury are still ongoing for funding for the second half of 2021/22.

The CFO further advised that a Trust budget has been submitted to NHSEI in March 2021 before the NHS Income position for 2021/22 was finalised and it does not include a number of income mitigations that are still being worked through with the SWL ICS which target a breakeven position for the first half of this financial year.

The CFO went on to provide a summary of the financial position as of 31 May 2021. The Trust reported a £1.1m surplus year to date, £4.7m adverse to budget. This was largely driven by lower Donated Asset Income than budgeted. At the control total level, the Trust was £2.2m in deficit year to date, £0.1m favourable to budget. The CFO confirmed that the lower than budgeted private patient income position is mostly due to phasing of international travel and was not an area of concern. The Board queried the increase in operating cost, and it was agreed that the CFO will explore the reasons behind the increase and will revert back to members.

It was noted that as of date capital expenditure stood at £8.8m year to date, which was £4m favourable to the Trust's capital plan, largely due to Oak Centre costs phasing. Cash in bank of £156.3m, an increase of £6.1m compared to the year-end position as at 31st March 2021.

The Board noted the financial position as at the end of May.

11/21 Mortality Review

The Medical Director presented the Mortality Report for quarter 4. He noted that this report had been discussed in detail at the Quality Assurance and Risk Committee on 28 June. He advised there were 67 deaths in the quarter with all standards being met. The Medical Director confirmed there is a treatment escalation plan for all patients. There were 19 structured judgement reviews, and no issues were identified. There were 17 Covid-19 related deaths in the quarter, of these 3 deaths were probable hospital acquired infection (defined as testing positive between day 8 and 14 of admission) and 2 were definite hospital acquired (defined as testing positive from day 15 of admission on wards). These 5 deaths were also reviewed. The Medical Director confirmed that duty of candour discussions had taken place in every instance, and this will be added to the report as suggested by the Chief Nurse.

The Board noted that overall, from the review of the data the Trust is RAG-rated Green for the period between January to March 2021.

The Board noted the mortality report.

12/21 Board Assurance Framework

The Company Secretary introduced the Board Assurance Framework (BAF) and explained that the purpose of the 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 Company Secretary drew the attention of the Board to the five risks that are exceeding the risk tolerance threshold as follows:

- RM and RMPs regional and national leadership roles in cancer are recognised via changes in policy and the implementation of Integrated Care Systems
- Covid-19 – Delivery of a safe, effective and responsive service; Development of the Cancer Hub and ensuring the right capacity is in place to deliver timely and effective treatment
- Delivery of financial plan
- Developing and implementing a flexible and sustainable workforce model which attracts and nurtures the very best talent
- Ensuring a sustainable paediatric service model at RM.

The Board agreed that these were current risks facing the organisations and discussed the risks that are exceeding their risk tolerance threshold. It was recognised that the BAF is being actively used as a tool to manage the key risks facing the organisation and it was agreed that these risks are sufficiently discussed at greater depth at Board meeting and at the NEDs huddles.

The Board reviewed and approved the BAF.

13/21 **13.1 Communications Briefing – for information**
The Board noted the communications briefing.

13.2 Membership Report
The Board noted the Membership Report.

14/21 **Any other business**
No other business was raised.

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:**
28 September 2021	4.1
Title of Document:	**To be presented by:**
Children and Young People Service Review	Nick van As, Medical Director

1. <u>Status:</u> For Noting and Information

2. <u>Purpose</u>:

Relates to:	
Strategic Objective(s)	✓
NHS policy / consultation	✓

3. <u>Summary</u>

Since the Trust Board Meeting of May 2021, the NHSE London programme has remained largely paused whilst the NHSE London Region team make decisions about how to manage the next stage of the process. Meetings with the finance team have continued in order to develop the financial considerations for the bidding process and to ensure all potential providers have sight of the workforce requirements to deliver the CYP PTC service.

The RM CYP team continues to meet both SGUH and GOSH teams to develop the two proposed models that involve RM (RM/SGUH and RM/GOSH). Meetings with the GOSH teams continue to underline patient pathway and workforce complexities in this model including management of teenagers (aged 13-16 years) which in North London is usually delivered by UCLH – agreement has been reached to simplify this as far as possible.

Each model will be submitted in the form of a series of templates covering the clinical model, research model, workforce and finance. Templates are currently being written for both models to ensure these meet the (now deferred) submission timelines.

4. <u>Recommendations / Actions</u>

The Board's input is sought on a number of points that will be discussed at the meeting.

The ROYAL MARSDEN
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BOARD PAPER SUMMARY SHEET

Date of Meeting: 28 September 2021	**Agenda item:** 4.2
Title of Document: Digital Transformation (including DHR) Update	**To be presented by:** Cally Palmer, Chief Executive Marcus Thorman, Chief Financial Officer

1. Status: **For Information**

2. Purpose:

Relates to:	
Strategic Objective(s)	*X*
Operational Performance	
Legal / regulatory / audit	
Accreditation / inspection	
NHS policy / consultation	
Governance	
Other	

3. Summary

This report provides a summary update on progress in delivery of the Digital Transformation programme, including the new Digital Health Record in collaboration with Great Ormond Street Hospital.

4. Recommendations / Actions

The Board is asked to note the contents of the report for information and assurance.

The ROYAL MARSDEN

Digital Services
Delivering digital excellence

Digital Transformation Programme

August 2021 Update

1.0 Executive Summary

The August report to the Digital Transformation Board (DTB) received updates on progress across all work streams. Key areas to highlight included:

- Approval of the Digital Health Record full business case (FBC) in collaboration with Great Ormond Street Hospital (GOSH). A summary of progress is included in this report.
- In terms of infrastructure programmes, the network replacement programme has now gone beyond the 50% completion rate, with Sutton at 85% completion. The server migration project (part of the transition from Sphere) is due to complete in November 2021.
- The Unified Communications business case is ready to enter formal Trust governance.
- Within Digital Diagnostics, the Stem Cell project is tracking slightly ahead of the revised plan, and new Blood Tracking capability has been deployed.
- Within Digital Research and Informatics, the Hyland electronic trial management solution is currently in the testing phase. Design sessions have been held for the new trusted research environment to develop use cases.
- The deployment of clinical research remote monitoring continues to widen with over 400 users (monitors and staff) now using the system.
- Project resource has been stood up for the Digital Pathology programme.
- A new Digital Coach has joined the RM Digital Services team this month with a focus on supporting staff to fully exploit collaboration tools such as Microsoft Teams, and to ensure that new staff entering the Trust are inducted appropriately.
- The digital specification for the new Oak Cancer Centre has been completed.

In summary, good progress continues to be made in all areas of the programme, noting that this remains a challenging undertaking in particular with respect to the infrastructure programmes that are due to complete later this calendar year.

During the next period (September – November) the following key activities are expected to complete:

- Signature of the RMH/Epic contract and Partnership Agreement with GOSH.
- Completion of DHR programme recruitment and commencement of training for design and configuration teams.
- Completion of the wired and wireless network replacement programme.
- Completion of the server migration programme (to new secure, offsite data centres).
- Approval of the Unified Communications business case and commencement of procurement activities.
- Completion of the build phase of the new Data Warehouse and Trusted Research Environment.
- Final stages of the new Blood Tracking project.

2.0 Digital Health Record Update

Following approval of the FBC by the Board on 27 July, considerable work has been undertaken under the direction of the DHR Steering Board, chaired by the CEO.

It is intended that the contract with Epic, and the Partnership Agreement with Great Ormond Street Hospital will be ready for signature later in September.

A summary of key progress since July is provided below:

- **Recruitment:** good progress has been made, with the appointment of 36 analyst and configuration staff and some key design roles. A second round of recruitment is currently underway, including for key clinical leadership roles. Training of these staff is due to commence in October.
- **Accommodation:** space has been identified for a proportion of the team at the Chelsea site, with refurbishment works underway to meet the October training deadline. Further space is currently being identified and it is likely that there will be a need to use space at the GOSH site to co-locate.
- **Governance:** a review is currently being undertaken, for presentation to the DHR Steering Board in early September for approval.
- **Contracts:** Work is ongoing on both the Epic/RMH contract and the Partnership Agreement with GOSH. Key contractual terms for the Partnership Agreement have been set out, and a meeting is being held in early September for the two organisations to ratify the Agreement.
  The DHR Steering Board will review the RMH/Epic key contract terms in September to then bring through the appropriate Trust governance for final approval to sign.

3.0 Recommendation

The Board is asked to note the contents of this progress update for information and assurance.

Lisa Emery

Chief Information Officer

September 2021

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 28 September 2021	**Agenda item:** 4.3
Title of Document: Update on the Oak Cancer Centre (OCC) development	**To be presented by:** Cally Palmer, Chief Executive

1. Status **For Information**

2. Purpose:

Relates to:	
Strategic Objective(s)	*X*
Operational Performance	
Legal / regulatory / audit	
Accreditation / inspection	
NHS policy / consultation	
Governance	
Other	

3. Summary

The Board will be shown a video at the meeting of the OCC development at the Sutton site.

Excellent progress has been made by the contractors and the concrete frame of the building is now complete. The contractors 'topping out' ceremony was held on September 13th with a further on-site event for several of the major donors being held later this month.

Work on the external facade and the roof has commenced. The building should be watertight before the end of November and the roof and steelwork are due to completed in January.

The link between the OCC and the current hospital building has commenced with the necessary enabling works completed on the hospital side.

The total funding raised so far for the OCC is now £67.2m against a target of £70m.

4. Recommendations / Actions

The Board is asked to note the update.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 28 September 2021	**Agenda item:** 4.4
Title of Document: The Green Plan	**To be presented by:** Karl Munslow Ong, Chief Operating Officer, Sunil Vyas, Director of Project and Estates

1. Status: For Decision / Approval

2. Purpose:

Relates to:

Strategic Objective(s)	
Operational Performance	
Legal / regulatory / audit	*UK legal target to cut carbon emissions by 78% by 2035 and for the UK to achieve net zero by 2050*
Accreditation / inspection	
NHS policy / consultation	*Delivering a Net Zero National Health Service and* How to Produce a Green Plan, a 3 Year Strategy Towards Net Zero
Governance	

Executive Summary

The NHS has set a target to achieve net zero carbon emissions by 2040, with an ambition to achieve 80% of this target between 2028 and 2032. This commitment was made by Sir Simon Stevens in the October 2020 document, Delivering a "Net Zero" National Health Service. Only 15% of NHS carbon emissions relate to building infrastructure, water and waste. The Trust now needs to start measuring emissions associated with business travel, staff travel and the carbon emissions we influence through procurement.

All NHS Trusts have been told by NHSE to produce a Green Plan showing how they will achieve net zero by 2040, this is set out in "How to Produce a Green Plan, a 3 Year Strategy Towards Net Zero," published June 21). We report to NHSE every 3 months on sustainability against a set of 20 questions, i.e. "Does your organisation have an up-to-date, board approved Green Plan in place which is aligned to the ambitions set out in Delivering a Net Zero NHS?"

A Green Plan is a Board approved, live strategy document outlining the organisation's aims, objectives, and delivery plans for sustainable development. Once approved, Trust Green Plans are submitted to our ICS and they will produce a consolidated system wide Green Plan by March 22, to be peer reviewed and subsequently published. Progress against the Green Plan should be formally reported annually to the Trust Board and should be updated annually to consider:

- the progress made and ability to increase or accelerate agreed actions
- new initiatives generated by staff or partner organisations
- advancements in technology and other enablers
- the likely increase in ambition and breadth of national caron reduction initiatives and targets.

On the 20th April, the Prime Minister announced new climate change commitments will set the UK on course to cut carbon emissions by 78% by 2035. The PM's commitments, enshrined in law, will bring forward the current UK target for reducing carbon emissions. The current national target remains net zero by 2050, but the 78% reduction target broadly aligns with the ambitious NHS target of an 80% reduction by between 2028 to 2032.

The Trust's Green Plan is a vision document setting out high level aims and ambitions, each significant step to reduce carbon emissions or improve sustainability is likely to require its own business case, such as the current CHP Chelsea project. Some detail of how we plan to achieve reductions is mapped out for the next 3 years, but with technology rapidly developing it is difficult to plan with any certainty beyond a 3-year horizon. One of our largest emissions relates to gas consumption, it is therefore a significant challenge to be able to reduce natural gas consumption down to zero.

This Green Plan drives a focused approach to sustainability where it is embraced and driven by senior leadership team. The Green Plan considers how to minimise negative environmental impacts of the Trusts healthcare work and maximise opportunities to support the local economy and community wellbeing. The Green Plan also looks at our asset management and utilities, travel and logistics, our adaptation to climate change, capital projects, our people, our carbon emissions and sets out a governance and monitoring process to assess progress against the plan.

The Trust's Green plan can be accessed here:

Royal Marsden NHS
FT Green Plan Septem

3. Recommendations / Actions

The Board is asked to:

- approve the Green Plan and confirm an annual reporting cycle to Trust Board.
- approve the Chief Operating Officer as the Trusts "Net Zero" lead board member.

The ROYAL MARSDEN
NHS Foundation Trust

The Royal Marsden NHS FT

Green Plan 2021/22 – 2023/24

Trust Board Summary

September 21

NHS

Executive Summary

This plan aims to support the delivery of the best, most efficient and forward-thinking healthcare; it outlines the specific aims of the Trust's sustainability strategy and the objectives that will need to be achieved in order to meet the targets. It considers how to minimise negative environmental impacts and maximise opportunities to support the local economy and community wellbeing.

In 2020, the NHS set more ambitious targets than the UK Climate Change Act[1] net zero emissions 2050 target, with the aim to become the world's first net zero national health service. The two targets set are:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

The challenge is substantial – the health sector's carbon footprint accounts for approximately 4-5% of UK carbon emissions[2].

Carbon reduction is just one element of delivering sustainable healthcare; developing and delivering services in a sustainable manner also requires improving our natural environment and enhancing wellbeing, whilst limiting environmental impacts and reducing inequalities.

The Royal Marsden NHS Foundation Trust is committed to delivering sustainable healthcare and achieving the emission reduction targets set by the NHS.

1. *Greener NHS campaign to tackle climate 'health emergency'*
2. *SDU - Reducing the use of natural resources in health and social – 2018 report*

Executive Summary

The Trust has already taken steps to embed sustainability into Trust operations, including, the installation of energy efficiency measures such as the combined heat and power (CHP) engine at Sutton, setting up 'Green Matters', a Trust staff environmental improvement focus group and implementing a Travel Plan.

The Royal Marsden has partnered with Globechain, a reuse marketplace, to give items to charity and small businesses instead of being thrown away as waste. Globechain is an environmental, social and corporate governance reuse marketplace that connects enterprises to charities, small businesses and individuals to redistribute unneeded items.

This Green Plan drives a focused approach to sustainability and pushes the Trust into a position where sustainability is embraced and driven by senior leadership. The Trust acknowledges that staff, patients and visitors are key to delivering sustainable healthcare and has undertaken engagement exercises to understand stakeholder priorities.

The Trust will continue to update and report progress made against this plan in the annual report and via a newly established sustainability report.

Achievements	Goals
33% decrease in gross CO_2e emissions between 2009/10 and 2020/21	Carbon targets aligned with Greener NHS campaign targets
Approximately 178k people use the station shuttle service a year	On target to achieve BREEAM excellent for the New Oak Cancer Centre
Zero waste to landfill in 2020/21	Green Matters to support staff to initiate, drive and champion positive environmental change

Executive Summary

The Trust has aligned its carbon reduction targets with the Greener NHS 2040 and 2045 targets. The Trust has also set year-on-year utility savings targets to reduce our energy consumption. The Royal Marsden NHS FT is committed to achieving these targets and reducing its environmental impact. Consequently, aligned with wider NHS organisation commitments, we have highlighted the following top 10 practical actions to make significant progress towards our environmental goals:

1. *Use our collective NHS voice and declare a Climate and Health Emergency now.*
2. *Shift to 100% renewable electricity.*
3. *Switch to low energy LED lights across our sites.*
4. *Have a plan to halve the amount of patient travel, by delivering high quality telephone and video clinics in outpatients.*
5. *Reduce emissions from anaesthetics by increasing intravenous anaesthetics.*
6. *Install solar panels across Trust sites.*
7. *Cut plastics and incineration of clinical waste. Ensure processes and facilities are in place to enable proper waste segregation.*
8. *Buy sustainable and green products and services and commit 10% of tender weightings to sustainability procurements.*
9. *Reduce paper use and switch to 100 per cent recycled paper.*
10. *Set an ambition to be Net Zero Carbon by 2040 and produce a detailed road map to get there.*

The Trust has already made significant progress on number of these actions, including switching to 100% renewable electricity, installing LED lighting and solar PV panels on Trust buildings, and reducing emissions from anaesthetics with over 90% of anaesthesia given at the Trust being total intravenous anaesthetics, and no desflurane use. We will continue to prioritise progress against these top 10 actions.

Governance and Monitoring

The Trust will set up a Green Plan Steering Group (GPSG), chaired by the Chief Operating Officer, to oversee the implementation of the plan. The implementation of the Green Plan will be monitored through bi-annual review and reported to the Audit and Finance Committee on an annual basis and also through the Trust's annual report. The group will review and report on progress against the requirements of the Trust's Green Plan on a quarterly basis.

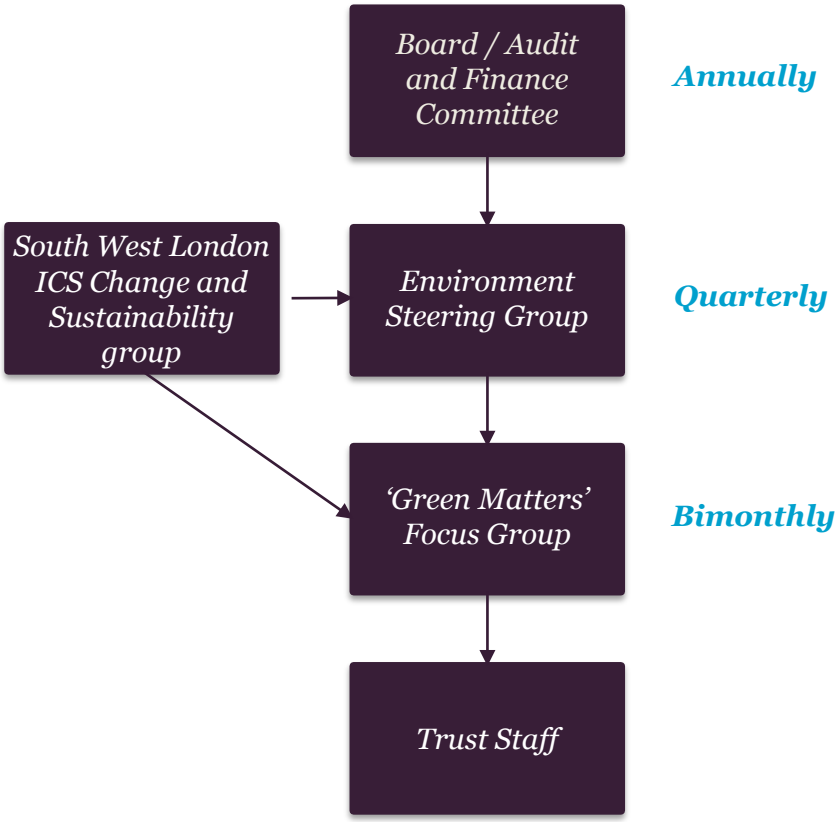
Green Matters* brings together representatives from across the Trust with the aim of ensuring continual focus on opportunities for improvement in sustainable development and carbon reduction. Progress will be provided to the Green Plan Steering Group on a quarterly basis. Green Matters membership is open to all staff showing an interest in environmental improvement.

The action plan in this document also recommends that the Trust establishes dedicated sustainability leads to drive forward the implementation of the Green Plan. This will ensure that efforts to integrate sustainability through projects and daily operations are coordinated and successful.

The dedicated sustainability leads will liaise with the 'Green Matters' focus group and support the Facilities, Projects & Estates team to oversee the forum. This dedicated sustainability leads will also report feedback from the staff engagement programme.

The diagram across the page shows the implementation and reporting structure of this Plan, as well as the frequency of reporting.

Additionally, the South West London Integrated Care System (ICS) has formed a Change and Sustainability Group that will produce a SWL ICS Green Plan and includes a delivery group which meets monthly. A more formal accountable meeting occurs quarterly where progress across the ICS is reported.



* Staff focus group referred to on page 3

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 28 September 2021	**Agenda item:** 4.5
Title of Document: RM Partners' 3-year plan	**To be presented by:** Susan Sinclair, Managing Director RMP, Emma Kipps, Clinical Director for RM Partners

1. Status: For Information

2. Purpose:

Relates to:	
Strategic Objective(s)	*X*
Operational Performance	*X*
Legal / regulatory / audit	
Accreditation / inspection	
NHS policy / consultation	
Governance	
Other	

3. Summary

Cancer Alliances have been given the National mandate to:

- Develop the cancer strategy for our ICSs, to ensure whole system cancer planning and delivery of cancer care to meet the aspirations of the Long Term plan around early diagnosis and survival;
- Lead delivery of the Cancer Plan in both ICSs to improve early diagnosis and survival;
- Support and lead strategic changes in cancer care to ensure equity of access and outcomes across our geography.

To deliver this, RM Partners is integrated into the ICS governance structure in NW and SW London and embedded in primary care leadership to ensure cancer remains a focus across all workstreams.

A presentation will be provided at the meeting.

4. Recommendations

The Board is asked to note the plan.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 28 September 2021	**Agenda item:** 5.1
Title of Document: Trust Recovery and Restoration Plan	**To be presented by:** Karl Munslow-Ong, Chief Operating Officer Nick van As, Medical Director

1. Status: For Discussion

2. Purpose:

Relates to:	
Operational Performance	✓
Governance	✓

3. Summary

The Trust has continued perform well in recovering from the latest wave of the pandemic although the summer months have seen an expected dip in activity volumes which we anticipate will pick up again in September.

The Trust continues to over-achieve against the latest Elective Recovery Fund targets although planning is underway to ensure we have the right level of capacity in place for the second half of the financial year.

We continue to have to manage our clinical activity in line with the National Guidance (COVID-19 Infection Prevention and Control (IPC) Guidance: Care Pathways). This means streaming patients on a blue (un-planned or not fully isolated) and green (planned) pathway adhering to clear guidance regarding screening and isolation.

The trust is looking to make some revisions to our clinical pathways to increase flexibility in the use of our capacity without compromising safety although our position around social distancing and working a hybrid model with our corporate staff remains in place.

Finally, the paper provides an update on the vaccine booster programme which will be rolled out over the autumn in line with national guidance.

4. Recommendations / Actions

The Board is asked to note and comment on progress with our recovery and restoration plans and our proposal for ongoing site management arrangements and the vaccine booster programme.

The ROYAL MARSDEN
NHS Foundation Trust

RECOVERY AND RESTORATION PLAN

1.0. Activity Planning – Overview

The Trust submitted activity plans to the SWL ICS in April 2021 based on the assumption that the Trust would continue to maintain the prevailing run-rate of each activity modality type for the first 6 months of the year.

%BAU	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Elective Inpatient Adms	**107%**	**98%**	**96%**	**100%**	**98%**	**94%**
Consultant OutpatAttends	**104%**	**106%**	**108%**	**108%**	**111%**	**106%**
MRI	**115%**	**107%**	**106%**	**116%**	**113%**	**110%**
CT	**106%**	**102%**	**104%**	**109%**	**106%**	**105%**
U/Sound	**93%**	**96%**	**95%**	**94%**	**102%**	**97%**
Endoscopy	**89%**	**99%**	**76%**	**82%**	**94%**	**87%**

The table above translates the plan into %age business as usual (BAU), based on a working-days adjusted version of the same month in 19/20. Some of the peaks and troughs in the above table are due to a smooth profile plan being measured against single months of high or low activity 2 years ago.

The Elective Recovery Fund (ERF) provides the opportunity to receive financial top-ups above block where Trusts/ICSs exceed a target threshold of %age BAU each month. At the start of the year these thresholds were set as follows :

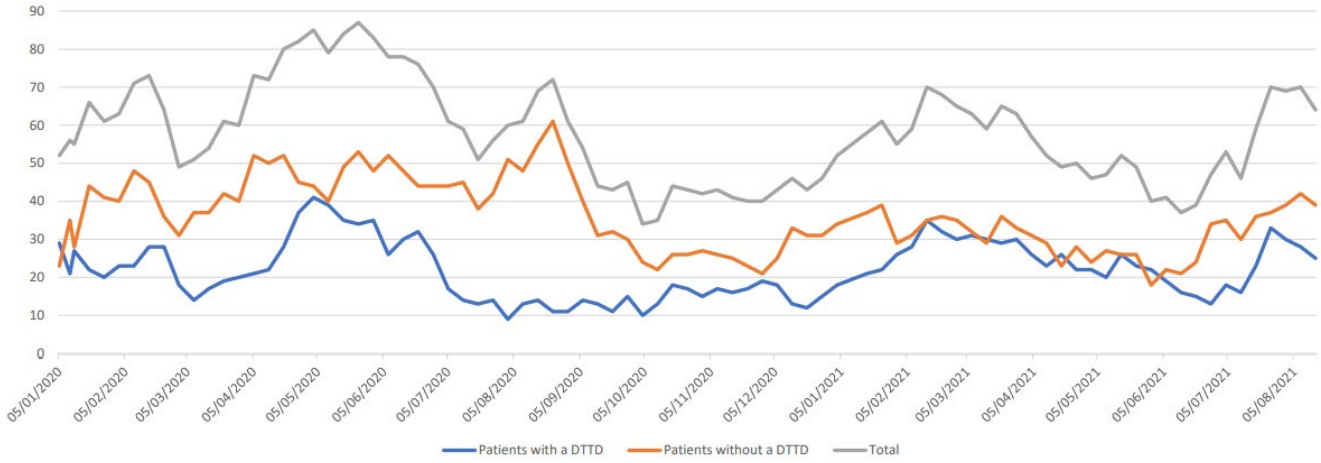
%BAU	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Top-Up Funding Threshold	**70%**	**75%**	**80%**	**85%**	**85%**	**85%**

However, after Q1 proved to be more successful nationally than anticipated the thresholds for July-September were increased from 85% to 95%.

