The Royal Marsden NHS Foundation Trust

Quality Report

Fulham Road
Chelsea
London
SW3 6JJ
Tel: 020 7808 2101
Website: www.royalmarsden.nhs.uk

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Marsden NHS Foundation Trust is split over two principal sites, in Chelsea and Sutton, and a day-case unit on the site of Kingston Hospital. As a specialist trust, the Royal Marsden receives referrals from beyond the immediate areas, including national and international referrals. The trust also provides community healthcare services at a range of sites throughout the London Borough of Sutton, to a population of approximately 196,000.

We inspected the Royal Marsden NHS Foundation Trust as part of our specialist NHS inspection programme as well as applying our NHS community health service inspection methodology also. We inspected the trust between 19 and 22 April 2016 as well as carrying out additional visits following the announced inspection to collect further information and to corroborate findings.

The Royal Marsden Community Services formed Sutton and Merton Community Services (SMCS) in 2011. Various community health services were provided in the London Boroughs of Sutton and Merton. From 1 April 2016 The Royal Marsden Community Services stopped providing services to Merton and formed Sutton Community Services (SCS). Our reports in to community health services include data from the 12 month period leading up to our inspection which was before the disaggregation of services and therefore contains some data relating to Merton. We have included separate data where it was available. Our site visits during the inspection were limited to Sutton only.

Overall, we have rated the trust as good. We rated it good for providing care which was safe, effective, responsive to the needs of the population, and well-led. We rated the trust outstanding for the caring domain.

Additionally, we rated the radiotherapy service as outstanding across both hospital locations. This was because the radiotherapy service was patient centred; care was provided in line with national standards, with radiotherapy services participating in national and international research programmes.

Our key findings were as follows:

- There were robust processes for staff to follow in relation to incident reporting and investigation. Staff understood the importance of being open and honest, as per the duty of candour.
- Learning outcomes, arising from incident investigations, were, in the main, shared with staff and applied in practice. Improvements were required within the adult's community service to ensure that learning from incidents was shared across all teams.
- Staffing arrangements supported the delivery of safe diagnostics, treatment and care within the hospital setting. However, staffing shortages within the community nursing teams meant that the delivery of end of life care fell to more experienced staff who had attended relevant training, this meant that there was limited staff available to deliver end of life care.
- Specialist staff did not feel they were always being contacted quickly enough to support the timely commencement and delivery of end of life care for patients both in the hospital setting and within the community.
- The environment in which people received treatment and care was clean and organised in a manner, which identified and responded to potential or actual infection control risks.
- Medicines, including controlled drugs, and chemotherapy were safely prepared, managed and optimised.
- In the majority of cases, vulnerable individuals were identified and protected under safeguarding practices and through the application of the Mental Capacity Act and associated Deprivation of Liberty Safeguards. Improvements were required within the community adult's services to ensure capacity assessments were routinely recorded. Staff working within community adults services required further support in helping them to understand the concepts of the Mental Capacity Act.
- Staff were enabled to perform their duties through the provision of professional standards and guidance. However, within community services, staff were not consistently following best practice in their approach to wound assessments. This meant that changes to wound presentation were less likely to be accurately recorded and deterioration may not have been

addressed as readily. Additionally, community staff were not routinely following the quality standard for nutrition support in adults which required care services to take responsibility for the identification of people at risk of malnutrition and provide nutrition support for everyone who needed it.

- In the majority of care settings, treatment outcomes and other departmental audits enabled staff to monitor the effectiveness of the services provided.
- Strong multidisciplinary team work across disciplines facilitated the delivery of effective services to people.
- A full range of diagnostic and technological equipment was available, and was used by appropriately trained staff to monitor and deliver treatment and care.
- Staff had the right qualifications, skills, knowledge and experience to undertake their roles and responsibilities. They had access to developmental training and were supported by senior staff through a range of approaches.
- Staff had opportunities to receive feedback on their performance.
- People were treated with kindness, dignity, respect and compassion whilst they received care and treatment from staff.
- Staff took into account and respected people's personal, cultural, social and religious needs.
- Staff were observed to take the time to interact with people who used the service and those close to them in a respectful and considerate manner. They showed an encouraging, sensitive and supportive attitude towards people receiving treatment and care, as well as those close to them.
- People who used the services and those close to them were involved as partners in their care. Staff communicated with people so they understood their care, treatment and condition. They recognised when people needed additional information and support to help them understand and be involved in their care and treatment and facilitated access to this.
- People received appropriate and timely support and information to cope emotionally with their care, treatment or condition.

We saw several areas of outstanding practice including:

- Critical care staff worked with a specialist in aromatherapy massage as part of a trial to identify if this type of therapy would result in better sleep patterns amongst patients. This trial was in progress at the time of our inspection and aimed to find if non-pharmacological intervention could be an effective alternative to support sleep to high doses of drugs.
- The Critical Care Unit's (CCU) research programme was well structured and there were multiple safety nets in place for staff conducting this. The Committee for Clinical Research had oversight of every project and only approved them after a positive peer review and ethics approval. The research profile was internationally recognised and staff represented the unit at the NHS National Institute of Health Research and the National Critical Care Research Group. Senior research staff worked academically and clinically, which meant they could ensure critical care projects were conducted according to established multi-professional best practice.
- Staff in CCU prescribed patients who were considered high-risk for complications a pre-rehabilitation programme before they underwent surgery. A physiotherapist led this programme and provided patients with an exercise regime and diary. This helped them to prepare for rehabilitation and to support their health to improve their condition after surgery.
- The environmental adaptations in the Chelsea CCU demonstrated exemplary focus on individual care and attention to detail. This included adapted environments for patients with dementia, bariatric patients and teenagers.
- Senior staff actively promoted staff welfare and had provided tai chi, complementary therapies and meditation sessions to promote wellbeing and relaxation.
- The Marsden is the only NHS hospital to have the updated version of the da Vinci Xi surgical robot. This less invasive surgery allowed improved patient recovery. The 10 year fellowship programme meant that 30 surgeons would be trained by the trust to operate the robot.
- There was an extensive range of information, including films for patients, which provided detailed support.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

Summary of findings

- Staff demonstrated high care, arranging patient transportation and accommodation for those that did not live near to the hospital.
- The investment by the trust ensured that staff were developed and highly trained. Many staff had studied for master degrees and specialist courses in cancer.
- Research, ongoing quality improvement projects and auditing were of a high level and drove the quality improvement agenda.
- Nursing and therapy staff had the commitment and time to provide person-centred care that often went the 'extra mile'
- The introduction of ambulatory care had managed to reduce patient bed stays and improve patient experience.
- The end of life supportive care home team (SCHT) was a part of a Sutton CCG (clinical commissioning group) vanguard relating to improving end of life care in care and nursing homes. Members of the SCHT were involved in developing the service and had been invited to speak about the model and share this development with other services. The end of life supportive care home team (SCHT) was a part of a Sutton CCG (clinical commissioning group) vanguard relating to improving end of life care in care and nursing homes.

However, there were also areas of practice where the trust needs to make improvements.

Importantly, the trust must:

- Implement and embed the World Health Organisation Safety Checklist in the outpatients department.
- When patients (aged 16 and over) are unable to give consent because they lack the capacity to do so, the trust should ensure staff act in accordance with the Mental Capacity Act 2005.
- Ensure that records contain accurate information in respect of each patient and include appropriate information in relation to the treatment and care provided, particularly with regard to risk assessments.
- The provider should take action to understand the shortfalls in recording of risk assessments and individualised care plans in the integrated community teams.
- Review the staff compliment for community adult services to ensure there are sufficient numbers of appropriately skilled staff to meet patient's needs.
- The provider should strengthen the reporting on the assurance of effectiveness of governance arrangements to the trust board; this specifically relates to community services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to The Royal Marsden NHS Foundation Trust

Sites and locations:

The trust has two principal sites: The Royal Marsden Chelsea and The Royal Marsden Sutton.

Additionally, the trust provides community services throughout the London Borough of Sutton to a population of approximately 196,000.

In total, the trust has 212 beds; 196 beds are allocated for general and acute care and 16 are dedicated to the provision of critical care services. The trust employs 4,203 staff, of which 402 are medical, 1,255 nursing, 1,203 "other clinical" and 1,342 "other non-clinical".

Activity

During 2014/2015, the trust recorded 9,842 inpatient admissions and 190,117 outpatient attendances. Within community health services, the trust carried out a total of 510,693 community attendances between July 2014 and December 2015, with community nursing accounting for the largest share of attendances (37%).

The trust ceased providing community health services within the London Borough of Merton as of 31 March 2016.

Our inspection team

Our inspection team was led by:

Chair: Robert Aitken

Head of Hospital Inspection: Nick Mulholland

The team included CQC inspectors and a variety of specialists with the following expertise: Consultants in Clinical Oncology, Palliative medicine, Anaesthetics, and Critical care. We also had expertise from nurses with experience in end of life care and oncology; a Consultant General Surgeon; a Medical Director; Director of Nursing and Operations; Radiology and Radiography and a clinical Psychologist. We had one expert by experience assisting us and analytical support.

