

# The Royal Marsden NHS Foundation Trust

## The Royal Marsden - Chelsea

### Quality Report

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This report describes our judgement of the quality of care at this hospital. 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 hospital	Outstanding	☆
Critical care	Outstanding	☆
End of life care	Good	●
Outpatients and diagnostic imaging	Good	●
Chemotherapy	Good	●
Radiotherapy	Outstanding	☆
Adult solid tumours	Good	●

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Royal Marsden Hospital NHS Foundation Trust is split over two principal sites, one in Chelsea and the other in Sutton. The Trust also has a day-case unit on the site of Kingston Hospital. As a specialist trust, the Royal Marsden receives referrals from beyond the immediate areas, and the population covered by acute services cannot therefore be meaningfully estimated. However 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.

The Chelsea, Fulham Road hospital has 112 inpatient beds and 81 used for day case admissions.

This report describes our judgement of the quality of care at this hospital. 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.

Overall we rated this location as outstanding.

We rated the radiotherapy service as outstanding. This was because the radiotherapy service was patient centered service placed patients at the centre of the their care. Care was provided in line with national standards, with radiotherapy services participating in national and international research programmes.

We further rated the hospital as outstanding for the key question of caring.

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 shared with staff and applied in practice.
- Staffing arrangements supported the delivery of safe diagnostics, treatment and care.
- 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.
- Vulnerable individuals were identified and protected under safeguarding practices.
- Staff were enabled to perform their duties through the provision of professional standards and guidance.
- 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.
- All staff recognised the uniqueness and the diversity of patients and responded appropriately with support and advice as required.
- 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.

# Summary of findings

- 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.
- Staff encouraged participation from those close to people who used the services, including carers and dependents. People were encouraged and supported to manage their own health, care and wellbeing and to be as independent as able.
- Patient flow from admission, to discharge was managed effectively and ran smoothly.
- Services were organised to meet people's treatment needs in relation to their cancer, as well as their wider holistic needs for spiritual and psychological support and for relaxation.
- There was some flexibility in appointment times to meet the needs of patients who were working or had care responsibilities.
- Patients had the option of having their blood tests, consultation and treatment on a single day (known as one stop) or of attending the medical day unit on two separate days, one for assessment, and one for treatment.
- Arrangements were established with other hospitals where patients were treated for non-cancer related conditions.
- There was clear information and additional culturally appropriate support services for international patients receiving private treatment.
- There were responsive arrangements for treating patients with possible neutropenic sepsis both within the hospital and for those admitted to A&E departments in other trusts.
- There were few complaints and those that were received were addressed in a proactive manner.
- Staff understood and respected the trust's vision to be leaders in cancer care. They shared the objectives of the wider trust to provide safe, effective and high quality care to all patients.
- Staff were proud to work for the hospital and would want their friends and family to be treated there should the need arise.

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 provide tai chi, complementary therapies and meditation sessions to promote wellbeing and relaxation.

# Summary of findings

- 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.
- 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.

However, the trust should:

- Theatre staff should ensure de-briefing are recorded after surgical activity.
- The trust should ensure medicines are stored securely and in line with legal requirements.
- Regular checking processes of the resuscitation trolleys must ensure the drawers are locked to prevent unauthorised access to intravenous drugs and fluids.
- To meet national recommendations the Linear Accelerator replacement programme must be kept up to date.
- Ensure staff are conversant with the requirements of infection control procedures.
- Review strategies to enforce compliance with hand hygiene and infection control measures amongst clinical visitors to the critical care unit.
- Ensure staff understand security arrangements.
- Review the risk register for items that can be closed.
- Ensure single-use disposables are managed for expiry dates.
- Develop a consistent approach across the trust for recording and logging cadaver storage temperatures.
- Ensure Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms always have dates by which they should be reviewed, and these are completed.
- Consider the introduction of formal bereavement support throughout the hospital.
- The provider should review outpatient booking rules to ensure clinics are not overbooked to reduce the time patients wait to be seen.
- The provider should review the waiting area to provide additional space on busy clinic days.

Professor Sir Mike Richards

**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Critical care

### Rating

Outstanding



### Why have we given this rating?

Overall we rated critical care as outstanding at the Royal Marsden Hospital, Chelsea location because:

- Consistently good nurse and doctor staffing levels met national benchmarks and best practice guidelines.
- A robust incident reporting system was in place, which staff spoke enthusiastically about as a key feature of their ability to develop and progress. There was a clear track record of detailed investigations into incidents and learning as a result.
- There was consistent input from a multidisciplinary team of cancer and other medical specialists, including pharmacy, occupational therapy, dietetics and microbiology. On-site pharmacists and technician support ensured a high standard of medicines management and equipment readiness. Such specialist teams also provided staff with teaching and learning opportunities on a regular basis.
- Critical care services fully met the National Institute for Health and Care Excellence guidance on the rehabilitation of patients. This included a follow-up clinic led by highly experienced clinicians who constantly strived to improve the service by asking for feedback from patients and their relatives and acting on this.
- A well-developed rolling programme of clinical audits was overseen by a clinical lead, outreach matron and clinical nurse lead. Unit staff were involved in the discussion of results and contributed to re-audits, which established improved care pathways for patients. The audit programme was in addition to expected national data contributions such as the Intensive Care National Audit Research Centre.
- There was a focus on providing individualised care based on feedback from patients and their relatives. This included use of a patient experience survey and a culture of openness and collaboration in which staff acted on informal feedback.
- Staff responsiveness to individuals needs was evident in the design and resources of the unit, which demonstrated attention to detail in areas that could

# Summary of findings

make a material difference to patients. This included photosensitive glass, modified bed spaces for patients living with dementia and obesity as well as adapted spaces for teenagers.

- Governance and risk management processes were robust and fit for purpose and demonstrated a very positive working relationship between all staff teams in the unit and the trust's senior executive team. The team focused on service innovation and sustainability and had a number of strategies to achieve this. This included an extensive specialist education programme for nurses and a range of nurse-led service improvement teams who had accountability for changes in practice and policy in specific areas. However;
- There was room for improvement in infection control practices and hand hygiene audit results were variable. Senior clinical staff demonstrated appropriate action to improve the outcomes of such audits.
- A dedicated clinical nurse educator ensured staff remained up to date with mandatory training although the unit was slightly short of the trust's target figure.

## End of life care

Good



Overall we rated the End of Life Care (EoLC) at the Royal Marsden Hospital, Chelsea site as good because:

- The specialist team were highly skilled and knowledgeable throughout the hospital and provided effective support to clinical staff.
- Patients were provided with good quality and safe care at the end of their life. Patients were cared for in a caring and compassionate manner by staff at all levels. Their privacy and dignity was maintained throughout their stay in hospital.
- Staff ensured patients and their relatives were fully informed and involved in their treatment decisions. Consent and capacity were considered appropriately.
- There was an extensive education programme to support staff in delivering this care in line with appropriate national standards and best practice guidance.
- Regular and meaningful clinical audits were carried out in a variety of topics relating to EoLC. Information and learning points relating to incidents and

# Summary of findings

complaints were shared across the trust.

Improvements had been made across the service because of this, and staff were able to describe these changes.

- Patient care records and risk assessments were thorough and complete, with appropriate consideration given to different aspects of holistic care at the end of life.
  - The needs of individuals were considered and largely met by the service. The majority of patients achieved their preferred place of death.
  - Pain relief, nutrition and hydration were considered in nearly all cases and patients were happy in regard to these outcomes. Symptom control was considered and well managed, using both traditional medical methods and complementary therapies.
  - The trust had a clearly defined vision and strategy to improve palliative care provision.
  - Regular meetings and forums took place that addressed issues in EoLC with various stakeholders with a view to strengthening this provision.
  - Senior staff were supportive and approachable, encouraging an open and transparent culture.
- However;
- Referral to palliative care was not always made earlier in the patient pathway. This affected their access to psychological support and advanced care planning at the end of life. Psychological support often carried a long waiting time and there was no formal bereavement support offered to bereaved families through the hospital. There was a lack of quiet or private space in the wards for grieving relatives.
  - Porters were broadly unaware of the procedures to follow in terms of infection control and escalation of potential problems in relation to the body store.
  - The arrangements for checking temperature storage in the mortuary were not sufficiently robust.
  - Body store fridge checks were not retained, and there was a lack of consistent approach across the trust sites for this.
  - When asked staff were not aware that there was a lay member with responsibility for EoLC on the trust board, there was also little knowledge of items relating to EoLC on the trust risk register, and no awareness that items should be added that presented a potential issue affecting patient care

# Summary of findings

## Outpatients and diagnostic imaging

Good



We rated the outpatient and diagnostic imaging service at the Royal Marsden Hospital, Chelsea site as good overall because:

- The outpatient and diagnostic imaging departments were providing safe, effective, caring and responsive services, and was well led.
  - There were sufficient staff with appropriate skills in the outpatients and diagnostic imaging departments to provide safe services. Staff in both departments felt well supported and had access to training and development opportunities.
  - The outpatient service was using the London Cancer Alliance holistic needs assessment process to assess patient's care and plan the treatment they received.
  - There was good patient information in outpatients and diagnostic imaging about the treatment options available.
  - Staff in outpatients and diagnostic imaging understood the importance of reporting and learning from incidents. Information about incidents was passed on to staff in a variety of ways including staff meetings in the morning before outpatient clinics started, and at departmental meetings.
  - An outpatient transformation project was underway to respond to areas where there were recognised problems with waiting times.
- However;
- Systems for controlling access to medicines in the outpatient department were not robust. When we brought these issues to the attention of managers, they immediately put measures in place to improve the storage and security of medicines.

## Chemotherapy

Good



We rated the service at the Royal Marsden Hospital Chelsea location as good overall because:

- Chemotherapy drugs were prepared in an aseptic (germ free) environment, prescribed through an electronic prescribing system. Drug administration was monitored safely, and patients were made aware of potentially life threatening side effects that could occur between treatments and knew what action to take.
- There was a strong culture of multidisciplinary working between nurses, specialist nurses, doctors and allied health professionals. Patient treatment was decided in multidisciplinary meetings (MDTs) and there was regular in-depth MDT patient review.



# Summary of findings

- There were clear arrangements for responding quickly to patients with possible neutropenic sepsis both within the hospital and for those admitted to A&E departments in other trusts.
- There were established non-cancer pathways and agreements with other hospitals for patients needing treatment for other conditions such as respiratory and neurological conditions. There were formal agreements with some other hospitals where patients were treated for non-cancer related conditions.
- Services were organised to meet people's treatment needs in relation to their cancer. They also took into account patients wider holistic needs for spiritual and psychological support and for relaxation. Staff treated patients as individuals.
- Patients told us staff at all levels were courteous, thoughtful, and kind in their dealings with them, in many small ways that went well beyond the administration of treatment. The number of compliments far exceeded the complaints.
- The atmosphere of the units was calm and welcoming and patients we spoke with and their families were full of praise for the sensitivity staff showed to their feelings and concerns and to the needs of some patients for emotional support in coping with their treatment and condition.
- Nurses recognised the uniqueness of each patient, and the diversity of patients, and responded appropriately with support and advice as required.
- There was an open culture of reporting and learning from incidents and near misses without blame and patients were protected from avoidable harm because staff understood the risks of treatment and the nature of incidents.
- The chemotherapy day units, the clinical assessment unit and some wards were modern and welcoming, and we observed high standards of cleanliness.
- Staff were clear about the vision for the trust's services to be leaders in cancer care. They shared the objectives of the wider trust to provide safe, effective and high quality care to all patients. All those we spoke with were proud to work for the hospital and would want their friends and family to be treated there should the need arise.

# Summary of findings

- There was a very wide range of information available to patients to supplement what they were told by clinical staff, including films for patients to help them look after their CAVD devices. Information was available in other languages.
- However;
- The acute oncology service did not operate at weekends.

## Radiotherapy

### Outstanding



Overall we rated the Radiotherapy service at the Royal Marsden Hospital, Chelsea as outstanding because:

- Safety was embedded across all areas involved in the radiotherapy pathway from the maintenance of equipment to the delivery of accurate complex radiotherapy treatments.
- Incident reporting played a major part in the safe and effective delivery of the service. Clinical, non-clinical and radiation incidents were reported through the appropriate mechanisms, investigated and learnings were shared across all multi professional groups of staff.
- The department submitted radiotherapy error reports (RTE) to Public Health England (PHE) Towards Safer Radiotherapy data set. This disseminated learning from RTE's across the radiotherapy community to influence local practise and improve patient safety.
- The clinical equipment available in the pre-treatment, physics planning, and treatment areas allowed high standards of treatments to be planned and delivered. This included Intensity Modulated Radiotherapy (IMRT), Image Guided Radiotherapy (IGRT) and Stereotactic radiotherapy. All of which followed national recommendations as best practice to deliver improved outcomes to patients.
- The radiotherapy service was a major contributor to local and national clinical trials with 33 trials open. With this high level of engagement, the department supported the implementation and evaluation of new radiotherapy techniques such as adaptive radiotherapy and IMRT.
- All professional groups of staff were very well supported by the trust through mandatory and continuing professional development training, (CPD). High percentages of staff had postgraduate qualifications, which enriched their knowledge, allowing high levels of care to be delivered.

# Summary of findings

- There was a comprehensive system for ensuring and measuring competencies, which supported the continuing development of all the staff groups. There was a strong multidisciplinary teamwork, which supported improved patient pathways.
- Electronic patient records and a quality management system ensured staff could access clinical information, protocols, and procedures to support the delivery of evidenced based good care.
- We observed staff being caring and compassionate to patients, relatives and all staff groups. We observed patients being treated as a person and not a group of symptoms. All relatives were actively included, with patients' consent, in the patient centred care delivered.
- The service performed well against the 31 day waiting time standard for definitive and subsequent treatments. Data confirmed all patients were seen within 20 minutes of their scheduled treatment time unless unforeseen circumstances developed. All patients started their radiotherapy within the time constraints recommended in the Manual of Cancer Standards.
- A strong, visible, and approachable senior management team led the service with a strong governance structure, which ensured a safe and effective service. Staff felt fully supported and presented at national and international conferences with the work they were undertaking across the service.

## Adult solid tumours

Good



We rated the solid tumours service at The Royal Marsden Hospital, Chelsea location as good because:

- The solid tumour services at The Royal Marsden Chelsea had good safety performance, with few serious incidents.
- Appropriate procedures supported the delivery of safe care.
- There were sufficient staff with a range of skills and expertise, and staff were encouraged to develop.
- Theatres and wards were clean and there were safe practices to minimise the risk of infections arising.
- There were good multidisciplinary team input between surgeons, doctors, nurses and other members of staff to provide a safe patient pathway of care.

# Summary of findings

- There were good surgical outcomes for the complex high-risk surgery undertaken at the trust, and the trust performed well in national audits.
- Specialist surgery, using the latest equipment and advanced practices were available to patients.
- Patients received timely effective pain relief.
- The trust demonstrated continual improvement, with comprehensive auditing and projects.
- We saw staff being compassionate, kind and caring to patients across the whole trust.
- The trust scored well on the Cancer Patient Experience Survey, being in the top 20% for many statements.
- The trust supplied an extensive range of accessible therapies for patients.
- The use of enhanced care pathway plans for patients and the involvement of staff in designing these.
- Patient flow from admission, to theatre, then on to the ward and finally to discharge was managed effectively and ran smoothly.
- The service was fully accessible to patients with disabilities.
- There was a clear strategic plan and staff demonstrated a shared vision with the trust.
- There was effective leadership, which provided strong support to staff. Leaders were visible and staff felt they were approachable. Matrons and clinical leads were present and supportive of their staff.

# The Royal Marsden - Chelsea

## Detailed findings

### Services we looked at

Adult solid tumours; Chemotherapy; Radiotherapy; Critical care; End of life care; Outpatients & Diagnostic Imaging

# Detailed findings

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## Background to The Royal Marsden - Chelsea

The Chelsea, Fulham Road Hospital location is registered with the commission as The Royal Marsden NHS Foundation Trust. This means that as a foundation trust hospital it is part of the NHS and is expected to treat patients according to NHS principles of free healthcare according to need, not the ability to pay. Being a foundation trust means it is better able to provide and manage its services to meet the needs and priorities of the local community, as the Trust is free from central Government control.

The Chelsea, Fulham Road Hospital is one of two locations, which make up the Royal Marsden NHS Foundation Trust. It is located within Chelsea in south west London, approximately five miles from central London. There are 196 general and acute beds at Chelsea, Fulham Road hospital. There are 16 critical care beds on the Chelsea Fulham Road site.

The trust is staffed by approximately 4203, including; 402 medical, 1255 nursing, 1203 other clinical and 1343 other non-clinical. Many staff work across both hospital locations and a number also staff the service provided at Kingston Hospital.

Our visit to the trust took place as part of our comprehensive scheduled inspection programme. During the inspection of the Fulham Road Chelsea location we reviewed six core service areas, as follows:

- Adult solid tumours
- Chemotherapy
- Radiotherapy
- Critical care
- End of life care
- Outpatients and diagnostic imaging

## 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 End of Life Care and Oncology, a Consultant General Surgeon, a Medical Director, Director of Nursing and Operations, Radiology and Radiography.

We had one expert by experience assisting us and analytical support.

# Detailed findings

## 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. It should be noted here that some of the information provided is based on trust wide data and as such has not been possible to split by location.

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 NHS 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 18 May 2016 to the critical care unit.

During our inspection we spoke with 66 patients and 20 relatives/friends, who provided feedback on their experiences of using the hospital services. We looked at 49 patient records where it was necessary to support information provided to us.