The Trust has been able to deliver high volumes of diagnosis and treatment throughout the pandemic into 21/22, but in April referral-driven demand increased to levels above the pre-pandemic average. Elective capacity was also challenged by the need to separate green / blue inpatient pathways according to patients COVID risk, with added pressure coming from test and trace isolation requests at the start of the year and more latterly the holiday period in July and August.

The Trust maintained a relatively strong grip on backlogs, but inevitably in the summer months cancer and RTT backlogs did increase as staff took much needed annual leave, although the backlog has not reached the levels seen in 2020.

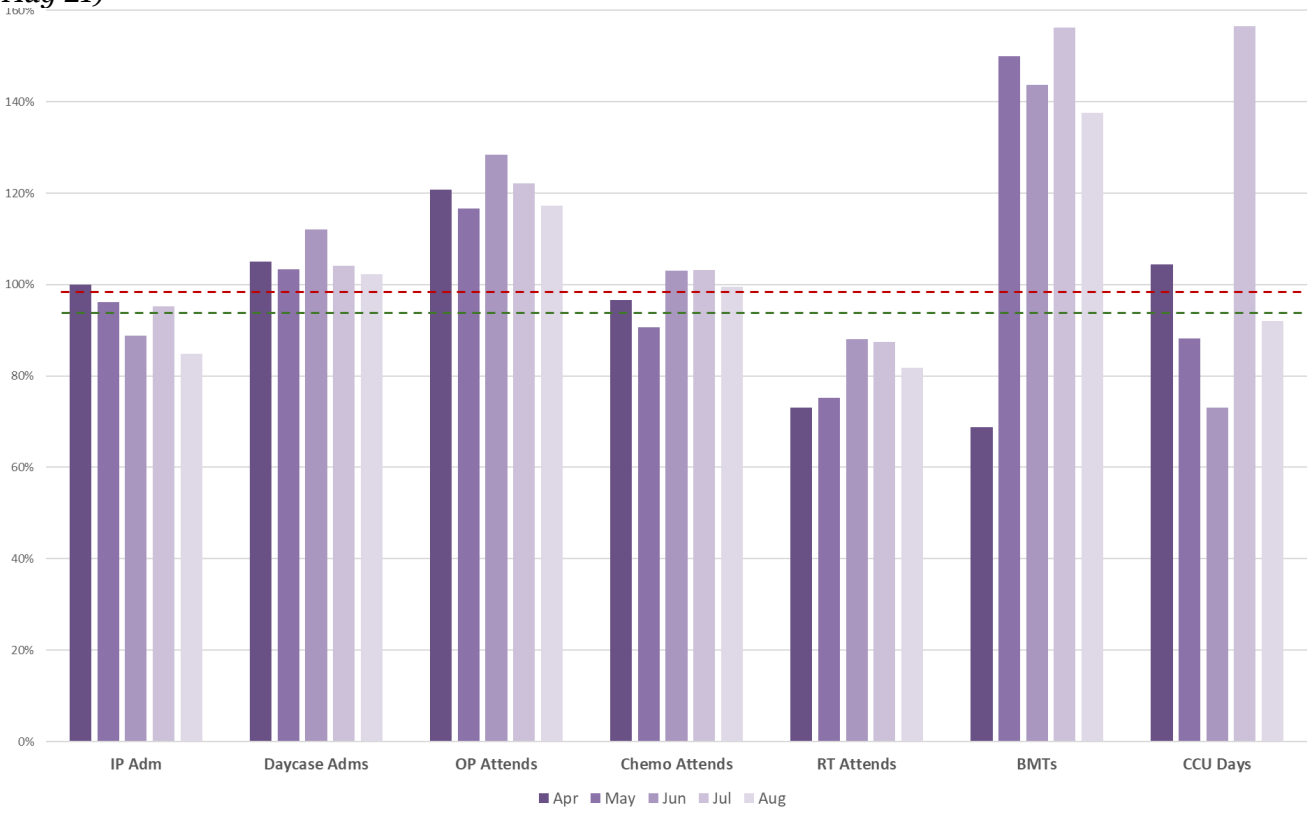
Figure 1. Cancer 62 Day Backlog patient with/without decision to treat date (DTTD) Jan 20-Aug 21



2.0. Year To Date Activity

The graph below shows NHS monthly activity levels (April to August 2021) compared to the 19/20 average BAU baseline. The dashed lines show the 95% ERF threshold (green) and the 100% BAU level (red).

Figure 2. NHS Treatment activity compared to 19/20 BAU baseline, by modality (Apr 21 – Aug 21)



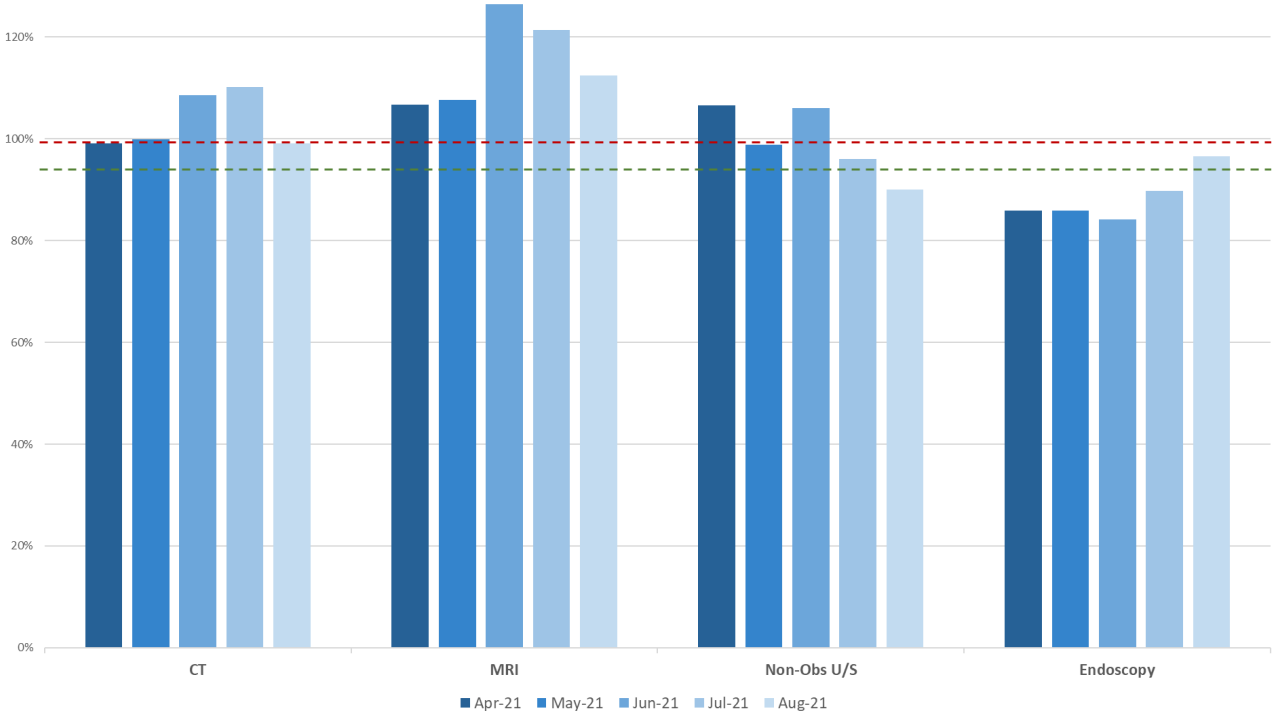
As can be seen above, the majority of treatment activities are above the ERF 95% thresholds, with most ambulatory activity consistently above 100%. BMTs have performed substantially above the pre-pandemic baseline since May.

Radiotherapy is consistently reporting below 100% BAU due to changes in treatment protocols that now result in fewer attendances, that said, due to different casemix this is having a greater impact at Chelsea, whereas Sutton activity remains high.

Inpatient admissions have hovered around the 95% level and have been impacted by the need to manage pathways differently due to high rates of community COVID prevalence.

The chart below shows NHS diagnostic activity in a similar format.

Figure 3. NHS Diagnostic activity compared to 19/20 BAU baseline, by modality (Apr 21 – Aug 21)



Most diagnostic modalities have seen activity levels consistently above the ERF thresholds. Ultrasound activity dipped slightly in August as referrals reduced for the summer holidays, and Endoscopy activity has slowly climbed throughout the year to reach 97% BAU in August.

3.0. |Elective Recovery Fund

Elective recovery fund (ERF) quantums are nationally calculated from standard NHS data submissions. The national formula only includes selected elective NHS activity covered by the national tariff. As such, much of the Trust's activity such as Chemotherapy, Radiotherapy, BMTs and complex sarcoma surgery are excluded from the calculation.

The table below shows how the Trust's activity levels shown above distil down to an ERF %age when the national formula is applied. It was always anticipated that we would see a dip in July and August with an anticipated pick up again in September. It should also be noted that whilst the ERF provides additional income top-up when activity is above baseline, it does NOT deduct income when overall activity is below baseline.

	Apr-21	May-21	Jun-21	Jul-21	Aug-21*
ERF Achievement vs BAU	129.7%	129.1%	113.1%	106.3%	*95.2%*

*August 2021 is an early low-case position based on part-coded data. The ERF is confirmed in-line with standard commissioning timetables and so this data will not be finalised for another month and will increase when fully coded.

As can be seen above all months have exceeded the 95% BAU threshold and so on that basis the Trust has achieved a positive ERF position. The actual funds payable to the Trust are determined at system level and this income could be at risk if SWL fails overall to achieve a positive ERF position.

4.0. Capacity and System Planning

As the holiday period draws to an end, referrals are expected to rise again and the Trust is working hard to explore additional capacity options to ensure that we can meet predicted demand levels (both NHS and PP) and reduce our NHS backlog from now and through the autumn. This includes additional sessional activity in different modalities of care and the possibility of commissioning independent sector capacity with partners. Our planning will in part depend on what funding arrangements are available for trusts and systems through the new government settlement for the second half of the financial year.

5.0. Site Management Arrangements

In line with the National Guidance (COVID-19 Infection Prevention and Control (IPC) Guidance: Care Pathways), the Trust continues to accommodate patients safely on a blue (un-planned or not fully isolated) and green (planned) pathway adhering to clear guidance regarding screening and isolation. Despite the recent relaxation of lockdown restrictions in July, the latest National Guidance (2nd Sep 2021) concerning pathways has not changed. This is resulting in significant daily challenges, particularly at the Chelsea site with managing inpatient capacity across the two streams (green and blue).

In addition, there is a high level of acuity on the non-elective wards adding to further pressure on staff who are also facing a lack of available community support to fast track some of our more complex patients out of hospital.

Work is now underway to implement a mixed pathway model for the side rooms at the Chelsea site meaning the site team can flex side rooms between blue and green which will maximise capacity. Patients will undergo a thorough risk assessment to ensure suitability with close monitoring of associated nosocomial infections by IPC and the Non-Elective working group. This will enable us to reduce admission delays, enhance patient experience and ensure continuity of care for all RM patients requiring specialist treatment.

Following the National easing of lockdown, the RM is reviewing when visitors are able to return on site. It is proposed that we will open initially to inpatients having one designated visitor who will be provided with an inpatient visiting card. The rate of associated nosocomial infections will again be closely monitored prior to increasing our visiting numbers further. Visiting restrictions for ambulatory patients will be reviewed in line with the removal of social distancing regulations.

For our non-clinical and support staff existing arrangements including maintaining social distancing and following IPC guidance on site continues. Many of our corporate teams continue to deploy hybrid working arrangements including time on site and off site. We are

also continuing to conduct the majority of our meetings virtually as a result of needing to maintain social distancing. These arrangements are now likely to be in place until the end of the calendar year in the first instance although we are continuing to keep this under regular review.

6.0. Vaccine Programme

We closed the RM COVID-19 vaccination clinics on 21 May 2021 having delivered over 19,000 vaccines and currently signpost staff and patients that have not had a first dose, or due a second dose, to the national NHS booking system. We have developed a pathway for international and Embassy Private Patients to access the vaccination at the Science Museum, Marble Arch Vaccination Centre and with SWL CCGs via a direct booking system.

We are also now actively planning for phase three of the COVID-19 Booster vaccination programme updating all relevant SOPs. There are several clinical and supply issues that remain unknown and therefore our approach to planning and design of the booster programme will need to remain flexible.

A decision on what vaccine will be administered has not yet been made - a final decision is contingent on the outcome of clinical trials that are on-going. However, it is anticipated that the booster will be the Pfizer/BioNTech vaccine, and that a recommendation will be made for this to be given to everyone irrespective of what type of dose they received for 1st/2nd vaccines (Pfizer, AZ, Moderna etc).

For logistical and operational issues, the requirement to deliver Flu and COVID-19 Booster vaccines at the same time, through the same clinic, has been relaxed in recent NHSE/I communications in preference of allowing Trusts to adopt an approach that best suits the local situation. All SWL Trusts are reporting that they will be delivering Flu and COVID-19 Boosters through different clinics.

NHS England term the ongoing commitment to provide a first dose of the COVID-19 vaccine to anyone eligible who have not yet accessed it as the '*evergreen offer'*. There is an expectation that operational vaccine sites during phase three commit to supporting the *evergreen offer*. RM is committed to ensuring that we support this *offer* to maximise vaccination uptake by staff.

NHSE/I had initially informed sites that the Booster programme will go live from 6 September 2021, however this has been delayed. We are due to receive the vaccine on 20 September and due to our patient population have been given approval to open the vaccine programme to patients that are eligible for a 3rd dose (those that are immunodeficient / immunosuppressed / undertaking immunosuppressive therapy) – this 3rd dose is in addition to the Booster.

JCVI has recommended vaccination of those aged 12 and above that are immunosuppressed and /or who are considered clinically extremely vulnerable. We will deliver a vaccine programme at the CYP Unit for patients and their families.

The RM Booster programme will run for approximately 4 weeks on both sites with a mop up clinic on a weekly basis for those that were not vaccinated when the programme first started in December 2020 or had a delayed 2nd dose.

7.0 COVID-19 testing update

In July COVID-19 testing for both patients and staff was transferred to the new in-house service provision from the private provider HSL. Over 6,000 patient and 3,000 staff PCR tests have been undertaken on site so far. Importantly moving forward this new testing technology

will not only provide COVID test results within 24hrs, but also enable rapid turnaround flu and RSV panel testing for high-risk groups such as critical care & haemato-oncology patients. Work is underway to establish this service prior to the flu season.

The third round of staff antibody testing started in August with 448 tests undertaken, of which there were only 4 negative results, all for staff who had not been vaccinated. This staff testing programme has been paused temporarily due to the national shortage of blood bottles but will be recommenced once the issues in the supply chain have been resolved.

To support compliance with the weekly asymptomatic swabbing protocols for day chemotherapy patients, volunteers are supporting the Day Unit staff with the creation of swabbing packs. The potential to expand the volunteer roles to further release clinical resource is currently being explored.

The in-house Test and Trace service identified, and risk assessed contacts for 90 positive staff cases in July and August. An evaluation of the risk rating conversion into positive PCR results for contacts is being undertaken. A de-isolation policy has been created and implemented to ensure front line staff who would normally be required to isolate having been 'pinged' by the NHS tracing app, are assessed and where appropriate return to work. This process follows government guidance alongside the same principles as the Trust's Test and Trace risk assessment, with an electronic form assessing suitability for de-isolation based on a set of operational criteria. Over 150 staff were assessed in August, and where appropriate, staff returned to work whilst ensuring the safety of staff, patients and volunteers. 26% of the front line staff who had been 'pinged' were able to return to their roles on site following this risk assessment process.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
28 September 2021	6.1
Title of Document: Monthly Quality Account – June (May Data) 2021	**To be presented by:** Mairead Griffin, Chief Nurse

1. Status: For Information

2. Purpose:
Central to the core strategy of The Royal Marsden NHS Foundation Trust is safe effective care and a positive patient and family experience. This strategy is made more overt and demonstrable from the bedside to the Board in the Quality Account presented to the Management Executive and the Board monthly.

Relates to:

Operational Performance	✓

3. Summary
The quality account dashboard was reviewed prior to Q1 of 2021/2022. Due to the number of changes to KPIs in 2020/21, these broadly remain the same. Following consultation, several indicators have altered to improve usability of the dashboard for key stakeholders. These are outlined on page 3 of the report.

Good Performance:

- Second round of Covid vaccinations ended on 21st May 2021
- Friends and Family Test - 99.6% of patients would recommend Royal Marsden inpatient care (national average 95%) and 97.3% outpatient care (national average 93%).
- In May we had a slight decrease in *c.difficile* cases from 9 to 6 cases (with 4 attributable cases).
- Reduction in hospital acquired pressure ulcers (n = 3). All low harm injuries. Trends observed: 0 acquired in Sutton site, 0 acquired in cancer services division.
- Ongoing compliance with VTE risk assessments achieving 97.6% against an 85% target.
- Significant improvement in performance of haematology day unit, improving 12.5% to 56.1%.
- The Trust nurse vacancy rate decreased to 4.9% and is below the Trust target of 5%.

Area for Improvement / Note:

- Increase in *e.coli* numbers (n =6). Devising volunteer role to support with encouraging hydration with patients in inpatient and outpatient settings
- There were 20 falls recorded for May, 5 of which related to 2 patients. All low harm but noted 28% occurred between 09.00 – 11.59 hrs. All wards to focus on orientating patients to bed spaces and encouraged to use call bell to request for assistance with mobilising.
- The Trust Nursing voluntary turnover rate increased from 11.2% to 12.6% in month and is slightly above the Trust target of 12.0%. Whilst voluntary turnover rates for both band 5 and band 6 nurses reduced to 18.4% and 8.7% respectively, there were 11.9 WTE band 5&6 voluntary nurse leavers which is the highest amount over the last 12 months, the main reasons given include relocation and promotion. Retention remains a key focus and includes a review of career pathways, stay conversations, staff engagement and learning from others.

4. Recommendations / Actions
Board members are asked to review and comment on this report.

The Royal Marsden NHS Foundation Trust

Monthly Quality Account

JUNE 2021 (May Data)

A report by the Acting Chief Nurse: Andrew Dimech

Monthly Quality Account (QA)
Table of Contents

Quality Account dashboard 21/22 review

- There was a significant review to KPIs in 20/21. As a result the 21/22 review resulted in minimal changes to existing KPIs in the QA :
  - Number of attributable medication incidents with moderate harm and above – annual target reduced from nine to six, due to better than threshold performance in 2020/21
  - Trust is awaiting the national trajectories on E-Coli Bacterium and Clostridium difficile (rolled over 2020/21 targets until guidance released).
- Following consultation, the following indicators have been introduced to improve usability of the dashboard for key stakeholders, who review data from a range of dashboards :
  - Datix (staff with >5 overdue incidents) – target under review
  - Investigation outstanding actions – target under review
  - Sickness rate (rolling 12 month average)
  - Trust voluntary staff turnover rate
  - Appraisal & PDP rate
  - Local induction
  - Mandatory Training: % of staff compliant with training
- The following indicator was included in line with Trust priorities
  - Number of RMH published CMC records (applies to London CCG only)
  - Cavendish Square will be added as a site in the QA metrics from May data with the activity in the PP dashboard
- The Trust also produces divisional scorecards, which are presented at divisional meetings. These were also reviewed:
  - KPIs updated with changes to the Trust QA (as above)
  - RAG ratings were introduced, to improve usability
- The Trust is carrying out its annual review of the Board Scorecard KPIs and thresholds and will be submitting a paper to the Executive Board and the Chair of QAR in July

Quality Account dashboard 21/22 (1/2)

May-21

Indicator		Annual Target	Aim	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	2020/21
Safe care																	
Hospital Standardised Mortality Rate (rolling 12 months, NHS and PP)		80	Below	(Q4 20/21)			(Q1 21/22)			(Q2 21/22)			(Q3 21/22)				N/A
Mortality audit		Green		(Q1 21/22)			(Q2 21/22)			(Q3 21/22)			(Q4 21/22)				N/A
SIs: Number of SIs (including PU cat 4)		7	Below	0	0											0	7
Datix (staff with >5 overdue incidents)		TBC	Below	59	33											92	32
Investigation outstanding actions		TBC	Below	79	50											129	69
Number of diagnoses of Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia		0	Below	0	0											0	0
Number of diagnoses of Methicillin-sensitive *Staphylococcus aureus* (MSSA) (Attributable)		6	Below	1	0											1	3
Clostridium difficile (C. Diff)	Number of reportable cases - Community Onset Hospital Associated and Hospital Onset Hospital Associated	67		5	4											9	52
E-Coli	Total number of E. Coli Bacterium	65		3	6											9	70
	Number of Attributable E. Coli Bacterium	No target		2	5											7	33
Covid-19 positive tests	Positive tests – patient admissions (hospital onset, definite and probable)	0		0	0											0	38
	Staff new positive tests	No target		0	1											1	590
	Reportable outbreaks	0		0	0											0	N/A
PPE audit	Trust	95%		96.2%	97.0%												N/A
Hand hygiene	Trust	95%		97.1%	97.0%												N/A
Sepsis	% of inpatients screened for sepsis	90%	Above														99.1%
	% of those screened positive who received IV abx within 1 hour	90%	Above														96.5%
Falls	Attributable Moderate Harm Incidents while patient under RMH care	5	Below	0	0											0	6
	Attributable Major Harm Incidents while patient under RMH care	0	Below	0	0											0	0
	Attributable Death Incidents	0	Below	0	0											0	1
Number of patients with attributable pressure ulcers	Number of patients	No target		8	3											11	130
	Category 1	No target		0	0											0	29
	DTI	No target		1	1											2	18
	Category 2	No target		6	2											8	56
	Category 3	No target		0	0											0	19
	Unstageable	No target		0	0											0	8
	Category 4	0	Below	0	0											0	0
Number of attributable medication incidents with moderate harm and above		6	Below	0	0											0	4
Number of cardiac arrests		No target	Below	1	2											3	24
Failure to recognise deterioration in a patient leading to death		0	Below	0	0											0	0
VTE risk assessment		95%	Above	96.2%	97.7%											96.9%	95.6%
DoLS applications		No target		1	0											1	22

Quality Account dashboard 21/22 (2/2)

May-21

Indicator		Annual Target	Aim	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	2020/21
Effective Care																	
Chemotherapy waiting times: % chemo patients starting treatment within 1 hr of appointment time	Chelsea	*85%*	Above	87.0%	87.1%											87.1%	*85.9%*
	Sutton	*85%*	Above	76.4%	78.2%											77.3%	*76.3%*
	Kingston	*85%*	Above	89.7%	92.7%											91.1%	*93.5%*
	Cavendish Square	*85%*	Above	N/A	93.3%											93.9%	*N/A*
Chemotherapy waiting times: % chemo patients starting treatment within 3 hrs of first appointment of day	Chelsea	*85%*	Above	74.1%	75.0%											74.5%	*74.8%*
	Sutton	*85%*	Above	82.6%	82.0%											82.3%	*82.7%*
	Kingston	*85%*	Above	96.0%	98.6%											97.3%	*96.3%*
	Cavendish Square	*85%*	Above	N/A	86.7%											84.8%	*N/A*
Number of RMH published CMC records - applies to London CCG only		*(Target under review)*		22	10											32	*209*
Caring																	
RMH Inpatient Friends and Family Test: % overall experience		95%	Above	99.2%	98.6%											98.8%	*99.3%*
RMH Inpatient Friends and Family Test: Number of responses		*No target*		125	208											333	*1499*
Responsive																	
% of complaints responded to in required timescale		81%	Above	85.7%	100.0%											91.7%	*91.4%*
Number of complaints		*No target*		4	9											13	*74*
Number of complaints per 1000 daycase and inpatient discharges		4.08	Below	1.85	4.24											3.03	*3.36*
Number of concerns received		*No target*		13	22											35	*231*
Number of compliments received		*No target*		9	46											55	*627*
Well-led																	
Number of Freedom To Speak Up (FTSU) alerts		*No target*															*75*
Trust vacancy rate		*7%*	Below	10.3%	6.3%											8.3%	*10.2%*
Nurse vacancy rate		*8%*	Below	8.7%	4.9%											6.9%	*9.5%*
Trust sickness rate (one month in arrears)		*3%*	Below	3.0%	3.2%											3.1%	*4.3%*
Sickness rate (rolling 12 month average)		*3%*	Below	4.0%	3.7%											3.9%	
Nurse sickness rate (one month in arrears)		*3%*	Below	4.7%	4.3%											4.5%	*5.1%*
Trust voluntary staff turnover rate		*12%*	Below	11.7%	10.9%											11.3%	
Nurse turnover rate		*12%*	Below	12.1%	12.6%											12.4%	*12.5%*
Appraisal & PDP rate		*90%*	Above	80.7%	76.1%											78.4%	*84.5%*
Local induction		*85%*	Above	82.0%	64.3%											71.9%	*79.0%*
Mandatory Training: % of staff compliant with training		*90%*	Above	88.5%	90.5%											89.5%	*87.1%*

Divisional dashboards are also produced monthly and are shared at divisional governance meetings for discussion and action.