How we carried out this inspection

To understand patients' experiences of care, we always ask the following questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Our inspection was announced in advance to the trust. As part of the preparation and planning stage the trust provided us with a range of information, which was reviewed by our analytics team and inspectors.

We requested and received information from external stakeholders including, Monitor, The General Medical Council, The Nursing and Midwifery Council, The Royal College of Nursing, and The Royal College of Anaesthetists. We received information from NHS England Quality Surveillance Team, NHS England Specialised Commissioning and Health Education England. Local clinical commissioning groups also shared information with us.

We considered in full information submitted to the CQC from members of the public, including notifications of concern and safeguarding matters. Members of the public spoke with us at our open days held at the trust on 11 April 2016.

We held focus group discussions with separate groups of staff during the week commencing 4 April 2016. Participants included; allied health professional, administration and clerical staff, band 5 and 6 nurses,

senior sisters and charge nurses, matrons and clinical nurse specialists. Focus group discussions were held with consultants, junior doctors and members of staff at different grades from black and ethnic minorities during the inspection week. Our announced inspection visit took place over the 19 -22 April 2016. We also undertook a further announced visit on 6 May 2016 to the Sutton site and 18 May 2016 to the critical care unit located at the Chelsea site.

During our inspection we spoke with 155 patients and relatives/friends, who provided feedback on their experiences of using the hospital services. We looked at over 50 patient records where it was necessary to support information provided to us. Whilst on site we interviewed more than 400 staff, which included senior and other staff who had responsibilities for the front line service areas we inspected, as well as those who supported behind the scene services, and volunteers. We requested additional documentation in support of information provided where it had not previously been submitted. Additionally, we reviewed information on the trust's intranet and information displayed in various areas of the hospital.

We made observations of staff interactions with each other and with patients and other people using the service. The environment and the provision and access to equipment was assessed.

Facts and data about this trust

The trust provides a specialist tertiary service for patients diagnosed with cancer. The Royal Marsden treats local patients and patients referred from other parts of England for treatment, patients participating in clinical trials and private patients.

The trust provides a full range of diagnostic and treatment services, including surgery, services for children and young people, chemotherapy, radiotherapy, haematology and bone-marrow transplant services, end of life care and outpatients and diagnostics.

The London Borough of Sutton is in south west London and forms part of outer London. It has a population of 191,123. The proportion of both younger people aged 0-19 years and those aged 35-44 years is higher in Sutton compared to the national profile, while the birth rate and the population of young children (0-4 year old) is lower compared to London or England. In 2011 79% of people living in Sutton were of white ethnicity. This is lower than England (85%) and higher than London (60%). Deprivation: At borough level Sutton ranks 196 out of 326 boroughs (where 1 is the most deprived and 326 is the least deprived).

The health of people in Sutton is generally better than the England average. It has some of the lowest avoidable mortality rates (people dying before the age of 75 years) compared to London and England. cancer remains the biggest single cause of death in those under 75 year olds, and the proportion of cancer deaths has increased over the last five years. Over the same time, the proportion of deaths from circulatory disease reduced and there was a small decrease in deaths from respiratory conditions.

According to Public Health England June 2015 figures, the health of people in the boroughs of Kensington and Chelsea is varied, when compared with the England average. Whilst life expectancy for both men and women is higher than the England average. In the most deprived areas, life expectancy is 14.3 years lower for men and 4.3 years lower for women. Deprivation is higher than average, and there are about 21% (4,100) children living in poverty.

Safe

- Between January 2015 and February 2016 25 serious incidents were reported by the trust. Of these 20 were related to pressure ulcers. 16 cases or pressure ulcers were attributable to community health services, of which 10 were recorded as grade 3 ulcers and 6 were recorded as grade 4. During this time period, seven incidents occurred within Merton community health services; as of 31 March 2016, the trust ceased providing community health services within the London Borough of Merton.
- For the same period 3,454 incidents were reported to NRLS which was higher than the England average. Of these only one caused severe harm or death to the patient.

Summary of findings

- The trust reported 795 NRLS incidents occurring in the community setting between February 2014 and January 2016. The majority of these incidents were classified as low harm. Eight incidents involved abuse or allegations of abuse.
- In 2015 25 pressure ulcers, 11 falls with harm and six catheter urinary tract infections were reported.
- There were 42 cases of Clostridium difficile reported in the trust between January 2015 and January 2016.
- There were no reported cases of Meticillin Resistant Staphylococcus Aureus in the same period.
- The trust reported 11 cases of Meticillin Sensitive Staphylococcus Aureus between January 2015 and January 2016.
- The trust employs proportionally more registrar staff than England average, and a smaller share of junior doctors.

Effective

- In the 2015 Bowel Cancer Audit the trust performed better than London Cancer Alliance and England average for data completeness and readmission rates, but has a higher mortality rate.
- In the 2015 Prostate Cancer Audit the trust performed better than England average for most screening completion rates.
- The trust performed better than the England average in eight out of ten measures on the UK Radiotherapy Equipment Survey 2013.
- No evidence of risks or mortality outliers were identified for any of the mortality indicators.

Caring

- Family and friends test scores for the trust were greater than or similar to the England average for January –December 2015. The scores ranged from 95 – 95.5%.
- In the 2013/14 cancer patient survey the trust score was in the top 20% of trusts for 9 of indicators (bottom 20% for four indicators and in the middle 60% for remaining questions).
- The hospital scored better than the England average for three of the four domains in the Patient led Assessment of the Care Environment (PLACE). It scored just below the England average for privacy and dignity and well-being.
- From the 2015 CQC inpatient survey the trust scored better than other trusts for all of the questions.

Responsive

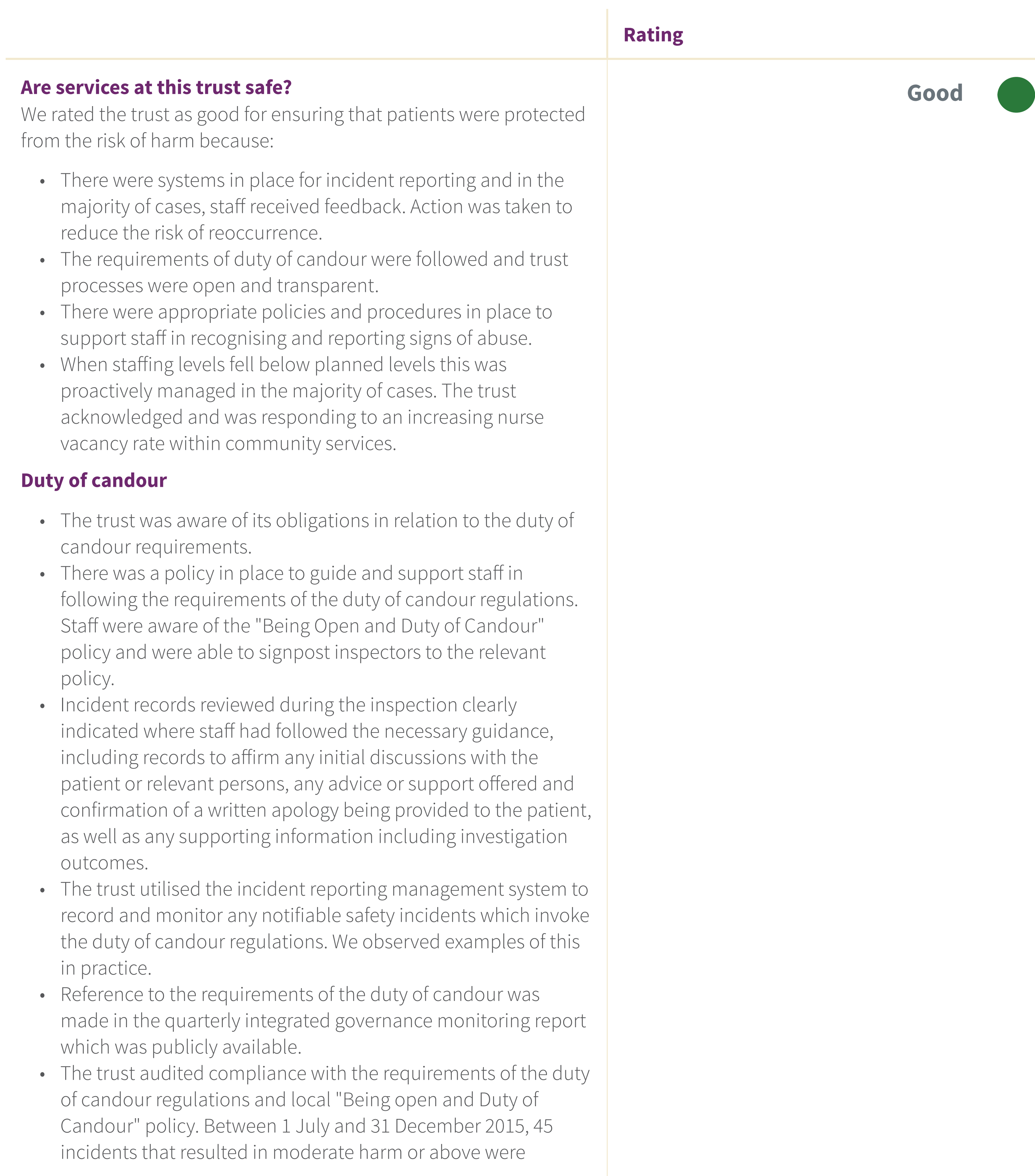
- The trust received 118 complaints in 2015 of which 117 had since been closed. The percentage of complaints reopened was 8%.
- The bed occupancy has been below the national average since quarter 2 2014/15.
- From February 2015 – January 2016 referral to treatment times have been above the national average for outpatients receiving consultant led treatment.
- Between September 2015 – December 2015 98.3% of patients with suspected breast cancer were seen in two weeks by a specialist following referral by their GP. The figures for blood malignancies including leukaemia were 100%, 93% for head and neck cancer, 100% for upper gastrointestinal, 93% for sarcoma, 96% for urological cancers (not including testicular).
- There were 188 delayed transfer of care in the trust (number of delayed bed days, Jan'15 – Dec'15). The majority of these (55) were waiting further NHS non-acute care, whilst 52 were awaiting care packages to be provided in their own home. Patient or family choice accounted for 48 delayed transfers of care whilst 28 were awaiting a nursing home placement or availability. The remaining five were awaiting referral completion or equipment.