Whilst on site we interviewed more than 242 staff, which included senior and other staff who had responsibilities for the frontline 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 The Royal Marsden - Chelsea

Population served:

The trust provides services to approximately 196,000 people. As a tertiary service it also provides services to a much wider population, as well as for overseas patients. The trust provides a full range of diagnostic and treatment services, including; radiography, pathology, surgery, radiotherapy, and chemotherapy.

Deprivation:

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.

# Detailed findings

## Activity:

Between 2014 and 2015 the trust facilitated:

- inpatient admissions 9,842
- outpatient attendances 190,117

## Key intelligence indicators:

### Safe

- No risks were identified in the most recent Intelligent Monitoring report.
- No never events were reported from February 2015 to January 2016.
- The trust had 25 serious incidents requiring reporting and investigating via the Strategic Executive Information System (STEIS). The majority, (20) of these related to pressure ulcers. In addition, there were 3454 incidents, which were reported via the National Reporting and Learning System (NRLS) in the same period. Of these, over half resulted in no harm to the patient. It should be noted, the trust has a higher percentage rate of NRLS incidents than the England average.
- There were 42 cases of Clostridium difficile reported across 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

- No evidence of risks or mortality outliers were identified for any of the mortality indicators.

### Caring

- The percentage of friends and family that would recommend the trust in the Friends and Family Test (FFT) FFT was similar to the England average throughout January-December 2015. The lowest was score was 83.1% in quarter one 2015/16.

- The trust was rated in the top 20% for nine indicators in the Cancer Patient Experience Survey; they were in the bottom 20% for four, and the middle 60% for remaining questions.
- The Patient led Assessment of the Care Environment (PLACE) scores were better than or equal to the England average for all domains at the Chelsea Fulham Road site.
- The CQC Inpatient Survey 2014, ranked the trust as amongst the best performing for eight questions, and “about the same” for the remaining four.

### Responsive

- Bed occupancy has been below the national average since quarter two, 2014/15.
- 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, awaiting care package in own home, (52). Patient or family choice accounted for 48 of these, and 28 were awaiting a nursing home placement or availability. The remaining five were awaiting referral completion or equipment.
- The Trust received 118 complaints in 2015, of which 117 have since been closed. The percentage of complaints reopened was 8%.

### 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 than the England average between June 2012 and September 2015.
- At the time of the inspection 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.

## Our ratings for this hospital

Our ratings for this hospital are:



# Detailed findings

	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

## Notes

# Critical care

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

## Information about the service

The critical care unit at the Royal Marsden Hospital in Chelsea has 16 beds separated into a 12-bedded intensive care unit and a four-bedded high dependency unit (HDU). There are six positive pressure isolation rooms and some of the side rooms have access to a secure external balcony. The unit has the capacity to expand to 19 beds if staffing levels are safe. There is a two-bedded HDU at the hospital's Sutton site, which is used as a 'step-up' unit for sick patients. The unit provides specialist care for critically ill patients and is able to offer a range of ventilation procedures prior to transfer to the Chelsea site.

The unit is a centre of research and academic study and clinicians reflect this status with a programme of rolling, innovative and internationally-recognised studies, which contribute to good patient outcomes.

A critical care outreach team operates 24-hours a day, seven days a week at both sites.

In the 12 months prior to our inspection, 1317 patients were treated in the Chelsea unit. Most patients are admitted following cancer surgery and the unit also treats patients with haematological malignancy and after bone marrow transplant. The average occupancy rate of the Chelsea unit in 2015/16 was 64%. In the same period, 65 patients were admitted to the Sutton step-up unit. Patients are admitted to this unit after elective surgery or as part of a 'treat and transfer' protocol if their condition deteriorates while they are on a ward. In 2015, 38 patients were transferred from Sutton to Chelsea.

To reach our assessment of the service, we spoke with 24 members of staff across both the Chelsea and Sutton sites as well as allied health professionals and clinical specialists. We spoke with five patients, five relatives, and looked at all clinical and patient areas. We also reviewed over 80 items of evidence.

# Critical care

## Summary of findings

Overall we rated critical care at the Royal Marsden, Chelsea as outstanding, because;

- Consistently good nurse and doctor staffing levels met national benchmarks and best practice guidelines.
- A robust incident reporting system was in place, which staff spoke enthusiastically about as a key feature of their ability to develop and progress. There was a clear track record of detailed investigations into incidents and learning as a result.
- There was consistent input from a multidisciplinary team of cancer and other medical specialists, including pharmacy, occupational therapy, dietetics and microbiology. On-site pharmacists and technician support ensured a high standard of medicines management and equipment readiness. Such specialist teams also provided staff with teaching and learning opportunities on a regular basis.
- Critical care services fully met the National Institute for Health and Care Excellence guidance on the rehabilitation of patients. This included a follow-up clinic led by highly experienced clinicians who constantly strived to improve the service by asking for feedback from patients and their relatives and acting on this.
- A well-developed rolling programme of clinical audits was overseen by a clinical lead, outreach matron and clinical nurse lead. Unit staff were involved in the discussion of results and contributed to re-audits, which established improved care pathways for patients. The audit programme was in addition to expected national data contributions such as the Intensive Care National Audit Research Centre.
- There was a focus on providing individualised care based on feedback from patients and their relatives. This included use of a patient experience survey and a culture of openness and collaboration in which staff acted on informal feedback.
- Staff responsiveness to individuals needs was evident in the design and resources of the unit, which demonstrated attention to detail in areas that could

make a material difference to patients. This included photosensitive glass, modified bed spaces for patients living with dementia and obesity as well as adapted spaces for teenagers.

- Governance and risk management processes were robust and fit for purpose and demonstrated a very positive working relationship between all staff teams in the unit and the trust's senior executive team. The team focused on service innovation and sustainability and had a number of strategies to achieve this. This included an extensive specialist education programme for nurses and a range of nurse-led service improvement teams who had accountability for changes in practice and policy in specific areas.

However:

- There was room for improvement in infection control practices and hand hygiene audit results were variable. Senior clinical staff demonstrated appropriate action to improve the outcomes of such audits.
- A dedicated clinical nurse educator ensured staff remained up to date with mandatory training although the unit was slightly short of the trust's target figure.

# Critical care

## Are critical care services safe?

Good



We rated critical care at The Royal Marsden, Chelsea site as good for safe, because;

- The unit had a consistent track record in providing harm-free care, with no unit-acquired infections, or falls in the 12 months prior to our inspection. There was a system of evidence-based improvement to reduce instances of pressure ulcers.
- Staff embedded the principles of safeguarding in practice and there were numerous examples of how their expertise ensured people were protected from potential harm.
- A team of seven consultant intensivists led medical care on the unit on a 24-hour, seven day basis. All patients had a treatment plan established by a consultant within 12 hours of admission. This meant the unit met the requirements of the Faculty of Intensive Care Medicine.
- Mandatory training was monitored and kept up to date by a clinical nurse educator, who also provided additional specialist and ad-hoc training for staff.
- Staff developed deteriorating patient protocols based on their skills and experiences in the hospital.
- Escalation strategies relating to deteriorating patients were in place and we observed staff use them appropriately. The critical care outreach team provided rapid reviews of deteriorating patients and support to ward staff.

However:

- The results of hand hygiene audits were inconsistent and we did not always observe following infection control procedures stringently.
- Audit results indicated 66% compliance with microbial prescribing guidelines against a target of 100%.

### Incidents

- Between March 2015 and March 2016, the unit reported 363 incidents. There were no instances of patient harm as a result of incidents in this period. The most frequently-reported incidents related to pressure damage and medication errors. The unit was a pilot site for the medications safety thermometer to identify potential harm from medication errors.

- Staff reported incidents using an electronic system that allowed clinical leads to track and audit incidents for patterns. The clinical nurse lead, clinical lead or critical care outreach matron investigated each incident and completed a root cause analysis for serious incidents or those involving pressure sores.
- There was a culture of encouragement for staff to submit incident reports and ensure they were investigated proportionately and by staff with appropriate knowledge and competence. A junior doctor and patient safety fellow had undertaken a focused project on safety awareness to improve incident reporting by junior doctors.
- There was evidence of learning from incidents. For example, the nurse-led pressure awareness group had introduced signage at each bed space to remind staff of turning times and educators had introduced a simulation exercise to help staff deal with dislodged tracheostomies. Clinical leads encouraged staff to explore innovative solutions to incidents as part of their professional development and to reduce incidents. This included the trialling of pressure-relieving foams to reduce pressure damage and the redesign of a recording tool for deteriorating patients on wards.
- One incident involved the programming of a patient-controlled analgesia pump. As a result the clinical nurse educator devised a new competency booklet that staff had to successfully complete before being able to work with this equipment. A new policy had also been approved, which guided nurses in the use of the devices.
- A relative had slipped in the shower and staff immediately fitted a non-slip surface.
- There had been one serious incident in the previous 12 months which had been investigated using the serious incident framework of the NHS National Patient Safety Agency. The investigation documentation showed staff had escalated this as a serious incident after it was originally submitted as a standard incident in order to proactively identify learning from it. The incident related to a delay in the escalation of a deteriorating patient. The investigation team was multidisciplinary and appropriately concluded there was no harm caused by the delay. They identified areas for learning and development, including improved training on patient escalation for clinical site practitioners.
- Incident records indicated staff were accountable with Duty of Candour responsibilities and there was evidence

# Critical care

relatives and patients were involved in discussions about treatment errors. Staff showed us they used a colour coding system to identify patient-related incidents and the urgency of communication with relatives under the Duty of Candour. Junior nurses said the Duty of Candour was often discussed in the message of the week.

- The clinical nurse lead communicated learning points from incident investigations through a weekly 'message of the week' to all unit and outreach staff. Learning from incidents was also a permanent agenda item at monthly clinical governance meetings, multidisciplinary meetings and staff meetings. Where an incident investigation involved more than one hospital service, opportunities for learning were discussed at joint working meetings.
- Consultants led a quarterly mortality and morbidity (M&M) agenda as part of multidisciplinary and clinical governance meetings to identify learning from patient outcomes and deaths.

## Safety thermometer

- Staff in critical care contributed to the NHS Safety Thermometer programme. Information was collected on a monthly basis and clear, easy-to-read information was displayed for staff, patients and visitors.
- In the 12 months prior to our inspection the unit delivered harm free care of 85% against a trust target of 93%. During this period three new pressure ulcers were reported and staff demonstrated a proactive approach to reducing the risk of this condition.

## Cleanliness, infection control and hygiene

- A trust-wide infection control team and a nurse-led infection control service improvement group (SIG) completed regular infection control audits. Audit results were prominently displayed at key access points to the unit.
- The infection control SIG disseminated audit results and learning from these at clinical governance meetings, multidisciplinary team meetings and through the message of the week publication. This was supplemented by quarterly meetings of the infection control group.
- Alcohol hand gel was available at each bed space and at each unit access point. Signs mandating its use were clearly posted although this was not always enforced. Staff were proactive in enforcing the trust's 'bare below the elbows' policy.

- Staff screened patients for Meticillin Resistant Staphylococcus Aureus (MRSA) and antibiotic resistant organisms on admission and once per week.
- In the 12 months prior to our inspection, there were no cases of MRSA or Clostridium Difficile (C.Diff) reported in the unit and no catheter related bloodstream infections.
- Staff used a 'saving lives' audit programme to assess performance against a number of care bundles, including blood culture sampling and peripheral intravenous (IV) cannula insertion. Overall performance was very high, with a 12-month average of 100% compliance in the central venous access device insertion bundle, 98% compliance with the peripheral IV cannula insertion bundle and 97% compliance with blood culture sampling. From January 2015 to September 2015, the unit achieved 99% compliance with the central venous catheter care bundle.
- Compliance with hand hygiene in the unit was variable against the trust's 100% target. From March 2015 to March 2016, the unit achieved 100% in three months. Other monthly results ranged from 67% to 95%. The clinical nurse lead worked with the infection control group to ensure staff improved practice with hand hygiene and to enforce this amongst colleagues. This process had room for improvement. For example, we saw an x-ray technician put on appropriate personal protective equipment (PPE) and enter a bed space. The patient was not ready for x-ray and the technician left the bed space and entered another to remove the PPE. They did not gel their hands and critical care staff did not challenge them.
- Although staff demonstrated good practice generally, we did observe one member of staff not following good hand hygiene protocols. The clinical nurse lead reminded all staff about the need to follow trust and World Health Organisation guidance as a result and this was documented in staff meeting minutes.
- To improve hand hygiene, the clinical nurse lead piloted an automatic handwashing assessment device that monitored handwashing techniques amongst staff for efficacy. In April 2016 the device found staff handwashing technique to be 94% compliant with best practice.
- During our observations, adherence to infection control processes was good on most occasions. There was room for improvement in some areas. For example, we noted a nurse did not use a blue tray to hold syringes when giving intravenous drugs. Instead they held both

# Critical care

syringes in one hand. This presented a safety risk and the potential for cross-contamination. Doctors entered the unit wearing white coats from the theatres. This presented a cross-contamination risk. We spoke with a consultant about this who arranged for disinfected white coats to be kept in the critical unit at the entrance for doctors to change into. We observed one member of staff take off their gloves and apron after attending one patient and then walk directly into another bed space without gelling their hands.

- During wound dressing procedures staff consistently used the aseptic non-touch technique which protected patients from avoidable infection.
- In the January 2016 – March 2016 patient experience survey, 92% of patients described the unit as very clean.
- Each bed space had its own uniquely coloured apron to help staff reduce the risk of cross-infection.
- The hospital housekeeping team conducted a weekly deep clean of the Sutton step-up unit and daily equipment cleanliness checks were documented.

## Environment and equipment

- A clinical engineering team was based in the unit at Chelsea between 9am and 5pm, seven days a week. Outside of these hours an escalation policy was in place to enable staff to access rapid support in the event of equipment failure. The team ensured equipment was maintained and ready for use and provided medical device training to doctors and nurses as part of their induction. At Sutton, an on-site medical engineering team maintained equipment and was available on-demand to support HDU staff.
- The clinical engineering team attended clinical governance meetings to discuss medical device alerts.
- At the Sutton site, on-site clinical engineering support was available Monday to Friday from 8am to 6pm.
- Both the Chelsea and Sutton sites were equipped with resuscitation trolleys and difficult airways trolleys and the Chelsea site had a major haemorrhage trolley. Staff maintained a daily record of safety checks on the equipment and recorded action taken where a fault or problem was found. Resuscitation equipment and staff processes were compliant with the requirements of the Resuscitation Council (UK).

- Daily recording was consistent in all areas except a difficult airway trolley in the high dependency area at the Chelsea site. Each site had transport bags for patient transfers. Staff documented daily checks on the bags and after every use.
- A fridge used to store emergency intubation drugs had been identified on the unit's risk register as it could not be locked and a replacement fridge was unserviceable. However, the drugs inside the fridge were sealed and the trust's lead pharmacist had approved the storage.
- The clinical nurse educator supported the unit to act as the pilot site for a transfer bag audit and universal transfer bag trial as part of the critical care network. This identified if transfer bags were fit for purpose and appropriately stocked.
- There was room for improvement in the stock rotation system for disposable equipment items. For example, we found several central venous catheter lines, and a needle used to remove fluid from the pericardial sac (a pericardial anastomosis set) had expired. In addition, the stock room had posters for staff to state it was organised alphabetically to help them locate items quickly. However, storage did not follow this system and not all items were arranged alphabetically. This meant new staff or temporary staff could be delayed if they needed to find equipment and disposables quickly. Several bile bag plastic parts had perforated their protective plastic packaging, which meant they were no longer sterile and should not be used.
- The storage of chemicals in the dirty utility room did not always comply with control of substances hazardous to health guidance. For example, cleaning chemicals were stocked in unlocked cupboards and were unattended by staff. Exposure to chemicals was included on the unit's risk register and was due to be briefed to staff in June 2016.
- Staff completed and documented a comprehensive range of safety checks on equipment in the Sutton step-up unit on a daily basis. There were no gaps in this documentation for the four months we checked and staff documented advance planning for the replacement of equipment that would expire soon.
- The Sutton unit was meticulously well maintained but staff recognised the tiredness of the environment. A refurbishment was planned for shortly after our inspection in line with a major improvement plan of the whole site.



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- Patients we spoke with at the Chelsea site were very positive about the environment. For example, one patient said, “The building doesn’t smell like a hospital, it doesn’t feel like a ‘dying place’. It gives us hope for the future.”
- The unit had undergone an inspection from a Patient-Led Assessment of the Care Environment team. This team had rated the environment highly.

## Medicines

- An e-prescribing system was part of the unit’s electronic patient system. Staff could only use this system following specialised training and the successful completion of a test in its use.
- A part time pharmacy technician was dedicated to the Chelsea unit and provided support with stock rotation and prescribing.
- Each patient had a lockable medicine cupboard at their bedside that could be accessed only with a key code.
- Staff checked and recorded the temperature of rooms and fridges in which medicine was stored on a daily basis. Recording was consistent in the 12 months prior to our inspection and indicated medicines were always stored within the manufacturers’ recommended temperature range.
- There was an effective system in place to manage the storage and use of controlled drugs. This included locked storage, an allocated key holder per shift and effective incident reporting of any discrepancies. Cytotoxic drugs were stored in a locked cupboard.
- Medication dispensing was through a secure electronic system whereby each member of staff had their own unique code to obtain medicines.
- The unit was a pilot site for a new national medications safety thermometer tool. The safety thermometer involved a monthly selection of drug charts to identify harm resulting from drug errors. Staff measured compliance with allergy status and medicines reconciliation with pharmacy. This was a check that a pharmacist ensured medicines prescribed on admission were appropriate to those the patient had been prescribed in the ward. In both measures the unit reported 100% compliance.
- From January 2016 to March 2016, medicines errors were the most frequently reported incidents. The clinical nurse lead identified sub-categories of the errors to understand the most appropriate action to take to reduce them. For instance, medicines errors could relate

to a wrong dose or strength, the wrong medication being administered, a prescribing error or a storage problem. Medication errors were included in the unit’s risk register and the clinical nurse lead tracked these to identify areas where staff might benefit from additional support and training.