Monthly 'Big Four' (B4) Safety Messages May 2021

The Big 4 is the monthly patient safety bulletin from the Chief Nurse, Medical Director and Chief Pharmacist. The B4 details four key safety messages as well as a '**good-safety-catch**' by a member of staff. B4 can support your local shift safety briefings, local weekly B4 quality huddles or team meetings.
Using the B4 is simple – Team Leaders and Managers are asked to verbally brief and disseminate a copy of the B4 to your teams once per month.

B1- Assessment of mental capacity

Documentation: Record of Assessment of Mental Capacity (Previously Consent Form 4) and Best Interests Decision for Adults that lack Capacity.

Completing the form

Part 1. Q1 of the assessment: Be very clear on the decision that needs to be made i.e., what is the treatment and care you are proposing as you would to a person with capacity. Do not write that a patient is unable to decide on treatment due to a learning disability.

Q3-Q9: Provide the evidence.

Q10: What is the impairment affecting the persons capacity to make an informed decision? If the impairment is suspected dementia, for example, but has not been formerly diagnosed, you cannot record the person lacks capacity due to dementia. [Mental Capacity Act 2005, Section 2(1, 4), 3 (2, 3)]

B2- 'Best interest decisions'

If you are satisfied, on the balance of probabilities, that someone lacks capacity to make a specific decision, the person who needs to make the decision on their behalf, or to intervene in an individual's life, must do so in that individual's 'best interests'.

You must take into consideration the person's past and present wishes, their beliefs and values that would likely influence their decision as well as any other relevant factors. You must also take into account the views of anyone caring for the person or with an interest in their welfare.

[Mental Capacity Act 2005, Section 4 (1, 2, 3, 4, 5, 6a, 6b and 6c, 7)] Decision maker

Unless the patient has a Lasting Power of Attorney for Welfare and Health, and you have a copy of the LPA, you as the clinician are the decision maker. The Next of Kin cannot decide (consent) nor does the next of kin sign the document. It is good practice to let the next of kin know of the decision being made.

B3- Investigation 6- pressure ulcer grade 3

A patient was found to have a grade 3 pressure ulcer 5 days after admission. The patient's relative reported that this was a longstanding injury, and this was supported by the assessment of the area as it appeared to be an older wound. Due to a lack of documentation, it was not possible to confirm if this skin injury has been acquired in hospital. The staff involved reported that the patient had declined skin inspections and communication had been difficult due to language barrier and difficulty with access to interpretation services in blue area.

Key Learning:

1. Staff to ensure skin assessment is completed within four hours of admission and documented in the medical notes where clinically appropriate.

2. Staff to document using the 'declining equipment' form and escalate to Matron/Divisional Nurse Director when a patient refuses treatment or intervention.

B4- Personal protective equipment and heat stress

Wearing personal protective equipment (PPE) when working in warm or hot conditions increases the risk of heat stress. To help prevent this:

• Aim to take regular breaks; find somewhere cool if you can and change your PPE regularly.

• Make sure you are hydrated and try to drink more water than usual (checking your urine is an easy way of keeping an eye on your hydration levels – dark or strong-smelling urine is a sign that you should drink more fluids).

• Be aware of the signs and symptoms of heat stress and dehydration (thirst, dry mouth, dark or strong-smelling urine, urinating infrequently or in small amounts, inability to concentrate, muscle cramps, fainting).

• Do not wait until you start to feel unwell before you take a break.

• At your daily huddle discuss using a buddy system with your team to look out for the signs of heat stress (e.g., confusion, looking pale or clammy, fast breathing) in each other.

• Between shifts, try to stay cool as this will give your body a chance to recover.

Heat stress can present as heat exhaustion and lead to heatstroke if the person is unable to cool down. Heat exhaustion is not usually serious if you can cool down within 30 minutes. If it turns into heatstroke, it needs to be treated as an emergency.

Monthly ‘Big Four’ (B4) Safety Messages May 2021

What is the ‘Big 4’ and how should I use it in my department

The ‘Big 4’ (B4) is the monthly patient safety bulletin from the Chief Nurse, Medical Director and Chief Pharmacist. The B4 details ‘four’ key safety messages as well as a ‘**good-safety-catch**’ by a member of staff.

The B4 can support local shift safety briefings, local weekly B4 quality huddles or team meetings.

The ‘Good Safety Catch’ *award is given by the Chief Nurse to a member of staff or team each month for action intercepting and stopping an error from reaching patients or staff members.*

1. A patient with a latex allergy was having a procedure in theatres. Whilst doing the routine documentation the member of staff noticed that a latex catheter had been inserted into the patient. Upon seeing the "Latex Mark" she escalated the problem to the circulating, scrub nurse and surgeon who acknowledged the problem and immediately changed the catheter into Latex free.

2. During a surgical procedure the member of staff noticed that a surgical instrument that had been intact at the beginning of procedure was broken and missing a part. She immediately informed the team who worked together to locate the missing part. An extensive search was performed, which enabled the missing part to be found thus preventing a never event.

Suggestions for the B4 or safety catch, can be sent to helen.mills@rmh.nhs.uk

Healthcare Associated Infections & Hand Hygiene

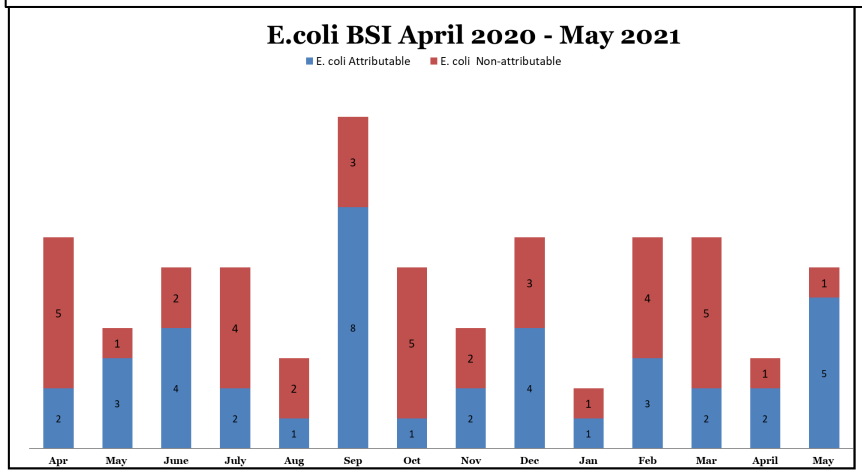
Data Owner – Pat Cattini – Deputy Director of Infection Prevention and Control.

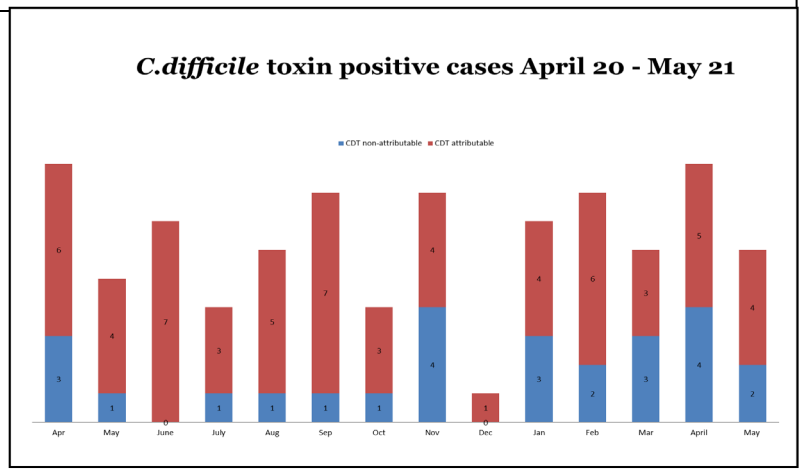
Review of reportable attributable *C.difficile* and *E.coli* infections is used to identify opportunities for improvement through a healthcare infection learning panel.

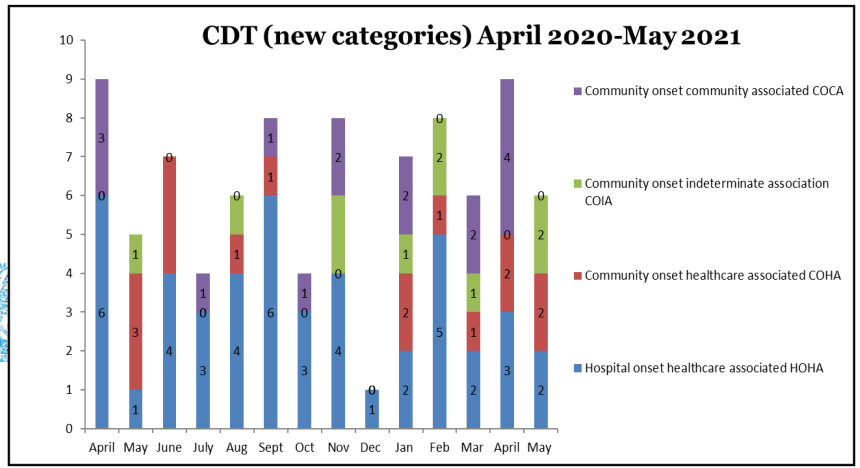
Hand hygiene and other audits continue via the 'Perfect Ward' app. We continue to work with the matrons to maintain high standards despite the pandemic.

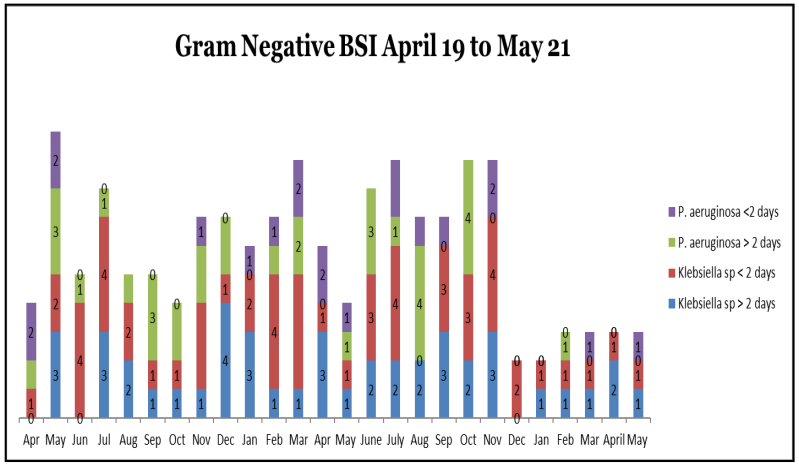
The IPC and Micro teams continue to support the C-19 effort. There numbers have declined significantly, though we are still seeing sporadic cases. Incident meetings are held to assess any positive cases only if required. There remains a focus on use of masks and visors, face mask fit testing and appropriate use of PPE. Advice also includes patient flows, assessment of working environments and continued staff support.

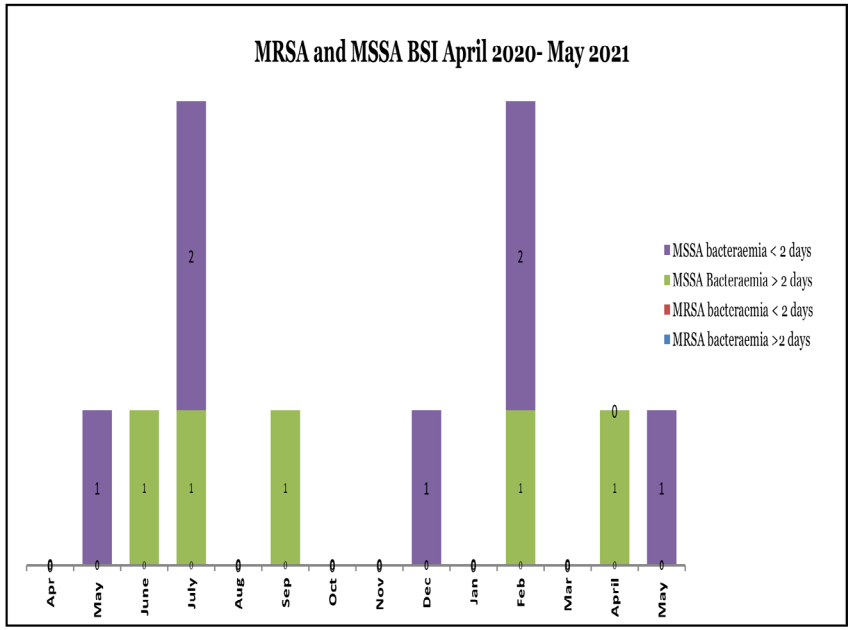
There is a concerted programme to vaccinate staff against C-19. Over 85% of staff have had a first dose. Second doses started on 15th March. The vaccination service finished on 21st May and thereafter staff and patients will use other local services.

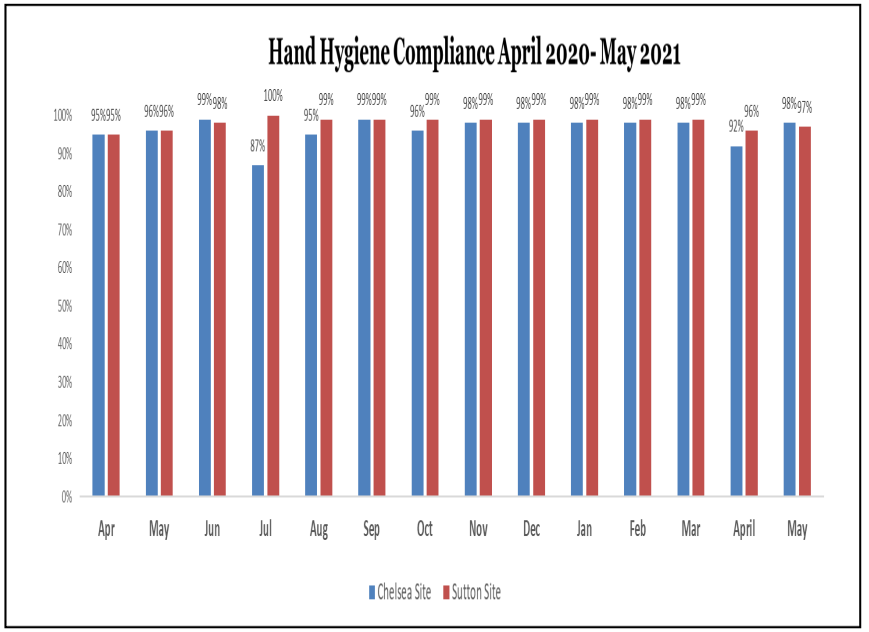


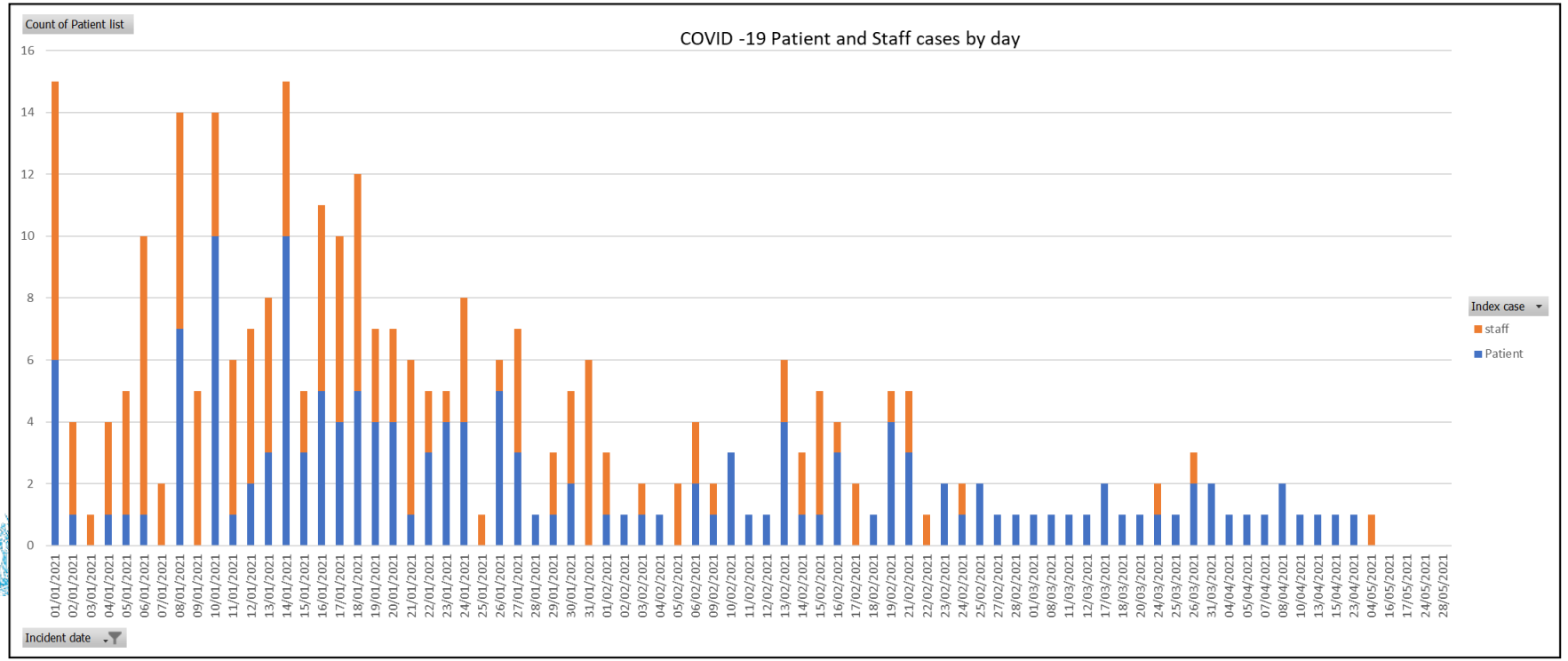







MRSA and MSSA BSI April 2020- May 2021
MSSA bacteraemia < 2 days
MSSA Bacteraemia > 2 days
MRSA bacteraemia < 2 days
MRSA bacteraemia >2 days
Apr
May
June
July
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
April
May


Hand Hygiene Compliance April 2020- May 2021
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
April
May
Chelsea Site
Sutton Site

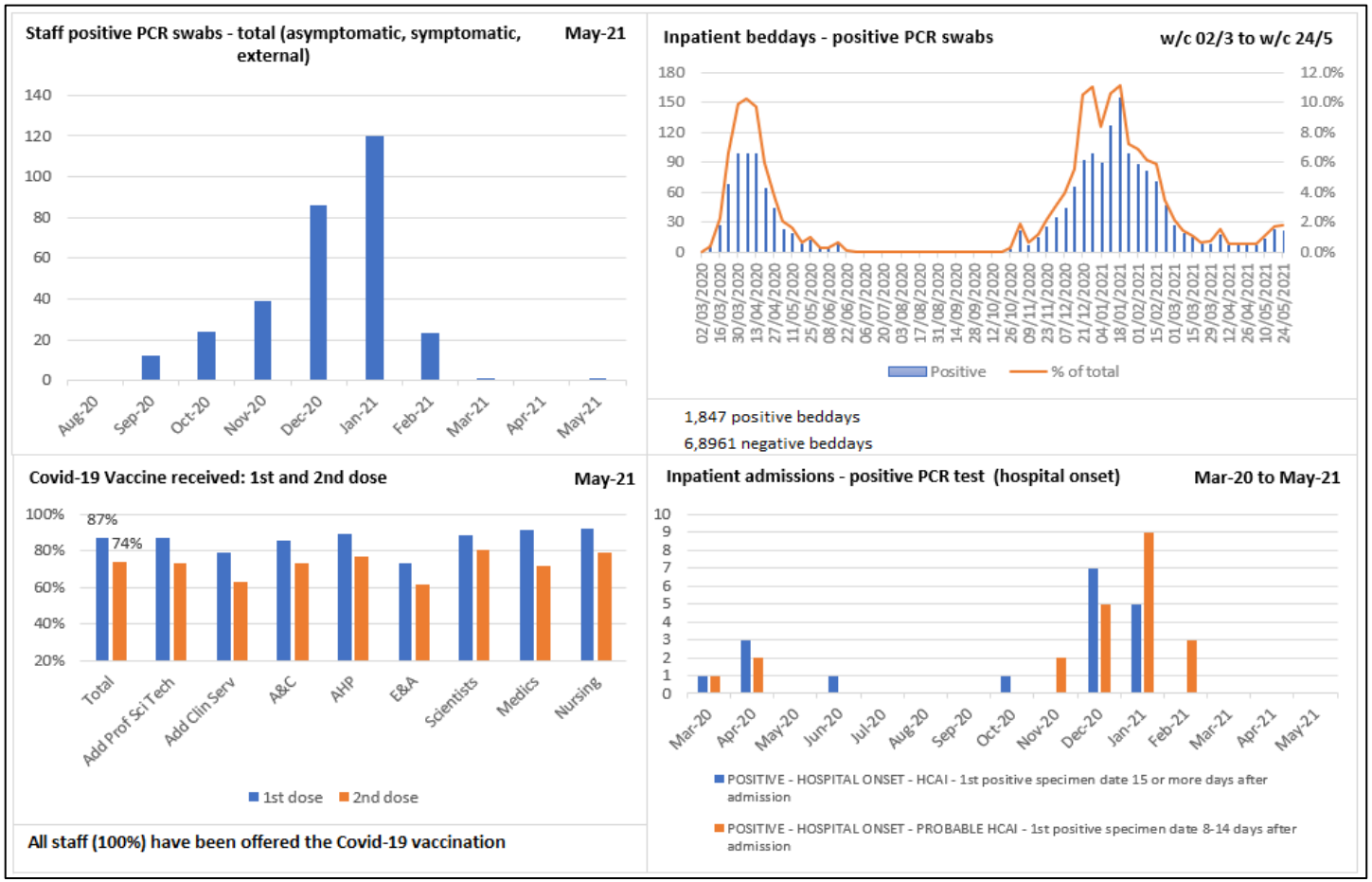

Count of Patient list
COVID -19 Patient and Staff cases by day
Index case
staff
Patient
Incident date

IPC COVID dashboard (1/2)

May-21

IPC COVID dashboard (2/2)

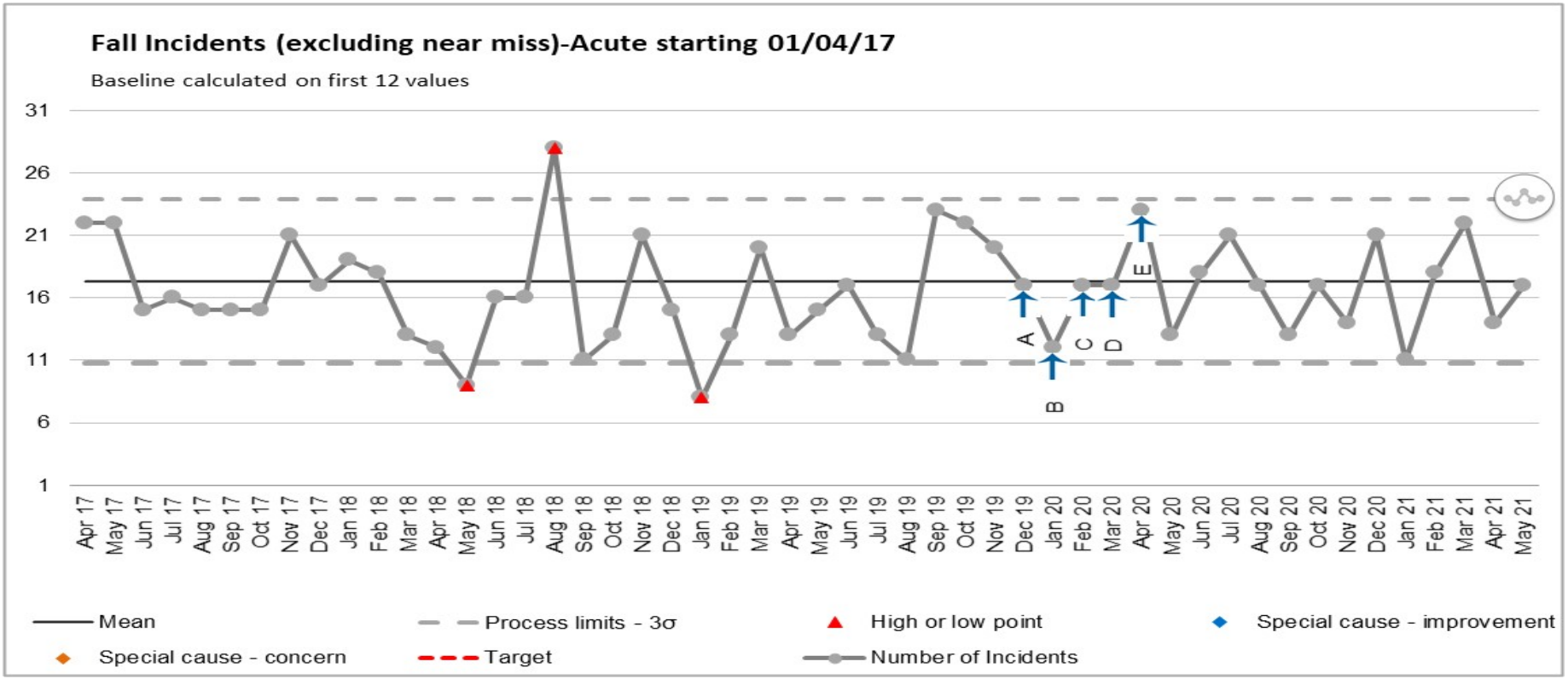
May-21



Patient Fall Incidents

Target: <0.7 falls with moderate or above harm

Data Owner: Teresa Deakin (Matron): There were 20 falls recorded for May – slight increase of 3 in comparison to April. One patient fell twice – low harm reported on each occasion. The other had 3 falls reported, 2 of which were assisted – once again all low harm. There have been no moderate harm falls for the last 3 months. From June 2020 to May 2021 there have been 251 falls reported Trust wide which is a 1.6% decrease compared to the same time period last year with a 5.5% decrease in falls on the wards. During May, 28% of falls reported on the wards occurred between 09.00 – 11.59 hrs. Over the last 12 months 19% of falls occurred during this time period – the most common period of time.