Well-led

- NHS Staff Survey 2015 reported 19 positive findings and one negative. The latter related to staff working additional hours over and above their expected hours. The trust score was 78.3%, with an England average of 73%.
- The trust reported sickness absence rates which were consistently lower (better) than the England average between June 2012 and September 2015.
- The trust performed worse than expected for three measures on the GMC Training Scheme (2015). They were below outlier for having a supportive environment, and receiving feedback. With regard to doctors in training induction, the trust was within the lower quartile. The remainder of measures were within expectations.

Summary of findings

Our judgements about each of our five key questions



	Rating
Are services at this trust safe?	Good

Are services at this trust safe?

We rated the trust as good for ensuring that patients were protected from the risk of harm because:

- There were systems in place for incident reporting and in the majority of cases, staff received feedback. Action was taken to reduce the risk of reoccurrence.
- The requirements of duty of candour were followed and trust processes were open and transparent.
- There were appropriate policies and procedures in place to support staff in recognising and reporting signs of abuse.
- When staffing levels fell below planned levels this was proactively managed in the majority of cases. The trust acknowledged and was responding to an increasing nurse vacancy rate within community services.

Duty of candour

- The trust was aware of its obligations in relation to the duty of candour requirements.
- There was a policy in place to guide and support staff in following the requirements of the duty of candour regulations. Staff were aware of the "Being Open and Duty of Candour" policy and were able to signpost inspectors to the relevant policy.
- Incident records reviewed during the inspection clearly indicated where staff had followed the necessary guidance, including records to affirm any initial discussions with the patient or relevant persons, any advice or support offered and confirmation of a written apology being provided to the patient, as well as any supporting information including investigation outcomes.
- The trust utilised the incident reporting management system to record and monitor any notifiable safety incidents which invoke the duty of candour regulations. We observed examples of this in practice.
- Reference to the requirements of the duty of candour was made in the quarterly integrated governance monitoring report which was publicly available.
- The trust audited compliance with the requirements of the duty of candour regulations and local "Being open and Duty of Candour" policy. Between 1 July and 31 December 2015, 45 incidents that resulted in moderate harm or above were

reviewed as part of the most recent audit. Results were compared with those from the previous audit from January to June 2015. Improvement included an increase in recording the number of patients being informed of an incident from 85% to 93%.

- There had been an increase in the number of patients offered a written apology from 38% between January and June 2015 to 88% between July and December 2015.

Safeguarding

- The chief nurse was the executive lead for safeguarding. All safeguarding and vulnerable adults' activity was overseen by the vulnerable adult working group.
- Staff were able to describe situations in which they would raise a safeguarding concern and how they would escalate any concerns.
- The trust had appropriate safeguarding policies and procedures were in place for both adult and children. The policies and procedures were supported by staff training.
- Oversight of trust-wide safeguarding arrangements was by way of regular quarterly reports to the integrated governance committee. Section 7 of the integrated governance monitoring report clearly set out the number of safeguarding concerns raised within the trust including summative information on the category of abuse. The majority of safeguarding concerns related to the pressure ulcers. Twice monthly pressure ulcer review panels existed to review complex cases where pressure ulcers were attributable to the trust.
- As of March 2016, 93% of staff had received training in level 1 adult safeguarding and 95% in level 2 adult safeguarding.
- 89% of staff had received level 1 child safeguarding training; 88% level 2 training and 83% of applicable staff had received level 3 child safeguarding training. The training compliance rates for each level of child safeguarding was marginally lower than the trust target of 90% for 2015/2016.
- During 2015/2016, 57% of school nurses and 75% of health visiting staff had received one to one supervision. The trust acknowledged a number of contributing factors in regards to the lower than expected supervision rates including significant organisational change due to the re-commissioning of Merton community health services to a third party; long term sick leave of staff members and sick leave of supervisors.

Summary of findings

Incidents

- Between July 2014 and June 2015, the trust reported 3,454 incidents to the national reporting and learning system (NRLS). 1,962 incidents resulted in no harm; 1,365 resulted in low harm; 101 resulted in moderate harm and 1 resulted in severe harm or death.
- The trust reported more incidents per 100 admissions when compared nationally (11.1 incidents per 100 admissions versus 8.4 nationally). This may be an indicator of a positive incident reporting culture within the organisation, especially when factoring in the number of no harm incidents reported.
- The trust had reported no never events between February 2015 and January 2016.
- Between January 2015 and February 2016 25 serious incidents were reported by the trust. Of these 20 were related to pressure ulcers. 16 cases or pressure ulcers were attributable to community health services, of which 10 were recorded as grade 3 ulcers and 6 were recorded as grade 4. During this time period, seven incidents occurred within Merton community health services; as of 31 March 2016, the trust ceased providing community health services within the London Borough of Merton.
- In the 2015 NHS staff survey, the trust was rated in the top 20% of all NHS trusts for:
  - Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month
  - Percentage of staff reporting fairness and effectiveness of procedures for reporting errors, near misses and incidents.
  - Percentage of staff reporting a high level of confidence and security in the reporting of unsafe clinical practice.
- The trust was rated about the same as other trusts in the 2015 NHS staff survey for the key question:
  - Percentage of staff reporting errors, near misses or incidents witnessed in the last month.

Staffing

- The trust reported staff vacancy rates on a quarterly basis within the integrated governance monitoring report. The trust target for staff vacancy was set at 5%. The total trust vacancy rate for quarter 4 of 2015/2016 was 6.3%; this was an improving trajectory when compared to quarter 2 and quarter 3 performance.
- Community services consistently flagged as a rag rating of red for staff vacancy with quarter 4 reporting a turnover rate of 16.5%. It was noted that staff vacancy within community

services was increasing, having been 10.2% in quarter 1 of 2015/2016. The executive team attributed to the high vacancy rate in part to the dis-aggregation and transfer of some community services to a third party at the end of March 2016.

- The overall nurse vacancy rate as at the end of quarter 4 for 2016/2017 was 11.7% with the highest vacancy rate noted within community nursing services at 20.6%. Nurse vacancy rates for a part of the community services risk register. Staff were seen to be proactively prioritising community patients to ensure that those with the most complex needs were seen first and by the most experienced members of staff.
- The GMC staff survey for 2015 identified the trust as being within the middle quartile for workload.
- In the 2015 NHS staff survey the trust performed in the top 20% for the following percentage of staff feeling pressured in the last 3 months to attend work when feeling unwell.
- The trust performed about the same as other trusts in the 2015 NHS staff survey for the percentage of staff reporting work related stress in the last 12 months.
- The trust performed in the bottom 20% of trusts in relation to the percentage of staff working extra hours. The majority of staff working within adult community services reported that they would rather work additional time to ensure that patients were seen and treated within expected time frames; this was acknowledged by the community management team.

Are services at this trust effective?
Evidence based care and treatment

Good

- Staff were aware of National Institute for Health and Care Excellence (NICE) guidance relevant to their specialty and we saw they had access to the guidance via the trust's intranet.
- Local protocols were in place in line with NICE guidance. In particular we found there were well written protocols and pathways for use in many services which were followed by staff.
- Integrated care pathways were also used to ensure adherence to national guidance.
- Many clinical specialities were responsible for and engaged in the development of national and international clinical standards.
- The trust was a founding member of the London Cancer Alliance, an integrated cancer system working across South and West London. The LCA was clinically led and was responsible for setting clinical standards and for establishing care pathways to ensure patients received evidence based care and treatment.