- Clinical staff did not always adhere to trust guidance on the prescription and administration of antimicrobials. Between August 2015 and January 2016, doctors were 66% compliant with the guidance.
- An antibiotic policy was available in the unit and was managed by the pharmacist. We looked at the records of three patients prescribed antibiotics and found this not to adhere to the policy. We asked the pharmacist about this who said this happened when an antibiotics regimen was started by staff in theatre prior to critical care admission. Their medicines reconciliation process ensured adherence to varying policies was safe.

## Records

- The unit used an integrated electronic patient records and observation system. This meant staff could record and track medical, nursing and multidisciplinary notes and data for immediate analysis. This was a different electronic patient records system in use in the rest of the hospital and the critical care system was able to send admission and discharge summaries to it. This meant staff could access records seamlessly and patient care was not delayed as a result.
- A dedicated full time IT technical support member of staff worked in the Chelsea unit Monday to Friday and provided staff with bedside support and troubleshooting. All staff on the unit with patient responsibility, including agency nurses, had specialised training in the use of this system prior to using it without supervision.
- Each trolley in the unit contained two spare temporary notes folders to help staff record observations for emergency admissions. This helped reduce delays to care whilst staff waited for patient notes from another department.
- An audit of the risk assessment records of patients who were taken for x-ray or other scans highlighted a need for improvement document control as the risk assessment forms were often missing.

## Safeguarding

- All clinical staff had safeguarding training levels one and two, for both children and adults.

# Critical care

- A safeguarding service improvement group contributed to the message of the week and worked with the trust-wide safeguarding team to ensure updates to the law or trust policies were communicated to staff.
- Staff had been briefed on the recognition of female genital mutilation, and were able to obtain specialist support from an on-call team.
- Staff were able to define triggers that would prompt them to obtain a safeguarding assessment for patients. This included issues such as unusual family dynamics, multiple pressure sores or malnourishment.

## Mandatory training

- The trust had a mandatory training target of 95%. From March 2015 to March 2016, the average compliance rate for critical care staff was 88%, 95% for outreach nurses at Chelsea and 86% in Sutton.
- Mandatory training included safeguarding, consent, mental capacity and the Deprivation of Liberty Safeguards and medicine management.
- Equipment mandatory training was prioritised based on the frequency of use of each item. For example, where an item of equipment was present in every bed space, all staff were expected to complete training in this. Where an item of equipment was more specialised, the clinical nurse lead and clinical nurse educator prioritised training and assessment based on the individual responsibilities of staff. The unit differentiated training and practical assessment and all staff who had been trained in clinical equipment were scheduled for an associated assessment. Overall 84% of nurses and healthcare assistants (HCAs) and 100% of doctors had up to date competency training on essential critical care equipment.

## Assessing and responding to patient risk

- The clinical lead and clinical nurse lead reviewed planned patient admissions one week in advance and were able to plan for increased staffing if a patient with complex needs was identified. Staff used a multi-risk scoring system to assess needs, including the Marsden Mortality Index.
- The critical care outreach team (CCOT) provided 24-hour hospital-wide urgent care for deteriorating patients on wards at both hospital sites. The team used the national early warning scores system to identify patients who

were sick and would benefit from a critical care assessment. The team also provided training to ward nurses and doctors on the use of the escalation policy to ensure patients who deteriorated were seen quickly.

- The team began the modified early warning score system for each patient four hours before their planned discharge. This was an effective approach to ensure the patient remained fit and safe for discharge.
- The CCOT team delivered acute cancer practice teaching across the hospital as part of deteriorating patient training.
- The CCOT team had standardised the use of the situation, background, assessment, recommendation (SBAR) tool across the trust. This resulted in easy-access SBAR pads being available at each clinical phone station. The team had also produced an SBAR safety film as part of their educational role to support nurses outside of critical care. We followed one discharge handover from critical care to a ward and saw ward nurses did not use SBAR or an alternative tool.
- The CCOT team supported patients with sepsis using establish guidelines through Sepsis6.
- Staff at the Chelsea site used the acute oncology service model to ensure the early escalation of critically ill patients.
- The unit did not consistently contribute to the patient safety audit's observations and trigger documentation. This audit established whether staff recognised triggers for additional observations and had escalated this appropriately. Between March 2015 and March 2016, no data was available in seven months. In two months, compliance was 0%, in one month it was 50% and in two months it was 100%, against a trust target of 100%.
- The clinical nurse lead or consultant was able to increase the ratio of nurse to patient care in instances where a patient was delirious or confused.
- A member of clinical staff with advanced life support training was present on every shift.
- Staff had identified a risk in the use of mouthwash with some ventilated patients who had pneumonia. To reduce the risk they introduced twice-daily tooth brushing instead.
- Records of patients who had been transferred from the Sutton step-up unit to the Chelsea critical care unit indicated staff followed appropriate national guidance on the critically ill patient, monitored their condition using regular observations and ensured the decision to transfer was clinically appropriate.



# Critical care

- Nurses adhered to clinical policies relating to patient safety including never leaving a patient alone in a side room if they had an arterial line inserted.
- All patients had a documented risk assessment for venous thromboembolism (VTE) on admission.

## Nursing staffing

- A team of 86 nurses, led by a clinical nurse lead, provided care in the unit, alongside a full-time dedicated audit nurse and eight healthcare assistants.
- A matron led the CCOT team of 16 senior nurses and a clinical care assistant.
- Nurses worked within a buddy system when caring for teenagers, young adults and vulnerable adults.
- Nurse staffing levels and nurse to patient ratios consistently met the requirements of the Intensive Care Society (ICS). This meant patients who needed 'level three' care, by ICS guidance, received one-to-one care and 'level two' patients received care on a ratio of one nurse to two patients.
- An established staffing escalation plan enabled staff to contact the clinical nurse director in instances where over 50% of the nurses on shift were not trained in intravenous fluid management or over 20% of the nurses on shift were agency staff. This helped senior staff to ensure additional substantive nurses or doctors could be secured to provide continuous, safe care.
- There was a supernumerary nurse coordinator on each shift, which met the standards of the Royal College of Nursing. In addition, two 'float' nurses were assigned to each shift to support staff with high-acuity patients or those with complex needs. One float nurse was assigned to cover transfers from the Sutton site if they became necessary.
- A safer staffing census was used to determine safe staffing levels on the unit and to ensure they complied with the Faculty of Intensive Care Medicine (FICM) guidelines for the provision of intensive care services. The staffing model used allowed senior staff to plan staff levels based on predicted admissions and adjust this accordingly. Where staffing levels fell short, staff had submitted an incident report and this had been acted upon by the senior team. Staff had also use escalation policies appropriately to ensure patient safety was not compromised.
- Cancer course nurses rotated into the unit for six month periods and were supported by substantive staff.

- The CCOT team staffed the Sutton step-up unit and an HCA was permanently based there. This member of staff was able to conduct patient blood gases.
- Nurse handovers took place twice daily. The nurse in charge demonstrated good knowledge of every member of staff on shift, their skill set and competency level.

## Medical staffing

- A team of seven consultant intensivists led medical care on the unit and were all dual-accredited with the FICM and Fellowship of the Royal College of Anaesthetists.
- Consultants covered both the Chelsea and Sutton critical care sites during their shift with a telemedicine ward round for the Sutton site when a patient was being cared for in the step-up unit. This process was used to facilitate early planning for a transfer to the Chelsea unit.
- Each consultant had a specialist lead role, including education, research, IT, audits and quality improvement. One consultant was the lead for the Sutton site and the transfer process used between hospitals.
- The consultant team was supported by two intensive care medicine trainee doctors, four junior doctors, 14-16 registrars or fellows, one higher intensive care medicine trainee and two specialty anaesthetic doctors. A post-fellowship intensive care medicine or anaesthetic registrar provided out of hours cover at each hospital site and a junior doctor was additionally available at the Chelsea site.
- Two special anaesthetists, a research fellow and a clinical fellow provided medical cover in the Sutton unit.
- The consultant team contributed actively to peer review critical care services. For example, consultant additional roles included the North West London Critical Care Network Lead, the training programme director for intensive care medicine and the chair of the division of professional development of the European Society of Intensive Care Medicine. Collaborative peer links with such organisations meant consultants were able to benchmark unit practice against national and international centres of excellence.
- Registrars who covered both the Sutton and Chelsea sites were either post-fellowship anaesthetists or specialty intensive care medicine doctors.
- Medical handovers took place twice daily and used information automatically updated by the electronic patient system.

# Critical care

- Medical staffing was maintained when consultants or registrars left the units with a patient transfer. This was achieved by securing an on-call consultant to attend or ensuring an anaesthetic consultant was available to cover the critical care unit. We looked at the records of five patients who had been transferred from Sutton to Chelsea. In all cases appropriate medical cover had been provided in the transfer ambulance by a doctor with advanced airway and life support training.
- The clinical lead and a junior doctor had established a more responsive medical handover procedure based on a study that took into account interruptions and handover structure. As a result staff had created individualised handover sheets using the electronic bedside system that included personal patient information and antibiotics. This helped to reduce unnecessary delays. The audit also highlighted areas for improvement. For example, previous medical history and nutrition information was sometimes missed and senior staff used this to remind staff to base their handovers on patient need rather than a rigid and inflexible model.
- All of the junior doctors we spoke with said they felt well supported, adequately supervised and cited the educational opportunities in the unit as significant benefits of working there.

## Major incident awareness and training

- Staff took part in an annual major incident simulation exercise and had undertaken a fire simulation in February 2016.
- Evacuation plans were up to date and staff received practical training on these.
- A business continuity plan enabled staff to protect patients from harm in the event the unit became uninhabitable or in the event of a major incident.
- Patients with delirium could present a safety risk to staff. This was because of the elevated possibility of violence. Following an incident in which a delirious patient violently attacked a member of staff, the trust provided violence and aggression training, including enhanced training for senior nurses. However, staff we spoke with did not always understand the security arrangements or how to obtain help in an urgent situation. For example, one nurse said they sometimes didn't feel safe in a side

room because they couldn't reach the emergency alarm if anything happened. One nurse also said they didn't know how to urgently obtain security staff support and said they would call a porter in the first instance.

## Are critical care services effective?

Good



We rated critical care at the Royal Marsden, Chelsea as good for effective because:

- The unit mortality ratio was significantly better than the national average.
- Clinicians led an extensive programme of audits focused on improving the care and health outcomes of patients with the most complex cancer and critical care needs. There was evidence of robust, embedded learning and practice change based on audits and a track record of establishing pilot audits to check their usefulness.
- The unit performed positively in national audit data in the unplanned readmission or non-clinical transfer of patients. Staff actively avoided out of hours transfers.
- Multidisciplinary specialist input into patient care was consistent and contributed significantly to patient outcomes. This included a dedicated pharmacist and pharmacist technician, dietitian, speech and language therapists, occupational therapists, physiotherapists and microbiologist. A clinical psychologist and massage therapist were readily available and provided highly individualised support to patients, their relatives and staff. The range of specialties available was significantly extended by a range of service level agreements with nearby hospitals for consultant specialist cover.
- Staff had access to specialist training offered proactively by a dedicated clinical nurse educator. This member of staff facilitated an environment and culture that placed a high value on education and staff were supported logistically and financially to undertake research and academic study to doctoral level. This resulted in a highly specialised team well equipped and resourced to provide care to acutely unwell patients.

However:

- There was room for improvement in the training rates and practical assessments of staff on some items of equipment, particularly nasogastric tubes.

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- Pain relief was consistently scored but patients did not feel their pain was always effectively managed.

## Evidence-based care and treatment

- Staff were developing a pathway for high risk surgical patients as part of surgical strategy links with multidisciplinary pre-operative assessment and a pre-rehabilitation programme.
- Nurses were part of service improvement groups (SIGs), which focused on specific areas of the service including end of life care, safety, and safeguarding and infection control.
- Staff completed an audit to assess how hospital and community services followed up with patients who had a Deprivation of Liberty Safeguards (DoLS) authorisation while in the unit. In 2015 this applied to seven patients, of which five patients had a documented follow up and a local authority safeguarding officer visited one.
- Staff benchmarked their practice against six key areas of clinical guidance from the National Institute for Health and Care Excellence (NICE). This included guidelines for acute illness, acute kidney injury, neutropenic sepsis, rehabilitation, delirium and intravenous fluids. This meant patients received care and treatment based on national best practice.
- Staff trained in airway management practised this based on Difficult Airway Society guidelines.
- Clinical staff were proactive in their contribution to national drives to improve patient care and outcomes. For example, staff contributed to reports on tracheostomy care, sepsis and non-invasive ventilation for the National Confidential Enquiry into Patient Outcomes and Death as well as new NICE guidance on acute medical emergencies.
- The unit encouraged and supported staff to attend international conferences, multidisciplinary meetings and a weekly journal club as a strategy to ensure their practice was based on the latest evidence and learning available.
- The critical care outreach matron led a programme of patient safety audits that included cardiac arrests, community 999 calls and hospital transfer data.
- A follow-up clinical service was provided for patients as part of their rehabilitation. This was an evidence-based process based on a study staff completed on the use of different channels of communication for follow-up. In addition, the senior clinical nursing research fellow had conducted a study of 20 follow-up clinic patients and

assessed them for post-traumatic stress disorder and quality of life. This study helped to redefine the parameters of the service and ensure it was as effective as possible.

- Staff assessed and cared for deteriorating patients in accordance with NICE clinical guidance 50 relating to the care of acutely ill adults in hospital. The critical care outreach team audited the performance of each ward at the Chelsea and Sutton sites for their use of the guidance including the types and regularity of observations completed and the completion of fluid balance charts. The outreach team provided training and education support to ward staff to help them maintain NICE standards.
- Staff completed a monthly audit on the use of a ventilator-associated pneumonia care bundle to check their practice met national best practice guidance. Between January 2015 and January 2016, the unit achieved 100% compliance.
- Staff introduced a tracheostomy 'passport' as a result of a research project that identified gaps in the information provided during the use of a care pathway. The passport acted as a reference point for multidisciplinary staff to check the management of tracheostomies.
- Staff assessed patients for counselling or mental health needs by using the hospital anxiety and depression scale. This tool was validated for use by telephone if needed after the patient had been discharged.

## Pain relief

- A member of the hospital's pain team was present on the daily ward round, which was supplemented by a weekly ward round led by a pain consultant.
- Staff documented pain assessments and scores on the electronic patient system where they could also access critical care pain guidelines.
- We asked four patients about pain relief and were given varying feedback. One patient said staff asked them continually about pain. Another patient said they were in pain overnight and felt staff were slow to respond. One patient said pain management was "okay" but they were concerned their nausea hadn't been dealt with.

## Nutrition and hydration

- An on-site catering facility was available in the critical care unit and dedicated food and drink hosts were available.

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- Each patient had a nutrition assessment on admission, which was recorded in the electronic bedside system using a nutrition assessment tool.
- A dietitian reviewed each patient during the daily ward round Monday to Friday. During the weekend a consultant provided nutrition support and a dietitian was on-call for urgent referrals.
- Staff recorded patient fluid balance using the electronic observation system on an hourly basis and then transcribed this onto each patient's discharge documentation. This was audited monthly and between March 2015 and March 2016 the compliance rate was 90%.
- There was room for improvement in the training and assessment of staff in the use of nasogastric feeding tubes. For example, 50% of staff had undertaken training and only 39% had undertaken a competency assessment.

## Patient outcomes

- 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 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.
- A medical research lead and nursing research lead managed a portfolio of research projects focused on patient outcomes. In the three years prior to our inspection, research staff in the unit had contributed to 24 international published studies, each of which influenced practices at the hospital. The team was developing research in peri-operative critical care and

treatment outcomes for haematological malignancy. Specialised working groups presented research findings to clinical staff and worked together to apply learning to clinical practice.

- The CCOT team had completed two studies focused on the management of patient transition from ward-based care to end of life care with critical care outreach input. The study identified areas to prioritise for such patients and a larger study was planned to help staff create a new pathway.
- Staff 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.

## Competent staff

- A clinical nurse educator (CNE) was dedicated to the critical care teams and supported new nurses to achieve national critical care competencies and a foundation course in cancer care, including oncology modules. The CNE ran eight study days per year for different bands of staff, including clinical simulation days for staff nurses and team building and leadership days for band seven nurses. There was a vacancy for an additional part time CNE and the existing member of staff managed the nurse education programme while awaiting a new member of staff.
- All staff were allocated protected study time for mandatory training and specialist days, such as medical device training.
- The clinical nurse lead was dual trained in cancer and intensive care.
- Between March 2015 and March 2016, 82% of critical care nurses overall and 100% of consultants had an up to date appraisal. While nurses did not meet the trust's target of 85% as an average, in four months during this period the unit performed better than the target.
- Staff attended trust inductions appropriate to their job role and planned contract. For example, junior doctors attended a one-day critical care induction and a one-day trust induction. New nurses attended a five day trust induction and a specialised two day induction. New agency staff completed a temporary staff induction checklist and this was monitored centrally by the trust's human resources team.