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

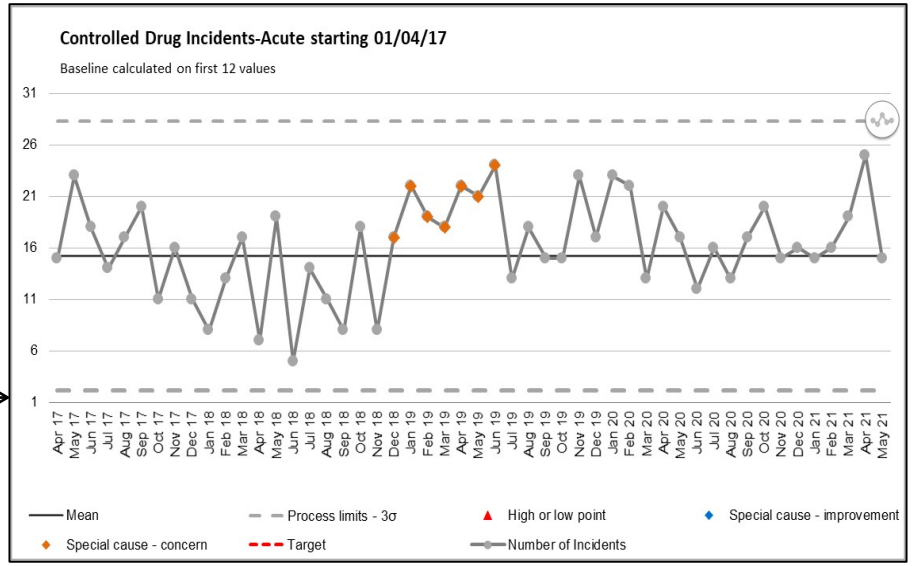
Medication Incidents

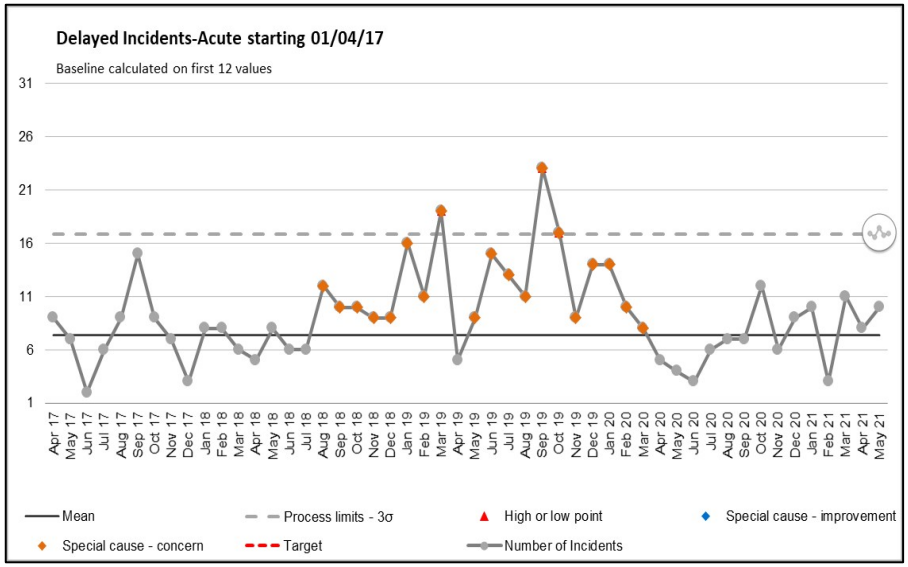
Data owner: Suraya Quadir, Medication Safety Officer

May 2021: There were 133 medication incidents, of which 26% were due to chemotherapy reactions when used as intended.

All of this month's incidents were no harm (98) and low harm (35).

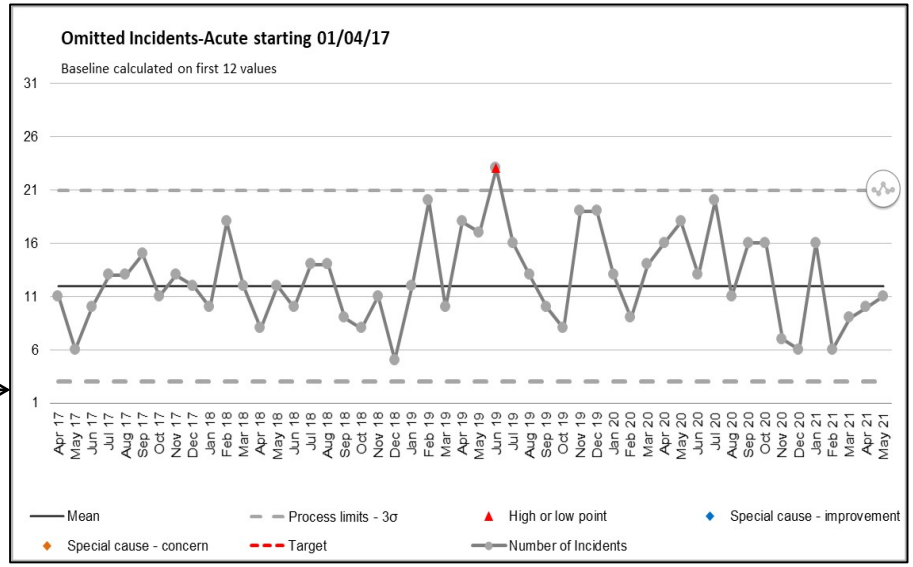
Controlled Drug (CD) Incidents (14): The majority of this month's incidents were due to accounted for losses-spillages (4), administration incidents, namely delayed doses (2) wrong formulation (2), and the prescribing of wrong dose/frequency (3). An incident occurred where a patient was found to have administered oral morphine from his own supply. This was due to safe custody of medication processes out of hours non-adherence.





Delayed medicines (9): The main theme were delays in chemotherapy administration (5), these were mainly from aseptic preparation due to IVRS issues within CT regimens. There were also 4 cases of dose delays of which the majority was CDs.

Omissions (11): The main themes here were dose omissions (5), expired medications (4) and supportive medicines being omitted from proforma (2). An incident occurred where expired intravenous amoxicillin was administered to a patient. This highlights the importance of checking expiry when selecting medication particularly prior to patient administration.



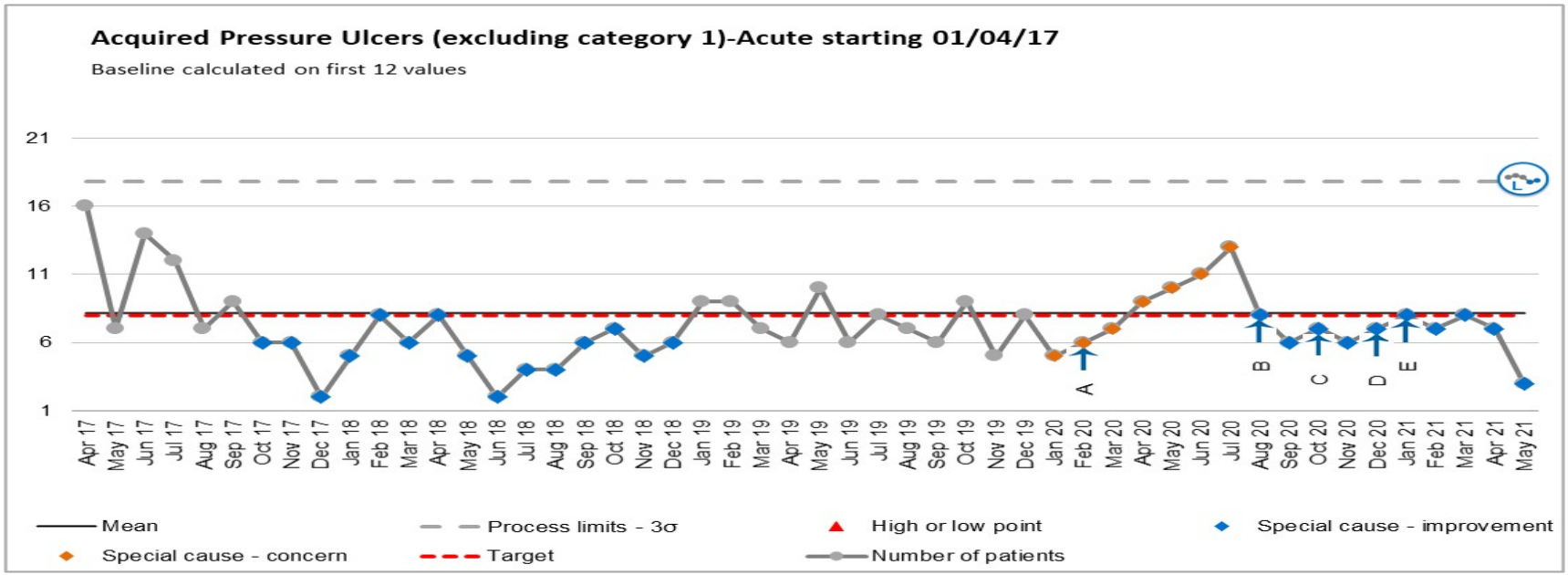
Hospital Pressure Ulcers* – excluding category 1

Target: Zero grade 4 pressure ulcers

Data owner: Anna Collins (Matron)

In May we had n= 3 hospital acquired pressure ulcers (HAPU) excluding Category 1. Two Category 2 and One Deep Tissue Injury. All low harm injuries.
Trends observed – 0 acquired in Sutton site, 0 acquired in cancer services division.

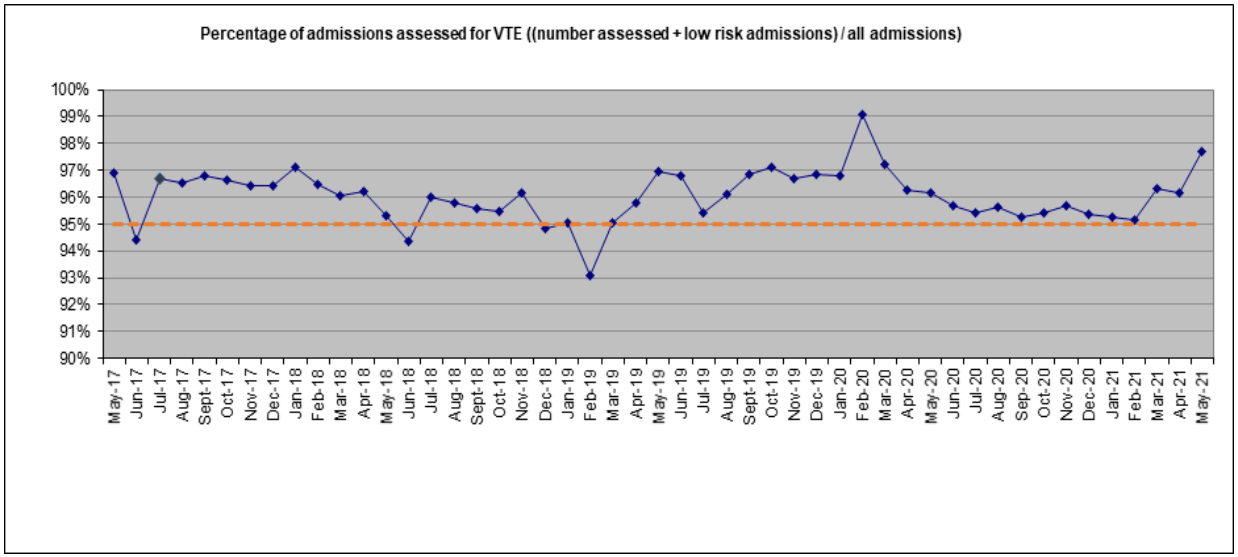
Themes observed:
N= 1 caused by medical devices (VTE Stocking)
N=1 patient declining care and skin inspections
N=1 not on appropriate pressure relieving air cushion



Key Interventions

A	Launch of Pressure Ulcer E learning module
B	Targeted education provided to areas with increased PU prevalence
C	Launch of Level 2 Tissue Viability Champions Training
D	Launch of Healthcare Support Workers Booklet
E	Launch of updated Equipment selection guides

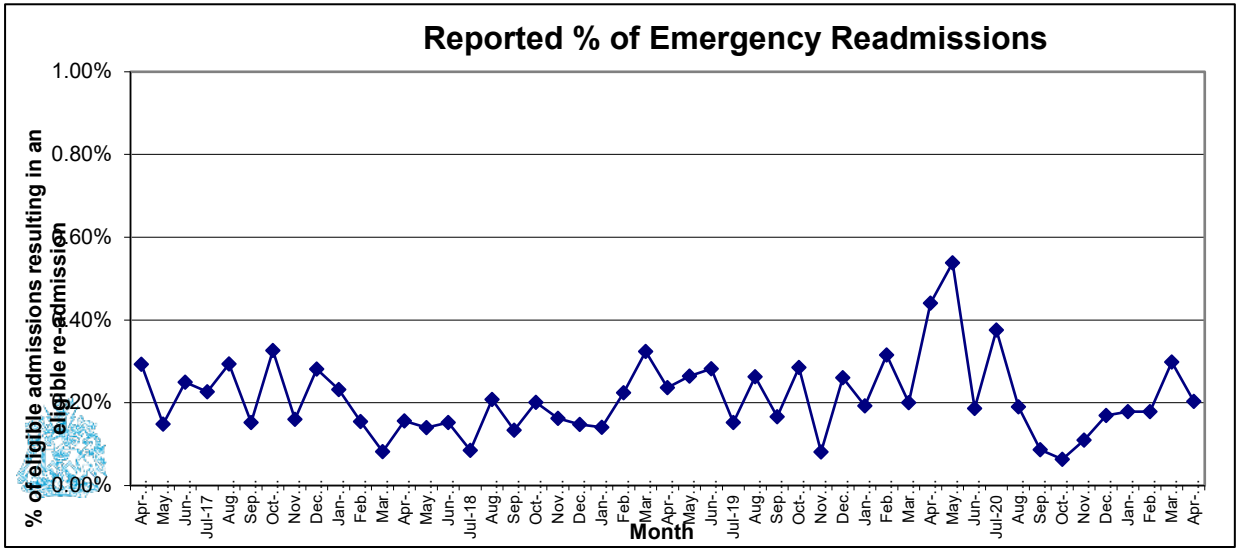
Hospital VTE Screening (May 2021) and Readmission Performance (April 2021)



Data Owner: Joanna Waller, Acting Deputy Chief Nurse

VTE Data: May 2021:

VTE passed: 97.6%.
Ongoing work in progress to streamline electronic Venous Thrombus Embolism Risk Assessment (VTERA) on ICCA with potential workaround identified. Planning to remove VTE assessments from prescription charts in Q2 2021 to encourage electronic reporting.



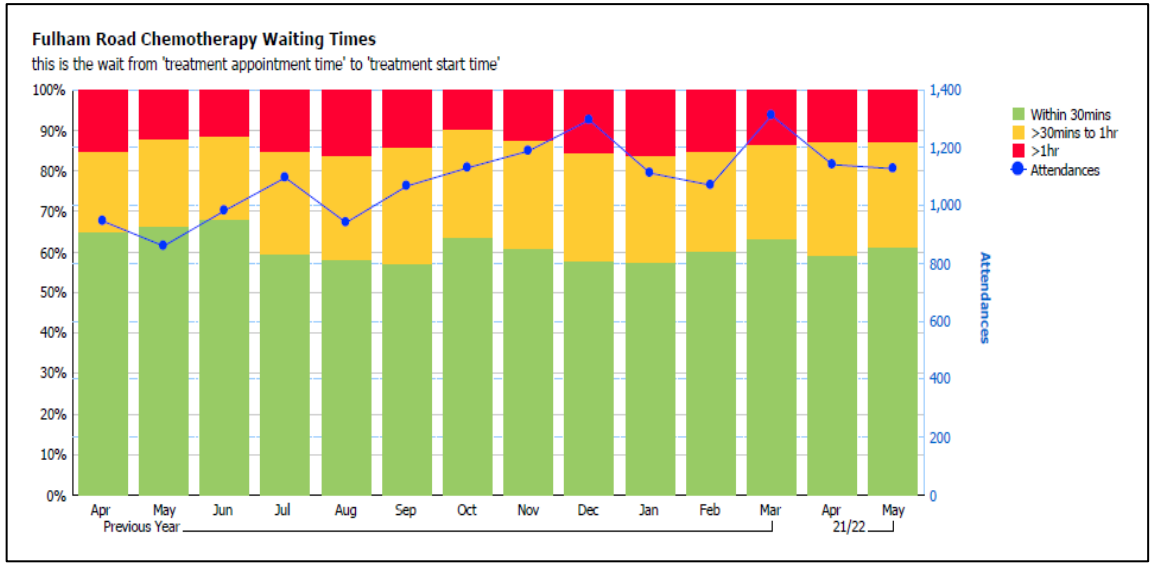
Data Owner: Joanna Waller, Acting Deputy Chief Nurse

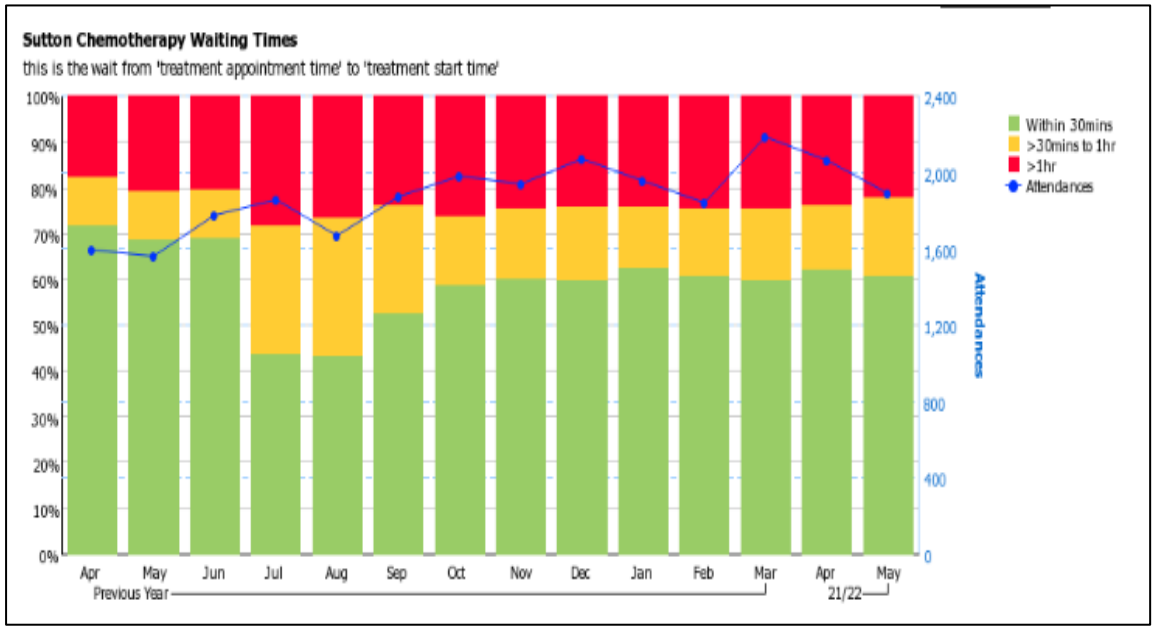
Readmissions Data: April 2021

There were 10 readmissions in April; 1 of which related to symptom control, 1 surgical complication, 2 surgeries, 4 via clinical assessment unit and 2 'other'. Review of all these readmissions showed none were COVID-19 related.

NB: readmission performance data is reported 2 months retrospectively. This enables data validation for non elective patients admitted at the end of the month.

Chemotherapy Waiting Times & Prescribing





Data Owner: Jatinder Harchowal, Chief Pharmacist; Eleanor Bateman, Divisional Director; Cat Liebenberg, Transformation Programme Manager.

May performance at the Trust was 82.6% of patients starting chemotherapy within one hour of their treatment appointment time (against a target of 85%). This is an improvement on April when it was at 81%. May data saw a significant improvement in the performance of haematology day unit improving to 56.1% in May from 43.6% in April.

An improvement programme has been put in place at the Trust focusing on the haematology and children's day units. The following actions have been put in place:

Haematology specific actions

- Increasing two-stop pathways and improving the rate of pre-prescribing
- Ensuring confirmation of treatment is carried out in a timely manner
- Reviewing administration processes
- Reviewing clinic flows to reduce delays
- Implementing zoning in the day care area
- Implementing the chemotherapy recording rules, already rolled out in the two main MDUs

Children's and TYA specific actions:

- Administrative review has been concluded and an associated workstream within the improvement programme developed
- E-scheduling training and rollout – commenced in June
- Review of clinical confirmation process
- Review of chemo clinic timetable and scheduling
- Improving the rate of pre-prescribing
- Reviewing and refining day care paperwork
- Reviewing administrative processes and creating new process flows, guidance and admin KPIs

The Trust is starting to see improvement in the performance data and will continue to monitor and track progress in the haematology and SACT recovery groups.

Patient Experience

Service

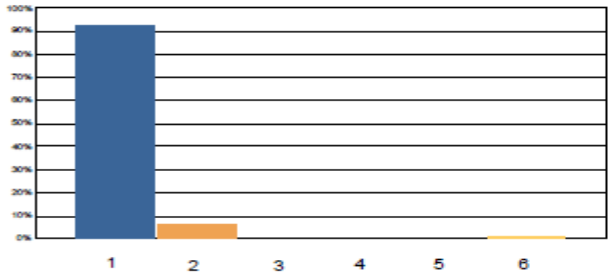
Cancer Services

Star Rating

Positive 98.44%

Negative 0.39%

Overall Scores



Response Option	Responses	Percentage
1 - Very good	237	92.22%
2 - Good	16	6.23%
3 - Neither good nor poor	0	0.00%
4 - Poor	1	0.39%
5 - Very poor	0	0.00%
6 - Don't know	3	1.17%

Service

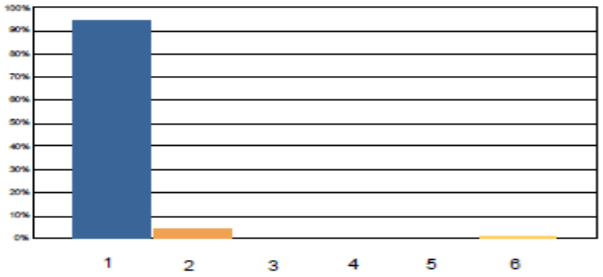
Clinical Services

Star Rating

Positive 98.60%

Negative 0.28%

Overall Scores



Response Option	Responses	Percentage
1 - Very good	337	94.40%
2 - Good	15	4.20%
3 - Neither good nor poor	1	0.28%
4 - Poor	0	0.00%
5 - Very poor	1	0.28%
6 - Don't know	3	0.84%

Data Owner: Kayleigh Hawes (Head of Assurance)

May 2021: Patient Experience Feedback Summary

The external data submission for the Friends and Family Test has now been reinstated after being paused from February 2020 to November 2020 in response to the COVID-19 pandemic. However, national response data will be published quarterly rather than monthly until further notice. This national data has still not yet been published.

The numbers of responses has decreased since April due to the COVID-19 pandemic and we are currently working without external service provider to introduce SMS and IVM methods to collect feedback, as well as looking at other digital methods.

Training for staff on the Patient Experience Platform is taking place on 21 July 2021 to enable to staff to manage and respond to comments locally as well as generate actions and 'you said we did' to inform patients of the actions taken in response to their feedback,

Patient Experience

The patient comments below are captured via our paper FFT comments cards in February 2021. Information is fed back directly to ward teams. Ward Sisters ,Matrons and clinical leads review the data as it arrives and action appropriately. The information is also reviewed at the CBU Performance Review meetings and the monthly Divisional Quality, Safety and Risk meetings.

Examples of positive comments this period

Amazing as always! Understanding when asked to recline chair for blood tests. Friendly, chatty - put me at ease. Organised and professional. Could be improved: No improvements. Thank you for being awesome!
Admissions and Pre-assessment Unit Chelsea

Lovely and extremely patient. Made you feel special and could not fault their care and attention.
Radiosurgery Chelsea

Wonderful personal care. Nothing was too much trouble. Great sense of being "looked after" by committed people. Difficult to suggest improvement. Maybe later meal time in the evening but that is a resource issue.
Oak Ward

Excellent and prompt professional care applied with patience, understanding and great kindness. Person centred care adapted to the individual including holistic planning. As a Christian and it being Holy Week the centre of my faith it was great that I was able to go to Holy Communion in the chapel and visits by a variety of chaplains, much appreciated. Wonderful and caring medical team, ward cleaner and ward host.
Horder Ward

Comments where care can be improved this period

Nearly everyone was very kind and attentive. There were a lot of different staff, which could be confusing if you are not familiar with various uniforms and are not prepared to ask the correct questions from the appropriate staff, especially when you had had tranquillisers. It would be useful to know what medication is being given - as much of it looks unfamiliar and timings are not as at home. **Wilson Ward**

Wilson Ward Action: *Nursing staff reminded of importance of explaining medicines individually to patients.*

Improvements on the mobile chemo unit - pump action hand sanitisers. The ones they have you have to hold and squeeze, which defeats the object! Two tiny bins in toilet are always full/overflowing. They need bigger bin or empty more. **Mobile Chemotherapy Unit**

Mobile Chemotherapy Unit *Action:* *Sanitisers and larger bins put in place.*

Extremely friendly team, always with a smile and time to talk personally. Lucia (name) was amazing, helping me through those first post-op hours, both emotionally and physically. All staff were very motivating about helping me achieve daily recovery targets especially Jack (name). A quick replacement of a faulty Doppler would have helped staff and reduced wake-ups to locate shared machine. Advising cleaning staff to not start cleaning and leaving door open when patient is doing a personal bowel wash.
Kennaway Ward

Kennaway Ward Action: Doppler reported to clinical engineering. ISS staff provided with patient feedback and will be reiterated at staff meeting.