Summary of findings

- Robust procedures existed for ensuring that existing guidance and clinical protocols were updated routinely to reflect current best practice. For example, the Integrated Governance and Risk Management Committee considered 40 items of guidance published by the National Institute for Care and Health Excellence to determine whether they were relevant to the provision of care at The Royal Marsden NHS Foundation Trust; 12 guidance documents were considered relevant.
- Where national alerts were issued, there were procedures in place to ensure trust policies were updated. For example, staff involved with intrathecal chemotherapy had to use the trust policy in conjunction with the national guidance HSC 2008/001 and the rapid Response Report NPSA/2008/RRR004 relating to intravenous vinca-alkaloid administration.
- The trust had an established and accredited research trials programme and worked in partnership with national partners including the Institute of Cancer Research which was co-located at the Royal Marsden Sutton campus.
- At the time of the inspection, the trust was leading on 33 clinical trials to develop best practice for radiology. In addition, the trust was leading the cancer element for 100,000 Genomes project.
- Where care or treatment was recommended by clinical teams which deviated from standard care protocols, staff were required to complete deviation forms; this was especially applicable to patients receiving care under the haematopoietic stem cell transplant unit (HSCT) which was accredited with the Joint Accreditation Committee of the International Society for Cellular Therapy and the European Group for Blood and Marrow Transplantation (JACIE). The HSCT service was first JACIE accredited in 2009, and had last undergone a re-accreditation inspection in October 2013. At the time of the inspection, the service was undertaking a document review to ensure the trust was compliant with the latest JACIE quality standards.
- In response to the withdrawal of the Liverpool Care Pathway, the trust had piloted a new end of life care document "Principles of Care of the Dying" which was based on the "One Chance to get it Right, 2014" care standards. Subsequent to the introduction of the new care document, the trust had reported improvements in regards to discussion regarding hydration, preferred place of care and preferred place of death. The documentation of spiritual needs had improved from 43% to 100% since the document had been introduced. There were

concerns however that patients could sometimes experience delays in being referred for end of life care support because of a curing culture within the organisation which was appropriate in all cases.

- Many policies were based on the Royal Marsden Hospital Manual of Clinical Nursing Procedures, 2015.
- The trust utilised audit processes for ensuring compliance with policies and procedures. It was noted that performance and compliance against the Sepsis Six care bundle had improved significantly between quarter 2 2015/2016 and quarter 4 2015/2016. The checking of lactate had increased from 41% in Q2 to 78% in Q4; antibiotic delivery within an hour had also increased from 41% in Q2 to 94% in Q4.

Patient outcomes

- There were no active CQC mortality outliers for the trust.
- The chemotherapy service held an ISO9001:2008 quality accreditation and was assessed by an external auditor from the British Standards Institute (BSI) twice a year. The ISO chemotherapy committee had monitored and discussed waiting times.
- The radiotherapy quality management system had been accredited by the British Standards Institute since 1997 and was re-accredited for a further three years in March 2015. As part of the radiotherapy ISO 9001:2008 certification a programme of internal audits needed to be completed, along with audit reports.
- Endoscopy services had attained accreditation with the Joint Advisory Group (JAG) in 2015.
- Research facilities including the Phase 1 clinical trials unit was registered with the Medicines and Healthcare products Regulatory Authority (MHRA) and had last been assessed for compliance shortly prior to this inspection.
- Children's services were Unicef friendly baby accredited to level 3.
- The trust was working on attaining accreditation with the Imaging Services Accreditation Scheme (ISAS) for its imaging and radiology services.
- The Stem Cell Transplant Facility was licensed by the Human Tissue Authority.
- With the Royal Marsden method of analysis, chemotherapy was started by 1,281 patients in Quarter Four (January to March 2016). Of these patients, 78 (5.7%) died in the 30 days after receiving chemotherapy. Over the eight-year monitoring period there has been a 2% decrease in the number of patients dying in the 30-day period.

- Fifty-three stem cell transplants took place in Quarter Three (October to December 2015). No patients died in the 100 days following transplant.
- Of the 2,564 patients who had surgery or anaesthesia in Quarter Four (January to March 2016) eight (0.4%) died in the 30 days following surgery or anaesthesia.
- An audit conducted between October and December 2015, the trust found 43 of the 51 (84%) patients who died were referred to and seen by the specialist team before their death. However, of these 43, only 8 (16%) patients were referred to the specialist team more than one month before death. There was a feeling amongst many staff that we spoke to that referral to the team could be made earlier in the patient pathway in some cases. Staff were of the opinion that this was due to the specialist nature of the hospital and the type of treatments offered, which often were the last line of treatment available. Patient expectations were focused on cure and conversations about dying could be difficult to instigate. This had been identified as an area for improvement by the trust and an improvement work stream was scheduled to commence shortly following the inspection.
- Patient mortality was significantly lower than the national average of 3.5%, at less than 0.5%. For patients with haematological malignancies, the average mortality rate was 34% compared with the national average of 43%.
- The critical care unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant the outcomes of care delivered and patient mortality could be benchmarked against critical care units nationwide. The latest published data at the time of our inspection related to patients in the unit up to September 2015. Between September 2014 and September 2015 less than 2% of patients were readmitted within 48 hours, which was better than the national average.
- Staff contributed to the EuroQol Research Foundation EQ-5D health questionnaire that measured patient outcomes after medical treatment. After three months and use of the follow-up clinic, 72% of patients reported an overall good quality of life.
- Within community services, staff did not consistently use outcome measures to monitor and outcome a patient's progress; for example, key outcome measures such as the Braden Assessment of pressure ulcer risk and nutrition scoring.

Multi-disciplinary working

- There were excellent examples of multi-disciplinary working to secure good outcomes. For critical care services, a daily multidisciplinary ward round took place each morning. This

was attended by critical care clinicians, physiotherapists, a dietitian, a pharmacist and a speech and language therapist. The daily ward round was supplemented by a substantive weekly meeting, which included the Sutton site by video-link. The acute oncology service, palliative care team, microbiologist and occupational therapist additionally contributed to this meeting.

- A critical care multidisciplinary team led a weekly rehabilitation ward round, including physiotherapists, occupational therapists, a pharmacist, a dietitian and a massage therapist. A clinical psychologist was dedicated to critical care and could join this ward round when needed.
- Members of the specialist end of life care team participated in multidisciplinary team (MDT) meetings and worked with other specialists to provide good quality EoLC across clinical specialities. A weekly specialist MDT meeting was held at the hospital. Members of the MDT included consultants, doctors, clinical nurse specialists, discharge co-ordinator, physiotherapists, occupational therapists and a chaplain.
- There was a strong culture of multidisciplinary working within the chemotherapy service. Multidisciplinary teams (MDTs), based on tumour types, decided patient eligibility for systemic therapies (chemotherapy). All new patients were assessed in an MDT. Case review meetings were also held.
- There were separate MDTs for patients with cancers of unknown origin in line with NICE guideline CG104(February 2014).
- We attended some MDTs. Attendance was monitored and recorded to ensure meetings were quorate. Videoconferencing was used with the trust's Sutton hospital. Investigations were decided and outcomes were recorded live. Although there was good multidisciplinary attendance (Pathologists, Clinical Nurse Specialists, Consultants and Junior Doctors), in those we observed there was not always a clear MDT lead, and many attendees did not actively participate in discussion.
- Clinical pharmacists were well integrated into the multidisciplinary team that facilitated effective and efficient delivery of care and design of treatment pathways, for example: they led in design of clinical trials and treatment protocols, pharmacy research and the medicines safety agenda in the Trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff explained procedures for gaining consent from patients before providing care and treatment.