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- The unit exceeded the Royal College of Nursing standard of at least 50% of nurses with a post-registration qualification in critical care as 53% of nurses had achieved this. In addition, 55% of nurses had completed a specialist cancer module and 40% of nurses had completed a mentorship programme.
- Senior staff supported nurses to complete a preceptorship programme, which six individuals had completed in 2015/16.
- A 'New to Critical Care' programme for new nurses helped to ensure they developed their skills and competencies in line with the acuity of critical care patients.
- Staff completed life support training proportionate to their clinical responsibilities and grade. For example, registrars had advanced life support training and advanced airway skills and all critical care outreach (CCOT) team nurses had advanced life support training. The healthcare assistant (HCA) assigned to the Sutton unit was trained to intermediate life support and their experience enabled them to support advanced life support trainers.
- Junior doctors rotated through the unit on a four-month basis. During this time they completed the Basic Assessment and Support in Intensive Care Course (BASIC). Junior doctors completed a one-day induction and were encouraged to complete chest drain and central line courses provided by the hospital.
- Senior clinical staff demonstrated a passion for ensuring nurses were supported to progress clinically, professionally and academically. This included structured development pathways for band five and band six nurses and support to complete postgraduate diplomas and Master's degree courses.
- Education was a key focus for the senior team and this was demonstrated through the extensive range of specialist clinical training offered to staff. This included the CCOT team, amongst which 45% of nurses were qualified non-medical prescribers and 70% were qualified in advanced physical assessment. An advanced critical care nurse practitioner role had been secured alongside patient safety fellows and educational fellows.
- A simulation suite was available at the Chelsea site and all critical care staff had access to this for teaching and learning as part of multidisciplinary exercises.
- Nurse-led SIG arranged training sessions from external specialists to provide staff with learning and competencies in focused areas. For example, the safeguarding and vulnerable adult SIG arranged for a dementia expert provided staff with advice on the effective use of the environment for patients living with dementia. The moving and handling team SIG arranged for staff training using bariatric suits.
- The pressure ulcer and wound SIG used learning from pressure incidents to implement a trial using new turning record charts displayed on bed bay doors. The group also selected new dressings and trialled new mouth care products to try and reduce pressure incidents, such as prophylactic dressings over patient's ears. In addition, the nurses in this group and shift lead nurses had been trained to take medical photographs of pressure areas during out of hours periods for medical review. The unit also introduced daily measurements of patient's legs to ensure the correct sized stockings were used.
- The CNE had identified a number of agency nurses who regularly worked on the unit. Those who knew the unit's policies well and demonstrated they could work within the ethos of the team were offered intravenous fluid training. This would enable them to take more responsibilities on the unit with appropriate training.
- Peer teaching and learning was encouraged amongst staff of all grades. For example, staff in each of the SIGs delivered specialised training to colleagues. The dedicated healthcare assistant in the Sutton unit was a basic life support trainer and delivered this training to other HCAs and staff across the hospital.
- Staff involved in the administration of chemotherapy had been appropriately trained and assessed for competency.

## Multidisciplinary working

- The CCOT matron and the senior clinical nursing research fellow operated a follow-up clinic as part of patients' rehabilitation. Clinicians and other staff who had been involved in a patient's care were able to join follow-up meetings, which were used to discuss progress and concerns. The follow-up clinic was available to patients who had been cared for in the unit for over 48 hours and was offered three months after discharge. This meant the unit adhered to NICE clinical guidance 83 (CG83) which relates to the rehabilitation of critically ill patients.
- Two physiotherapists completed an audit of the unit's compliance with NICE CG83. The study found staff



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adhered to the guidance in 100% of cases with the exception of the use of short clinical assessments and 'about me' bedside information boards.

Physiotherapists presented the results of the study at a critical care multidisciplinary meeting and introduced an education programme to improve adherence to the guidance.

- A range of allied health professionals were dedicated to the critical care unit. This included a dietitian, 2.6 physiotherapists, a pharmacist, a pharmacy technician, an occupational therapist, a speech and language therapist and support from clinical psychology and massage therapy. A team of four administrators supported the unit.
- 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 videolink. The acute oncology service, palliative care team, microbiologist and occupational therapist additionally contributed to this meeting.
- A 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.
- A microbiologist was available daily and conducted a dedicated ward round six days a week. On one day a week this was combined with the multidisciplinary round to ensure collaborative working.
- The unit was part of the London Cancer Alliance through the collaboration for leadership in applied healthcare research.
- The acute oncology service worked with the CCOT team during weekly multidisciplinary meetings.
- Multidisciplinary teams led two weekly ward rounds, one for general critical care patients and one for rehabilitation.
- The unit had a number of service level agreements with nearby hospitals that could provide critical care services for patients with specific needs, such as those with cardiology, gastrointestinal and respiratory conditions.
- Staff were encouraged to work with other hospital teams to gain skills and experience from working in

multi-professional teams. For example, the HCA dedicated to the Sutton unit led a weekly chest drain clinic and was able to provide central venous access in patients undergoing cell therapy.

- A research nurse worked with local GP surgeries to support GPs to provide care for critical care patients after discharge. This included helping them to understand the terminology used in discharge letters.

## Seven-day services

- Consultants were available on the unit until 8pm daily and contacted the senior doctor on shift at 10pm by telephone. A consultant was always available within 30 minutes of both hospitals out of hours. This meant the unit met the medical cover requirements of the Intensive Care Society.
- A senior airway trained anaesthetic or intensive care medicine registrar was available 24-hours, seven days a week at both hospitals.
- A hospital at night service was in place at both hospital locations, and this provided additional support for critical care staff out of hours.
- Staff had 24-hours, seven day access to interventional radiology services through a shared rota with another hospital.
- Cardiology cover was available 24-hours, seven days a week through a service level agreement with a nearby hospital. This meant staff at the Chelsea site could obtain a cardiology consultant or registrar out of hours who would visit their unit for patient assessment.
- Dedicated routine dietetics cover for critical care was not available overnight or at weekends. Although there was an emergency on-call system, staff were trained to use total parenteral nutrition protocols in place of a dietician during these times.
- The Sutton step-up unit had access to a consultant anaesthetist 24-hours, seven days a week. The site also had 24-hour laboratory support.

## Access to information

- Staff had access to medical history and records from other areas of the hospital and other providers through the electronic system. This information could be viewed alongside current observations and assessments to help clinical staff in their treatment plans and decision-making.

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- Discharge plans and letters could be generated from the electronic system which ensured GPs and community health providers received timely and up to date treatment summaries.
- The critical care pharmacist used the electronic system to complete medicine reconciliation to ensure new patient prescriptions were appropriate based on existing prescriptions.
- Staff at both the Chelsea and Sutton sites had access to the same information and could view this concurrently during video-based patient reviews.

## Consent and Mental Capacity Act

- Staff followed a number of protocols in ensuring they provided effective care to people who had a mental health need. For example, a doctor would establish if a patient who lacked capacity did so because of delirium or confusion rather than an existing mental illness, which would ensure they received the most appropriate treatment. Unit protocols also provided staff with guidance on the management of challenging behaviour, such as attempted violence.
- Vulnerable patients were identified on admission and indicated to staff the additional types of support they should consider. If a patient could not provide verbal consent for an examination or procedure due to communication difficulties, staff obtained the rapid support of the Speech and Language Therapy team.
- An on-site psychiatric liaison team provided support to patients who were subject to a Mental Health Act order and critical care staff could contact them out of hours if needed. This helped clinical staff ensure they acted legally and in patients' best interests.
- A consultant conducted a mental capacity assessment during the morning daily ward round. If the assessment indicated the patient may lack capacity, a best interest assessment (BIA) was completed and a Deprivation of Liberty Safeguards (DoLS) application was made. Staff could record and submit both processes at the patient's bedside using the electronic system.
- Staff had rapid access to all trust and unit policies relating to the Mental Capacity Act (2005), mental capacity assessments, BIAs and DoLS on the electronic system and demonstrated how they could use these to support them to provide appropriate care.
- A consultant and a junior doctor led a research project into the applicability and efficacy of DoLS in critical care. As a result of the study, staff considered the use of

pre-consent for surgical patients and enhanced the DoLS training new staff received at induction. The unit also implemented Faculty of Intensive Care Medicine 2016 DoLS guidance.

## Are critical care services caring?

Outstanding



We rated critical care at the Royal Marsden, Chelsea as outstanding for caring because:

- Staff identified 'compassion' as one of the unit's four core values and worked to embed these into every element of the care and service they provided.
- Staff at all levels demonstrated dignity, kindness and compassion when speaking with patients, their relatives and visitors
- Families we spoke to told us staff were courteous and respectful and they felt involved in the treatment decision making process.
- Emotional support and counselling services were available to patients and their relatives, including on-site multi-faith Chaplaincy and clinical psychology.
- Patients and their relatives were involved in every stage of care and treatment. This was through bedside conversations, conversations about consent and an innovative enquiry service accessible by e-mail.

## Compassionate care

- Compassion was one of the unit's four values that staff worked with and they embedded this in all areas of practice, from clinic treatment to time spent talking with relatives. For example, we saw staff talking gently to patients who were sedated and ventilated while moving them to reassure them and explain what was happening, in case they could hear.
- The unit contributed to the Friends and Family Test (FFT) and conducted a separate, patient experience survey. From January 2016 to March 2016, 98% of patients rated the care they received as excellent or very good. In the 12 months prior to our inspection, 100% of FFT respondents rated their care as excellent or very good in all but one month.

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- Staff were undertaking a study of patients' quality of life after they were discharged from critical care and how they perceived their time in the unit. The results of the study would be used to inform how staff shape and deliver compassionate care.
- Qualitative feedback from the FFT and the patient experience survey were displayed in the unit each month. Recent feedback included plaudits for "Knowledgeable, professional and positive" staff and for their "Gentleness and constant care."
- A patient told us, "Staff are passionate about what they do. They are totally committed. I've had nothing but kindness shown."

## Understanding and involvement of patients and those close to them

- A large, easy to understand information board was on display at the main entrance to both units. The boards included photographs of each member of staff along with their job title and information for patients on who they could contact for support, such as the clinical nurse lead.
- Between January 2016 and March 2016, 81% of patients who responded to the patient experience survey said they felt able to talk to staff about their worries and fears.
- Staff evaluated the follow-up clinic and in the latest results, from 2014/15, 97% of patients said they found the clinic helpful.
- An information leaflet was available for patients and relatives that explained the transfer process for when a patient needed to be transferred between sites. This information was produced by the critical care network.
- Staff had created a video for patients about critical care. This included short interviews with staff and former patients and explained what they could expect. Former patients discussed their experiences to try and help reduce patient anxiety about a critical care admission.
- The clinical nurse lead conducted a family round every two weeks for the relatives of patients who were being cared for on a long-term basis. This enabled them to catch up with the family privately, discuss their concerns and obtain feedback from them on the care received.
- A relative we spoke with said, "The consultant explained [family member's] treatment very well and rang me personally at home after their surgery to explain the next steps."
- A folder was available for relatives that included photographs of key equipment in the unit as well as an easy-to-read explanation of what it was used for.

## Emotional support

- A clinical psychologist was available on site at all times and staff could refer patients or relatives to them for support.
- A follow-up nurse sent a bereavement card to all families who lost a loved one in the unit. Where staff considered it beneficial, people were also able to return to the unit to speak with staff and look at the area in which their loved one was cared for. An on-site bereavement service was available but staff told us the time they had to refer someone to this was very slim and they would sometimes have to refer people back to the GP for counselling.
- There were multiple thank you cards and messages on display from patients and relatives expressing their gratitude for the support and care they received.
- Staff recognised the emotional support pets could provide to people and had established a risk assessment and protocol for relatives to bring pets to the unit to visit patients. This ensured patient safety was not compromised and included guidance for infection control and hygiene.
- The palliative care team worked with family members to support their emotional needs and develop individualised end of life care pathways.
- As part of the follow-up clinic, patients had access to post-traumatic stress testing and staff could refer them to the Improving Access to Psychological Therapies service, to a cognitive behavioural therapist and to community cancer support centres.

## Are critical care services responsive?

Outstanding



We rated critical care at the Royal Marsden, Chelsea as outstanding for responsive. This was because:

- Staff demonstrated a commitment to meeting the individual needs of people, particularly needs that made them vulnerable. This included attention to detail in the adapted environment and rapid referrals to specialist teams.



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- Facilities for patients and relatives in the unit included on-site catering, an outdoor balcony area and a bathroom with piped air and oxygen. Overnight accommodation was available for relatives.
- Numerous service improvement nurses were in post to support individual needs, such as people living with dementia and learning disabilities.
- The unit performed positively compared to the national average for discharge delays and unplanned readmissions. The clinical nurse lead and nurse coordinators were proactive in identifying areas of slow flow and access and working with them to reduce delays.
- There was a robust transfer protocol in use when patients were transferred from the Sutton step-up unit to the Chelsea site. This process was led by senior clinicians with airway training and senior nurses with transfer and advanced life support training.
- Formal complaints were rare. When they had been received, an appropriate investigation process had been used to identify opportunities for learning or changes in practice.
- The rehabilitation pathway met national best practice guidance and was led by experienced staff that continually looked for opportunities to improve it.
- The use of patient diaries was based on extensive research conducted by a senior clinical nursing research fellow. Staff paid exemplary attention to detail in the preparation of the diaries, including adhering to cultural and confidentiality needs.
- Staff encouraged vulnerable patients who would be planned elective admissions to the unit to visit with their relatives. This helped senior clinical staff to plan their stay and make any tailored adaptations they could.
- En-suite accommodation was available in the unit for relatives who wished to stay overnight. The unit also had a service agreement with the hospital's accommodation provider, which relatives could use. Staff could organise reclining chairs and fold-away beds for relatives who wished to stay at the patient's bedside.
- Staff had organised civil ceremonies in the unit for patients who were cared for on a long-term basis.
- 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.
- An 'about me' board was posted at each bedside. Staff used this to record the likes and dislikes of each patient as well as any other important family information. Their named consultant and nurse was also recorded and there was a section titled 'Other things to know about me.'
- The Sutton step-up unit provided capacity for critically unwell patients to be treated immediately and then transferred to the Chelsea site for more intensive therapy. There was a robust, established and safe transfer policy, and we saw evidence it was used consistently. A consultant or airway-trained registrar would always accompany a transfer patient along with a senior nurse with specialist transfer training.

## Service planning and delivery to meet the needs of local people

- Staff actively supported children to visit the unit and provided guidance and information to relatives to help them do so without the risk of stress to the child. This included an information leaflet for patients and relatives that outlined common concerns about bringing children into a critical care unit and how they could ensure the visit was safe and beneficial. Parents were able to contact a paediatric psychologist at a nearby hospital who provided psychological support for children visiting the critical care unit.
- A team of welfare rights advisors were available at both hospital sites and nurses encouraged patients to contact them if their length of stay in critical care and their recovery was likely to impact their financial situation.

## Meeting people's individual needs

- Staff used a patient diary for each patient who was in the unit longer than three days. Nurses, doctors, relatives and visitors could contribute to the diary and include details of the patient's progress and treatment. After the patient was discharged, staff in the follow-up clinic used the diary to discuss the patient's stay with them. This was a useful tool, which helped people to remember some of their time and to reduce anxiety around missing memory or delusions that can occur after a critical care admission. The use of patient diaries was based on a research project staff in the unit had

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completed that focused on the most effective way to use them and whether patients would benefit substantively from their use. Staff had identified diaries were sometimes forgotten as they looked very similar to a patient information booklet. To address this, a new stock had been ordered with a different colour cover.

- As part of the results of the research project, staff gave the patient their diary only at the follow-up clinic. This was to reduce the anxiety that could be caused by reading it for the first time themselves. Staff also paid attention to detail in their use of the diaries. For example, to safeguard patient confidentiality, staff did not record very personal details such as HIV status. If the patient's culture meant it would be insensitive to mention 'cancer', staff respected this in their entries.
- A multidisciplinary follow-up clinic operated weekly, alternating between the Sutton and Chelsea sites. Patients usually joined the clinic between two and three months after discharge and could do so in person or by phone or e-mail. As part of the clinic, staff provided a health assessment, and were able to refer patients to other services if they felt it would help their rehabilitation. The follow-up clinic was tailored to patients' individual needs and was a highly-regarded service to help people plan for the future.
- The unit had capacity to admit patients for a short overnight observational stay from theatre recovery. Such patients are admitted at 8pm and discharged within 12 hours using a specific model of care.
- Staff had access to a learning disability resource folder to help them communicate effectively with people who could not speak or who had difficulty understanding the spoken word.
- 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 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).
- The unit included a dedicated room for teenagers and young adults with age-appropriate wall art and design chairs and large windows for increased natural light. They also had access to wifi and iPads with games and entertainment.
- Where patients' family members or friends could not visit them in person, staff provided the facility for video chat which people could use privately.
- Patients had access to a bathroom with piped oxygen and air and a wet room shower. A balcony was accessible directly from part of the unit. Staff completed risk assessments for patients who were in the unit on a long-term basis and could support them to spend time outside on the balcony. Relatives could join them and this was equipped with tables, chairs and landscaping.
- Each bedside space was equipped with an entertainment system including internet access and international TV channels.
- Bed spaces were equipped with 'intelligent glass' to help staff provide privacy and dignity for patients. This meant the transparency of the glass could be altered to allow the patient to undergo examinations and assessments privately.
- The senior nurse co-ordinator and clinical site practitioner liaised at the end of each critical care ward round to plan admissions and discharges. This was a proactive, structured process that minimised access and flow disruption. It was also responsive to consultant staffing levels and meant all admissions took place within four hours of the decision being made.
- All patients were reviewed by a critical care consultant within 12 hours of admission. This met the guidance of the Faculty of Intensive Care Medicine.
- There were established visiting times in the unit to help staff conduct essential ward rounds uninterrupted. However, the senior team recognised the need for flexibility with this and agreed other visiting times were appropriate.
- The moving and handling SIG had trialled and implemented a number of new items of equipment and processes to help bariatric patients be cared for safely. This included a dedicated bed bay with ceiling hoist, reinforced floor, flat side sheets for lateral transfers and tubular slide sheets for up and down transfers. Staff had been trained in the safe use of all of this equipment.
- During a nurse handover staff demonstrated their commitment to meet individual patient needs. For

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example, one patient would not respond if staff called them by their documented legal name. Instead they preferred a different name. During the handover staff made sure everyone understood this.