Our Patient Experience Friends & Family Test (FFT)

National Friends & Family Test Data (data as of April 2020) Due to COVID-19, national uploads were on hold until December 2020. This was reinstated in December 2020 and national data will be now published on a quarterly basis.

Inpatient data was collected for 156 Acute NHS trusts and independent sector providers. Nationally, the overall average percentage for those patient that had a positive experience was 95% in March 021. **The trust is above this with a score of 100%.**

Outpatient data was collected for 226 Acute NHS trusts and independent sector providers. Nationally the overall average percentage for those who would recommend outpatients to friends and family was 93% in March 2021, **The trust is above with a score of 98 %**

INPATIENTS FFT	Q1 20/21	Q2 20/21	Q3 20/21	Q4	Apr 21	May 21
The Royal Marsden inpatients who would recommend	National upload suspended due to covid	National upload suspended due to covid	National upload suspended due to covid	99.6%	National data not yet published	National data not yet published
National average	National upload suspended due to covid	National upload suspended due to covid	National upload suspended due to covid	95%	National data not yet published	National data not yet published
Response number	National upload suspended due to covid	National upload suspended due to covid	National upload suspended due to covid	313	National data not yet published	National data not yet published

OUTPATIENTS FFT	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Feb 21	Mar 21
The Royal Marsden outpatients who would recommend	National upload suspended due to covid	National upload suspended due to covid	National upload suspended due to covid	97.3%	National data not yet published	National data not yet published
National average	National upload suspended due to covid	National upload suspended due to covid	National upload suspended due to covid	93%	National data not yet published	National data not yet published
Response number	National upload suspended due to covid	National upload suspended due to covid	National upload suspended due to covid	634	National data not yet published	National data not yet published

Patient Feedback – Complaints

Data Owner: Kayleigh Hawes (Head of Assurance): Complaints Summary: 9 new complaints were opened in May 2021. 4 complaints were for Cancer Services, 2 complaints were for Clinical Services, 2 complaints were for Private Services and 1 complaint was for Corporate Services. 1 complaint was reopened and in total, 14 complaints remain open at the beginning of June 2021. No themes were identified.

Table 18.0 May 2021 Received Complaints – Grouped by Subjects

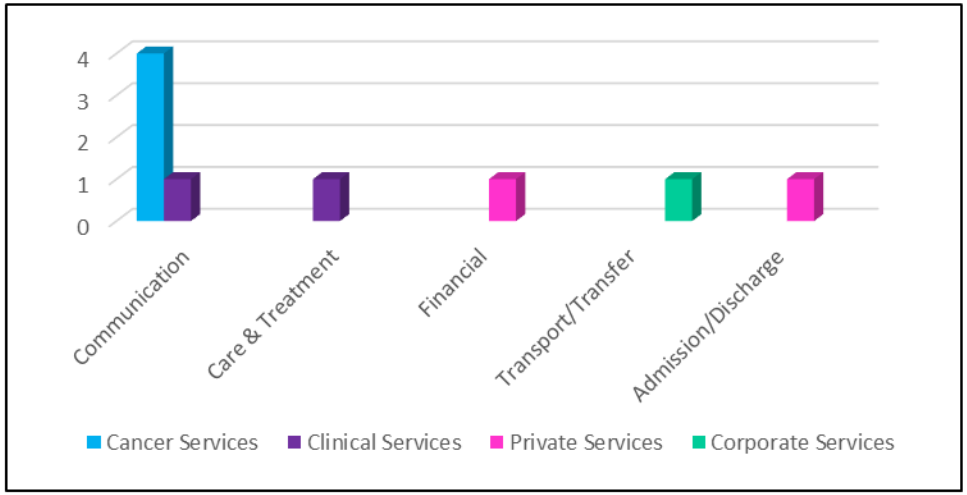


Table 19.0 Subject narrative :

For the 9 complaints received, the subjects were:

- Communication (5)
- Care & Treatment (1)
- Financial (1)
- Transport/Transfer (1)
- Admission/Discharge (1)

Table 20.0 Closed Complaints

Complaints	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	April	May
Cases closed	5	6	5	5	9	4	8	7	9	11	9	6
PHSO - Upheld/Partially Upheld	0	0	0	0	0	1	1	0	0	0	0	0
PHSO - Not upheld	0	0	0	0	0	0	1	0	0	0	0	0

Safer Staffing: Nurse Recruitment

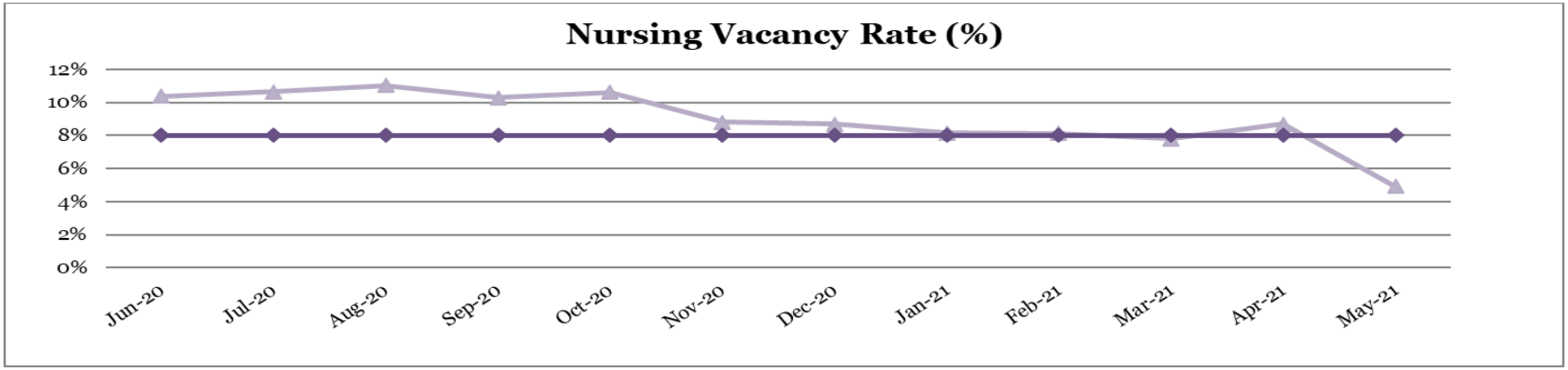
Data Owner: Karen Musee (Head of Resourcing): The Trust nurse vacancy rate decreased to 4.9% and is below the Trust target. The Trust vacancy rate has dropped significantly due to the financial alignment to ESR where posts with staff in them have been changed to show no budget. We continue to make use of associated national funding to increase health care support workers (HCSWs) and international recruitment of nursing staff to ensure we continue to grow our workforce sustainably. There are 81 wte nurses in the recruitment pipeline of which 36 wte had a start date agreed. There were 4 wte band 5/6 new joiners in May a decrease of 4 on the previous month. International recruitment continues and we have 22 international nurses in our recruitment pipeline.

May 2021 Nurse Recruitment Activity:

1. Continue to undertake a range of recruitment activities, rolling adverts for hotspot areas and targeted newly qualified events. 19 Newly qualified nurses have been offered positions for September 2021 and a 2-year Early Career's programme developed to support these Nurses. A Coffee morning for the Newly Qualified Nurses has been arranged for early September to meet the senior team as part of the onboarding process.

2. International recruitment interviews continues with a focus on Critical Care and Oncology Nurses. 15 Internationals in the pipeline, with 4 due to arrive on 22nd July 2021. A new MS Feedback form is being developed to capture the opinions of new recruits and their experience with the onboarding process, in order to implement any improvements or adaptations to the current process.

3. A registered nurse recruitment day will be held on the 15th June, and we plan to hold a non-virtual recruitment day at the end of July. SNAP has been rolled out as the new testing system for all external nurses, the system will ensure all candidates are tested prior to being offered and will streamline this process for both managers and recruitment.



Nursing Joiners - Band 5-6													
Month	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Total**
Starters (fte)	4.0	12.3	11.0	22.0	13.6	4.0	9.0	9.0	6.0	10.1	8.0	4.0	111.9

Safer Staffing: Nurse Turnover & Retention

Data Owner: Karen Musee (Head of Resourcing): The Trust Nursing voluntary turnover rate increased from 11.2% to 12.6% in month and is slightly above the Trust target of 12.0% The voluntary turnover rates for both band 5 and band 6 nurses reduced to 18.4% and 8.7% respectively. There were 11.9 wte band 5&6 voluntary nurse leavers which is the highest amount over the last 12 months, the main reasons given include relocation and promotion. Following the 2020 staff survey results, feedback is being cascaded through divisions and local action plans will be devised focusing on morale, fairness and equality.Retention remains a key focus and includes a review of career pathways, stay conversations, staff engagement and learning from others.

Nurse 'Leavers' cumulative position

Nursing Voluntary Leavers - Band 5-6													
Month	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Total**
Leavers (fte)	5.6	8.3	5.0	10.3	8.0	3.0	3.7	8.8	1.8	8.0	8.0	11.9	70.1

Reasons for leaving

Voluntary Nurse leavers Bands 5&6	FTE
Adult Dependants	0.6
Promotion	3.0
Relocation	3.8
Education / Training	1.0
Work Life Balance	0.6
Other/ Not Known	2.9
Total	**11.9**

Safe Staffing (Adult Inpatients): May 2021

RAG rating
Green ≥95%
Amber ≥ 85% <95%
Red -<85%

	RN Fill %	NA Fill %	HCA Fill %	Total CHPPD	Red Flags
Burdett Coutts	86.0%		88.0%	9.7	
Critical Care Unit	97.0%		67.0%	31.8	
Ellis Ward	91.0%		167.0%	9.8	
Granard House 1	100.0%	118.0%	154.0%	12.6	
Granard House 2	96.0%	116.0%	105.0%	12.0	2
Granard House 3	99.0%	116.0%	100.0%	12.5	
Horder Ward	96.0%	131.0%	190.0%	14.9	
Markus Ward	102.0%		111.0%	12.4	3
Wilson Ward	93.0%		158.0%	9.4	4
Wiltshaw Ward	93.0%		98.0%	12.3	1
Bud Flanagan East Ward	88.0%		100.0%	11.8	3
Bud Flanagan West Ward	89.0%		132.0%	10.0	1
McElwain Ward	92.0%		90.0%	11.0	
Kennaway Ward	103.0%		67.0%	12.7	
Oak Ward	94.0%	100.0%	95.0%	26.5	
Robert Tiffany Ward	100.0%		233.0%	13.6	
Smithers Ward	115.0%	59.0%	163.0%	10.6	
Teenage and Young Adult Unit	110.0%		257.0%	18.9	1

Comments

Even though patient numbers on some wards has been low the acuity across both sites remains high, with increasing numbers of unwell patient.

Fill % variances for April across a number of units was lower due to reduced patients numbers however an increasing number were left unfilled due to lack of available bank/agency staff.

The higher fill % rate for HCA was due to a high number of patients requiring specialling (1 to 1 nursing care)

TCT – High use of specials and staffing 2:1 at times due to the complexity of patient needs – approved by CN. This also links to their high CHPPD this month.

CHPPD was slightly high on some units and reflects the high use of specials on the ward.

Red Flags : The key themes with these this month was Missing key skills/ Delay/omission of elements of care. These occurred either through shifts not being covered, increased patient acuity/ requirements that did not reflect staffing on the ward.

Safe Staffing: May 2021

Ward name	Fill% RN Days	Fill % NA Days	Fill % HCA Days	Red Flags
Bud Flanagan AC	97.00%		121.00%	1
APU C	90.00%			
APU S	96.00%			
CAU L	100.00%	79.00%	68.00%	
CAU S	89%			
Cavendish Square	85%		70%	
Childrens Day unit	103.00%		115.00%	1
DSU	96.00%		68.00%	1
Endoscopy	107.00%		99.00%	
MDU C	84%		69.00%	2
MDU Kingston	98.20%		69.00%	
MDU Sutton	92.00%		50.00%	
Oak Day unit	88.00%		67.00%	
PPMDU C	99.00%		85%	
PPMDU S	98.00%		79.00%	
PPOPD C	92.00%		105%	
PPOPD S	97.80%		83.30%	
PPDSU	111.00%			
Outpatients C	93.80%		91.30%	
Outpatients S	92.00%	86.00%	87.20%	
RDAC C	89.00%		96%	1
RDAC S	81.00%		98.00%	
Theatres C	94%		95.00%	
Theatres S	94.00%		101.00%	
West Wing	95.00%		82%	

Data Owner: Sharyn Crossen: Safe Staffing Lead

Cavendish Square has now being added to this report – staffing reflects current activity levels.

Day areas are being supported by Matrons and where able additional HCA used to support.

Fill % across many units remain below trust target- mainly due to vacancies not been covered.

MDU C and RDAC Chelsea both experiencing high levels of long term absences.

Red Flags – The key theme remains this month to being is 1 RN on shift/2clinical staff short.

RAG rating
Green ≥95%
Amber ≥ 85% <95%
Red -<85%

Quality of Care of the Dying- *Key Performance Indicators*

Data Owner: Angela Halley (Palliative Care Consultant)

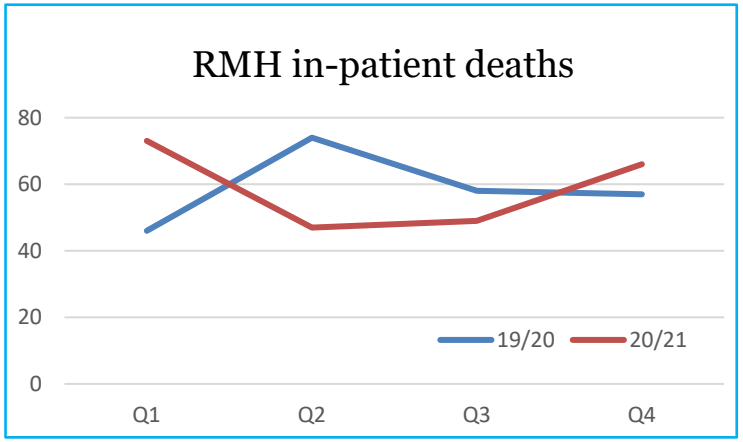
- The symptom Control and Palliative Care team review care of the dying across the trust quarterly.
- The NICE Quality standards Care of Dying adults in the last days of life (Quality Standard: QS144) are used to audit against.
- Internally we set a KPI of 80% of those recognised as dying within the trust should be commenced on the Principles of Care for the dying person. This is to ensure excellent and holistic care of the dying from all members of the MDT.

Headlines (Q4 2020/21 data):

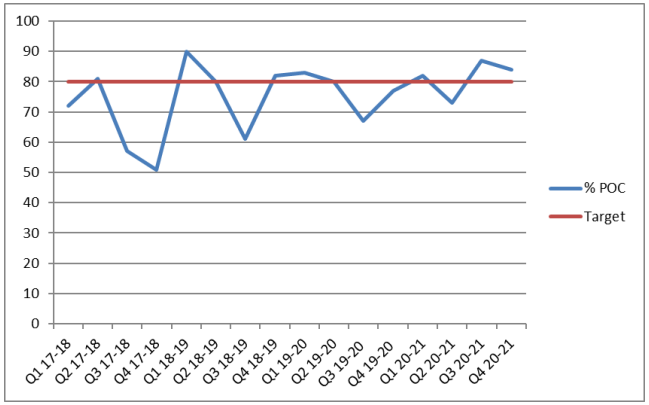
- Q4 was during the 2nd peak of the COVID-19 pandemic.
- Q4 deaths for 2020= 66 (52 ward, 14 CCU)
- 84% of inpatient deaths outside of CCU had been commenced on the Principles of care (Q3: 87%)
- 92% had anticipatory medications prescribed (Q3: 90%)
- 87% had documented discussion regarding hydration (Q3: 90%)
- 94 % had family discussion to discuss recognition of dying (Q3: 92%)
- Family visiting took place at the end of life in 90% cases
- 17 deaths with COVID-19 on death cert (12 ward, 5 CCU)
- Total number of inpatient death 20/21- 235 (19/20- 235)

Action plan to improve performance:

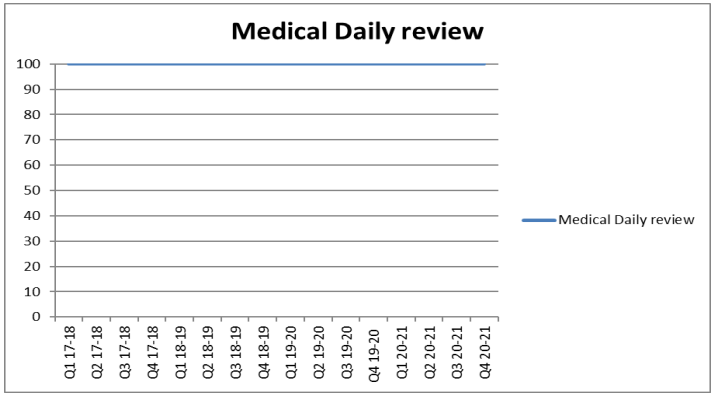
- Results shared at Symptom Control and Palliative Care Research and Audit meeting to model good practice of use of Principles of care document
- Continue sharing results with Nurses via Ward meetings
- Share results at junior doctor teaching and induction
- Ongoing internal quarterly audit
- Ongoing review of end of life care for COVID-19 deaths as part of service evaluation



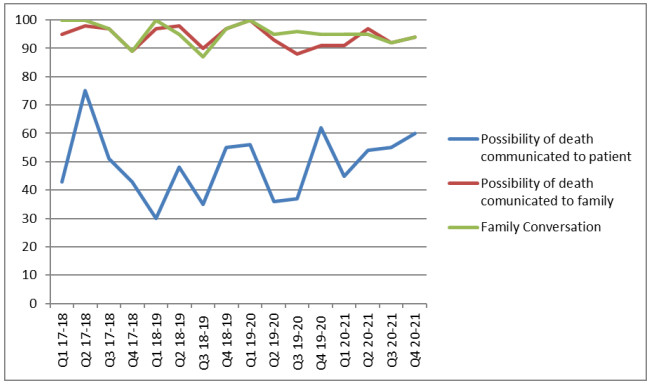
All patients who die across RMH who are diagnosed as dying should have a principles of care for dying patient's document initiated



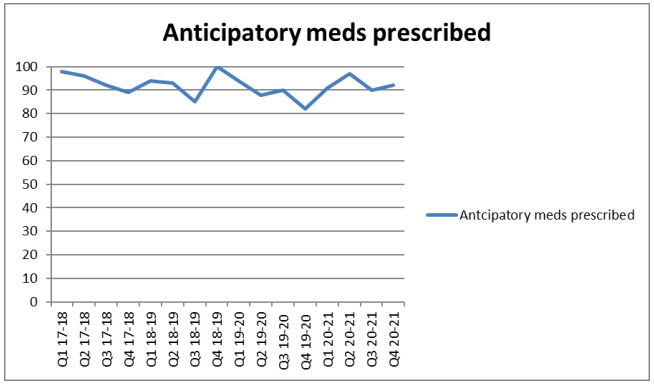
NICE Quality Standard 1- Adults who have signs and symptoms that suggest they may be in the last days of life are monitored for further changes to determine if they are nearing death, stabilising or recovering



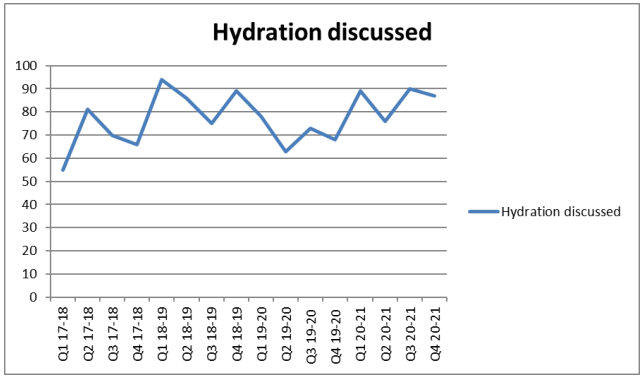
NICE Quality Standard 2- Adults in the last days of life and people important to them are given the opportunity to discuss, develop and review individualised care plan



NICE Quality Standard 3- Adults in the last days of life are prescribed anticipatory medicines with individualised doses and route



NICE Quality Standard 4 - Adults in the last days of life have hydration status assessed daily and have a discussion about the risks and benefits of hydration options



The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 28 September 2021	**Agenda item:** 6.2
Title of Document: Key Performance Indicators – Q1 2021/22	**To be presented by:** Karl Munslow-Ong, Chief Operating Officer

1. <u>Status:</u> Information / Discussion

2. <u>Purpose</u>:

Relates to:

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

3. <u>Summary</u>

Provides an update on the Trust's performance for quarter 1 2021/22.

4. <u>Recommendations / Actions</u>

To note and discuss the Quarter 1 position.

The ROYAL MARSDEN
NHS Foundation Trust

KEY PERFORMANCE INDICATORS

QUARTER 1 2021/22

1. Purpose

This paper provides the Board with an update on the Trust's performance for quarter 1 2021/22. 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. Balanced scorecard annual review

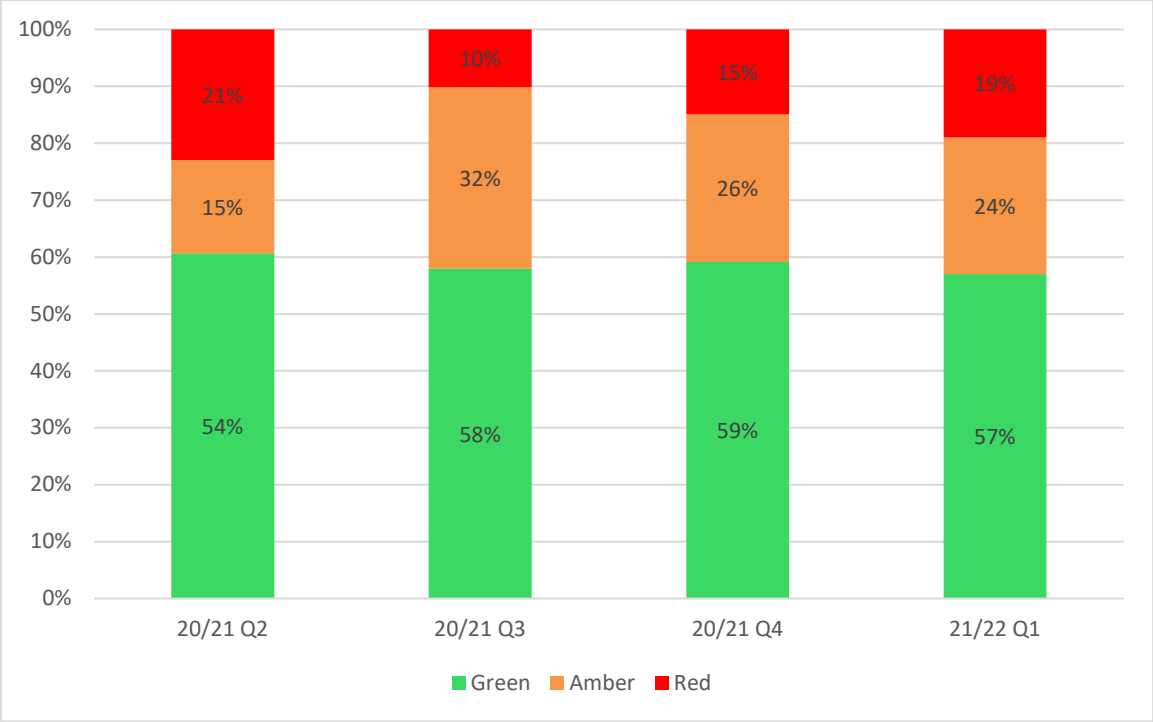
The KPIs within the scorecard were reviewed at the start of the financial year to ensure they remain in line with national targets and organisational priorities. A paper detailing the changes was approved by the Executive Board in July and QAR/AFC in September.

The Performance and Information Team has reviewed the latest Board Assurance Framework (BAF) and annotated on the scorecard any KPI that relates to the BAF. It has also ensured that significant new projects, are reflected in the KPIs at an appropriate time (for example the inclusion of a KPI relating to Cavendish Square, now that it has gone live).

New KPIs are as follows:

- Following national guidance released in August 2021, the Trust now reports the attributable E. Coli Bacterium cases. The total number was included previously.
- KPIs for the number of cases of P. aeruginosa and Klebsiella (number of attributable cases): national thresholds were released in August 2021 and therefore the board scorecard has been updated to include these KPIs.
- Flu vaccine: % offered: in line with previous years, it is likely that there will be a target relating to % offered in addition to uptake (applicable from Q3)
- COVID-19 vaccine: The Trust will incorporate any national standards or expectations, once released.
- In line with the Elective Recovery Fund (ERF) guidance, the recovery metrics have been replaced with a metric reflecting ERF financial performance (%) against the national benchmark. The number provided in the scorecard for Q1 is RMH's estimation and therefore will be shown in italics. Once commissioners confirm the value, the figure will be amended in arears the next quarter.
- Cavendish Square: the scorecard has been updated to include a KPI relating to the new PP service at Cavendish Square, launched at the end of April 2021. The agreed KPI is income against plan.
- Non-PP Debtors over 90 days (£m) and achievement of efficiency programme (YTD %) indicators: the finance directorate has revised the indicators to ensure they remain relevant and appropriate.