Summary of findings

- The trust had a policy in place that detailed the procedures for obtaining consent. This included the process for obtaining consent, recording and responsibilities.
- Clinical staff had a good understanding of mental capacity issues and were able to describe the process they followed to assess a patient's capacity to make decisions or to be involved in decisions.
- A wide range of regimen specific consent forms clearly listed the potential risks and their likelihood for each treatment regimen. For example, the information explained that 10 in 100 patients might experience a specific side effect but that other side effects might only be experienced by one patient in 1000. The consent forms also listed rarer side effects and toxicities. Staff gave all patients a copy of their signed consent forms and scanned these into patient records.
- There were separate arrangements for asking patient's consent for storing tissue samples and for research and clinical trials, for example of new and approved types of chemotherapy. These were governed by the trust ethics committee.
- Community nursing managers told us they each had over 300 allocated cases per team and some patients would have health conditions that meant they might have fluctuating capacity or be unable to consent. Over 50% of staff we spoke with said they had never completed the trusts best interest paperwork because there was no need. One told us it could not be completed online and they had to print a copy and complete it manually which all took time. Several staff did not know where to find the form and said they never used it.
- Staff said they would consult other family members if concerned and do what was in the best interest for the patient. They told us they did not record them as best interest decisions on trust paperwork or record them on the electronic patient record.
- Discussion at the vulnerable adults working group (December 2015) highlighted similar issues and confirmed what staff told us. For example: "staff have anxiety over MCA (Mental Capacity Act) they escalate to the GP when it's a best interest as it is very difficult and also takes a long time to assess and the Community Nurses are very stretched and don't have the time". Whilst it had been noted in the minutes there was no action plan in place and it was not on the community risk register.
- We looked at the patient electronic record (PER) of 13 patients receiving community based care. 70% did not have consent for care recorded. Three records had identified a preference as to who information could be shared with. Staff told us consent to care information would be written on the patients paper

records in their own home. We looked at eight paper records in patients own home. Consent had not been signed by patients in six out of eight records. Trust policy on consent stated that patients must give consent to treatment and this must be recorded on their records.

Are services at this trust caring?

Outstanding

We rated caring as outstanding because:

- Feedback from patients and their relatives was consistently positive about all aspects of their care. All staff consistently communicated with patients in a kind and compassionate way and treated them with dignity and respected their privacy.
- We observed and were told of many examples of staff at all levels going the extra mile to meet patients' needs.
- We observed a commitment to providing care that was of a consistently high standard and focused on meeting the emotional, spiritual and psychological needs of patients as well as their physical needs.
- Staff were committed to placing the patient at the centre of their work; this person-centred culture was visible across the trust.
- Staff went out of their way to ensure the atmosphere within the trust was one which promoted calm and reassurance.

Compassionate care

- In the Cancer Patient Experience Survey 2013/14 the trust was in the top 20% of trusts for nine out of 34 indicators, bottom 20% in four questions and the middle 60% for the other 21 measures.
- The trust ranked among the best for eight questions and "about the same" for the remaining four areas.
- Patient-led assessments of the Care Environment (PLACE) were better or equal to the England average for all domains at Chelsea and for three of four domains for Sutton.
- The trust's response rate and scores to Friends and Family Test (FFT) was consistently above the England Average between January and December 2015.
- In Q4 2015/2016, 337 letters of praise were received by the Head of Legal Services, Complaints, Patient Advice and Liaison Service (PALS) and Patient Information.
- In a 2015 LCA survey, 156 patients (100%) rated their care as excellent or very good across both radiology departments.

- In the LCA experience study across both radiology departments, 88% of patients questioned said their dignity and privacy was maintained when they were getting changed in the treatment room. This was the highest percentage across the four providers surveyed.
- Clinical staff followed the Sage and Thyme model, developed in 2006. The model was designed to show staff of all grades, how to listen and respond to patients who are distressed and concerned.

Understanding and involvement of patients and those close to them

- Patients receiving end of life care had the opportunity to discuss their wishes for their future in terms of resuscitation, preferred place of death at end of life and decisions to refuse treatment.
- Patients reported staff going out of their way to find out information for them; explaining everything clearly, listening and answering questions. They said they were fully involved in decisions about their care and treatment and knew how to access advice and, if necessary, emergency care.
- Patients we spoke with told us they were given adequate information about the part of the radiotherapy pathway that applied to them. In the LCA survey, 98% of patients said the information given on the first day was excellent across both departments.

Emotional support

- Counselling support was available for all patients and offered at pre-assessment and throughout the patient's treatment. Staff at pre-assessment, set aside time for discussion of patients emotional needs. Psychological care and counselling services were available however this was a service, which was under significant pressure due to limited staff numbers. If patients became upset during pre-assessment appointments, the Psychological Support Team was able to respond.
- A chaplaincy service and multi faith prayer rooms were available for patients and relatives 365 days a year. Patient's pastoral needs were responded to quickly.
- Supportive therapies were available for patients. Some examples included acupuncture, art therapy, wig and hair loss advice, massages, reflexology and yoga. Usual referral for these services was through the outpatient department.

- Support groups were offered and information was given to patients. Groups such as living well after surgery with oesophageal and gastric cancer, the sarcoma support group and pre-transplant relatives coffee morning were available to patients and relatives.

Are services at this trust responsive?
Service planning and delivery to meet the needs of the local people

Good

- The Royal Marsden NHS Foundation Trust was a registered Vanguard provider. Vanguard providers will take a lead on the development of new care models which will act as the blueprints for the NHS. The NHS England vision for vanguard sites such as this is that they will make health services more accessible and more effective for patients, improving both their experiences and their outcomes.
- The strategic plan for the trust included the development of new models of care including RM@ franchise operations and the development of hospital chains or networks, led by the Royal Marsden. In addition, the trust reported that as part of the Vanguard initiative, a system wide redesign of whole patient pathways would be considered in order that care could be more localised where possible to ease access for patients but to centralise services where necessary to improve quality and value for money.
- The executive team acknowledged the opportunities that being a combined health provider brings. The executive team spoke of the opportunities to develop integrated models of care across acute, community and home care provision to help improve both efficiency and patient experience.
- The trust acknowledged the need to increase existing capacity at the Chelsea site in order to accommodate current and future demand for services which was partly linked to a decision to modernise services across the trust, resulting in a reduction of bed stock by some 30%. The trust further acknowledged the need to modernise both the inpatient and outpatient facilities on the Sutton campus which had already commenced with some £140 million of capital funding secured to improve the infrastructure and redevelopment of the campus through the "Sutton for Life" initiative.
- The integrated community teams offered a range of services dedicated to treating patients needs that included prevention of admission and the Crisis intensive discharge service as part

of the “unplanned” care pathway. The services were able to provide a range of different treatments and therapeutic interventions including rehabilitation therapies and intensive home support.

- The Hospitals2Home service recently expanded its reach in order to meet needs of people outside the M25 by providing telephone consultations to local agencies to handover care more effectively. Face-to-face consultations were already offered to those living in the local area. Although this service managed mostly patients from the outpatients department, wards were also able to refer more complex patients.
- Between October and December 2015, 51 patients died in hospital (across both sites). Of these patients, 29%(15) had chosen the Royal Marsden as their preferred place of death (PPD). No patients died at the Royal Marsden whilst fit for transfer and waiting for a hospice or continuing care bed.
- Clinics were organised so that patients could access services together for example breast and plastic surgery clinics were organised on the same day. Testicular cancer and urology clinics were run as joint clinics.
- The rapid diagnostic assessment centre (RDAC) provided a rapid diagnostic service for breast, skin and urology cancers. Some patients received a diagnosis on the day, other patients who required more tests or investigations would be contacted with their results quickly once the results were available.
- An outpatient clinic utilisation model was being developed to match the level of clinical activity with staffing and clinic spaces.

Meeting peoples individual needs

- Information was available to patients to inform them about the trust’s general services and to support them in their treatment. Translation services were available to those that required it.
- On the Chelsea campus, Arabic was the second most common language spoken by patients and their relatives. To facilitate better communication, publications were available in Arabic and an interpreter was available on-site Monday to Friday from 9am to 5pm. This service was due to become six days per week. Translators were trained in medical terminology and were able to attend ward rounds and handovers. Staff also had access to communication cards to aid them with communication.
- The Speech and Language Therapy team provided specialist assessments for patients who experienced communication difficulties.
- There was a dedicated dementia-friendly bed bay in the Chelsea critical care unit. This bed bay had adapted lighting,

dark blue curtains and flooring to reduce sensitisation and improve orientation amongst patients with dementia. It also had large clocks to help patients orientate themselves to the time of day. The clocks were an innovative addition to the unit following a successful trial led by the safeguarding and vulnerable adult service improvement group (SIG).

- Staff used a blue butterfly symbol on the patient notice board to discreetly highlight where a patient had additional needs such as a language barrier, communication problem or those identified as living with a form of dementia.
- Patients with learning disabilities received a ‘passport’ during their pre-assessment visit to the critical care unit. This provided easy-to-read information on what to expect during their stay and who would help them.
- Ward staff moved patients at the end of life to side-rooms whenever possible to provide privacy with their family and friends. Relatives were able to stay overnight to spend time with their loved ones at the end of life.
- The hospital ensured the faith needs of its patients were met. The chaplaincy team provided spiritual support for different faiths. The team was supported by a range of pastoral volunteers and an extensive network of connections with faith leaders from other religious traditions who visited patients of other religions if required.