- Physiotherapists established a 'spring into action' programme for patients who were discharged with a rehabilitation plan. This involved a review of their physical condition and if physiotherapy could improve their recovery, the hospital team would refer the patient to community physiotherapy.
- Staff used a blue butterfly symbol on the patient noticeboard to discreetly highlight where a patient had additional needs such as a language barrier, communication problem or dementia.
- Patients with learning disabilities received a 'passport' during their pre-assessment visit to the unit. This provided easy-to-read information on what to expect during their stay and who would help them.
- Staff had developed an innovative non-emergency phone and e-mail contact service, called 'ASKMACC' (Ask Marsden Critical Care). Patients could use the service to ask questions about their recovery after they were discharged and relatives could use it to ask questions about the unit and types of care.
- Relatives had access to a significant amount of information to help them understand care, treatment and procedures in critical care. This included information on delirium, which was detailed but written clearly and accessibly to help relatives understand what could be an upsetting condition.

## 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. During this period, between 18% and 30% of patient discharges were delayed by up to four hours.
- 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.
- The nurse co-ordinator conducted daily 'huddles' with other clinicians and the hospital site practitioners to reduce delayed discharges. The clinical nurse lead worked with matrons across the hospital to identify wards with restricted capacity that contributed to delayed discharges and to consider solutions.
- CCOT saw approximately 1600 patients per year at Chelsea and 500 patients per year at Sutton.

## Learning from complaints and concerns

- The complaints policy was displayed prominently in the unit and in relatives' waiting rooms. The senior nurse or doctor on duty dealt with informal complaints at the time they were made in order to resolve them immediately. The clinical nurse lead took responsibility for formal written complaints and investigated these with support from senior nurses.
- Between March 2015 and March 2016, one formal written complaint had been submitted. This was better than the trust annual target of five written complaints. The clinical nurse lead investigated the complaint and worked with the person to resolve it.
- 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.
- In response to informal feedback from patients about light and noise at night, staff provided earplugs and eye masks at night time to help them sleep. These items were also available for relatives and demonstrated the unit's proactive approach to responding to feedback. In addition, staff had been issued with larger name badges and reminded to introduce themselves by name at every patient contact. This followed feedback from a patient who said they found it difficult to identify staff.
- A nurse told us the critical care team had changed the way they communicated discharge plans to patients following informal feedback. For example, a patient had expressed disappointment that their discharge had

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been delayed and they felt they had not been kept informed. Staff looked into this and the discharge had gone to plan but there was a difference in understanding about what 'ready for discharge' meant to patients and doctors. As a result doctors communicated this more clearly to patients.

## Are critical care services well-led?

**Outstanding**



We rated critical care at the Royal Marsden, Chelsea as outstanding for well-led, because:

- Staff had established a vision and strategy for the unit based on the trust's overarching development plan. This was clearly embedded in the unit. Staff were enthusiastic and confident in its delivery and could demonstrate how this contributed to improved patient experience, management and care.
- The clinical leadership team demonstrated a tireless approach to evaluation and reflection of the service and actively sought the experiences of staff to drive a programme of quality improvement.
- The clinical governance structure was robust with a clear leadership and accountability structure that contributed to a confident, service-focused unit team. There was significant local evidence of exceptional teamwork between all levels and grades of staff.
- Staff were encouraged to develop their innovative practice through research projects and piloting new projects. A critical care outreach nurse had won an award for their work in patient safety.
- A programme of regular meetings was scheduled in advance to maximise the number of staff who could attend. The minutes of meetings showed us they were used effectively to communicate changes in practice and policy to staff.
- Engagement with staff was continuous and they were able to influence the running of the unit and develop their leadership skills through continuous professional and clinical development.
- The unit had a substantial international critical care research profile. Research was used to contribute to dynamic treatment pilots in the unit and enabled the unit to fund innovative trials and projects led by its own staff.

## Vision and strategy for this service

- Critical care had its own vision and strategy that focused on the specialised needs of its patients. This included developing innovative and precision medicine to enable patients with cancer to return to oncological treatment after an admission to critical care. Staff had contributed to the unit's strategy through engagement sessions with the senior clinical team. Their contribution was also used to form the service improvement groups (SIGs), which were based on improving patient experience and outcomes within the vision and strategic plan.
- Staff at all levels of the unit told us they had contributed to the development of the vision and strategy and could tell us how this applied to their work and professional interests.
- The senior nursing team monitored the work of the SIGs to make sure patient experience and outcomes were benchmarked and were used to sustain the unit's future plans.
- The unit's research profile and demonstrable investment in professional clinical research posts formed part of a plan to establish long-term patient outcomes for those in critical care. Staff at all levels were encouraged to develop research as part of the unit's future work.
- The unit had secured significant investment in new technology, which would enable staff to perform more accurate and advanced assessments and treatment.

## Governance, risk management and quality measurement

- There was an established and robust clinical governance structure, which ensured the unit and staff teams were managed appropriately using guidance that supported them to develop professionally. The critical care units were part of the clinical services division management structure. A clinical nurse lead led the nursing team, audit team, healthcare assistants, housekeepers and ward clerks. A clinical lead led consultants, specialist registrars and trainee doctors and a critical care and theatres service lead managed a team of critical care personal assistants. A clinical governance meeting was held monthly.
- The clinical nurse lead and clinical lead chaired monthly clinical governance meetings during which complaints, incidents morbidity and mortality and quality improvement projects were discussed. Senior staff

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contributed to further structured governance processes to assess and develop the service, including a six-monthly delivery group meeting with representatives from the trust executive team and quarterly divisional management meetings.

- A monthly nursing dashboard was used to track occupancy, staff sickness and vacancies and capacity.
- A multidisciplinary governance team prepared quarterly reports to review patient satisfaction, the follow-up clinic and rehabilitation pathways.
- The cross-site critical care outreach team ensured consistency of practice and maintained their currency in practice through a monthly video link meeting.
- Members of the critical care governance structure represented the unit at the trust's integrated governance and risk management meeting to review adherence to National Institute for Health and Care Excellence clinical guidance.
- The unit was part of the North West London Critical Care Network. This relationship included peer reviews to check for quality outcomes. In the latest 2015/16 quality review, the unit was 95% compliant with measured indicators and consistently performed highest within the network.
- Senior staff maintained a risk register to manage risks that could not be fully resolved immediately. It was not always evident that risks on the register were appropriate or fully understood. For example, one entry on the register related to theft from a staff room. It was identified the failure of agency staff to return swipe cards and the disabling of the security system to the unit had contributed to this. We asked staff about this. Three nurses told us they were aware of thefts from the staff room but were not aware of any problems with or changes to the security system.
- A senior clinical nursing research fellow supported good clinical governance standards in all research in the unit. This was through representation at ethics boards and a committee for clinical research, which approved research projects following adequate peer review.
- Risks relating to research conducted by clinical staff were managed by a senior research nurse who was qualified in clinical research ethics. In addition a service improvement group focused on research and development was able to provide nurses with ethics support in their projects.

- A quarterly rehabilitation meeting was used to review all critical care activity including a complete review of each patient's care, treatment and journey through the unit. Staff used this element of clinical governance to strategize changes and improvements to the service.

## Leadership of service

- A staff management board was displayed at the main nursing station that listed all staff on duty, including the clinical sister on shift for the management of escalation issues.
- The clinical nurse lead and divisional nurse director operated an 'open door' policy which meant any member of staff could speak to them at any time they needed support or guidance. All of the staff we spoke with said this worked well in practice and helped them to feel confident and supported.
- The clinical nurse lead or senior nurse team leaders provided monthly supervision sessions to nurses as needed. The sessions could also be used for debriefs after a patient's death and enabled staff to speak candidly about their experiences. Staff said this structure was useful but they felt able to approach the senior team whenever they wanted, without the formality of an appointment.
- All of the clinical staff we spoke with told us they were happy with the support from the clinical nurse lead, outreach matron or clinical lead. One nurse said, "The matron is really visible. If she's not on the unit she's not far. Everyone knows her number – it doesn't matter if you're the most senior nurse or a new healthcare assistant, you can always call."

## Culture within the service

- Critical care operated within four established values, which staff contributed to through their work ethic and communication with each other, patients and relatives. Staff had created the four values through engaging with the senior team and identifying which of the hospital's overall values most represented the work of the critical care unit
- The senior team demonstrated commitment to staff welfare and wellbeing. For example, team building activities included sports events, picnics and charity runs. Staff had also been provided with meditation sessions. Staff we spoke with told us they felt "very much looked after" as a result of the support activities and that they felt more able to come to work rested and with a focused mind.



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- Staff Awards were provided as a strategy to maintain morale. Staff were also able to influence their own working patterns, work flexibly and secure study leave and funding for professional development.
- Staff told us they felt they worked in a unit that valued excellent performance and they were supported to do this. One nurse said, "I like that we see people at different points of their treatment. Seniors know exactly what your skills are and are there for you all the way to help develop. Because of this I never go home wishing I'd done more – they know how to get the very best out of you."

## Public engagement

- The unit actively sought feedback from patients and relatives. All of the relatives' areas, including quiet rooms, included a contact card for real-time feedback. This included for relatives of patients admitted at the Chelsea site directly and patients who were transferred from the step-up unit at Sutton.
- Nurses had formed a new service improvement group for 2016 focused on patient experience and planned to work closely with the rehabilitation group.
- Staff were active in fund-raising projects with the public, including taking part in the 'Marsden March' and preparing a 'food day' auction to raise funds for a natural disaster. This helped to engage visitors with staff on a non-clinical level.
- There was an active public and patient involvement group made up of 50 former critical care patients. This group had supported a content analysis of qualitative patient feedback to help senior staff understand trends in feedback, both good and bad.

## Staff engagement

- The clinical nurse lead demonstrated a proactive approach to managing the nurse turnover rate. They established a programme of exit interviews and found the majority of nurses left the unit to take up a promotion.
- Team meetings were offered at two different times to enable all staff to attend.
- The trust conducted an annual staff survey which complemented local clinical leads in improving the working environment based on staff feedback. For example, sinks had been changed in one part of the unit to reduce noise and additional curtains had been provided to improve patient privacy when the high dependency beds were in use.

- The new patient experience group would additionally engage with staff to use their experience of caring for patients on rehabilitation pathways to improve future outcomes.
- Feedback from staff and actions taken were documented in staff meeting records and followed up by the clinical nurse lead or shift leaders. For example, one team raised concerns about some attitudes towards them and senior staff took steps to remind the whole unit of the expected values and respectful communication.
- New staff completed a short resume and displayed this with a photograph in the staff room when they started worked on the unit. This helped the rest of the team recognise them and get to know them.
- Team leaders organised a team day twice each year. Part of this was to provide specialist training, which teams could nominate. The senior team had a focus on staff welfare and morale and had provided tai chi and meditation sessions during team days to promote relaxation and wellbeing.







## Innovation, improvement and sustainability

- Clinical staff with specific expertise and interest contributed to a patient-centred research programme that focused on perioperative critical care and outcomes following treatment for haematological malignancy. This was a multi-site multidisciplinary collaborative project with other NHS and academic centres. Other areas of research included cardiac injury associated with chemotherapy and surgery and cellular therapy for septic shock.
- The unit had secured funding for a new simulation nurse lead who would be dedicated to critical care.
- A new consultant with an interest in research had been appointed who would contribute to building the unit's research portfolio. An increase in the number of research nurses was also planned to contribute to this.
- As part of a broader plan to increase clinical staff sustainability and drive forward innovative practice, a new advanced critical care practitioner role had been developed within the Faculty of Intensive Care Medicine framework. This included a robust clinical and professional development programme with structured supervision.

# Critical care

- The unit was part of a network of European cancer critical care data contributor sites. This involved participating in multicentre international research studies to share learning and development of practice specific to critical care patients with cancer.
- The unit was a pilot site for the new North West London Critical Care Network peer review programme.
- Clinical research staff in the unit were developing a frailty care pathway to improve post-surgical care for cancer surgery patients. Two Darzi fellows had been appointed as part of this project, which embedded the unit's commitment to sustainability and innovation in evidence-based care and treatment. The unit's research profile was internationally recognised and as a result the unit had been selected to host a global conference on perioperative care of the cancer patient.
- The clinical leadership team promoted innovation and development in clinical equipment and had secured new items to help with the use of blood products for haemato-oncology patients and to monitor liver function.
- A family study was in progress to develop a toolkit for supporting families who had spent time visiting a relative in the unit. Staff planned the toolkit to be an electronic resource with links to complementary therapy services as an emotional support strategy.
- The unit accepted eight to 10 student nurses per year. The clinical leadership team demonstrated flexibility when a student nurse on placement elsewhere in the hospital had asked to switch their placement to the unit. The student had been allocated a supervisory nurse and spoke very positively of their experience. Senior staff understood this could be a potential source of future nurse sustainable recruitment.
- 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.

# End of life care

Safe	Good 
Effective	Requires improvement 
Caring	Outstanding 
Responsive	Good 
Well-led	Good 
Overall	Good 

## Information about the service

End of life care (EoLC) refers to patients who have been identified as having entered the last 12 months of their life or less. It refers to health care, not only of patients in their final days or hours of their lives, but more broadly the care of all those with a terminal illness or terminal disease condition that has become advanced, progressive and incurable.

Palliative care is a multidisciplinary approach to specialised medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress and mental stress of a serious illness, whatever their diagnosis is (cancer or non-cancer). The goal is to improve quality of life for both the patient and the family. Palliative care can be provided along with curative and non-curative treatment and is appropriate at any age and at any stage in a serious illness.

The specialist care team for the Royal Marsden Hospital Chelsea site is made up of clinical nurse specialists, consultants and staff facilitating the care of patients in the final phase of life. They collaborate with the chaplaincy service, social workers, the pain team and pharmacists. The team works closely with the patient and their relatives, the hospital doctors, ward nurses and other professionals in supporting the patient's needs. They also liaise with hospices and other community support agencies. The hospital have established a Hospital2Home service in order to improve effective handover and transfer of care to community providers.

The specialist service is a seven day service. The palliative care nurses work Monday - Friday 9am - 5pm. Out-of-hours cover is provided by palliative care Specialist Training Registrars (StRs).

The hospital has a dedicated ward for EoLC patients; however patients who are identified as being at the end of life may also be admitted to other wards within the hospital.

There were 1,293 referrals to the specialist team in the same year, although this covered both the Chelsea and Sutton sites.

We visited a variety of wards across the hospital including: Horder, Wilson, Wiltshaw, Ellis, Burdett Coutts and Granard House 1, 2 & 3. We also visited the Patient Advice and Liaison Service (PALS) office, the body store, the hospital chapel and the prayer room. We reviewed the medical records, drug charts and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records of seven patients at the end of life. We also reviewed patient comments and thank you cards, as well as a variety of data.

During this inspection, we spoke with over 70 members of staff; including members of the specialist team, ward nurses, matrons, health care assistants, trainee doctors, consultants, allied health professionals, porters, the chaplain and the bereavement officer. We spoke with nine patients and eight family members and friends of patients. We reviewed seven sets of care records. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the hospital and trust.



# End of life care

## Summary of findings

Overall we rated the End of Life Care (EoLC) at the Royal Marsden, Chelsea as good because:

- The specialist team were highly skilled and knowledgeable throughout the hospital, and provided effective support to clinical staff.
- Patients were provided with good quality, safe care at the end of their life. Patients were cared for in a caring and compassionate manner by staff at all levels. Their privacy and dignity was maintained throughout their stay in hospital.
- Staff ensured patients and their relatives were fully informed and involved in their treatment decisions. Consent and capacity were considered appropriately.
- There was an extensive education programme to support staff in delivering this care in line with appropriate national standards and best practice guidance.
- Regular and meaningful clinical audits were carried out in a variety of topics relating to EoLC. Information and learning points relating to incidents and complaints were shared across the trust. Improvements had been made across the service as a result of this, and staff were able to describe these changes.
- Patient care records and risk assessments were thorough and complete, with appropriate consideration given to different aspects of holistic care at the end of life.
- The needs of individuals were considered and largely met by the service. The majority of patients achieved their preferred place of death.
- Pain relief, nutrition and hydration were considered in nearly all cases and patients were happy in regard to these outcomes. Symptom control was considered and well managed, using both traditional medical methods and complementary therapies.
- The trust had a clearly defined vision and strategy to improve palliative care provision.

- Regular meetings and forums took place that addressed issues in EoLC with various stakeholders with a view to strengthening this provision.
- Senior staff were supportive and approachable, encouraging an open and transparent culture.

However;

- Referral to palliative care was not always made earlier in the patient pathway. This affected their access to psychological support and advanced care planning at the end of life. Psychological support often carried a long waiting time and there was no formal bereavement support offered to bereaved families through the hospital.
- Porters were broadly unaware of the procedures to follow in terms of infection control and escalation of potential problems in relation to the body store.
- The arrangements for checking temperature storage in the mortuary were not sufficiently robust.
- Body store fridge checks were not retained, and there was an inconsistent approach across the trust sites.
- The staff we spoke with were not aware that there was a lay member with responsibility for EoLC on the trust board. There was also little knowledge of items relating to EoLC on the trust risk register, and no awareness items should be added that presented a potential issue affecting patient care.