3. Performance Summary 2021/22



In quarter 1 2021/22, there was an increase in the percentage of red-rated indicators and a decrease in the percentage of green rated metrics.

The following five indicators turned red in quarter 1 either from amber or green in the previous quarter:

- 31 day wait from diagnosis to first treatment (All Treatments)
- Capital Expenditure Variance YTD (£000)
- Bed occupancy – Sutton
- Appraisal & PDP rate
- Completed induction

However, improvement was seen in several indicators including the following that turned green in Q1:

- Covid-19 positive new PCR test (hospital onset, definite and probable): zero were reported in Q1
- 62 day wait for first treatment: Screening referral to treatment (Reallocated)
- Statutory and Mandatory Staff Training
- Additionally, Total NHS Referrals turned amber in quarter 1 from red in the previous quarter.

The following section of the report provides a commentary on the red-rated indicators identified in Q1 reporting, including actions underway to improve performance. It also provides a commentary on positive COVID-19 tests and reportable outbreaks within the quarter, which whilst amber-rated are important to highlight.

4.1 Patient Safety, Quality and Experience

Q1 2021/22	**COVID-19 positive tests – Positive new PCR test (hospital onset, definite and probable) - (amber rated)**		
	Actual: 0	**Target: 0**	**Forecast: Amber**
	PHE reportable outbreaks (amber rated)		
	Actual: 1	**Target:0**	**Forecast: Amber**

The number of hospital onset positive COVID-19 tests in Q1 was zero compared to 21 in quarter 4 2020/21. In total, the Trust reported 8 staff new positives tests across Q1 (compared to 144 in Q4 2020/21). The highest number of new positive tests in Q1 was in June 2021 with 7 staff members testing positive. There was one reportable outbreak during the period (in Granard House Outpatient department), however it did not result in a service closure and therefore rated amber.

A comprehensive programme to reduce the risk of transmission of COVID-19 has been in place at the hospital since the beginning of the pandemic to minimise the spread of infection across the Trust. As previously reported, this includes, symptomatic and asymptomatic testing of patients and staff, the implementation of blue and green pathways, a comprehensive immunisation programme, enhanced cleaning and PPE. A monthly IPC Dashboard to provide Covid-19 assurance is taken to the Trust's Tactical Command Meeting and Board on a monthly basis, which includes PPE compliance, staff and patient testing data and other key trigger metrics.

4.2 Effective Care: National Waiting times

Q1 21/22	**31 day wait for first treatment**		
	Actual: 95.2%	**Target: ≥96%**	**Forecast: Green**

The Trust did not meet the 31 day target for first treatment in Q1. This was primarily the result of working through the backlog of cases as services re-opened following the peak of the Covid-19 pandemic. A significant proportion (42%) of the breaches in Q1 were low clinical priority cases that had been delayed in line with national guidance during the peak of the COVID-19 pandemic.

Q1 21/22	**31 day wait for subsequent treatment: Surgery**		
	Actual: 85.7%	**Target: ≥94%**	**Forecast: Green**

Performance was challenged throughout the quarter, as surgical capacity opened up for low clinical priority cases. In addition, the impact of key infection prevention guidance reduced the flexibility to schedule patients within tight timeframes. In Q1, 20 of the 37 breaches (54%) were priority 3 cases, delayed during the peak of the pandemic in line with national guidance. 14 breaches (38%) were the result of capacity challenges linked in part to the requirements to self-isolate ahead of elective surgery and adhere to green pathways.

Q1 21/22	**62 day target from urgent suspected cancer referral to treatment: GP referral to treatment (Reallocated)**		
	Actual: 81.1%	**Target: ≥85%**	**Forecast: Green**

Review of Q1 breaches indicates that over half (54%) were unavoidable, resulting from patient-initiated delay, patient fitness, unavoidable covid related delays, priority 3 cases delayed during the peak of the pandemic and complex pathways.

Analysis of the avoidable breaches indicates a mixture of outpatient capacity and elective surgical capacity challenges. This was due to demand and activity returning to pre-COVID levels coupled with the pressures of staff absences due to sickness or isolation. In Q1, Trust internal compliance (GP referrals direct to the Trust) was measured at 88.2%.

4.3 Effective Care: Finance, Productivity and Efficiency

Q1 2021/22	PP activity Income Variance YTD (£000)		
	Actual: -1,871	**Target: B/even or >plan**	**Forecast: Amber**

Private Care income remains below the plan due to international travel restrictions. Whilst insured and self-pay activity is high, Embassy business is not yet back to pre-covid levels due to access restrictions. The Trust expects the income position to improve in line with the increased numbers of private referrals to the Trust during quarter 1 and the backlog of international patients starting to come through.

Q1 2021/22	PP Aged debt at >6months		
	Actual: 29.1%	**Target: ≤23%**	**Forecast: Red**

Private Care aged debt has improved from 35% in Q4 2020/21 to 29.1% in Q1 21/22. However, Embassy debt over 6 months old is still a concern and remains a focus of the Trust. Embassy credit control continue to work collaboratively with the embassies ensuring queries are resolved and invoices are prioritised. This is having an impact, with steady improvements delivered over the past 9 months on embassy debt.

Q1 2021/22	Non-PP Debtors over 90 days (£m)		
	Actual: £2m	**Target: Less than £1m**	**Forecast: Amber**

The Trust has set an ambitious target to reduce non-pp aged debt in year. Although the aged debt is down on the previous year it is just above amber levels at quarter end. Non-PP debt is reviewed regularly and the Finance team continue to work with SBS to reduce the debt.

Q1 2021/22	Capital Expenditure (CDEL) YTD (£m)		
	Actual: £0.7m	**Target: YTD Plan**	**Forecast: Red; green by Q4**

Capital spend is above plan at Q1. However, this is due a phasing difference to budget and is expected to recover by the end of the year.

4.4 Effective Care: Productivity & Asset Utilisation

Q1 2021/22	Bed occupancy - Sutton		
	Actual: 75.2%	**Target: ≥82% ≤87%**	**Forecast: Amber**

Sutton site recorded a decrease in bed occupancy from 78.4% in quarter 4 to 75.2% in quarter 1 moving the KPI from amber to red. A review was taken of the wards that reported the biggest drops in bed occupancy. The Kennaway surgical day area was opened, along with the increased use of the ambulatory pathway for haematology which diverted some activity to day areas. In addition, the blue (non-electives, symptomatic patients) and green (elective patients) pathways has caused challenges in ensuring beds are utilised fully.

Q1 2021/22	Theatre utilisation - Sutton		
	Actual: 59.7%	Target: ≥70%	Forecast: Amber

Performance against the theatre utilisation KPI in Sutton has improved compared to Q4 (49.5%). However, it continues to be below target. Utilisation also improved throughout Q1 (55,2% in April, 58,4% in May and 65.6% in June). The Clinical Services Team is monitoring utilisation at weekly recovery meetings and working with the Cancer Services team to continue with this progress.

4.5 Effective Care: Clinical and Research Strategy

Q1 2021/22	Total PP referrals		
	Actual: 1734	Target: ≥1526≤1679	Forecast: Amber

Private care saw a significant increase in referrals in Q1, compared to Q4. The number of referrals received was greater than the threshold and was mainly driven by the increase in tertiary referrals. This is in the main due to the continued recovery in the insured sector along with an easing in some travel restrictions leading to an increase in international patients.

The Trust sets a range for 'green' rather than a minimum to ensure higher than expected referrals are also reviewed due to the possible impact on capacity and waiting times. Referral activity is monitored and reported in Private Care weekly Operational meeting and monthly performance review meetings and any resultant capacity challenges (for example, beds and theatres) are worked through with the NHS teams.

4.6 Effective Care: Research

Q4 2020/21	Accrual to target (1Q arrears) - National definition (% of closed commercial interventional trials meeting contracted recruitment target (excluding trials that had no set target)		
	Actual: 57.9%	Target: ≥85%	Forecast: Amber

Reporting against this KPI was paused from Q4 2019/20 to Q3 2020/21 due to the Covid-19 pandemic. The reporting reinstated in Q4 2020/21. The Trust did not meet the target in quarter 4. This was mainly caused by the trials closing prior to target date and trials being withdrawn by the sponsor therefore not providing the opportunity to recruit to the agreed target. No adjustment has been made by the NIHR for studies withdrawn by the sponsor before the planned recruitment end date.

The National average for trials meeting time to target was 55.4%, meaning the Trust has performed better than the national average.

4.7 Well Led: Quality and Development

Q1 2021/22	Appraisal & PDP rate		
	Actual: 76.8%	Target: ≥90%	Forecast: Amber

Appraisal & PDP rate declined in quarter 1 compared to Q4 (84.0%). The Learning and Development Team continues to work with HR Business Partners (HRBP's), Divisional leadership teams and staff to support increased compliance. Reports have been sent to HRBP's to share with divisional leads to target line managers to complete appraisals as well as

individual emails to those non-compliant. This will remain the strategy to improve the overall appraisal compliance.

Q1 2021/22	Completed induction		
	Actual: 71.1%	**Target: ≥85%**	**Forecast: Amber**

Completed induction declined significantly in quarter 1 compared to the previous quarter when it was at 80.0%. The Trust is continuing to streamline the process for local induction, making the system more user-friendly. The team is also working with staff and line managers to ensure that compliance is also being recorded within the Learning Hub. The Trust continues to work with new starters, their line managers and Divisional leadership teams to offer support in increasing levels of compliance with local induction. Additionally, the Trust continues to include Local Induction reporting to Divisional Directors on a monthly basis and target individuals who are not compliant by email.

5.0 Conclusion

The Board are asked to note the Trust's balanced scorecard and commentary for quarter 1 2021/22 and are invited to discuss the position.

APPENDIX B

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
Brain/CNS	100.00%
Breast	93.83%
Gynaecological	63.41%
Haematological (excl. Acute Leukaemia)	50.00%
Head & Neck	63.64%
Lower GI	92.31%
Lung	100.00%
Sarcoma	63.64%
Skin	75.00%
Upper GI	71.43%
Urological	75.51%
Unknown Primary / Other diagnosis	95.24%

The Royal Marsden NHS Foundation Trust
Balanced Scorecard 21/22

Denotes different targets applied for 2020/21 performance
NHSE / BAF* *Denotes NHS England and KPI related to risk on the BAF*

1. Safe Care

	Patient Safety and Quality		Target in 2021/22	Q1 (Apr- Jun 21/22)	Q4 (Jan-Mar 20/21)	Q3 (Oct-Dec 20/21)	Q2 (Jul-Sep 20/21)	Q1 (Apr - Jun 20/21)
BAF 5	Covid-19 testing/IPC metrics	Positive tests – patient admissions (hospital onset, definite and probable)	0	0	17	15	0	6
BAF 5		Reportable outbreaks	0	1	10	10	1	New measures for 2020/21 Q2 onwards
BAF 5		PPE audit results monthly (from Q2)	≥95%	97.0%	97.7%	96.0%	94.4%	
BAF 5		Hand hygiene audit results (from Q2)	≥95%	97.3%	97.7%	98.0%	98.0%	
NHSE	Quality Account indicators	MRSA positive cultures (cumulative)	0	0	0	0	0	0
NHSE		Number of Attributable E. Coli Bacterium (at YTD)	≤52 per annum	15	70	54	37	17
NHSE		C Diff - Number of Reportable Cases (COHA/HOHA) (at YTD)	≤56 per annum	14	52	39	31	16
NHSE		Number of attributable P. aeruginosa cases (at YTD)	≤21 per annum	5	New measure for 2021/22			
NHSE		Number of attributable Klebsiella spp. Cases (at YTD)	≤33 per annum	4	New measure for 2021/22			
NHSE		VTE risk assessment	≥95%	96.8%	95.6%	95.5%	95.4%	96.0%
	Serious incidents (Including Level 4 Pressure Ulcers) (cumulative YTD)		≤7 /year	0	7	5	4	1
	Mortality							
	Hospital Standardised Mortality Ratio *(rolling 12 month - qtr in arrears - NHS & Private patients)*		≤80	78.17	79.29	78.06	88.50	85.97
	Mortality audit		G	G	G	G	A	G
	30 day mortality post surgery		≤0.7%	0.70%	*0.46%*	*0.40%*	*0.68%*	*1.49%*
	30 day mortality post chemotherapy		≤1.8%	1.87%	*1.63%*	*1.86%*	*1.76%*	*1.94%*
	100 day SCT mortality (Deaths related to SCT)		≤5%	1.82%	3.85%	3.08%	0.00%	0.00%
	100 day SCT mortality (All deaths)		≤5%	1.82%	3.85%	4.62%	3.45%	0.00%
	Medicines Management							
	% Medicines reconciliation on admission		≥90%	97%	98%	91%	95%	96%
	Unintended omitted critical medicines (Quarterly ratio)		0	1.3	1.0	1.6	3.7	1.5
	Cancer staging							
	Staging data completeness sent to Thames Cancer Registry (1 qtr in arrears)		≥70%	66.6%	68.4%	71.4%	74.1%	75.7%

2. Effective Care

	National waiting times targets		Target in 2021/22	Q1 (Apr- Jun 21/22)	Q4 (Jan-Mar 20/21)	Q3 (Oct-Dec 20/21)	Q2 (Jul-Sep 20/21)	Q1 (Apr - Jun 20/21)
NHSE / BAF 5	2 wk wait from referral to date first seen:	All Cancers	≥93%	94.3%	95.8%	92.2%	95.4%	96.1%
NHSE / BAF 5		Symptomatic Breast Patients	≥93%	95.9%	98.9%	99.0%	98.8%	97.4%
NHSE / BAF 5	28 day Faster Diagnosis Standard (FDS)	All Cancers	Shadow reporting until Q3	88.6%	90.4%	85.0%	76.8%	New measure for 2020/21 Q2 onwards
NHSE / BAF 5	31 day wait from diagnosis to first treatment	All Treatments	≥96%	95.2%	97.9%	98.0%	97.1%	91.0%
NHSE / BAF 5	31 day wait for subsequent treatment:	Surgery	≥94%	85.7%	90.5%	96.9%	91.6%	83.9%
NHSE / BAF 5		Drug treatment	≥98%	99.6%	99.0%	99.8%	98.5%	98.9%
NHSE / BAF 5		Radiotherapy	≥94%	97.0%	97.5%	98.5%	97.4%	96.6%
NHSE / BAF 5	62 day wait for first treatment:	GP referral to treatment (Reallocated)	≥85%	81.1%	82.9%	83.9%	89.8%	68.9%
NHSE / BAF 5		Screening referral to treatment (Reallocated)	≥90%	94.7%	89.6%	96.9%	100.0%	46.9%
NHSE / BAF 5	18 wks from Referral to Treatment	Incomplete Pathways under 18 weeks	≥92%	94.8%	93.6%	96.6%	91.2%	89.7%
NHSE / BAF 5	18 wks pathways - patients waiting > 52 wks. (distinct patients across the quarter)		≤6 a quarter	6	5	5	8	5

	Finance, Productivity & Efficiency	Target in 2021/22	Q1 (Apr- Jun 21/22)	Q4 (Jan-Mar 20/21)	Q3 (Oct-Dec 20/21)	Q2 (Jul-Sep 20/21)	Q1 (Apr - Jun 20/21)
BAF 10	Cash (£m)	On or > plan	152.0	150.1	142.6	148.5	149.0
BAF 10	Delivery against recovery plan	On or > plan	2.4	19.6	2.2	0.0	0.0
BAF 10	PP activity Income Variance YTD (£000)	B/even or > plan	-1,871	-2,869	-102	1,339	12,890
BAF 10	PP Aged debt at >6months	≤23%	29%	35%	40%	49%	34%
BAF 10	Non-PP Debtors over 90 days (£m) - absolute value at month end	<£1m	2	New measure for 2021/22			
BAF 10	Capital Expenditure Variance YTD (£000)	YTD Plan	0.7	67%	64%	58%	55%

	Contract performance (QUARTER IN ARREARS)		Target in 2021/22	Q4 (Jan - Mar 20/21)	Q3 (Oct-Dec 20/21)	Q2 (Jul-Sep 20/21)	Q1 (Apr-Jun 20/21)	Q4 (Jan-Mar 19/20)
	Contractual Sanctions incurred (£000)	Trust	0	0	0	0	0	0

	Productivity & Asset Utilisation	Target in 2021/22	Q1 (Apr - Jun 21/22)	Q4 (Jan-Mar 20/21)	Q3 (Oct-Dec 20/21)	Q2 (Jul-Sep 20/21)	Q1 (Apr - Jun 20/21)
	Bed occupancy - Chelsea	≥82% ≤87%	79.8%	84.3%	79.0%	76.2%	72.8%
	Bed occupancy - Sutton	≥82% ≤87%	75.2%	78.4%	76.6%	76.7%	76.8%
	Bed occupancy - Critical care Chelsea	≥67% ≤75%	66.4%	72.6%	62.8%	60.3%	61.0%
	Bed occupancy - Blue beds	≥82% ≤87%	86.1%	86.8%	83.6%	84.6%	New measure for 2020/21 Q2 onwards
	Care Hours per Patient Day Total Ratio	≥11.7 ≤13.3	13.1	12.3	13.1	13.0	14.0

The Royal Marsden NHS Foundation Trust
Balanced Scorecard 21/22

Denotes different targets applied for 2020/21 performance
NHSE / BAF* *Denotes NHS England and KPI related to risk on the BAF*

	Theatre utilisation - Chelsea		≥85%	**82.6%**	**76.7%**	**72.4%**	**72.9%**	**58.5%**
	Theatre utilisation - Sutton		≥70%	**59.7%**	**49.5%**	**58.1%**	**46.4%**	**42.9%**
NHSE / BAF 5	ERF metrics - Q1 and Q2	ERF financial performance against BAU (%)	≥ 80% Q1; ≥ 95% Q2	***123.5%***	**New measure for 2021/22**			
NHSE / BAF 5		% of outpatient appointments virtual	≥ 25%	**31.9%**	**New measure for 2021/22**			
	Clinical and Research Strategy		**Target in 2021/22**	**Q1** (Apr - Jun 21/22)	**Q4** (Jan-Mar 20/21)	**Q3** (Oct-Dec 20/21)	**Q2** (Jul-Sep 20/21)	**Q1** (Apr - Jun 20/21)
	Total NHS Referrals		≥5992 ≤6356	**5857**	***5503***	***5598***	***4962***	***3711***
BAF 9	Total PP Referrals		≥1526≤1679	**1734**	**1389**	**1651**	**1474**	**925**
BAF 9	Cavendish square - Income vs plan (£000)		Actual vs Plan	**923**	**New measure for 2021/22**			
	Research (1 QUARTER IN ARREARS)		**Target in 2021/22**	**Q4** (Jan - Mar 20/21)	**Q3** (Oct-Dec 20/21)	**Q2** (Jul-Sep 20/21)	**Q1** (Apr-Jun 20/21)	**Q4** (Jan-Mar 19/20)
BAF 1	Date site selected to first participant recruited	Mean number of days between date site selected and date of first participant recruited	≤90 days	**90.4**	**Data not released at time of publication**	**Suspend**	**Suspend**	**Suspend**
BAF 1	Accrual to target (1Q arrears) - National definition	% of closed commercial interventional trials meeting contracted recruitment target (excluding trials that had no set target)	≥85%	**57.9%**	**Data not released at time of publication**	**Suspend**	**Suspend**	**Suspend**
BAF 1	No. of 1st patients recruited in previous 12 months	No. of 1st UK patients	1	**6**	**13**	**13**	**13**	**14**
BAF 1		No. of 1st European patients	1	**2**	**3**	**2**	**2**	**1**
BAF 1		No. of 1st Global patients	1	**4**	**5**	**4**	**3**	**6**
BAF 1	Trials led by RMH	As percentage of commercial interventional trials with RMH involvement which opened in the last 12 months	≥20%	**54.3%**	**61.0%**	**63.0%**	**60.4%**	**50.0%**

3. Caring

	Patient Satisfaction	**Target in 2021/22**	**Q1** (Apr - Jun 21/22)	**Q4** (Jan-Mar 20/21)	**Q3** (Oct-Dec 20/21)	**Q2** (Jul-Sep 20/21)	**Q1** (Apr - Jun 20/21)
	Friends and Family Test (Inpatient and Day Care)	≥95%	**99.1%**	**99.7%**	**99.8%**	**98.5%**	**99.3%**
	Friends and Family Test (Outpatients)	≥95%	**97.5%**	**97.0%**	**98.5%**	**98.5%**	**97.4%**
	Percentage of Chemotherapy patients starting treatment within 3 hours of arrival	≥85%	**80.3%**	**80.9%**	**80.4%**	**81.9%**	**82.0%**
	Percentage of Chemotherapy patients starting treatment within 1 hour of appointment time	≥85%	**82.1%**	**80.4%**	**80.9%**	**79.1%**	**83.9%**
NHSE	Mixed sex accommodation breaches	0	**0**	**0**	**0**	**0**	**0**

4. Responsive

	Experience	**Target in 2021/22**	**Q1** (Apr - Jun 21/22)	**Q4** (Jan-Mar 20/21)	**Q3** (Oct-Dec 20/21)	**Q2** (Jul-Sep 20/21)	**Q1** (Apr - Jun 20/21)
	Complaints per 1,000 daycase and inpatient discharges	≤4.08	**3.74**	**3.10**	**4.34**	**2.65**	**3.35**
	Staff Friends and Family Test: Recommend – Care	≥96%	**Suspend**	**Suspend**	**N/A**	**Suspend**	**Suspend**
	Staff Friends and Family Test: Not recommend – Care	≤1%	**Suspend**	**Suspend**	**N/A**	**Suspend**	**Suspend**

5. Well Led

	Workforce productivity	**Target in 2021/22**	**Q1** (Apr - Jun 21/22)	**Q4** (Jan-Mar 20/21)	**Q3** (Oct-Dec 20/21)	**Q2** (Jul-Sep 20/21)	**Q1** (Apr - Jun 20/21)
BAF 3	Vacancy rate	≤7%	**7.8%**	**9.6%**	**9.7%**	**10.6%**	**10.9%**
BAF 3	Voluntary staff turnover rate	≤12%	**11.3%**	**9.9%**	**10.2%**	**11.3%**	**12.8%**
BAF 3	Sickness rate	≤3%	**3.4%**	**3.9%**	**4.3%**	**3.3%**	**4.5%**
	Quality and Development	**Target in 2021/22**	**Q1** (Apr - Jun 21/22)	**Q4** (Jan-Mar 20/21)	**Q3** (Oct-Dec 20/21)	**Q2** (Jul-Sep 20/21)	**Q1** (Apr - Jun 20/21)
BAF 3	Consultant appraisal (number with current appraisal)	≥95%	**93.0%**	**92.0%**	**94.0%**	**80.0%**	**98.3%**
BAF 3	Appraisal & PDP rate	≥90%	**76.8%**	**84.0%**	**91.0%**	**85.1%**	**78.2%**
BAF 3	Completed induction	≥85%	**71.1%**	**80.0%**	**75.9%**	**77.2%**	**69.2%**
BAF 3	Statutory and Mandatory Staff Training	≥90%	**90.1%**	**87.0%**	**91.3%**	**90.7%**	**86.8%**

***BAF Strategic Objectives**

Research and innovation

BAF 1. Increasing the scope and scale of our R&D expertise and impact in a greater number of tumour groups and treatment modalities including Early Diagnosis

Treatment and care

BAF 2. The implementation of Integrated Care Systems and recognition of RM and RMPs regional and national leadership roles in cancer

BAF 3. Developing and implementing a flexible and sustainable workforce model which attracts and nurtures the very best talent.

BAF 4. Ensuring a sustainable paediatric service model at RM.

BAF 5. Covid-19 – Delivery of a safe, effective and responsive service, Development of the Cancer Hub and ensuring the right capacity is in place to deliver timely and effective treatment

Modernising infrastructure

BAF 6. Maximising opportunities for Sutton via the successful delivery of the Oak Cancer Centre and agree a strategy and delivery plan in terms of RM's role in the new ESTH hospital

BAF 7. Modernising the Chelsea Estate supported by an investment strategy jointly developed with RMCC

BAF 8. Delivery of the IT Strategy

Financial sustainability and best value

BAF 9. Delivery of PP Strategy

BAF 10. Delivery of financial plan

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
28 September 2021	6.3
Title of Document:	**To be presented by:**
Financial Performance Report	Marcus Thorman Chief Financial Officer

1. Status: For Information

2. Purpose:

Relates to:

Operational Performance	✓

3. Summary

The paper provides a summary of the financial position at 31st August 2021. A Covid-19 financial framework is in place in the NHS for the first half of 2021/22. All trusts will receive block income contracts, calculated based on the NHS income received to month 9 2019/20, uplifted for inflation. High cost drugs remain outside of blocks and are pass-through in nature. In addition, a top-up payment has been awarded to each Trust, via their Integrated Care System (ICS) to help fund the additional costs associated with Covid-19 and to target bringing each provider to a breakeven financial position. Department of Health negotiations with Treasury have now concluded for funding for the second half of 2021/22, however details on the settlement are yet to be received.