Access and flow

- In the 12 months prior to our inspection, the average occupancy of the Chelsea critical care unit was 64%.
- During the same period, there were no out of hours discharges from the critical care unit. This was significantly better than the national average of up to 9%. The unit performed significantly better than the national average for delayed discharges between September 2014 and September 2015.
- The critical care team worked with theatres to plan activity one week in advance. As a result, there were no elective surgical cancellations due to a lack of critical care bed capacity in the 18 months prior to our inspection.
- Medical teams at the Chelsea and Sutton sites worked collaboratively to a ‘treat and transfer’ model of care for patients admitted at the Sutton site. A resident anaesthetist was always available at the Sutton site and communicated with the Chelsea team using video link to establish a timeline for transfer if needed. A critical care consultant was always on-call for both sites and was available within 30 minutes if needed to accompany a transfer. The average length of stay in the Sutton unit was 15 hours.

Summary of findings

- The Hospital2Home team supported the discharge of patients from active anti-cancer treatment at the hospital. Although the service mainly took referrals from outpatients, inpatient referrals would be considered for patients with particularly complex needs. The service was established as it was felt the impact of not being offered further active treatment could leave patients feeling isolated. After discharge, the team set a meeting as soon as practicable with the team taking over patient care. This would generally last around an hour and could include the patient's GP, district nurses, the community palliative care provider and social services, for example.
- Rapid discharge protocols and processes were seen to be effective in getting patients to their preferred place of care prior to dying. Rapid discharge was mostly next day and in some cases had been arranged within the same day.
- Referral data showed the Chelsea outpatient service consistently met the two-week wait referral standard for breast cancer including symptomatic referrals.
- Blood test (phlebotomy) services opened at 8am ahead of the main outpatient department so that patients could have their blood tests prior to consultations. The results were reported back electronically to staff in the clinics so the results could be discussed with medical staff.
- We visited the Chelsea outpatient's department on one of the busiest clinic days. The waiting area was very busy to the extent that patient's knees were touching as they sat waiting to be called for their appointment. We noticed taller patients were unable to sit comfortably due to a lack of space. We spoke to managers about this and they said they had done their best to re-organise the space they had available, and that previously patients and relatives sometimes had to sit on the floor because there were no chairs available. They had re-organised the waiting area in response to the feedback received from patients. A separate waiting area had been created re-using a clinical room, as awaiting area for head and neck cancer patients.
- A rapid access diagnostic assessment centre (RDAC) had been developed to provide a rapid diagnostic service for breast, skin and urology cancers. It enabled patients to access examinations, diagnostic tests and a variety of health professionals at one appointment. Patients we spoke with spoke with were very impressed by the one-stop clinics. Patients referred to the Rapid Diagnosis and Assessment Centre were seen within the urgent two week wait for suspected cancer.

- Operational standards are that 95 percent of patients treated as outpatients should start consultant-led treatment within 18 weeks of referral. The latest figures available for the whole of The Royal Marsden NHS Foundation Trust including Sutton and Chelsea for the final three months of 2015-2016 showed 96.3% of all patients started treatment within 18 weeks, achieving the operational standard.
- 50% of patients started outpatient treatment within two weeks. Operational standards were that 95 percent of non-admitted patients should start consultant-led treatment within 18 weeks of referral. 19 out of 20 patients commenced outpatient treatment within nine weeks, which meant the trust were meeting the operational standards.
- The percentage of patients with suspected breast cancer seen in two weeks by a specialist following referral by their GP during the three months between September 2015 and December 2015 was 98%. The figures were similar for the preceding six months prior to September 2015. The figures for blood malignancies including leukaemia were 100%, 93% for head and neck cancer, 100% for upper gastrointestinal, 93% for sarcoma, 96% for urological cancers (not including testicular).
- The percentage of patients who completed their treatment within 62 days of referral during the three months from September 2015 to December was 100%for breast, 57.1% for lung, 55% for urology (not including testicular), and 100% for skin. There was wide variation in the figures for the preceding six months from March 2015 to September 2015. For example, the percentage of patients who completed treatment for breast cancer improved from 83% to 100% and from 50% to 100% for patients with a skin condition whilst the figure for lung cancer improved from 28% to 80% reducing to 50% in the three months between September and December 2015.
- The trust had taken a number of steps to reduce the number of breaches in achieving the national standards for referral to treatment times. All breaches were reviewed at a breach meeting, which was convened to identify the cause and take corrective action.

Learning from complaints and concerns

- Information on the hospital's Patient Advice and Liaison Service was readily available and the service had an office on-site that people could visit for advice.
- Staff on the wards we visited were able to explain the process should a query or concern be raised. The person would be directed to the PALS office.

Summary of findings

- Oversight of complaints was by way of the integrated governance and risk committee. Themes from complaints, lessons learnt and actions plans were considered by the complaints team. Complaints were, in the main, divided in to four categories; communication, clinical issues, attitude and delays. Consideration was given to continuing or evolving themes or trends in order that senior managers could conduct service-level reviews as required.
- Outcomes of complaint investigations were redacted and placed into the public domain by way of the integrated governance monitoring report. Summaries of complaints included the nature of the complaint, any action taken and the outcome of the complaint i.e. whether the complaint was upheld, partly upheld, or not upheld.
- Between January 2015 and December 2015, the average length of time taken by the trust to process and award an outcome of a complaint was 42 days. In the same time period, 118 complaints were received by the trust, of which 39 were upheld, 66 were partly upheld and 12 were not upheld. 1 complaint remained open at the time of CQC requesting the information from the trust.
- As part of the inspection we reviewed 5 randomly selected complaints and associated documents. We considered that in each case, there was evidence that support had been provided to the patient; complaints were risk assessed based on the trusts local policy; there were consistently high levels of investigation carried out in each case; records were up to date and there was evidence of a documented outcome and associated actions.

Are services at this trust well-led?

We rated the trust as good for being well-led because:

Good

- The trust had a clear vision and strategy in place which could be described by both executive and non-executive directors and by staff working throughout the trust.
- Governance and assurance frameworks were, in the main, sufficiently robust to ensure the board had oversight of quality and risk at ward level. Some improvements were necessary to ensure that there was sufficient oversight of quality within community based services.
- The trust had a stable and visible leadership team whose priority was to drive high quality, harm free care.
- The culture amongst staff across the trust was aligned to the sixteen key values of the organisation.

- The trust had considered the changing landscape and complexities of providing specialist cancer and community based care and was working towards implementing new models of care which were sustainable.

Vision and strategy

- The vision for the trust was clearly articulated by the majority of staff we spoke with during the inspection. There was however some ambiguity amongst staff working in the community setting with regards to the future and vision of community services hosted by the Royal Marsden, and this was likely attributable to the recent move of community services within the London Borough of Merton to a third party provider.
- The Royal Marsden NHS Foundation Trust had a set of values which executive staff reported as being the foundation on which the organisations' reputation was based and was personified by staff across the trust. The 16 values were developed by staff from across all staff groups and departments within the trust and included:
- Characteristics (What we are):
  - Pioneering
  - Knowledgeable
  - Aspirational
  - Driven
- Attitudes (how we act):
  - Determined
  - Open
  - Confident
  - Resilient
- Relationships (relating to others)
  - Collaborative
  - Trusted
  - Supportive
  - Personable
- Emotions (how we feel)
  - Compassionate
  - Calm
  - Positive
  - Proud
- Through our observation and discussions of and with staff during the inspection, and through comments made by patients receiving care, it was apparent that staff across the trust were committed to the values of the Royal Marsden.
- The five year strategic plan 2014/15 - 2018/19 clearly set out the four key strategic themes which the trust were focused on. The trust recognised the need to become financially sustainable

whilst continuing to provide value for money; to modernise the infrastructure from which healthcare was provided; to implement new models of care so that care was more localised to people however centralised where essential and to focus on innovation and precision medicine.

- The trust acknowledged the importance of being a combined health provider, and so there was a focus on enhancing the opportunities that such an arrangement offered. There was a focus on transforming existing arrangements with regards to the early diagnosis of cancer, whilst also re-designing the existing cancer treatment pathways across London in order that services could become more readily accessible to service users, and in a timely way. Through the use of General Practice education days, there was a focus on enhancing the knowledge base of primary care physicians in order that cancer could be more easily diagnosed or recognised within the primary care setting as compared to a diagnosis being made when a patient presented to an emergency department.
- The trust had a robust estates strategy which included the redevelopment of some components of the Sutton site, through the "Sutton for Life" initiative. The executive team were well appraised of the clinical and support environments which required remedial works to ensure care could be provided in an appropriate setting.
- The trust had a Quality Strategy in place which had been refreshed in 2015 and was a five year improvement programme. The focus of the strategy was to outline the approach the trust was taking to ensure that it became "A learning organisation continuously striving to improve practice, safety, outcomes and experience across all areas of the Trust". The Quality Strategy had five pillars on which it was based:
  - Culture of continuous quality improvement
  - External accreditation/regulation of services
  - Recruit and retain the best staff, continued professional development
  - Harm free care - and learning from incidents
  - Data for improvement/audit

Governance, risk management and quality measurement

- A range of committees provided assurance to the board including the Quality, Assurance and Risk Committee, Audit and Finance Committee and the Executive Board. With the exception of the executive board, Non-Executive Directors chaired these committees and formal reports were submitted to the trust board on a regular basis.