# End of life care

## Are end of life care services safe?

Good



We rated end of life care at the Royal Marsden, Chelsea as good because:

- There was an open and transparent culture in regards to reporting incidents and learning was shared across the specialist team and trust.
- There were robust systems and processes to ensure infection prevention and control measures were maintained. The body store was visibly clean. Staff demonstrated appropriate hand hygiene.
- Policies and procedures were followed for the safe administration of controlled drugs and anticipatory medication.
- Patient care records and risk assessments were appropriate, thorough and complete.
- The training programme provided in EoLC by the specialist team was well considered and helped support staff in providing effective palliative care to patients.
- Staffing levels in the specialist team were sufficient for staff to perform their roles.
- We saw the documentation used in the body store for recording patients details and the ward staff were familiar with the systems to process the death, burial and cremation certificates.

However:

- Staff were unaware of an incident relating to the identification of a patient in the body store nor any learning arising from this.
- Porters were broadly unaware of the procedures to follow in terms of infection control and escalation of potential problems in relation to the body store.
- The monitoring of the temperature of the body store fridges was inconsistent and not in line with the body store operations policy and procedure document.

### Incidents

- Staff we spoke with were clear about how to report an incident using the Datix electronic incident reporting system and were confident any incidents reported would be investigated. Nursing staff we spoke with understood their responsibility to raise concerns and to record safety incidents and near misses.

- The palliative care senior management team met monthly. Incidents formed a standing item on the agenda of these meetings and were thoroughly discussed.
- When we spoke to staff they were able to describe the rationale and process of duty of candour. The duty of candour regulation was introduced for all NHS bodies in November 2014 to ensure organisations act in an open and transparent way in relation to care and treatment provided to patients
- During our inspection we identified an incident that had been logged regarding a patient who had two identity wrist bands on with two different names.

### Cleanliness, infection control and hygiene

- The trust had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this. Each ward also had an infection control link nurse. Link nurses acted as a link between the ward and the infection control team. Their role was to increase awareness of infection control issues and motivate staff to improve practice.
- We observed ward and departmental staff caring for patients at the end of life complying with the trust policies and guidance on the use of personal protective equipment. Staff were bare below the elbow, sanitised their hands between patient contacts and wore aprons and gloves when they delivered personal care to patients.
- We saw on all wards visited there were hand gels available at entrances and notices reminding staff and visitors to use them.
- The body store and viewing areas were visibly clean, tidy and smelt fresh. We did not observe hand cleaning procedures in use following our visit to the body store.
- The porters we spoke with were unaware of the appropriate infection prevention measures to take in relation to deceased patients. The trust confirmed all porters had undertaken infection prevention and control training.

### Environment and equipment

- The trust used T34 syringe drivers for delivering measured doses of pain medication. These conformed to national safety guidelines on the use of continuous

# End of life care

subcutaneous infusions of analgesia. The syringe drivers had in-date annual maintenance checks and/or corrective maintenance in line with the manufacturer's recommendations.

- Ward staff obtained syringe drivers from the equipment library. We were told there were no problems in accessing syringe drivers whenever they were needed for patients. We saw evidence of the availability of syringe drivers. If patients were discharged home with syringe drivers, they were given prepaid envelopes to return these after community resources had been sourced. The equipment library would follow-up these patients to ensure the syringe drivers were returned.
- The body store had capacity for 12 bodies. The fridges consisted of a number of labelled compartment bays, each containing racks for holding the body trays upon which bodies were stored. Bodies in a range of sizes were able to be stored due to the removable nature of the trays. There were arrangements with neighbouring mortuaries in case of emergencies. There was an automated temperature measurement system.
- The facilities department undertook a daily check of the body store fridges, the temperatures were noted in a log and were signed by the manager at the end of the week and then shredded. We identified on two days during the week of our inspection that the temperature of the fridges had exceeded the four degree temperature range identified in the body store policy and procedure document. We were informed the estates department had been informed of the increased in temperature outside of normal range and the fridge was rechecked at a later time during the day by the facilities department. They did not however; make a note of the temperature on the second viewing, so we were not assured the temperature had returned to the option temperature range.
- The fridges were linked by alarm to the switchboard for temperature control and 24 hour servicing arrangements were in place in the event of there being a problem. We were concerned by the lack of evident use of the escalation plan. The facilities manager informed us they reported to the estates helpdesk if the temperature of the fridges went above four degrees. In the weekly temperature log we were able to view the temperature on two occasions had been higher than four degrees. When we checked with the estates team the matter had not been reported to them on either

occasion. We were told the facilities teams would check the temperature a second time during the day if the temperature had been high but this was not reported or amended on the temperature log.

- We observed the systems to ensure the right person was in the correct body store and prevented the wrong person being taken by undertakers or presentation for viewings at the hospital.

## Medicines

- There were separate sections of the inpatient chart for controlled drugs (CDs), including opiates. There was also a separate CD prescription for outpatients and those who were going to be discharged. There was a patient information leaflet given to those patients prescribed strong opiates. This is in line with NICE Clinical Guideline 140, relating to the safe and effective prescription of strong opiates.
- In the event of a syringe driver being used, an additional chart was used to monitor the site and rate of infusion, as well as the battery and maintenance of the device. We saw four charts in use and correctly filled out by nursing staff to optimise patient safety and pain relief.
- There was a guide for medical staff to follow on the prescription of anticipatory medication. These were prescribed for patients, including those discharged to their own home or a hospice, to manage pain and common symptoms, if required. This prevented delays in symptom and pain relief. We saw evidence in notes guidelines on this checklist were considered in appropriate circumstances. The specialist team were usually involved when these medications were prescribed, as indicated by two junior doctors we spoke with.
- Some of the specialist nurses were nurse prescribers and supported junior medical staff in prescribing medicines at the end of life. This meant patient could access some medications without needing to wait for their doctor to prescribe it.
- With many overseas patients receiving treatment then returning home to their own country to receive further care, pharmacists ensured the medicines prescribed were available in the patients' home countries.

## Records

- Hospital staff used electronic patient records to record patients' needs and care plans. The seven records we reviewed were accurate, legible, up-to-date and stored securely.

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- Some nursing notes were still recorded on paper and these were stored appropriately behind locked doors with swipe card access.
- When members of the specialist team were involved in the treatment and care of patients at the end of life, they recorded the discussions and agreed actions on the electronic system. This formed part of the inpatient case notes section of the record. The specialist team commented they would ideally like a separate tab within this section for palliative care, especially for the 'Principles of Care' document, to ensure ease of access and increase usage. The document had only been rolled out electronically in the previous few months and ward staff awareness and utilisation varied.
- We saw Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) forms and all were completed fully with the exception of the date that the DNACPR should be reviewed by. The review date was not entered in to any of the DNACPRs we viewed.

## Safeguarding

- Staff understood their role with regards to protecting patients' from harm or abuse and reporting any issues. This included identifying any risks to patient's family such as children or vulnerable adults whose main carer may be a patient.
- Staff had access to the trust safeguarding policy and procedures on the trust's intranet.
- Safeguarding level 1 and 2 was part of the trust annual mandatory training; 88.1% of staff across the trust had completed the safeguarding children level one training, 89.3% safeguarding children level two and 62.9% had completed safeguarding children level three training. The majority of staff (91.6%) had completed safeguarding adult's level one training. Staff at all levels knew who to contact if they wanted further advice.
- Staff demonstrated a good knowledge and understanding of safeguarding vulnerable adults.
- The staff we spoke to were able to describe what constituted a safeguarding concern and were aware of their role and responsibilities to safeguard vulnerable adults from abuse. The trust had a dedicated Deputy Safeguarding lead.
- There was a trust wide Vulnerable Adults Strategy 2014 -2017 and a Trust Safeguarding Children and Adults Board, which met quarterly.

## Mandatory training

- The annual mandatory training programme for nursing staff and substantive consultant staff included end of life care (EoLC). There was also a short section relating to EoLC in the trust induction for new staff. The specialist team covered key areas such as what the team's role was, how to make referrals to the service and how to use the electronic 'Principles of Care' document effectively. The chaplaincy team also trained new staff in the basics of pastoral and psychological care.
- In addition to this, the specialist team ran in-house palliative care update days twice a year. Topics covered included pain management, nausea and vomiting, and identifying those in their last days of life. A series of workshops ran in the afternoon on subjects such as use of syringe pumps, procedures relating to last offices and rapid discharge in EoLC. We spoke to doctors and nurses and their feedback was these sessions were useful.
- Every four months the specialist team gave junior doctors formal teaching on subjects relating to EoLC and symptom control as part of their weekly teaching programme. One of the specialist consultants also organised other teaching sessions relating to EoLC for junior doctors. This consultant had won an award for 'Excellence in Education' in the staff awards in 2015. Junior doctors felt the training they received from the specialist team was very useful and they felt supported.
- Porters were also given annual mandatory training, covering topics such as safeguarding, patient handling, basic life support, information governance, infection prevention and EoLC. 100% of porters have completed the training.

## Assessing and responding to patient risk

- Clinical needs of patients were monitored through regular nursing, medical, therapy and pastoral care reviews.
- At the end of life, there were inevitable changes to the body such as weight and skin integrity. Staff used tools to assess risks to patients, such as pressure damage skin integrity assessments to identify and prevent pressure ulcers. Appropriate pressure relieving mattresses and regular repositioning were given to patients at risk.
- Falls risk assessments were undertaken in patients with impaired mobility. Management plans involving

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physiotherapists and mobility aids were put into place. Falls were reviewed each month at a falls steering group. This identified trends and themes which were emailed to all wards and displayed on ward notice boards.

- Early Warning System (EWS) were used by staff to identify if escalation of care was required. This system was used to identify patients who were deteriorating and may have required specialist team involvement.
- 'Principles of Care' documents were used by nursing and health care assistants for patients who had been identified as being in the dying phase to monitor discomfort and record symptoms. For patients where the progression of their illness was clear, the amount of medical intervention was reduced to a minimum. Care plans were based on ensuring the patient remained as comfortable as possible at all times.
- EoLC support was available from the Palliative care team covered 24 hours a day seven days a week.

## Nursing staffing

- The specialist team had at the Chelsea site had three whole time equivalent (WTE) clinical nurse specialists covering the inpatient wards. There was also a nurse consultant who worked across both sites.
- Across both sites, there was one reported vacant 0.6 WTE post for a clinical nurse specialist in palliative care, covering maternity leave. The nursing staff told us they had enough staff at the present time and would only need an increase in staffing if required to move to seven day working, which was not anticipated as current arrangements were thought to be sufficient.
- There were no statistics relating to bank or agency use available for the specialist team at Chelsea. Nursing and medical staff provided each other with cross-cover.

## Medical staffing

- The specialist medical team was shared across both sites and comprised 1.6 WTE consultants and 4 WTE specialist training registrars (StRs). Out-of-hours cover was provided by palliative care StRs and medical consultants. StRs routinely conducted ward rounds at each site during weekends and bank holidays. They would triage referrals at these times.
- The StRs covered both sites and would split their weekends across sites, spending one day at the Chelsea site and one day at Sutton. Medical staff reported the on-call rota worked well and there were no problems covering both sites.

- Risks were identified in relation to consultant level cover in the quarterly review in January 2016. However plans were in place to manage risk via recruitment of locums to ensure there was no compromise to patient care. Two consultants were currently off (one on long term sick until April 2016 and one on sabbatical due to return June 2016). Another locum consultant was on maternity leave. The service lead explained this consultant gap had not affected patient care as two regular locum consultants and another locum StR had been recruited to cover. There were plans to make one of these posts substantive.

## Are end of life care services effective?

Requires improvement



We rated end of life care at the Royal Marsden, Chelsea as requires improvement for effective because:

- Although there were many good things about the service, the 'Principles of Care' document was sometimes implemented late in the patient pathway and there was a feeling amongst many staff that we spoke to that referral to the team could be made earlier in the patient pathway.

However;

- The hospital had implemented standards as set by the National End of Life Strategy 2008 published by the Department of Health, National Institute of Health and Care Excellence's (NICE) End of Life quality Standard for Adults (QS13) and 'One chance to Get it Right' 2014 by the National Leadership Alliance for the Care of the Dying Person.
- We saw the hospital had a regular audit programme and improvements had been made across the service as a result of the findings from these.
- The specialist team provided an EoLC service 24 hours a day, seven days a week.
- A multidisciplinary team approach was in effect both across the specialist team and with the wards and services they worked with.
- The DNACPR records we reviewed, had documented that appropriate discussions had taken place with relatives regarding decisions
- Pain relief, nutrition and hydration were well managed and patients were happy in regards to these outcomes



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- Symptom control was considered and well managed.

## Evidence-based care and treatment

- Palliative care was managed in accordance with national guidelines, which formed the basis of trust policy. For example, the guidelines for symptom control were based on World Health Organisation (WHO) guidelines for management of pain.
- All new national guidance was reported at senior management meetings and shared with the wider team.
- Weekly Journal clubs attended by medical staff provided opportunities to present current research.
- The specialist team had responded promptly to the report of the independent review of the Liverpool Care Pathway and introduced a replacement document based on the five priorities of care (One Chance To Get It Right, 2014), called 'Principles of Care of the Dying'. The 'Principles of Care of the Dying' document included holistic prompts for staff to consider in the daily review of the patient. This was piloted and audited between May 2014 and August 2015. Improvements were seen with respect to discussions on hydration, preferred place of care and preferred place of death. The documentation of spiritual assessments also improved dramatically, from 42.9% to 100%. The document was introduced in paper form in September 2014 and rolled out electronically in January 2016. Nursing staff confirmed an education and training programme had taken place.
- Some of the staff we spoke to felt some patients were not put on the end of life pathway soon enough. This was said to be due to the curative culture within the organisation.
- The trust was in the process of auditing the use of the tool on the electronic records system.

## Pain relief

- Effective pain control was an integral part of the delivery of effective EoLC and was supported by the specialist team.
- We found anticipatory prescribing followed the National Institute for Health and Care Excellence (NICE) guidelines for symptom control. Patients told us their pain was effectively managed with timely pain relief.
- We reviewed seven patients' medical and care records and drug charts and saw patients had regular assessments for pain and appropriate pain relief medicine was given frequently and as required, as per their prescription.

- Where appropriate patients had syringe drivers, which delivered measured doses of pain relief medicines over a 24 hour period.

## Nutrition and hydration

- Nutrition and hydration needs were identified in patients' care plans. We saw dehydration risk assessments had been completed.
- There were clear guidelines for the assessment of mouth care, hydration and nutrition. The patient records we observed showed these were being completed and updated by staff on a regular basis. There was also space to record what was discussed and the patient and families' responses to this discussion.
- Staff assessed each patient and support and guidance was provided on an individual basis.
- Dietitians attended the weekly specialist multidisciplinary team meetings (MDT), where each patient at the end of life was discussed. Dietitians were involved with patients to provide advice and support when needed.
- Nursing staff were able to tell us how they addressed patients' religious and cultural needs regarding dietary requirements. Halal and kosher foods were readily available for patients requiring them.
- Nursing staff on the wards we visited told us patients receiving EoLC could eat and drink normally, and would continue to do so unless their condition changed.

## Patient outcomes

- The trust carried out routine audits across the specialist service, providing information to improve patient outcomes. Staff were actively engaged in a range of ongoing audits on topics including the patient experience and the effectiveness of the electronic version of 'Principles of Care' document. A three monthly audit meeting was held to present results and to report on audits in progress.
- The trust had submitted data for the most recent End of Life Care Audit: Dying in Hospital 2016 and the results were published in May 2016, which showed improvements had been made following the National Care of the Dying Audit – Hospitals (NCDAH) results in 2014. The 2014 results had revealed short comings in a number of clinical and organisational areas.
- The trust had analysed the main findings of this audit and put into place a number of recommendations and action plans to improve the provision of EoLC. They also looked at key performance indicators (KPIs) where they

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had scored higher than the national average but still felt they could improve upon. Actions put into place included: discussing spiritual care, hydration and nutrition in MDTs, highlighting these areas in the 'Principles of Care' document.

- Increased training for all health professionals in various aspects of EoLC was also put in place, along with improved information provision to patients and relatives and participation in the FAMCARE audit to gather relatives' views.
- We saw evidence of all of these improvements in the course of our inspection and through our data collection. In the modified End of Life Care Audit: Dying in Hospital 2016, the trust had achieved all five clinical KPIs. For example, a review of the patient's nutritional requirements, a review of the patient's hydration requirements and access to information relating to death and dying.
- The specialist nurses told us they had enough time and resources to be actively and meaningfully involved in each patient's case where required.
- We saw evidence the service strived to meet the needs of those suffering from side effects of treatment, such as nausea, fatigue and vomiting. The specialist team encouraged the use and regular review of both PRN (pro re nata or as required) and regular medication in view of changing symptoms. During the specialist team handover patient medication was discussed and changed to reflect the change in a patient over the previous night.
- Complementary therapies were also available to patients to help manage symptoms and side effects.

## Competent staff

- The specialist team provided formal and informal EoLC training to junior doctors and nursing staff.
- All of the nurses we spoke with could demonstrate a good understanding and knowledge of planning care for EoLC patients and were clear about when to seek help from the specialist team.
- The specialist team was made up of competent and highly trained individuals. They had opportunities to undertake personal development opportunities to enhance their skills.
- We saw evidence nursing staff participated in annual appraisals and had personal development plans.
- All wards had a nominated an EoLC link nurse, who attended the in-house palliative care update days and

fed new developments and ideas back to the rest of the ward team. These link nurses supported good practice by maintaining up to date palliative care resource folders on each ward, supporting other staff in the care of dying patients, and providing a strong link to the specialist team where required. Some of the specialist nurses were nurse prescribers and supported junior medical staff in prescribing medicines at the end of life.