For YTD August 2021, the key headlines are as follows:

- The Trust reported a **£10.6m surplus year to date**, £2.9m adverse to budget. This was largely driven by lower Donated Asset Income than budgeted. At the control total level, the trust was **£0.2m in deficit year to date**, £6.6m favourable to budget. This was largely driven by unbudgeted NHS income offsetting lower Private Patient Income than anticipated.
- Capital expenditure of **£21.1m year to date**, which was £8.3m behind the Trust's capital plan, largely due to Oak Cancer Centre costs phasing.
- Cash in bank of **£142.1m**, a decrease of £8m compared to the year-end position as at 31st March 2021.

4. Recommendations / Actions

The Board is asked to note the position as at 31st August 2021.

Financial Performance Report
31st August 2021

The ROYAL MARSDEN
NHS Foundation Trust

1. Introduction

The paper provides a summary of the financial position at 31st August 2021.

A Covid-19 financial framework is in place in the NHS for the first half of 2021/22. All trusts will receive block income contracts, calculated based on the NHS income received to month 9 2019/20, uplifted for inflation. High cost drugs remain outside of blocks and are pass-through in nature. In addition, a top-up payment has been awarded to each Trust, via their Integrated Care System (ICS) to help fund the additional costs associated with Covid-19 and to target bringing each provider to a breakeven financial position. Department of Health negotiations with Treasury have now concluded for funding for the second half of 2021/22, however details on the settlement are yet to be received.

The budget referred to in this paper was approved by the Board and submitted to NHSEI in March 2021 before the NHS Income position for 2021/22 was finalised. It does not include a number of income mitigations that are still being worked through with the SWL ICS which target a breakeven position for the first half of this financial year.

2. Summary Financial Position

Key headlines

For YTD August 2021, the key headlines are as follows:

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Financial Performance Report
31st August 2021

The ROYAL MARSDEN NHS Foundation Trust

August				Year to Date			Annual Budget
Budget £'000	Actual £'000	Variance £'000		Budget £'000	Actual £'000	Variance £'000	£'000
(20,513)	(23,339)	(2,826)	NHS Acute Income	(102,299)	(109,677)	(7,378)	(238,541)
0	(3)	(3)	Other NHS Clinical Income	0	11	11	0
(10,394)	(11,504)	(1,109)	Private Patients Income	(54,256)	(52,893)	1,363	(135,537)
(30,908)	**(34,845)**	**(3,938)**	**Total Patient Care Income**	**(156,555)**	**(162,558)**	**(6,003)**	**(374,079)**
(1,050)	(1,126)	(76)	R&D income	(5,249)	(5,478)	(229)	(12,598)
(1,395)	(1,114)	281	Commercial clinical trials	(6,977)	(6,758)	219	(16,746)
(1,474)	(1,562)	(88)	Grants income (Charitable contributions to Income)	(7,388)	(5,368)	2,020	(17,704)
(421)	(344)	78	Education income	(2,105)	(1,812)	293	(5,053)
0	(260)	(260)	Top up income	0	(260)	(260)	0
(2,226)	(893)	1,333	Other Operating Income	(11,130)	(9,825)	1,305	(26,712)
(6,566)	**(5,299)**	**1,267**	**Total Other Income**	**(32,850)**	**(29,502)**	**3,348**	**(78,812)**
(37,474)	**(40,144)**	**(2,671)**	**Total Operating Income**	**(189,404)**	**(192,060)**	**(2,655)**	**(452,891)**
20,867	19,309	(1,558)	Substantive	104,479	96,913	(7,567)	250,412
96	1,389	1,293	Bank	479	5,750	5,271	1,149
56	204	148	Agency	278	1,181	903	668
21,018	**20,901**	**(117)**	**Total Operating Pay**	**105,236**	**103,843**	**(1,393)**	**252,228**
8,020	7,680	(340)	Drugs	40,340	39,546	(794)	98,492
3,201	3,528	326	Clinical Supplies	15,891	16,616	724	38,653
822	754	(68)	Non Clinical Supplies	3,863	3,902	40	9,261
1,375	1,268	(106)	Premises	6,959	6,209	(750)	17,346
3,222	2,376	(846)	Other Non Pay	16,703	14,616	(2,087)	39,329
58	0	(58)	Divisional Reserves	288	0	(288)	691
16,698	**15,606**	**(1,091)**	**Total Operating Non Pay**	**84,044**	**80,889**	**(3,155)**	**203,772**
37,716	**36,507**	**(1,209)**	**Total Operating Expenditure**	**189,280**	**184,732**	**(4,548)**	**456,001**
242	**(3,637)**	**(3,880)**	**Total Operating (Surplus)/Deficit**	**(124)**	**(7,328)**	**(7,204)**	**3,110**
326	135	(191)	PDC	1,630	1,663	33	3,911
20	17	(3)	Finance Costs	98	86	(12)	235
(4,650)	(2,581)	2,070	Donated Asset Income	(23,252)	(13,819)	9,432	(55,804)
1,613	1,847	234	Depreciation	8,063	8,722	659	19,352
0	0	0	Impairment	0	0	0	1,250
(2,692)	**(582)**	**2,110**	**Total Non operating Income and Expense**	**(13,461)**	**(3,348)**	**10,113**	**(31,056)**
(2,450)	**(4,219)**	**(1,770)**	**Total (Surplus)/Deficit**	**(13,585)**	**(10,676)**	**2,909**	**(27,946)**
4,650	2,581	(2,070)	Deduct: Donated Asset Income and PPE	23,252	13,819	(9,432)	55,804
(560)	(579)	(20)	Add back: Depreciation on Donated Assets	(2,798)	(2,890)	(93)	(6,715)
0	0	0	Add back: Impairment	0	0	0	(1,250)
1,641	**(2,218)**	**(3,859)**	**Control Total**	**6,869**	**253**	**(6,616)**	**19,894**

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.

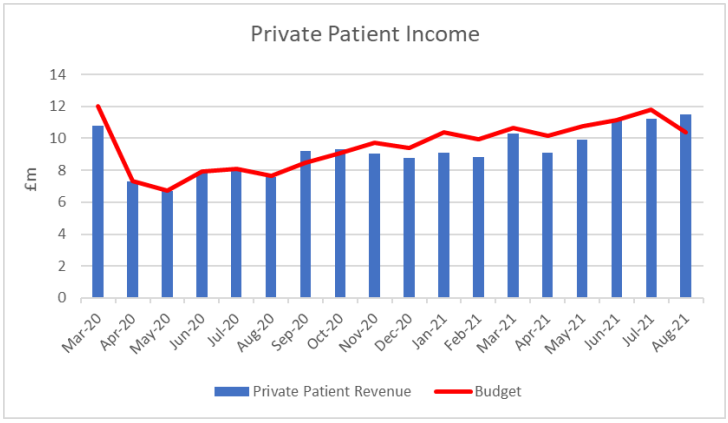
As a ratio the Trust is required to have more income as NHS than non-NHS and for month 5 the cumulative position was 66% of income was from NHS sources.

3. Income and Expenditure

Income – The income position was £2.7m favourable to budget year to date.

The in month position was driven by the receipt of £1.5m of non-NHS income loss funding received from SWL ICS, expected to total £9m by September 2021. This was not budgeted for and will improve the forecast position. Offsetting this were some NHS block changes that are being worked through.

Private Patient Income remains down on prior year levels but increased in month with £11.5m income recorded (£11m/month 19/20 average). This was 1.1m ahead of plan in month, but is 1.4m under budget year to date (see chart below). This reflects the ongoing challenge with international patient activity and the delay in opening of the travel corridors.

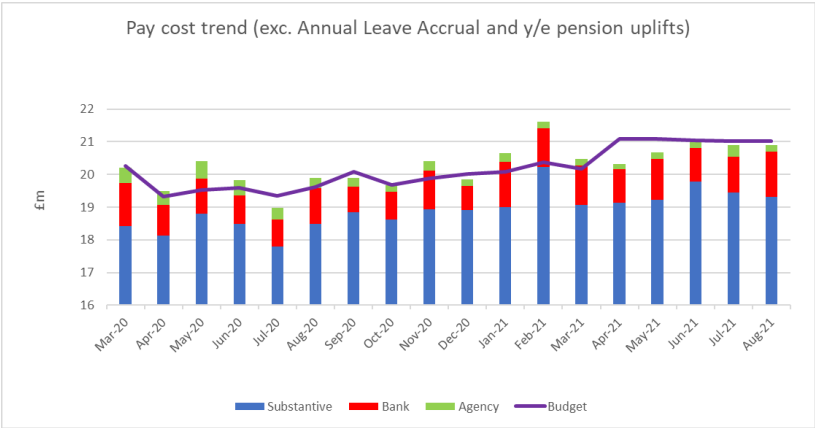


NIHR Research and Development Income has returned to prior year levels, with Commercial Clinical Trial Income also recovering, albeit more slowly, but on plan year to date.

Grant and Education Income are released in line with expenditure so although there are variances to budget, the net impact is zero. The in-month variance is due to Clinical Research, with similar underspends seen in pay and non-pay costs.

Pay expenditure – Pay expenditure was £1.4m favourable to budget year to date.

The pay trend shown in the chart below shows pay costs slowly increasing since. In February, £0.6m of local Clinical Excellence Awards were paid to consultants driving a peak in that month. Substantive pay is increasing due to the recruitment of Cavendish Square staff and Sphere staff TUPEing to the Trust in April following its dissolution. Costs are however under budget, largely due to Clinical Research posts not yet recruited to as planned (mirrored by lower grant income) as well as some Business Case posts. Agency spend has remained controlled, and at £0.2m in month, remains below 2019/20 and 2020/21 levels.



Non-pay expenditure – Non-pay expenditure was £3.2m favourable to budget year to date.

Non-pay costs have flexed largely in line with activity with drugs and clinical supplies over budget year to date. High cost drugs are funded as a pass-through cost, so much of this increase is funded. IT project spend drove the Premises variance and low Royal Marsden Partners activity drove the underspend in Other Non-Pay.

4. Capital Expenditure

In March 2021 the Board approved a draft capital plan for 2021/22 of £90.3m, consisting of £34.5m Trust funded schemes and £55.8m Royal Marsden Cancer Charity funded schemes. After consolidation into SWL ICS, the group saw a shortfall against their allocated CDEL. Plans are still being discussed with the London Regional team on how to address this shortfall, although due to additional capital funds recently being announced it is not expected to be an issue for the Trust. Both SWL ICS and London Region have stated that any underspends in London on capital would be the first call against any shortfall.

Capital Expenditure was £21.1m year to date, £8.4m under plan. £2.2m of Sphere transition infrastructure upgrade costs were recorded in May earlier than budgeted. Most other Trust funded schemes were on or slightly behind plan. RMCC grant funded medical equipment and the Sutton Oak scheme have lower costs than anticipated at this point in the year but are phasing differences and are expected to catch up soon.

Capital plan by funding source	Year to Date Plan	Year to date spend	Year to date variance	Initial plan
	£000	£000	£000	£000
Purchased	6,111	7,947	1,836	34,431
Donated	23,437	13,243	(10,194)	55,867
Grand Total	**29,549**	**21,191**	**(8,358)**	**90,298**

5. Cash and Debt

Cash – The Trust had £142.1m in cash at the end of August, a decrease of £8m from the year-end. The key movements this year are related to working capital movements with the Royal Marsden Cancer Charity as the Oak Cancer Centre expenditure increases.

Debt – Overall receivables have reduced by £24.9m in year, however accrued income has increased by £15.4m. This is predominantly driven by The Royal Marsden Cancer Charity as referenced above.

6. Conclusion and Recommendation

The Trust reported a year to date £0.2m deficit at the control total level, £6.6m favourable to budget. This was largely driven by unbudgeted NHS income offsetting lower Private Patient Income. Whilst the Annual Plan is currently a £19.9m deficit, a number of income mitigations are targeted to bring the first half of the year to breakeven.

In addition to the revenue pressures, capital has also been constrained for the ICS. The Trust is £8.4m behind year to date capital plans due to phasing of RMCC grant funded medical equipment and the Sutton Oak scheme but these are expected to catch up soon.

The cash position of the Trust remains strong.

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

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
28 September 2021	7.1
Title of Document:	**To be presented by:**
Medical Workforce Report	Nick van As, Medical Director

1. Status: For Approval

2. Purpose:

Relates to:

Strategic Objective(s)	*Workforce*

3. Summary

- There is a requirement for Board to annually review the arrangements for medical revalidation and the purpose of this report is 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 for whom the Trust is the Designated Body.
- Guardian of Safe Working report –a summary of exception reports (ER) in 2020-21.
- Update on the GMC Trainee Survey Findings 2021.

4. Recommendations / Actions

The Board is asked to:

a) Note progress with medical appraisal and revalidation

b) Note the report from Guardian of Safe Working for 2020-21

c) Note the current status of the GMC survey of trainees 2021

d) Approve the Chief Executive or Chair to sign off the new combined annual board report and statement of compliance due by 31st October 2021 (Appendix 1).

The ROYAL MARSDEN
NHS Foundation Trust

Medical Workforce Report 2020-21

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 2021. 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 2020 to 31 March 2021.

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 London 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 James Woolley, Consultant Liaison Psychiatrist. 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 London Region, Annual Organisational Audit to NHS England London 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 92% in 2020-21, 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 – 4 appraisals were deferred for a valid reason e.g. maternity or sick leave and 19 doctors who completed their appraisal but not within the deadline for a non-valid reason. This is excluding those due between March 2020 and April 2021 which were postponed by the Trust Due to the impact of Covid-19.

2.8 The non-valid deferral rate has been problematic in previous years and the Trust was a negative outlier in London. This has been addressed and the non-valid deferral rate reduced significantly from 24% in 2016-17 to 4.5% in 2019-20. Unfortunately, it did increase to 6% in 2020-21, partly due to the exceptional workload caused by the pandemic.

2.9 Due to the impact of Covid-19, appraisals due in March 2020 and April 2020 were postponed to September 2020. Because of this we saw a decrease in compliancy rates in September 2020 to 80%. The GMC also postponed revalidations due between March 2020 to March 2021 by 12 months.

2.10 Table 2 shows that 87 doctors were due to revalidate during 2020-21 who the GMC subsequently deferred by 12 months. The level of revalidation activity will therefore increase significantly during 2021-22.

Table 1 shows *appraisal performance data 2020-21*

Doctors with a prescribed connection	**Trust**	**Honorary**	**Total**	**Valid Deferrals**	**Number of appraisals due 2020-21**	**Number of completed appraisals**	**Non-valid Deferrals**
Cancer Services	157	22	179	2	179	162	15
Clinical Services	93	1	94	1	94	90	3
Clinical Research	30	8	38	1	38	37	0
Private Care	9	0	9	0	9	8	1
TOTAL	**289**	**31**	**320**	**4**	**320**	**297**	**19**

Table 2 shows revalidation data for 2020-21

Number of positive recommendations to the GMC for revalidation between 1/04/2020 - 31/03/2021 i.e. these are doctors who have met all the requirements and have actually been revalidated by the GMC	**NA**
Number of deferrals between 1/04/2020 - 31/03/2021 i.e. these are doctors who were due to be assessed for revalidation but the assessment has been deferred by the Trust	
Number of deferrals from GMC due to COVID-19	**87**

2.11 There are currently 100 trained (an increase of 25) new 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 have:

- Utilised 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 25 new Consultants to become trained appraisers, making it easier for appraisees to find a suitable appraiser (held in Nov-20 and March-21).
- Used the appraisal auditing, feedback, support and training for appraisers to continue to improve the quality of medical appraisals within the Trust;
- Liaised 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.

3. Guardian of Safe Working (GSW) – annual activity report 2020-21

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

3.2 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.

3.3 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 2020-21.

Exception Reports

3.6 There have been 15 ERs during 2020-21 as shown in table 4 below, which is a 45% reduction from 2019-20 when the Trust had 33 ERs. No ERs were submitted during the covid pandemic. Only specialties where ERs have been reported are shown in table 3 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 2020-21, continuing the pattern on from 2019-20.

3.7

Table 3: 2020-21 ER activity

Rota	ERs Q1	ERs Q2	ERs Q3	ERs Q4	Total
General Medicine Sutton	0	8	2	0	10
General Medicine Chelsea	1	0	0	3	4
Paediatrics	0	0	1	0	1
Total	1	8	3	3	15

3.8 Actions taken to address 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. This is due to fully be rolled out in September 2021.

3.9 The feedback from the GSW and from the BMA has been that exception reporting appears to be working as envisaged in identifying issues with working patterns and addressing problem areas. The GSW 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, to 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 2020-21 are shown in table 4 below:

Table 4: Breakdown of resolution to ERs

Resolution method	Number of times resolution was used	% of total
Time off in lieu	8/15	53%
Payment for extra hours work	2/15	13%
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	5	33%
Total	**15**	**100%**

3.12 During 2020-21 there was a significant reduction in the number of exception reports. Data on exception reporting has been shared with representatives from the Junior Doctor Forum, British Medical Association and Medical Workforce Committee. There is consensus that these low figures represent a significant underestimate of junior doctors working beyond their contracted hours. There has been a lot of work completed to communicate to the junior doctors and Educational Supervisors the importance of exception reporting. Reports in themselves should be seen as a routine part of junior doctor working under the 2016 contract. Their submission should not attract any disapproval, and they should be resolved as quickly as possible. A rise in exception report figures during 2021-2022 is expected.

4.0 GMC Trainee Survey Findings 2021

4.1 The General Medical Council conducts an annual Trainee Survey and requires Trusts to provide an action plan in response to the findings. 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 It should be noted that in 2020 the GMC survey was focussed on the Sars2-Cov-19 pandemic, so the last comparable survey was 2019.

4.3 The survey identifies outliers (a score that is distant, positively, or negatively from the average) and a colour rating is applied dependent on how far from the average the responses are, so a red is a strong negative outlier and a green, a strong positive outlier.

4.4 Trainee Results

4.4.1 Positive (green) outliers represent scores in the upper quartile nationally. Negative (red) outliers represent scores in the lowest quartile nationally.

4.4.2 These results show 27 positive outliers (17 in 2019), but three negative outliers (an increase from two in 2019). Overall an improvement on 2019 data, with 10 additional green flags in new areas including histopathology and haematology. The majority of positive outliers were in Palliative Care, with five in Haematology, four in Histopathology, three in Medical Oncology, and one each in Anaesthetics and Intensive Care Medicine.

4.5 There has been a loss of green flags from anaesthetics and Sutton IMT.

4.6 Negative outliers relate to one each in Clinical Oncology (Workload), Haematology (Facilities), and Paediatric Oncology (Regional Teaching).

4.7 Trainer Results
Overall, there are two green flags in handover and support for trainers, and no red flags.

4.8 The survey results have been shared with the Educational Leads for each of the specialties, who will be developing action plans in response to red outliers applicable to the Trust. The summary findings and detailed responses by site and indicator will be discussed at annual review meeting being held in the months of September/October.

5. Pension tax allowances and the consultant workforce (Annual Allowance Compensation Policy)

5.1 As a result of the impact that pensions tax rules were having on high earners particularly the consultant workforce, NHS England/I introduced this policy to help combat the problem. Clinicians who are members of the NHS Pension Scheme ('NHSPS') and face an Annual Allowance charge in respect of the 2019/20 tax year will be able to have this charge paid by the NHSPS by completing and returning a 'Scheme Pays' election form before 31 July 2021 meaning that they don't have to worry about paying the charge now out of their own pocket.

5.2 36 applications were received from consultants.

6. The Board is asked to:

a) Note progress with medical appraisal and revalidation

b) Note the report from Guardian of Safe Working for 2020-21

c) Note the current status of the GMC survey of trainees 2021

d) Approve the Chief Executive or Chair to sign off the new combined annual board report and statement of compliance due by 31st October 2021 (Appendix 1).

Appendix 1

Statement of Compliance*:*

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of The Royal Marsden NHS Foundation Trust can confirm that:

An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Comments: Dr Nicholas van As, Medical Director, is the Responsible Officer

1. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes. Action from last year: The Trust has appointed Divisional Medical Directors to provide additional support to the RO Comments: Dr Gary Wares and Dr Jayne Wood were appointed as Divisional Medical Directors

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

This is done through our Allocate/Zircadian system and GMC connect. All systems are updated and checked monthly.

3. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes, the medical revalidation policies and procedures are reviewed annually to ensure they remain up to date.

4. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

The Appraisal Lead conducts quarterly appraisal audits using the NHS England Medical Revalidation Excellence - Quality Assurance Tool. He is also available for all appraisers and doctors within the Trust for support and gain feedback.

5. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

All doctors within the organisation are asked to complete an appraisal within 6 months of joining unless they have a sufficient appraisal or ARCP completed within 12 months of the due date. They are provided with access to our online medical appraisal software, study leave entitlement and internal governance supporting information.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

All doctors within the Trust must provide annual multi-organisation working declarations to cover all of the above for practice outside of the organisation. The Trust provides a template for other organisations to complete or will accepted a signed letter on headed paper.

Internal email addresses for our Complaints and Risk (Significant Events) teams are provided for confirmations regarding their role within the Trust.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

N/A

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes, the Trust medical appraisal policy is compliant with national policy and was approved by two committees prior to final sign off.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes, the Trust has 100 trained appraisers for 320 doctors, which provides sufficient numbers for appraisees and allows appraisers the opportunity to hold regular appraisals throughout the year to maintain their skills. Action for next year:

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

The Trust holds annual medical appraiser update classroom training sessions, as well as offering e-learning to those unable to attend. The Appraisal Lead conducts quarterly appraisal audits using the NHS England Medical Revalidation Excellence - Quality Assurance Tool and support to all appraisers within the trust. Audit days are used for appraiser networking and development along with the Appraisal Lead having an open-door policy for all doctors within the Trust.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

The appraisal system and processes are quality assured by the RO, Appraisal Lead and Medical HR team. Updates regarding appraisal and revalidation are reported to the Board on an annual basis.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: The Royal Marsden NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	320
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	297
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	19
Total number of agreed exceptions	

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Recommendations are submitted to the GMC as soon as possible once the doctor becomes under notice for revalidation. The Trust ensures a submission is made by the due date at the very latest to ensure doctors have the chance to provide the necessary supporting information for a positive recommendation.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes, doctors are informed by email as soon as their recommendation has been submitted to the GMC and a deferral or non-engagement recommendation would be discussed with them prior to submission.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

> Yes, the Trust ensures an environment of effective clinical governance is provided for all doctors by having robust systems in-place.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

> Doctors are provided with information from the Complaints and Risk teams regarding significant events/incidents within the Trust as part of their appraisal supporting information. The Information team also provide annual reports regarding Activity and Audit data.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

> This is covered in the revalidation and appraisal policy and wider HR policies. The trust has a specific policy called Responding to Concerns about a Doctor's Practice.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

> There is a quality assurance process for responding to concerns about a doctor and findings are reported to the Board annually including the above information.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Information is shared through the Responsible Officer Network. The Trust uses MPIT and internal multi-organisation working forms to transfer information promptly and effectively between responsible officers.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Concerns are investigated in accordance with the Maintaining High Professional Standards in the NHS (MHPS) document.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

The Trust is compliant with NHS pre-employment checks for substantive and locum medical staff.

Section 6 – Summary of comments, and overall conclusion

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 complaints 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.

Review of the 2019-20 Action plan:

Place additional focus on the non-consultant grades who contributed to 67% of the unapproved missed appraisals in 2018-19.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

- The appraisal completion was 92% in 2020-21, exceeding the Trust target.

Provide new appraiser training for consultants wanting to become an appraiser, making it easier for appraisees to find a suitable appraiser;

- There are currently 100 trained (an increase of 25) new consultant appraisers in the Trust.

To further improve medical appraisals in 2020-21 we have:

- Utilised 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 25 new Consultants to become trained appraisers, making it easier for appraisees to find a suitable appraiser (held in Nov-20 and March-21).
- Used the appraisal auditing, feedback, support and training for appraisers to continue to improve the quality of medical appraisals within the Trust.
- Liaised 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

The Appraisal Lead continues to carry out quarterly appraisal audits and support appraisers with improving the quality of medical appraisals.

Feedback is sought anonymously from appraisees and provided to appraisers to help them identify areas for improvement.

Concerns and performance issues are dealt with under the Maintaining High Professional Standards Policy.

Section 7 – Statement of Compliance:

The Board of The Royal Marsden NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: The Royal Marsden NHS Foundation Trust

Name: Dame Cally Palmer Signed: _ _ _ _ _ _ _ _ _ _

Role: Chief Executive Date: _ _ _ _ _ _ _ _ _ _

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 28 September 2021	**Agenda item:** 7.2
Title of Document: Board self-assessment report	**To be presented by:** Brinda Sittapah, Company Secretary

1. Status: For Approval

2. Purpose:

Relates to:

Governance	*Board development*

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 2021

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.

1 Is there the **leadership capacity and capability** to deliver high quality, sustainable care?	2 Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver?	3 Is there a **culture** of high quality, sustainable care?
4 Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well led?**	5 Are there clear and effective processes for managing **risks**, issues and **performance**?
6 Is appropriate and accurate **information** being effectively processed, challenged and acted on?	7 Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	8 Are there robust systems and processes for **learning**, continuous **improvement** and **innovation**?

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.

Board members recognised that 2020/21 has been a very challenging year with the hospital being under extreme pressure and were impressed by the Boards actions and behaviour over the last 12 months. The Board praised the remarkable commitment of the Executive team during the pandemic and commended them for their excellent performance. The Executive team in turn felt that they were properly supported when required by the NEDs. Members concurred that the Board have provided excellent leadership and support as the Trust has responded to the pandemic both in terms of meeting our obligations to RM patients and providing a significant system contribution. 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.

All Board members agreed that the Chairman encourages a range of diverse views and constructive challenge. However, it was felt that the NEDs views are sought more than that of the wider executive team.