Summary of findings

- Each board committee was supported, and received information from a range of sub-committees including the integrated governance and risk management committee which in turn considered information from some 22 different steering groups and committees. The trust had eight corporate steering groups including the Equality, Diversity and Inclusion Steering Group, Workforce and Education, Research Executive and the Performance Review Group.
- In addition to the clinical and operational steering committees, the trust board also received advice and guidance via some six advisory committees including the Medical Advisory Committee, Nursing, Rehabilitation and Radiography Advisory Committee and the Patient Experience and Quality Account Group.
- The Integrated Governance and Risk Management Committee produced a publically available summary of all information it had received and considered on a quarterly basis.
- It was acknowledged through a board self-assessment, conducted by board members in February 2016 that further improvements could be made to the board sub-committees to ensure that there was appropriate interaction and exchange of information across sub-committees. Additionally, it was noted that chairs of board sub-committees should consider a periodic assessment to determine the effectiveness of the committee for which they were responsible for chairing.
- There was a Board Assurance Framework in place which had been refreshed in January 2016. The BAF was linked to the four over-arching strategic objectives of the organisation, as set out in the five year strategy of the Trust. Assurance scores were awarded to each of the sixteen sub-objectives for 2015/2016 which were linked to the umbrella strategic objective. Five objectives had been rated as red (minimal assurance of objective being delivered); ten rated as amber (medium assurance) and one rated as green (high assurance). Control measures were in place, as well as identified gaps in both controls and assurance processes. Discussion of the board assurance framework was noted within board papers. Executive leads had been identified as responsible directors for the delivery of each objective.
- Corporate and operational risks were recorded on the corporate risk register. Executive members were aware of the risks to which they were the assigned accountable officer and could describe the actions and mitigations being taken to manage recognised risks. The corporate risk register was

considered on a quarterly basis via the Quality, Assurance and Risk Committee. Risk registers were held at a local level by each division and there was a clear process for escalation of risk across the organisation.

- The trust had a well-established governance framework which was used to support the delivery of harm free care and to provide assurance from "Ward to Board". The Board and Council of Governor's, considered, on a quarterly basis, a balanced score-card which was set out in to six streams of data:
    - Patient safety, quality and experience
    - Finance and efficiency
    - Clinical and research strategy
    - Workforce
    - Monitor community measures
    - Staff friends and family test
- The board had conducted a board self-assessment in February 2016; this was presented at the open board in March 2016. The summary of the self-assessment concluded that "Board members demonstrated a positive response to most aspects of Board function and performance". A small number of board members indicated a Red or Amber rating (60% amber and 20% red) against the standard "Board members feel supported in their role through an effective training and development programme". It was noted that comments included "No systematic training occurs". It was acknowledged within the report that whilst an induction was provided, a more formalised process would have been welcomed. Following the self-assessment, the board had devised a five point action plan for 2016/2017 to address areas of comment and concern raised within the self-assessment.
- The trust had an internal audit programme and a clinical audit programme set for 2015 – 2016. The Integrated Governance and Risk Committee received quarterly reports on progress against the audit programme.
- At the March 2016 Open Board, the board were asked to consider the outcome of the most recent National Quality Board Safer Staffing report. A review of staffing was carried out at the Royal Marsden in December/January 2016. The trust sourced external support to conduct a review of dependency and acuity of patients against staffing levels using the nationally recognised Association of UK University Hospitals dependency assessment tool. The initial report concluded that "The Royal Marsden is on the whole well-staffed; the Trust is particularly well staffed in Band 6 RNs which may be due to the nature of the specialist and complex care that is required". The report considered clinical outcomes and key performance

indicators as an additional source of monitoring to ensure wards were suitably staffed. Whilst the report was focused on ward based care and that the board was minded to consider the fact that the trust was also responsible for providing sufficient numbers of staff within hard-to-recruit areas including community, critical care and theatres. Additionally, the board were asked to consider the specialist nature of the work conducted at the Royal Marsden and the need for the trust to adopt a proactive and timely response to changes in patient dependency. The trust had therefore introduced mitigations including twice daily safety huddles across the trust, pro-active reviews of staffing rotas as well as the Chief Nurse chairing a monthly Nurse recruitment group.

Leadership of the trust

- There was a well-established senior executive team; staff reported that the team were highly visible with high quality care seen as the driving motivation of the executive and the board. The Chief Executive and Chief Nurse were held in high regard by all staff we spoke with.
- There was a balance with regards to the tenures of those individuals who formed the executive board with some individuals having been in post for 18 years (CEO), whilst also conversely, there were new appointments including the medical director who had taken up post some three months prior to the inspection.
- The Chair had been in post for six years and was supported by Non-Executive Directors who had also been in post for longer terms as well as those recently appointed, within the last two years.
- There was a high level of clinical engagement across the organisation; this engagement came not only from doctors, but also from nursing staff, laboratory staff and allied health professionals including pharmacists, speech and language therapists, physiotherapists, radiographers and dieticians.
- In the 2015 NHS Staff survey, the trust was in the top 20% of all trusts for the percentage of staff who reported good communication between senior management and staff; effective team working; recognition and value of staff by managers and the organisation.
- In all of the teams we visited we found that most staff felt proud of working for the trust and were positive about their work. Managers spoke openly about the challenges with recent restructuring in community services and were positive about their ability to fully support the trust to improve the quality of services.

- Local leadership was praised by staff as visible, accessible and responsive.
- Each clinical division had a triumvirate leadership team, which had the clinical Chair as the person with overall accountability and responsibility for their division.
- The trust had built very good working relationships with their Council of Governors, with clarity about roles and purpose, so that governors contribute significantly to the success of the trust. The quality strategy for 2015-2019 recognised the importance of further enhancing the role of the Council of Governors through the use of supported ward clinical quality ward visits as an example.

Culture within the trust

- Staff we spoke with demonstrated a commitment to the delivery of high quality, harm free care. Staff told us they felt proud of the care they were able to give.
- The trust was rated in the top 20% of all trusts in the country in 17 of the 32 questions within the NHS staff survey for 2015. The trust had one key question ranked in the bottom 20% of all trusts which related to the percentage of staff working additional hours; this was acknowledged by the trust as an area for improvement.
- There was good evidence of collaborative multidisciplinary working, which was clear in the quality improvement work where staff jointly demonstrated a drive to improve patient care. The trust was rated in the top 20% of all trusts with regards to effective team working.
- Staff in all the focus groups we held were very positive about the trust and the support provided and the investment made in staff to develop; again this was reflected in the NHS staff survey 2015, where the trust was placed in the top 20% of all trusts with regards to the percentage considering the quality of non-mandatory training, learning and development to be good.
- There was an open and transparent culture, with a real commitment to learn from mistakes. This is reflected in the high level of reporting of incidents with no harm or low harm. The trust performed in the top 20% of all trusts in three of the four key questions relating to "Errors and Incidents" in the 2015 NHS Staff survey.
- There was a strong sense of a continuous drive for innovation and improvement which was ingrained in the culture of the organisation.
- The trust acknowledged that improvements were necessary to improve the opportunities and experiences of medical trainees. The trust had three indicators within the 2015 GMC survey

which were rated as negative outliers: Induction; supportive environment and feedback. We were assured that, following discussions with the medical director, significant improvements were being made to ensure that junior doctors were sufficiently inducted and supported during their training placements at the Royal Marsden. The medical director was candied with regards to the challenges faced by junior doctors, and was well sighted on the contributing factors which had led to the three outlier alerts.

Equality and diversity - including Workforce Race Equality Standards

- Of the 4,275 staff employed by the trust, 1,160 were of a black or minority ethnicity (27%). 98% of staff self-reported their ethnicity during 2015; a 1% increase on the previous year.
- The trust had a named lead for Equality and Diversity and there was an identified director with executive accountability. Additionally, the trust had a formal Equality, Diversity and Inclusion Steering Group who were responsible for monitoring the trusts' equality performance against the trust's equality objectives.
- The Royal Marsden Equality report, published in January 2016 reported that there had been significant improvements in the overall number of staff undertaking equality and diversity training (increase from 41% to 82% by the end of quarter 2 of 2015/2016) with an expected completion rate of 90% by April 2016.
- The trust had seen an increase in the number of staff declaring their sexual orientation (increase from 38% to 71%).
- Equality Impact Assessments had been considered in all organisational changes. The trust reported 28 assessments had been completed highlighting issues for consideration including ensuring accessible building design and supportive working patterns for carers.
- The trust reported a slight improvement in the percentage of black and minority ethnic (BME) staff reporting harassment or bullying (reduction from 35% to 27%). The trust had introduced mediation services to help support staff to resolve issues promptly and without the need for formal escalation.
- The trust launched a BME forum to assist staff in discussing key findings from the NHS staff survey as well as offering a regular means for engaging with BME staff.
- Improvements were noted in the number of staff reporting harassment or bullying from patients, relatives or the public with the trust performing in the top 20% of all trusts in four of the key questions for 2015.