## Multidisciplinary working

- Members of the specialist 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.
- Discussions at the MDT included all patients identified as requiring palliative care and patients who had died or been discharged from the service. They also discussed patients of particular concern where individual team members sought advice or support from the team.
- We were told about and shown collaborative working across the teams to provide good examples of care for EoLC patients.
- The MDT worked well together to ensure patients' care and treatment was planned and co-ordinated. There was evidence emotional support and anticipatory prescribing to support patients at the end of life work effectively.
- The private patient's wards were well integrated with the NHS services. Private patients did not receive preferential treatment over NHS patients. The specialist team worked collaboratively with the wards for all EoLC patients.
- We saw the weekly specialist team handover, where all patients on the caseload were reviewed. The handover was a well-managed session with clear priorities and work plans agreed.
- The bereavement officers within the Patient Liaison and Advice Service (PALS) reported good working relationships with the wards, chaplaincy and portering staff.
- The trust had introduced Schwartz rounds across both hospital sites to share working practices and increase support amongst staff of different disciplines. Schwartz Rounds are an evidence-based forum for hospital staff



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from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. Staff that we spoke to had actively engaged in these sessions and found them useful in promoting empathy and effective working. The sessions were well-advertised and the trust encouraged staff from all backgrounds to attend.

## Seven-day services

- The specialist team provided a seven-day service, 24 hours a day. The nurse specialists worked Monday to Friday, 8am – 6pm. Out-of-hours cover was provided by palliative care Specialist training Registrars (StRs) and medical consultants. StRs routinely conducted ward rounds at each site during weekends and bank holidays. They would triage referrals at these times. Doctors routinely attended the wards out-of-hours where required to provide care to dying patients.
- The chaplaincy service was available every day of the year, 24 hours a day. The team had arrangements with local faith leaders to provide an on-call out-of-hours service.

## Access to information

- Each ward had a palliative care resource folder for staff to refer to when required. It contained practical information such as how to obtain a death certificate, processes to follow on rapid discharge and guidelines for prescribing and administering anticipatory medication. The staff we spoke with were able to show us the folder when we requested.
- When a patient was discharged to their preferred place of dying, hospital staff gave information to ambulance crews about where to take the person if they died while being transferred. DNACPR forms were sent with the patient in the ambulance.
- Trust staff had access to 'Co-ordinate my Care' website: Co-ordinate my Care (CmC) was established in May 2012 to address the need for patients to have integrated, co-ordinated and quality care. CmC was an NHS clinical service and worked to empower patients to have choices about the care they received and to make those choices known to those who cared for them.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff undertook Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training as mandatory. There was a policy on the intranet to

support staff when considering MCA and DoLS. There was a section relating to mental capacity on each DNACPR form, which was filled out by the doctor completing it.

- Whilst visiting ward areas, we checked the medical records of seven patients and viewed the DNACPR forms for those patients. We saw all decisions were recorded on a standard form and signed by an appropriately senior clinician. All detailed full discussions with patients and their relatives. All the forms were kept in the front of the patient's care folder.
- Some staff felt conversations around EoLC and DNACPR could happen earlier.

## Are end of life care services caring?

Outstanding



We rated end of life care at the Royal Marsden, Chelsea as outstanding for caring, because:

- Staff provided sensitive, caring and individualised personal care to patients who were at the end of their life.
- Patients' privacy and dignity was maintained.
- Patients we spoke with told us they felt like equal partners in their care. They were listened to, and were involved in decision making at all levels.
- The chaplaincy team supported patients, relatives, ward staff and other professionals delivering EoLC.

## Compassionate care

- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. Staff on all the wards we visited demonstrated EoLC was a vital part of their role, and they were proud to develop a relationship with patients and their relatives.
- We observed staff whilst they provided care and support. We noted they took great care to explain what they were going to do and how they were going to do it, and ensured each patient and relative if appropriate, were happy for the care to be undertaken.
- We spoke with relatives of patients who were receiving end of life care and they told us they were very impressed by the level of care their relative had received. They told us nurses were compassionate,

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caring and understanding. One patient said “they work as a team, everyone talks together and I know what is going on”. Another patient told us the “nurses came quickly and relieved my pain.”

- We visited the body store and spoke with the porters who told us how they were respectful and caring of the deceased whilst they were being transferred to the body store. When the porters talked about moving the deceased they referred to the deceased in a respectful manner.

## Understanding and involvement of patients and those close to them

- The patients and relatives we spoke with said staff providing EoLC were professional, caring and supportive. They felt they were involved in the discussions and decisions about their care. They were given sufficient information about their diagnosis and treatment. They were able to ask questions and the answers they were given were easily understood. One patient told us “no one talks down to me, my wishes are always adhered to.”
- We observed patients being spoken to with respect. Staff introduced themselves to patients and relatives and asked permission to start examination or treatment.

## Emotional support

- Staff provided emotional support to EoLC patients. They were actively involved with patients, providing support and keeping patients and their relatives informed about their condition, prognosis and treatment.
- The chaplaincy services within the hospital provided spiritual and emotional support to patients and their relatives, irrespective of their individual faith or lack thereof. A book of remembrance was situated within the chapel.
- The hospital held an annual memorial service in St Luke’s a nearby church, for the families and relatives of the deceased. The families of patients we died in the last calendar year were invited to attend,
- During our inspection, we saw staff were responsive to emotional needs of patients and their relatives. Staff told us about examples of support they had provided for patients. For example, arranging the christening of a patient’s one month old baby on the ward in the visitor’s

room and a family told us that a nurse had talked to their family member and discovered that the patient loved to knit so had gone to the shop and brought wool and knitting needles for the patient.

## Are end of life care services responsive?

Good



We rated end of life care at the Royal Marsden, Chelsea as good for responsive, because:

- The specialist team were embedded in all clinical areas of the hospital. They were professional, responsive and supportive of patients, relatives and staff.
- Rapid discharge protocols and processes were effective in getting patients to their preferred place of care prior to their death. The discharge coordinator worked with commissioners of services, local authorities and other care providers from all over the country and abroad, co-ordinating care and facilitating access to appropriate services for EoLC patients.
- The body store view area was welcoming for relatives.
- The chapel accommodated all faiths as well as those of no faith. Staff respected the cultural, religious and spiritual needs of patients.
- Complaints were dealt with well and learning points were developed into actions to develop and improve the service.
- The chapel and Muslim prayer room were accessible 24 hours per day, 356 days of the year. The chaplaincy team provided 24 hour on call service for all faiths.

However;

- There was no formal bereavement support available through the hospital.

## Service planning and delivery to meet the needs of local people

- The Trust End of Life Care (EoLC) Strategy reflected the National End of Life Strategy and incorporated national guidance to form its objectives over the course of five years. The strategy took into account various stakeholders, such as the executive board, board of governors, staff, patients, other providers.
- The specialist team and discharge co-ordinator provided a rapid discharge for patients who wished to

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die at home, or in a hospice or other facility closer to their home. Staff told us they facilitated this and supported patients who wished to die in the place of choice.

- Where possible, staff cared for patients at the end of their life in a side room to ensure their dignity was maintained and a quiet, restful environment was provided.
- 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.
- The 'Principles of Care' document contained a section dedicated to the needs of the family, and family support was also included in the specialist MDT discussion we attended. In the booklet given to bereaved relatives, there was a section entitled "Where can I find additional information and support?" which signposted some other agencies that could be accessed for 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.
- The hospital had a viewing room where families could visit their relatives. They were escorted to the ward nursing staff, who would stay with the families in the viewing area for as long as they required. The viewing room was neutrally decorated, with seating and tissues provided. There was no religious insignia in the viewing room.
- The chapel and Muslim prayer room were accessible 24 hours a day every day of the year.
- However, staff we spoke with felt there was a lack of bereavement support for families as community agencies often had long waiting lists. Historically, there had been formal bereavement support, but this no longer existed.

## Meeting people's individual needs

- 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. A Christian service was provided in the chapel weekly on Thursdays and music was performed twice monthly on Wednesday for patients and visitors. The Muslim services were held in the prayer room on Fridays. The Muslim prayer room had separate washing facilities to meet the needs of the community.
- The body store was able to facilitate the transportation and storage of bariatric patients. The containment trolley was of sufficient size to carry bariatric patients and the body store fridges were large enough to hold bariatric patients.
- The body store viewing room was visibly clean and provided facilities for relatives such as seating and tissues. The room was neutral without religious symbols which allowed the room to accommodate all religions.
- The hospital had access to translation services via a telephone translation service and face to face interpreting services provided by 'thebigword'. We were told by staff they tried not use families as interpreters as a rule. Arabic Advocates within the trust provided a service for Arabic speaking patients. The PALS office had a display of patient information available in different languages such as Russian, Urdu, Punjabi, Polish, Chinese, Gujarati, Arabic and Portuguese on types of cancer, treatments and side effects. There was no leaflet available specifically on palliative care or bereavement.
- Two wards had been assessed as being dementia friendly wards, which meant they had been assessed by trained staff to ensure the environment was not distressing for people living with dementia needs. Walls and flooring were different colours and there were neutral coloured fabrics used.
- The hospital saw relatively few patients with complex needs such as people living with dementia or patients with learning difficulties. There were pain assessment tools available for ward staff to use for those who had difficulty communicating verbally.

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- Patients we spoke with were complimentary regarding the choice, quality and timely availability of food when they required it.
- Visits for relatives returning to the hospital following the death of a patient were now held on the ward in which the patient had died.
- Relatives could return to the ward to view the body before it was moved to the body store and collect the death certificate directly from the ward. Some relatives who found this distressing could opt to collect the certificate from PALS office.
- Ward staff gave relatives a locally produced leaflet entitled, 'My relative or friend has died in hospital: What do I need to do?' with information which covered all the practical tasks following a death in the hospital. There was advice on registering a death, viewing and funeral arrangements and where to get extra information and support. PALS were able to support families who needed additional advice or signposting in the event of bereavement.

## Access and flow

- Any member of staff in the hospital could refer a patient to the specialist team. Referrals were also accepted from patients or relatives, although this was a rare occurrence. Referring staff were encouraged to document the referral on the electronic documentation system and outline the patient's current clinical problems and reasons for the referral. The referral was discussed with the patient and medical permission was sought from the oncology consultant responsible for the patient's care. Ward nurses routinely referred patients to the service.
- The specialist team had a list of patients to be aware of who had not yet reached the threshold for referral.
- 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 in patients with particularly complex needs. The service was set up 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.

Referrals were moved to community providers within five days if possible. A follow-up call would be made the following week to check that the transition of care had been effective.

- Rapid discharge protocols and processes were seen to be effective in getting patients to their preferred place of care prior to dying. We spoke with the discharge co-ordinator who showed us examples of arranging discharge back to home or to hospice closer to patients' homes. Rapid discharge was mostly next day and in some cases had been arranged within the same day.
- Patients were reviewed within 24 hours of referral or more urgently if clinically indicated; 93% of patients were seen by the team within 24 hours of referral in the year leading up to inspection.
- The specialist nurses told us earlier referrals would be more likely if their official titles and name badges reflected this part of their role.
- We spoke to the specialist team and they told of their commitment to ensure patients' symptoms could be stabilised and patients could be discharged quickly to ensure they were able to die in a place of their choice.

## Learning from complaints and concerns

- There had been two complaints relating to palliative care between February 2015 and February 2016. One of these complaints took place in the local NHS hospital and the specialist team had not been involved. The other was in relation to management of EoLC in a challenging and complex patient. There had been many changes of medication and rapid changes in their presentation. The complaint had been made by the patient's family after their death. An incident investigation had taken place. This identified learning points such as ensuring families understood the reasons behind treatment decisions, and limiting the number of professionals at the patient bedside at any one time. Ward rounds had been modified so no more than two or three professionals would be present at the bedside at one time, unless at request of the patient. Clear escalation plans had been put into place in the event of future complex cases.
- 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.

## Are end of life care services well-led?

# End of life care

Good



We rated end of life care at the Royal Marsden, Chelsea as good for well-led, because:

- The specialist team had a vision to ensure EoLC was consistent with a trust wide approach. This was delivered in a timely, sensitively and culturally aware manner.
- There was a clear EoLC strategy and the management team understood the vision of achieving this.
- The EoLC team had governance and quarterly review meetings.
- The trusts culture encouraged candour, openness and honesty.
- The director of nursing was visible to the staff and worked on the wards weekly

However;

- The staff told us they did not see the chief executive or board members visiting the wards, however we recognise that other opportunities were available to staff to meet with the chief executive and board members.

## Vision and strategy for this service

- The trust had a clear vision and strategy for end of life care services and had applied resources appropriately to develop EoLC services as a priority. This aimed to ensure care for those in the last stages of life received safe and individualised care as mandated by the five priorities of care (One Chance To Get It Right, 2014). Key aspects of the strategy included increasing education and training on principles of EoLC, development of individual care plans, increased visibility of palliative care in the outpatient setting and improving the experience of patients and carers in the last year of life. Action plans and targets had been developed in these areas and the trust was working towards these goals. We saw evidence of the enhanced education programme and the introduction of the 'Principles of Care' document to provide individualised care to those dying in hospital.

- Staff in the specialist team were aware of the aims of the strategy and were able to discuss areas which needed improvement, such as advance care planning and earlier referral to EoLC services to improve the patient experience in the last 12 months of life.
- All staff we spoke with were committed to providing safe and good quality end of life care.
- They also achieved all but two organisational KPIs. The staff that we spoke with were not aware that there was a member of the trust board with responsibility for EoLC or any EoLC facilitators (a new KPI as on May 2015). the trust informed us that there was an EoLC trust board lay member.

## Governance, risk management and quality measurement

- Issues relating to EoLC were regularly reported and discussed at the Palliative Care Quarterly Review meeting. In this meeting, divisional leads discussed issues relating to finances, risks, complaints, incidents, establishment and resources, amongst other topics. Senior staff met monthly to discuss issues relating to governance of the service. There were also quarterly unit meetings, through which service wide issues and changes were discussed and shared with a wider group of staff.
- Other issues relating to EoLC were discussed in wider meetings. Concerns relating to the prescribing and administration of controlled drugs were discussed at the Executive Medicines Management group. There was also a monthly mortality and morbidity review group.
- The specialist team collated a range of information about their activity, for example the number of staff receiving EoLC training and the total number patients referred to the specialist team. The service was actively involved in meaningful audits that provided further information about the work of the team and of EoLC at the trust in general. Improvements were identified as a result of these audits and action plans to improve service provision had been developed.
- The specialist team collected data, which fed into the quarterly governance reports. This included number of referrals, research projects, training, leadership and strategic developments.
- We were told by staff there were no risks relating specifically to EoLC on the current trust risk register. However, the minutes from the last Palliative Care Quarterly Review meeting in January 2016 identified



# End of life care

lack of consultant cover as an on going risk, which had not been added to the clinical risk register. In line with the trusts risk rating matrix the EoLC risk identified was rated lower than the required level to be added to the risk register.

## Leadership of service

- A new clinical leadership model had been instated the week prior to inspection. Palliative care now sat under the new Clinical Business Unit (CBU) of 'Medicines Management and Clinical Support Services'. Each CBU will be led by a Clinical Director, CBU Manager and Lead Nurse. The aim of the restructure was to strengthen the clinical leadership model, improve accountability for quality and financial performance and simplify links to the executive board. Senior staff within the specialist team were positive about this move as they hoped it would improve access to therapies and psychological support, as they now sat in the same CBU. The chief pharmacist was now the Clinical Director for the unit. This meant they had direct contact to the hospital board and divisional management whilst maintaining a clinical caseload.
- The Lead Nurse played a role in maintaining an overview of EoLC at trust board level. There was currently no lay person or Non-Executive Director (NED) overseeing EoLC sitting on the board.
- Staff within the specialist team were familiar with the senior team. They spoke of an open leadership culture with a flattened hierarchy in which everyone's opinion was considered. Senior staff were approachable and clinically visible. The lead nurse worked on wards weekly. Ward staff told us the chief executive did not visit the wards and was not visible to them, however we recognise that other opportunities were available to staff to meet with the chief executive and board members.
- The leadership, governance and culture within the specialist team provided good quality person centred EoLC. The senior staff prioritised safe, high quality compassionate care through clear lines of leadership and an emphasis on being open and transparent.
- The 2014 National Care of the Dying Audit – Hospitals (NCDAH) recommended all trusts should have a named member on the board responsible for EoLC. For the

Royal Marsden, this was the Chief Nurse. The last audit also recommended all trusts have a lay member with responsibility for EoLC on their board. The Royal Marsden did not currently have this.

- We found the trust was committed to delivering excellent EoLC for all patients.
- The palliative care leadership team were of a high standard and this was confirmed by all of the staff we spoke with. The leadership we spoke with told us they were proud of their staff who worked hard to deliver high quality care for EoLC patients.

## Culture within the service

- We were told by staff and the leadership team the trust culture encouraged candour, openness and honesty.
- We observed a committed and caring group of staff within the specialist team. Staff were clearly committed to providing good EoLC for patients and felt valued by their managers and appreciated for how hard they worked. They were proud of the work their colleagues and department did.
- The hospital was small, with an open and friendly atmosphere. Many of the staff we spoke with told us they had worked at the hospital for many years and some told us they had returned to work at the hospital following a period working at other hospitals. The SPC team felt they had good working relationships with the ward teams, strengthened by the link nurses who acted as a bridge to each ward.
- Staff in the specialist team felt able to raise and discuss any concerns with their colleagues and managers, as appropriate. We observed a healthy environment where the specialist team felt able to challenge and share their thoughts or opinions with each other. Service leads dealt with any potential issues appropriately and swiftly. The senior staff welcomed staff to initiate new ideas and to critically review the existing service provision in order to improve patient care.
- Staff were aware of the need to support each other after a death. The trust facilitated regular 'Schwartz rounds', which were open to staff from all disciplines to discuss emotional and social issues, such as caring for dying patients.