There was widespread agreement amongst the Board members that the current Board composition has skills, experience and the knowledge required but it was felt strongly that diversity in terms of ethnicity and gender balance should be considered in any future Board appointments.

Board members acknowledged that the Board development plan has been impacted largely by the pandemic and should be a priority for the year ahead. It was felt that other than the compulsory online training, learning is somewhat self-initiated by individual directors. Board members suggested that a board development programme should be developed.

With regards the vision and strategy, Board members agreed that the vision is clear, and the Executive Team has worked hard to align the RMH strategy with local and national NHS policy, but this will need continued focus and adaptability. It was recognised that the strategy and ambitions of the Trust should be reviewed in the light of the NHS reform, the changing NHS landscape, particularly the development of ICS and impending legislation. Some members felt that there could be stronger Board leadership on changes within the NHS and national policy.

Board members agreed that the Board is determined to engage its staff and put the Health and Wellbeing of our People at the centre of all that we do. The Board appreciated the work that has been done on the Organisational Health and Wellbeing Plan which was positively received by 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 Board Committees reporting and oversight also helps with this in keeping the board vigilant. With regards the Equality and Diversity agenda, members agreed that the Board has responded to the wider societal issues raised around equality and diversity and since Covid-19 and Black Lives Matter this has become even more pressing and visible inside the organisation.

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 could be further strengthened with the newly appointed CEO and Chair of the ICR. Board members noted that there were difficult issues that were handled very well by the Chief Executive, but it was recognised that the NEDs are not very involved in external relationships, and this could be improved.

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 the Chairman encourages active engagement with Governors.

Regarding, 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 positively acknowledged the significant progress made on Risk Management in particular on the Risk Appetite, in the use of the BAF to inform the Board agenda, in the realignment of the BAF to the Risk Register. The Board noted that the risk processes are clear and well reported with regular review at both Board and its subcommittees. The Board firmly 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. It was suggested that further benchmarking work could be done to look at relevant efficiency metrics and a broader range of R&D KPIs.

Whilst it was recognised that quality and financial information are well covered at the Board and Committees, it was noted that sustainability requires more focus, in particular with the UK government plan to set in law the most ambitious climate change target, cutting emissions by 78% by 2035.

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, but the agenda could be managed more efficiently as occasionally the items are rushed through at the end. There was a feeling that there is not always sufficient debate and discussion are not always balanced to complexity/importance of item. Board members appreciated the way the BAF has been used to shape the agenda. Members positively welcomed the Board 'huddles' as these have kept the board well informed in a timely manner and ensure the Board deals with covid-related pressures. It was noted that given the level of pressure in the hospital, there were valid reasons to restrict access and Board members should be advised by the Executive Team on when physical meetings can resume.

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 and found the communications briefings received at the Board meetings very helpful. The occasional briefings from clinical specialists were positively acknowledged and Board members suggested that the Board has a 10-15 mins presentation 3-4 times a year by leading medical staff.

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) 2021**	**Board's View (Average scoring) 2020**	**Risk Rating**
KLOE 1	Is there the leadership capacity and capability to deliver high quality, sustainable care?	4.4	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?	4.3	4.6	
KLOE 3	Is there a culture of high quality, sustainable care?	4.4	4.7	
KLOE 4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?	4.7	4.7	
KLOE 5	Are there clear and effective processes for managing risks, issues and performance	4.6	4.4	
KLOE 6	Is appropriate and accurate information being effectively processed, challenged and acted on?	4.4	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?	4.6	4.3	
KLOE 8	Are there robust systems and processes for learning, continuous improvement and innovation?	4.5	4.2	
Additional question	Board operation/administration/governance	4.5	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 (Director of Workforce) • Executive views to be sought at Board meetings to ensure a balance discussion (Chairman)
KLOE 2: Vision & Strategy	• Strategy to be reviewed in line with changing NHS landscape and ICS design framework.
KLOE 3: Culture	• Board to be kept updated on Organisational Health and Wellbeing plan (Director of Workforce)
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 KLOE 6: Quality of information	• Undertake further benchmarking work on relevant efficiency metrics and a broader range of R&D KPIs. (COO) • Present sustainability work undertaken by the Trust to the Board (COO)
KLOE 7: Stakeholder awareness and engagement	• Further strengthen relationship with ICR (Chairman/Chief Executive) • Improve relationship with SWL/NWL ICS (Chairman/Chief Executive/NEDs) • More involvement of NEDs in building external relationships (NEDs)
KLOE 8: Robust systems, processes and continuous improvement and learning	• Board Development Framework/plan to be developed (Director of Workforce/Company Secretary)
Board Operation	• Ensure adequate time is allocated for all agenda items at Board meetings (Chairman/Chief Executive and Company Secretary) • Board Committees to provide a summary report to the Board rather than minutes of the meeting only (Committee Chairs/Company Secretary) • Ensure there is a 10-15 mins presentation by leading medical staff at Board meetings 3-4 times a year (Chief Executive/Medical Director/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:**
28 September 2021	7.3
Title of Document:	**To be presented by:**
Risk Appetite Statement/ Board Assurance Framework	Brinda Sittapah, Company Secretary

1. Status: For Noting

2. Purpose:

Relates to:

Governance	✓

3. Summary

The Risk Appetite Statement was approved by the Board in September 2020, and it was agreed that it will be reviewed annually. The joint Audit and Finance Committee and Quality Assurance & Risk Committee (AFC/QAR) has reviewed the Risk Appetite statement at their meeting on 8 September 2021 and no changes are being proposed. It was agreed that the Risk Appetite Statement remains fit for purpose in the light of the current NHS landscape and RM's position.

The Board Assurance Framework (BAF) was also discussed at the Joint AFC/QAR meeting and the comments made by members have been incorporated in the revised version presented to the Board.

There are currently five risks that are exceeding the risk tolerance threshold as follows:

- RM and RMPs regional and national leadership roles in cancer are recognised via changes in policy and the implementation of Integrated Care Systems
- Covid-19 – Delivery of a safe, effective and responsive service; Development of the Cancer Hub and ensuring the right capacity is in place to deliver timely and effective treatment
- Delivery of financial plan
- Developing and implementing a flexible and sustainable workforce model which attracts and nurtures the very best talent
- Ensuring a sustainable paediatric service model at RM.

The AFC/QAR were confident that these risks were sufficiently managed by the Board and the Board Committees and the BAF is used effectively to inform the Board agenda.

4. Recommendations / Actions

The Trust Board is asked to:

- review and approve the Risk Appetite Statement 2021;
- review and approve the Board Assurance Framework.

Risk Appetite Statement 2021

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 models of convening relevant stakeholders but without putting patients or the Trust and its reputation at risk.	**Moderate tolerance** (in respect of promoting new 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.	**Low tolerance** (to financial risks to safeguard public funds).
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.	**Moderate tolerance** (to commercial or capital risks in areas of proven operation and 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 Assurance Framework: September 2021

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.

2.0. Summary of current position

Strategic Objective	Initial Risk Score (L x S)	Residual Risk Score (L x S)	Risk Tolerance	Risk exceeding tolerance	Trust Risk Register Corresponding Risk	KPIs included in 20/21 Board Scorecard RAG rating is based on Q3 20/21 (R= red; A=Amber; G=Green; S= suspended national reporting due to COVID-19)
Research and innovation						
1. Increasing the scope and scale of our R&D expertise and impact in a greater number of tumour groups and treatment modalities including Early Diagnosis	15 (3x5)	9 (3x3)	High (16-20)	-	n/a	**Research metrics** -Date site selected to first participant recruited (S) -Accrual to target (S) -Number of 1st patients recruited in previous 12 months (G) -Trials led by RMH (G)
Treatment and care						
2. The implementation of Integrated Care Systems and recognition of RM and RMPs regional and national leadership roles in cancer	20 (4x5)	16 (4x4)	Moderate (11-15)	✓	n/a	n/a
3. Developing and implementing a flexible and sustainable workforce model which attracts and nurtures the very best talent.	16 (4x4)	12 (4x3)	Low (6-10)	✓	COR.069 - Junior Doctor Staffing Workforce to formulate integrated risk at Q4 20/21 review in April	**Workforce productivity and quality and development metrics** -Vacancy rate (A) -Voluntary staff turnover rate (G) - Sickness rate (A) -Consultant appraisal (A) - Appraisal and PDP rate (G) - Completed induction (A) - Statutory and mandatory staff training (G)
4. Ensuring a sustainable paediatric service model at RM.	20 (5x4)	12 (4x3)	Low (6-10)	✓	n/a	
5. Covid-19 – Delivery of a safe, effective and responsive service, Development of the Cancer Hub and ensuring the right capacity is in place to deliver timely and effective treatment	15 (5x3)	10 (5x2)	Low (6-10)	✓	COR.007 - Failure to achieve on aspects of performance (T550)	**COVID-19 testing/IPC metrics** -COVID-19 positive tests (hospital onset) (A) -Reportable COVID-19 outbreaks (A) -PPE audit results (G) -Hand hygiene audit results (G) **Recovery activity: Phase 3 response metrics** -% of outpatient appointments virtual (G) % of pre-COVID mean -Outpatient attendances (G) -Diagnostics (G) - Elective admissions (A) - SACT attendances (A) -RX attendances (A) **National cancer waiting times targets** -2WR (R) - Breast symptomatic 2WR (G) - 31 day first treatment -31 day subsequent (G) -62 day first treatment GP (R) -62 day first treatment screening (G) -18 weeks incomplete (G) -18 weeks -patients > 52 weeks (G)
Modernising infrastructure						
6. Maximising opportunities for Sutton via the successful delivery of the Oak Cancer Centre and agree a strategy and delivery plan in terms of RM's role in the new Epsom and St Helier acute hospital	15 (3x5)	12 (3x4)	Moderate (11-15)	-	COR.003 - Space/capacity constraints (non-clinical) (C1202)	n/a
7. Modernising the Chelsea Estate supported by an investment strategy jointly developed with RMCC	15 (5x3)	10 (5x2)	Moderate (11-15)	-	COR.003 - Space/capacity constraints (non-clinical) (C1202) Lack of Space and Facilities (Diagnostic Radiology Chelsea GH)	n/a
8. Delivery of the IT Strategy	16 (4x4)	12 (4x3)	Moderate (11-15)	-	IT.094 - Condition of Existing Sutton & Chelsea Computer Rooms IT.014 - Network Stability & Resilience IT.092 - Retirement of Key RM Digital Services Personnel IT.093 - Sphere Delivery Capacity	n/a
Financial sustainability and best value						
9. Delivery of PP Strategy	15 (3x5)	12 (3x4)	Moderate (11-15)	-	PP.027 - Recoverability of Embassy Aged Debt FIN.010 - Financial Sustainability (T1189) FIN.021 - Lower than forecast ROI for off-site Private Care Diagnostic Centre	Total PP referrals (A) PP activity income variance (A)
10. Delivery of financial plan	20 (5x4)	15 (5x3)	Low (6-10)	✓	FIN.010 - Financial Sustainability (T1189) FIN.021 - Lower than forecast ROI for off-site Private Care Diagnostic Centre RND.007 - Renewal of NIHR Biomedical Research Centre Status	**Finance, productivity, and efficiency** -Cash (£m) (G) -Delivery against plan (G) - PP activity income variance (A) -PP aged debt at > 6 months (R) -Non NHS/Non-PP debtors over 90 days (A) -Capital Expenditure Variance (A)

L x S = Likelihood x Severity

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.	Increasing the scope and scale of our R&D expertise, innovation and impact in a greater number of tumour groups and treatment modalities. Director of Clinical Research / COO <u>RM Board of Directors</u>	Failure to respond and innovate in areas of national and global priority present a risk to RM strategy of global leadership in cancer research.	**15**	Priority areas for development agreed through Joint Research Strategy Board and overseen by JEG: • Convergence science • Informatics & Computational Science • Early Diagnosis • Artificial Intelligence • Digital Pathology • Surgery • Biotherapeutics • Survivorship RMCC funding for building of initial hospital based clinical research infrastructure secured for Early Diagnosis, Surgery, Biotherapeutics & AI. Discussions around joint RM/ICR strategy in early diagnosis underway and Joint (virtual) Centre for Early Diagnosis Research to be launched Summer 2021 Strategy with Imperial with particular focus on Convergence Science to be over seen by JEG. IP Working Group reporting to Joint Research Strategy Board overseeing joint research portfolio and potential commercialisation/revenue	Recruitment to new RMCC funded infrastructure posts to commence Nov 2020 Update existing consultant workforce strategy to support long term intent and partnership with the ICR. BRC Stage 2 application to be submitted in September 2021.	**9**	**16-20**	Health informatics lead appointed. All new RMCC funded research infrastructure posts appointed to. Stage 1 BRC submission has passed through to stage 2 in full.

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
				Opportunities for key strategic collaborations being identified eg The Crick, The Royal Surrey, The Clatterbridge.				
	Treatment and care: Developing and leading new models of care; Leading Royal Marsden Partners; Address capacity constraints; Deliver cancer waiting times targets.							
2.	The implementation of Integrated Care Systems and recognition of RM and RMPs regional and national leadership roles in cancer COO RM Board of Directors	Devolution of national specialist commissioning budgets for cancer to ICSs in shadow form from April 2021, with formal devolution from April 2022 for some of the cancer specialist commissioning budget. Legislative changes have been set out on the statutory functions of ICSs to establish these systems as leaders of commissioning and provision of services in each geography. The full implications for NHS FT governance is	**20**	Active engagement in both SWL and NWL STP and Integrated Care System planning 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 and endorsed by partner ICS/STPs. RM/RMP are leading the cancer response and recovery plan to the COVID-19 pandemic on behalf of the NWL and SWL STP/ICS. 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. The proposed new SECH hospital at Sutton including RM cancer theatre redevelopment has been approved at SOC level (May 2021)	Complete OBC for SECH and Cancer Surgical development (Oct 2021) Undertake further work with other relevant specialist hospitals in both London and nationally to articulate our contribution to health and life sciences in the context of integrated care systems. RMP lead/co-chair the specialist services workstreams in NWL and SWL and are developing the cancer system strategy for both ICSs	**16**	**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
		unclear, although the expectation is that provider collaboratives will play a central role in overseeing future service models and the associated commissioning arrangements. There are significant risks around the funding of cancer services from 2022-23 given the recent announcement on the 3 year funding settlement.		RM has been designated as the ICS specialist services lead for SWL.				
3.	Developing and implementing a flexible and sustainable workforce model which attracts and nurtures the very best talent. Director of workforce/MD/Chief Nurse	Global shortage of healthcare staff exacerbated for UK by impact of Brexit and the Pandemic. Potential short- and medium-term pressure on recruitment and retention of staff Demographic changes and differing expectations in the	**16**	Clear 10-year strategic intention to provide purpose and service ambition A high-quality workforce model which provides the best training and employment experience and is confirmed by workforce metrics. To include ongoing monitoring of vacancy and turnover rates and qualitative feedback from staff survey A blended employment model for staff which supports NHS patient care, research and PP. To include ongoing monitoring of	Board level strategic conversation is ongoing and will continue to 21/22. Update existing consultant workforce strategy to support long term intent and partnership with the ICR. To include talent management, leadership development and succession planning to	**12**	**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
	RM Board of Directors	workforce requiring modernisation of the workplace and employment offer. Organisational positioning and profile amid growing sectorisation may result in weakening of employer brand and position in the labour market.		vacancy and turnover rates and qualitative feedback from staff survey Reporting of progress through Workforce and Education Committee /QAR and regular visibility by the Board. Ongoing role of the Learning and Development Team and the RM School to train and educate our clinical staff to ensure supply.	grow and retain the best people Create an attractive and inclusive workplace professional offer to reflect changing aspirations through local delivery of the People Plan and London WRES. and Wellbeing agenda. Agree plan in 20/21. Develop flexible clinical roles to deliver new models of care and a sustainable sub consultant medical model. New workforce models include Cavendish Square, the Oak Centre and other transformation projects 20/21 and ongoing. Extend robust flexible staffing provision to provide additional supply stream, potential gateway to substantive employment and creative approaches to enhancing retention post pandemic. Review all our provision of professional training,			

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
					learning and education to clarify future role and remit of our offer to ensure a consistent and complementary investment to achieve workforce we need. The Trust has been continually monitoring its workforce supply over the last 12 months and turnover of staff has remained steady at 12%.			
4.	Ensuring a sustainable paediatric service model at RM. CEO/MD <u>RM Board of Directors</u>	Primary Treatment Centre (PTC)- is decommissioned from RM as a result of NHSE mandating co-location with a PICU	**20**	CQC inspection gave Paediatrics a rating of "Good" and Trust overall rating of Outstanding Service deemed safe. Internal 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	Continue to work with St George's Hospital to optimally manage PTC beds under current governance model. Centre of Excellence collaboration with ICR and GOSH being developed (although on hold pending the outcome of the PTC review). Funding to be sought to progress this model that will embed a tripartite of clinical, research and academic leadership roles in RMH/ICR. Continue to engage NHSE as part of the PTC review and prepare to submit	**12**	**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
				retention of the PTC in line with commissioning requirements Staff and family briefing document completed (Jan 2021) and further briefing meeting held	proposals as part of an option appraisal (Q3 2021-22) Update briefings to be held for staff and families			
5.	COVID-19 pandemic COO/MD <u>RM Board of Directors</u>	Failure to deliver a safe, effective and responsive service following COVID-19 (Coronavirus) pandemic.	**15**	Command and Control structures are well tested and ready to be stood up should a further pandemic wave arise. Maintenance of blue / green pathways for patients which separates elective patients from urgent ones. Continue to maintain a covid light environment with significant restrictions on visiting and maintenance of IPC standards including social distancing in line with national guidance Recovery plan enacted with all material backlogs bar P3&P4 surgery now resolved. Vaccination programmes in place for all staff and cancer patients Comprehensive on site testing capability for all respiratory borne viruses now in place	Booster vaccination plan to be developed for Autumn 2021 Additional trust capacity plans being developed for predicted surge in demand in Q3 & Q4 of 2021/22 Complete P3 and P4 surgical backlog recovery plan (Q3 2021-22)	**10**	**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
	Modernising infrastructure: Modernisation of estate and facilities, including IT, to maximise opportunities for research, and manage capacity (NHS & Private Care).							
6.	Maximising 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 AFC	RM alongside it partners is unable to realise the full extent of the opportunities to develop the Sutton campus	**15**	Planning permission granted for the Oak Cancer Centre and building work on track for 2022 completion. LCH has now had approval to develop the first of its new buildings (Knowledge Hub) Epsom and St Helier Hospital Business Case has been submitted to regional and national teams for review which includes a Strategic Outline Case (SOC) for elective theatres, inpatient and daycase capacity for RM within the new Specialist Emergency Care Hospital (SECH)	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. More detailed Sutton site master planning working taking place with partners as part of the SECH and LCH developments	**12**	**11-15**	
7.	Modernising the Chelsea Estate supported by an investment strategy jointly developed with RMCC CFO/COO Board of Directors and AFC	Failure to provide the right estate infrastructure to support the Trust's long term ambitions on the Chelsea site	**15**	Initial outline proposal developed and shared with the Trust Board and RMCC trustees Ongoing engagement with RBH, ICR and the local council on the long term estate plans for the health and life sciences campuses on the Fulham Road	Updated paper on the Chelsea site development to be brought back to Trust Board and RMCC trustees in Autumn 2021 RM and RBH proposal to be set out on how to jointly use the existing estate to support the combined thoracic oncology service (October 21)	**10**	**11-15**	
8.	Delivery of high-quality, secure and innovative digital services to underpin the	Financial risk: inability to support productivity and efficiency gains through use of	**16**	Following the successful delivery of business cases documented in the 2018 Digital Strategy, a new Digital Strategy (2023-2027) is being developed for presentation to the Trust Board in early 2022/23.	Cyber action plan to achieve Cyber Essentials Plus accreditation. Financial support received from NHS Digital. Technical and legacy	**12**	**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
	Trust's overall strategic objectives. This includes the delivery and optimisation of a new fully integrated digital health record and patient portal, data warehouse infrastructure, and new technology solutions to enable developments in research and treatment. CFO/CIO <u>AFC / RM Board of Directors</u>	technology. Potential loss of income. Cyber-security risk: risk of a cyber-attack which poses a risk to patient safety, loss of income, reputational damage. Workforce risk: inability to provide modern, fit for purpose technology to support flexible working, and to attract and retain high-quality staff. Reputational risk: inability to keep pace with research and development and commercial opportunities.		All aspects of digital delivery (including infrastructure and cyber security) are now overseen by the Trust and governed via the Digital Transformation Board. The full business case (FBC) for a new Digital Health Record (DHR, to include LIMS) in partnership with Great Ormond Street Hospital was approved by the Trust Board in July 2021. A Chief Information Security Officer (CISO) has been appointed with responsibility to deliver the cyber security action plan and ensure the Trust meets the requirements of Cyber Essentials Plus accreditation. A NED chaired Programme Assurance Group (PAG) meets quarterly and receives external assurance reports from PWC, including gateway reviews for the implementation of the DHR. The AFC receives quarterly progress reports on the Digital Strategy and Cyber Security. Digital leadership through CIO, CCIO, CNIO and CRIO with divisional and specialist IO recruitment as part of the DHR programme.	system and device actions required to complete action plan (latter will be informed by DHR progress). Target for CE plus accreditation by Q2 2022/23. LIMS functionality will be provided via the new DHR. Go-live planned March 2023. DHR Programme Director in post, recruitment of programme team, clinical and technical resources underway. External programme assurance through PAG. Joint CEO-led Partnership Board to govern collaboration with GOSH. Strong clinical leadership model for DHR with appointment of Divisional CCIOs and a range of subject matter experts to support and steer the programme. DHR go-live planned for March 2023. Digital Workplace programmes (underpinning infrastructure improvements). Includes new wired and wireless network at all sites, Office			

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
					365, secure offsite data centres and backup/disaster recovery systems. Due to complete Q4 2021/22. New data warehouse and Trusted Research Environment programme 12 11-15 underway. Build phase due to complete by Q4 2021/22.			
	Financialsustainability and best value: Improve productivity and efficiency; Manage capital programme; Maximise commercial opportunities.							
9.	Successful delivery of the Private Care Strategy which requires short and medium term initiatives to enable profitable growth to meet trust financial targets. CFO/MD of Private Care <u>AFC / RM Board of Directors</u>	COVID-19 impact on revenue and profitability. A downturn in international patient volumes together with increased UK (PMI) competition presents a short to medium term threat to revenue. Lack of Private Capacity due to the demands of nhs and private care recovery Risk of volatile embassy business impacts debt and profitability. Consultant concentration	**15**	Private care recovery plan created with clear recovery milestones, risks and forecasts. Trust wide capacity plan to ensure governance, balance and efficiency of capacity allocation for PP and NHS use. Contract negotiations with Independent Sector to provide NHS capacity. Commercial strategy developed and updated quarterly to account for new risks and opportunities in a changing market. Consultant succession plan developed to identify and mitigate key areas of concentration risk.	Cavendish Square confirmed for opening in April 2021. Commercial plans for Cavendish Square developed and updated for Board review 31/03/21. Includes latest assessment of risk and commercial mitigations. Direct links/contracts with Gulf Referral institutions formed to improve patient flow. Clinical Advisory Group (CAG) regularly review consultant participation,	**12**	**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
		creates over dependency and risks new consultants establishing private practice with competitors.			key clinical risks and mitigation. 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.			
10.	Delivery of financial plan <u>CFO</u> <u>AFC/Board of Directors</u>	Failure to maintain financial sustainability The NHS financial framework for 2021/22 is on a block basis and therefore constrains the Trust to a revenue control total.	**20**	Finance & Performance Committee (FPC) monitors divisional performance against the plan on a monthly basis. The quarterly PRGs review the forecasts; Enhanced controls in place as agreed by PRG and EB: - Vacancy control panel; - Review of agency, overtime and bank usage; - Enhanced non pay controls in place; Business plan and significant business cases signed off by FPC and Board. Monthly financial PRGs in place for areas not meeting the plan to ensure it is achieved. A small surplus was delivered in 2020/21 despite the significant financial pressures. A similar framework is in place for the first half of 2021/22 so a similar position is targeted and expected. The funding framework for the second half of the year is not yet known which poses a risk to the Trust.	The Trust has a breakeven plan targeted for the first half of the financial year which it is on course to deliver. The Trust's plan for the second half of the year is more uncertain and will be updated at Q1 and following any updates in funding guidance from NHSEI.	**15**	**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
		Reduced BRC funding presents both a reputational and financial risk to RM and its ability to lead globally impactful research as a comprehensive cancer centre.		Clinical Research Executive meets weekly and oversees progress with the current BRC strategy BRC Steering Committee meets quarterly and BRC Theme Working groups meet regularly to actively drive forward work in each theme Clinical Research Operations Managers have been recruited to support each theme and operationalize theme strategies through RM tumour units. 2 BRC supported consultants have been recruited: (1) consultant drug development (2) consultant molecular pathologist. Working groups with Imperial AHSC meeting regularly	Early Diagnosis consultant recruited. To develop further interactions with Imperial under the AHSC umbrella with a particular focus on early detection and the digital strategy. Appoint senior clinical informatics project manager to support BRC digital theme BRC competition delayed by min 6 months with steady state funding expected at that time.			

Risk Rating Matrix

	Severity				
Likelihood	**1 INSIGNIFICANT**	**2 MINOR**	**3 MODERATE**	**4 MAJOR**	**5 CATASTROPHIC**
ALMOST CERTAIN 5	5	10	15	20	25
LIKELY 4	4	8	12	16	20
POSSIBLE 3	3	6	9	12	15
UNLIKELY 2	2	4	6	8	10
RARE 1	1	2	3	4	5