- In response to a decrease in the proportion of disabled staff believing the trust provided equal opportunities for career progression and promotion and the proportion of BME staff reporting bullying or harassment by other staff marginally increasing, the trust conducted a recruitment masterclass for experienced recruiters to consider the impact of unconscious bias in decision making.
- The equality report noted that overall, the workforce findings at the Royal Marsden were, amongst others:
  - The proportion of BME staff in Bands 1 – 4 is 31% and 66% for White staff compared with the Trust profile of BME staff (26%) and White staff (71%)
  - There is a slightly higher proportion of BME staff working in Medical roles (29%) compared with the Trust profile of BME staff (26%).
  - There are part time staff across all staff groups
  - The largest proportion of staff are aged between 31 and 50 years old
  - The highest proportion of staff report that they are Christian, however there is a wide spectrum of different religions and beliefs represented.
- Shortlisting and subsequent appointment of applicants from a range of ethnic backgrounds was also considered by the trust. The findings were that:
  - 22% of applicants were from of an Asian ethnicity, of which 13% were appointed.
  - 20% of applicants were of dual heritage or mixed ethnicity, of which 10% were appointed.
  - 22% were of black ethnicity of which 7% were appointed.
  - 30% were of "other" ethnicity of which 16% were appointed.
  - 33% were of white ethnicity of which 19% were appointed.
  - The trust reported that white staff were 1.91 times more likely to be appointed from shortlisting than BME staff. This was a decrease from the previous year where white staff were 1.68 times more likely to be appointed from shortlisting. Specific equality objectives were set for 2016/2017 with regards to recruitment and promotion processes to ensure that parity across the workforce.
  - BME staff were 2.20 times more likely to enter formal disciplinary processes than white staff. This was about the same when compared to the previous year. In response to this finding, the trust launched "Candid conversations" training to help support management staff in having difficult conversations regarding performance and to help improve outcomes.

Summary of findings

Fit and proper persons

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust had a policy in place to support the requirements of the regulation: Recruitment and Selection Policy and Procedure. This was further complemented by the Employments Checks Policy and Procedure, Employee Records Policy and Procedure and the Anti-Fraud, Bribery and Corruption Policy and Procedure.

Public engagement

- There was evidence of extensive engagement with patients and the public and the trust actively sought their views and opinions.
- As a means of seeking additional assessment of patient experience the trust had embarked on rolling out "iWantGreatCare" across the organisation.
- The initiative allows patients to leave meaningful feedback on their care and enables them to make comments of their overall experience, to suggest improvements and to make commendations or raise concerns.
- A breakdown of iWantGreatCare was as follows:
  - The Royal Marsden (Sutton) - 5 Star rating (10,253 reviews)
  - The Royal Marsden (Chelsea) - 5 Star rating (9,914 reviews)
  - Community Services - 5 star rating (352 reviews)
- The trust proactively engaged with children, young people and families and took appropriate action based upon the feedback they received.

Staff engagement

- The chief executive facilitated regular "Town hall" roadshows to update staff on major developments and provide opportunities to ask questions.
- The trust recognised the contribution of staff and celebrated their achievements and improvements to quality patient care and innovation through annual staff awards.
- Results from the 2015 NHS Staff Survey showed that the trust performed well, with 17 positive findings, 14 findings within expected levels, and one negative finding.

Summary of findings

- During the inspection and focus groups, staff described the trust as somewhere they felt they were listened to and were engaged in the future strategy of the trust. Some improvements were however required within the community setting where staff felt disconnected from the wider strategy of the trust.

Innovation, improvement and sustainability

- The trust has major research collaborations through its academic health sciences centre and biomedical research centre.
- The trust has a school dedicated to the education of nurses responsible for the delivery of cancer care.
- Staff and divisions were actively involved in initiatives to improve patient care, the environment and patient experience. These are detailed under each core service in the hospital location reports.

Overview of ratings

Our ratings for The Royal Marsden - Chelsea

	Safe	Effective	Caring	Responsive	Well-led	Overall
Critical care	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
End of life care	Good	Requires improvement	☆ Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Chemotherapy	Good	Good	☆ Outstanding	Good	Good	Good
Radiotherapy	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Adult solid tumours	Good	Good	☆ Outstanding	Good	Good	Good
Overall	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Overview of ratings

Our ratings for The Royal Marsden - Sutton

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for children and young people	Good	Good	☆ Outstanding	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Chemotherapy	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Radiotherapy	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Adult solid tumours	Good	Good	☆ Outstanding	Good	Good	Good
Haematology	Good	Good	☆ Outstanding	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Our ratings for The Royal Marsden NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Overview of ratings

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community health services for children, young people and families	Good	Good	Good	Requires improvement	Good	Good
Community End of Life Care services	Good	Good	Good	Good	Requires improvement	Good
Overall Community	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

In considering the overall ratings for the Royal Marsden NHS Foundation Trust, we have deviated from the standard aggregations rules. We considered that due to the size and activity of community services, when compared to the wider activity of specialist cancer services provided by the trust, it would have been disproportionate to have rated the trust as requiring improvement in the domains of safe, effective, responsive and well-led.

When considering the ratings, we have carefully considered all of the evidence available to us and have used our professional judgment to aggregate the final trust ratings. We have carefully considered the characteristics for ratings as set out in our guidance, and where we have identified that improvements are required, these have been identified within the individual core service reports; within the "must" and "should" section of reports and within the requirement notice sections of reports.

Outstanding practice and areas for improvement

Outstanding practice

- Critical care staff worked with a specialist in aromatherapy massage as part of a trial to identify if this type of therapy would result in better sleep patterns amongst patients. This trial was in progress at the time of our inspection and aimed to find if non-pharmacological intervention could be an effective alternative to support sleep to high doses of drugs.
- The Critical Care Unit's (CCU) research programme was well structured and there were multiple safety nets in place for staff conducting this. The Committee for Clinical Research had oversight of every project and only approved them after a positive peer review and ethics approval. The research profile was internationally recognised and staff represented the unit at the NHS National Institute of Health Research and the National Critical Care Research Group. Senior research staff worked academically and clinically, which meant they could ensure critical care projects were conducted according to established multi-professional best practice.
- Staff in CCU prescribed patients who were considered high-risk for complications a pre-rehabilitation programme before they underwent surgery. A physiotherapist led this programme and provided patients with an exercise regime and diary. This helped them to prepare for rehabilitation and to support their health to improve their condition after surgery.
- The environmental adaptations in the Chelsea CCU demonstrated exemplary focus on individual care and attention to detail. This included adapted environments for patients with dementia, bariatric patients and teenagers.
- Senior staff actively promoted staff welfare and had provided tai chi, complementary therapies and meditation sessions to promote wellbeing and relaxation.
- The Royal Marsden is the only NHS hospital to have the updated version of the da Vinci Xi surgical robot. This less invasive surgery allowed improved patient recovery. The 10 year fellowship programme meant that 30 surgeons would be trained by the trust to operate the robot.
- There was an extensive range of information, including films for patients, which provided detailed support.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Staff demonstrated high care, arranging patient transportation and accommodation for those that did not live near to the hospital.
- The investment by the trust ensured that staff were developed and highly trained. Many staff had studied for master degrees and specialist courses in cancer.
- Research, ongoing quality improvement projects and auditing were of a high level and drove the quality improvement agenda.
- Nursing and therapy staff had the commitment and time to provide person-centred care that often went the 'extra mile'
- The introduction of ambulatory care had managed to reduce patient bed stays and improve patient experience.
- The end of life supportive care home team (SCHT) was a part of a Sutton CCG (clinical commissioning group) vanguard relating to improving end of life care in care and nursing homes. Members of the SCHT were involved in developing the service and had been invited to speak about the model and share this development with other services. The end of life supportive care home team (SCHT) was a part of a Sutton CCG (clinical commissioning group) vanguard relating to improving end of life care in care and nursing homes.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

- Implement and embed the World Health Organisation Safety Checklist in the outpatients department.
- When patients (aged 16 and over) are unable to give consent because they lack the capacity to do so, the trust should ensure staff act in accordance with the Mental Capacity Act 2005.
- Ensure that records contain accurate information in respect of each patient and include appropriate information in relation to the treatment and care provided, particularly with regard to risk assessments.
- The provider should take action to understand the shortfalls in recording of risk assessments and individualised care plans in the integrated community teams.
- Review the staff compliment for community adult services to ensure there are sufficient numbers of appropriately skilled staff to meet patient's needs.
- The provider should strengthen the reporting on the assurance of effectiveness of governance arrangements to the trust board; this specifically relates to community services.