## Public engagement

- The service invited patient and public involvement through various engagement activities, satisfaction surveys, bereavement days, audits and research projects. They took informal feedback from patients and

# End of life care

improved small aspects of the service, as well as taking results from larger surveys or audits such as the most recent FAMCARE audit. Staff attended patient forums and met with carer representatives to discuss elements of good palliative care.

- The trust published the Royal Marsden magazine four times a year to update patients on happenings around trust and research developments. This often included items relevant to palliative care. In the most recent issue, one of the service leads was mentioned as they had won an award for 'Excellence in Education' in the 2015 staff awards.

## Staff engagement

- Staff told us they were actively encouraged to express their views, which could help to develop the service.
- The specialist team engaged with staff on the wards and attended various multidisciplinary team (MDT) meetings on a regular basis. This provided staff with easy access and advice from palliative care services. Ward staff were positive about the specialist team and the support they had received in caring for dying patients.
- There were quarterly staff forums to enable staff to share experiences with their peers. Staff in the specialist team also attended quarterly unit meetings, annual away days, bi-monthly clinical nurse specialist meetings and quarterly complex case review meetings. The meetings were designed to foster staff engagement, share information and drive forward improvement.







## Innovation, improvement and sustainability

- There was trust representation at a national and European level to ensure the service remained aware of developments and research. The hospital was part of the London Cancer Alliance (LCA) Vanguard and had been reaccruited as a recognised centre within the European Society of Medical Oncology (ESMO). There was staff representation at the National Institute for Clinical Excellence (NICE) and on the editorial board for the International Journal of Palliative Nursing.

- The specialist team were involved in collating information related to the development of a palliative care currency. A currency is a way of grouping patients' healthcare needs into units that are clinically similar and have broadly similar resource needs and costs. This enables commissioners to calculate funding for providers for delivering any particular service and plan service delivery more effectively. This data collection was completed by the NHS England Pricing Team and would be used to help provide a transparent basis for palliative care commissioning.
- There was a strong focus on research within the service. Staff were actively involved in service specific research projects, audits and education. There was a working group that examined the results of recently completed research, discussed ongoing studies and suggested potential further projects. We saw a number of articles, publications and short reports staff within the SPC team had written or contributed to. The team were committed and passionate about improving the service they provided.
- In collaboration with the London Cancer Alliance, the Palliative Care Team was in the process of taking forward a pilot study to support early advance care planning and referral to specialist palliative care for patients with non-small cell lung carcinoma. Phase 1 of this project, a retrospective audit of current practice, had been completed, which would inform Phase 2 of the pilot.
- A project entitled 'Deciding Right' was also underway to encourage patients to think about the care that they may want to receive should they become seriously ill, disabled or unable to make decisions for themselves. This was being considered alongside the above study and Coordinate my Care (CmC) to help ensure more timely advanced care planning and referral to specialist palliative care where appropriate.



# Outpatients and diagnostic imaging

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

## Information about the service

The outpatients department at The Royal Marsden NHS Foundation Trust Chelsea site is located on the first floor of the main hospital, close to the main entrance of the hospital. Within the waiting area, there is a café run by the Friends of the hospital.

There are 28 consultation rooms, and 160 clinics are held per week on the Chelsea site. Between July 2014 and June 2015, there were 145,200 outpatient attendances at the Chelsea site. These figures include a proportion of attendances for radiotherapy, which has a high number of follow up visits. 95% of consultations were follow up appointments, 4% were new referrals and patients who did not attend accounted for 1% of the appointments provided at Chelsea.

Outpatient clinics are held at Chelsea for all cancer specialties.

A large number of patients seen at the Chelsea site have travelled some distance to attend the outpatient clinics, as the hospital is a specialist centre for many rare cancer pathways. The hospital also receives high numbers of tertiary referrals from other hospitals and cancer centres.

A range of therapy services are also provided across site including; Nutrition and Dietetics, Speech and language therapy, lymphoedema, surgical appliance clinics, physiotherapy, occupational therapy, complementary therapy, and art therapy.

We spoke with 18 patients attending the outpatient clinics, managers, consultants and junior medical staff and five members of the nursing staff. We observed the care provided by nursing and medical staff and reviewed information provided by the trust about the service.

The hospital diagnostic imaging service was provided for outpatient, inpatient, and research referrals. A radiologist from this department was the clinical lead for the Support Services Clinical Business Unit. The Royal Marsden NHS Foundation Trust Chelsea hospital diagnostic department offered several imaging techniques including plain x-ray, dental and mammography x-ray, interventional fluoroscopy, computerised tomography (CT), and magnetic resonance imaging (MRI). A further two ultrasound rooms were located in the Rapid Diagnostic Assessment Centre (RDAC) for breast examinations.

During the inspection of the radiology services, we spoke with three patients and one relative. We also spoke with eight members of staff including reception staff, radiographers, consultant and managerial staff. We reviewed the systems and management of the department including the quality and performance information and the electronic radiology records. The diagnostic imaging department operated a 9am-5pm service, except for CT and MRI in Chelsea, which operates an 8.30am-8pm Monday to Friday, and Saturday working 9am-5pm.

# Outpatients and diagnostic imaging

## Summary of findings

We rated the outpatient and diagnostic imaging service at the Royal Marsden, Chelsea as good overall.

- The outpatient and diagnostic imaging departments were providing safe, effective, caring and responsive services, and was well led.
- There were sufficient staff with appropriate skills in the outpatients and diagnostic imaging departments to provide safe services. Staff in both departments felt well supported and had access to training and development opportunities.
- The outpatient service was using the London Cancer Alliance holistic needs assessment process to assess patient's care and plan the treatment they received.
- There was good patient information in outpatients and diagnostic imaging about the treatment options available.
- Staff in outpatients and diagnostic imaging understood the importance of reporting and learning from incidents. Information about incidents was passed on to staff in a variety of ways including staff meetings in the morning before outpatient clinics started, and at departmental meetings.
- An outpatient transformation project was underway to respond to areas where there were recognised problems with waiting times.

However;

- Systems for controlling access to medicines in the outpatient department were not robust. When we brought these issues to the attention of managers, they immediately put measures in place to improve the storage and security of medicines.

## Are outpatient and diagnostic imaging services safe?

Good



We rated the outpatient and diagnostic imaging service at the Royal Marsden, Chelsea as good overall for safety, because:

- Staff in outpatients and diagnostic imaging understood the importance of reporting and learning from incidents. Incidents were investigated and staff received information, including learning from investigations, which was applied where relevant to their practise.
- Patients were informed about incidents and the department followed their duty of candour requirements.
- The staffing establishment in outpatients was fully recruited to and staff were well supported with access to training.
- The diagnostic imaging department had robust policies and procedures based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The IR(ME)R regulations are set up to protect patients, staff and the public. The department had good support networks for expert advice from their Radiation Protection Advisory service.
- There were sufficient staff, with appropriate skills and expertise to manage the services provided. Staff were supported in their roles through safety and other speciality training.
- Staff understood their responsibilities to protect vulnerable patients and people with individual support needs.
- Patient protocols and standard operating procedures were used to support safe and effective treatment.
- Staff knew what actions they should take in the case of a major incident or emergency, and business continuity plans were in place.

However;

- Systems for controlling access to medicines in the outpatient department were not robust. A wide range of

# Outpatients and diagnostic imaging

staff had access to areas where medicines were stored. Managers had made improvements to the security of medicines, when we made a further unannounced visit shortly after our inspection.

## Incidents

- For the year 2015 at the Chelsea site 35 clinical incidents were reported within the outpatient department (OPD), the majority were graded as causing 'no harm' to patients.
- Diagnostic imaging services reported 229 incidents in 2014 - 2015. The majority of incidents reported were of minimal or no harm.
- Incidents in diagnostic imaging were reported on the trust's system and investigated appropriately. Learning was shared at various staff forums. Patients were informed about incidents and the department followed their duty of candour requirements. We heard how staff spoke directly with patients following an incident if they were still in the department.
- Outpatient matrons and sisters received incident summary reports, which were discussed with staff at the monthly outpatient department operational meetings.
- Staff we spoke with demonstrated a good understanding of the incident management process and were confident to report any incidents or near misses. All staff felt able to discuss any issues regarding safety with their line managers. Staff in diagnostic imaging were able to tell us of the learning that had been recently shared about an allergic reaction to contrast, and how they had seen a positive change in practice.
- Staff were aware of the 'Ionising Radiation Protection - Dealing with Medical Exposures to Ionising Radiation Greater than Intended' policy, and how to access it on the intranet. Senior staff were aware of their responsibilities to report radiological incidents involving unnecessary exposure of radiation to patients to the Care Quality Commission (CQC). Four CQC reportable incidents had been reported appropriately between December 2015 and March 2016.
- Incidents which related to diagnostic imaging were discussed at the monthly superintendent meetings. Senior managers told us they encouraged a culture of open incident reporting and staff confirmed this. Staff told us they received the feedback and lessons learnt via the staff meetings and individual emails.
- Staff we spoke to told us about their understanding of the duty of candour and their obligations to be open

and honest when dealing with patient concerns. They were confident systems were in use, which ensured patients were fully informed of the circumstances that led to any incident resulting in moderate harm.

## Cleanliness, infection control and hygiene

- The diagnostic imaging department reported over 95% of staff had attended infection prevention and control training against a target of 90% in the year to date.
- The percentage of staff in the outpatient department who had completed infection prevention and control training in the last 12 months was 96%. Nine nurses and healthcare assistants (HCSs) had completed level two infection control training.
- Equipment, which was ready to use had 'I am clean' stickers, which showed the date the item had been cleaned ready for use.
- The outpatient and diagnostic imaging department were visibly clean and tidy. The contractor who provided cleaning services completed monthly audits, which showed the scores for cleanliness in the outpatient department were 97% or above for the period August 2015 to January 2016. Supervisors were responsible for checking the cleanliness throughout the day and the records showing when the area had last been checked were displayed in the toilet areas.
- The cleaning schedules were organised to ensure areas such as the toilets were cleaned three times a day because of the large numbers of patients attending the clinics. Patient waiting areas and reception were cleaned daily.
- We saw the CT scanner room was deep cleaned following use by an infectious patient. Staff told us the domestic services were excellent and always attended as quickly as possible. There was a policy to guide staff for the decontamination of the diagnostic rooms.
- Three patients told us the outpatient department was always clean when they attended the clinics. One person commented on how good the standards of cleanliness were, given the large number of patients attending the clinics.
- Sisters and matrons carried out weekly hygiene checks, which included hand hygiene and equipment checks. Checks had also been carried out with the contractor's supervisors. The results of the audits were displayed for patients to see.
- The monthly hand hygiene audit for Chelsea outpatients showed staff had achieved 100%

# Outpatients and diagnostic imaging

compliance for five months between January 2015 and January 2016, 90% for four months, and 80% for three months. Results for April showed 100% compliance with hand hygiene requirements.

- We observed staff using hand gels and wearing gloves and aprons when examining patients. We saw radiology staff using the alcohol gel and washing hands in-between patients. Patients we spoke with also confirmed this and said they also used the gel available. There were clear notices around the hospital detailing hand hygiene and infection control measures for patients and visitors.
- We saw that all staff were 'bare below the elbows' in clinical areas. This reduced the risk of infections to staff and patients and was in line with good practice.
- The outpatient and diagnostic imaging services had adequate supplies of personal protective equipment (PPE) including glove and apron dispensers. Staff used and disposed of PPE safely and correctly.
- Infection control policies for the outpatient department and diagnostic imaging were available on the intranet, and staff were able to show them to us easily.
- The Meticillin Resistant Staphylococcus Aureus (MRSA) status was checked for all patients attending OPD and all new patients were screened for MRSA.
- We observed good waste streaming in diagnostic imaging with the use of hazardous waste bins and recycling bins.

## Environment and equipment

- All diagnostic imaging areas we inspected were spacious and bright. Staff ensured the rooms were well stocked and relevant equipment was available for use.
- There were 28 consultation rooms in the outpatient department. Consultation rooms were clustered together with a 'hub' room linked to four consulting rooms. Separate areas were available for blood tests. Consultation rooms were well equipped with examination couches and sinks for hand washing. Curtains could be drawn around the examination couches to provide patients with privacy.
- We saw the clinic storerooms, which were well stocked with equipment and other items needed to treat patients in the outpatient department. Staff we spoke with told us they had access to all the equipment and supplies they needed to provide patients with a good service.

- Emergency equipment was available to staff in the outpatient department and diagnostic imaging, and was subject to regular safety checks. We checked the resuscitation trolley in the outpatient department and found the equipment was checked daily. Staff locked and tagged trolleys and made regular checks of their contents and expiry dates.
- Staff in diagnostic imaging were seen wearing personal radiation dose monitors, which were monitored individual cumulative radiation in accordance with the relevant legislation. There was a large range of protective equipment available.
- Quality assurance tests on the x-ray equipment were routinely done and any trends or increases in exposure were reported to the RPS for further investigation.
- A full schedule of Quality Assurance checks were carried out by the Technicians and Physicists on all gamma cameras and Positron Emission Tomography (PET) systems.
- There were suitable safety arrangements in the diagnostics department to restrict access where x-ray and imaging equipment was in use. These included warning signs for patients and staff.
- We saw the bariatric patient policy in diagnostic imaging, which clearly outlined the equipment available and the capacity of each machine.

## Medicines

- Systems for controlling access to medicines in the outpatient department were not robust. The keys for the room in which medicines were stored were kept in an office, which could be accessed by a wide range of staff. We found prescription pads were not securely stored.
- We found medicines in a storeroom, which had been dispensed but staff did not understand why they were being stored there. Fluids used for intravenous administration were easily accessible to unauthorised people, which meant there was a risk they could be tampered with. We brought these issues to the attention of managers, who immediately put measures in place to improve the storage and security of medicines.
- There were no controlled medicines stored in the clinic room or used in the outpatient department. Chemotherapy planning clinics and chemotherapy treatment were both provided on the Medical Day Unit.
- Medicines incidents and errors were reported via the DATIX system. These incidents were reviewed monthly by the multidisciplinary executive medicines safety

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group, which included a patients' representative. Learning from these incidents was shared with staff across the organisation through local governance meetings such as ward sisters meetings and trust wide email termed 'message of the week'.

- The bespoke electronic chemotherapy prescribing system used by the trust had in built safety systems and version controls, which ensured all relevant information relating to the patient journey and treatment pathway were centrally held. Medicines policies were available on the trust intranet and were easily assessable to all staff.
- Although outpatient pharmacy dispensary services were provided by a commercial pharmacy based on site, the computer operating systems were provided by the trust, which increased patient's safety especially when dispensing supportive chemotherapy medicines and ensured the effective delivery of service, which had resulted in reduced pharmacy outpatient waiting times.
- Clinical pharmacists were integrated into the multidisciplinary team, which facilitated effective and efficient delivery of care and design of treatment pathways, for example: they led on design of clinical trials and treatment protocols, pharmacy research and the medicines safety agenda in the trust.
- The number of staff in the outpatient department who required medicines management training was 14. Figures supplied by the trust showed in January 2016, 12 staff (86%) of staff had received the required training. The trust's standards for mandatory training was 90%, therefore the number of trained staff fell short of the trust's target.
- We did not see any evidence of room temperature monitoring for clinical areas where medicines were stored in the outpatient department. Some medicines needed to be stored at a particular temperature to avoid deterioration and hospitals are recommended to check medicines are being stored within the temperatures advised by the manufacturers.
- There were effective arrangements in diagnostic imaging for managing medicines, including recording, handling, storage, and safe administration.

## Records

- An Electronic Patient Record (EPR) system was used by clinical staff during consultations. However, there were four clinics, which did not use the electronic record system. There were plans to include these clinics on the new electronic records system, which was due to be

implemented. Trial information, radiotherapy, and photographs were not recorded on the EPR. Some clinics required a summary of the last consultation to be printed in advance. If it was known the EPR would be unavailable for a period of time, the outpatient department administrative staff printed out the last consultation in preparation for the clinic. Where a paper record was required urgently, this could be requested via the medical records department.

- We found from reviewing eight records treatment decisions were being documented during the multidisciplinary team (MDT) meeting using a new computer based MDT system. This meant patients and staff could be informed about the next steps immediately after the decision had been made. This system had not yet been implemented in all clinics.
- The diagnostic imaging department had a central EPR system to record comprehensive details of each patient's imaging history. Radiology information was available to clinicians who needed it. All radiology images were stored on a picture archiving communication system (PACS), which was accessible across the hospital. Images could also be shared cross-site when required.
- All diagnostic imaging procedures followed a set protocol. The protocols were available electronically and in hard copy folders within the x-ray rooms.

## Safeguarding

- Staff were required to complete mandatory safeguarding training. Of the 29 eligible OPD staff, 26 had completed level one children's safeguarding training at the end of January 2016. 27 out of 29 staff had completed level one adult safeguarding training at the end of January 2016.
- All staff within the diagnostic imaging department were trained either to level one or level two safeguarding for both adults and children depending on their role. Attendance at the mandatory training course for adult and children safeguarding was recorded by the department as 90%.
- We spoke with three staff in outpatients about safeguarding people from the risk of abuse. They said they were aware of the need to be on the lookout for patients who might be at risk and said they did not see



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patients for long when they visited clinics, so they were aware they needed to be particularly vigilant. Staff knew who the safeguarding lead was for the trust and said they would raise any concerns with senior staff.

- Staff we spoke with in diagnostic imaging demonstrated they understood safeguarding processes and how to raise an alert. The hospital had identified leads for safeguarding. They were aware of who these leads were and how they could be contacted.

## Mandatory training

- The trust's standards required 90% of staff to participate in mandatory training. Figures provided by the trust showed 90% of eligible outpatient nursing staff had completed the required training for four out of 15 topics, 78% of staff had completed seven out of 15 topics, and 89% of staff had completed four areas. Mandatory training included adult basic life support, blood transfusion, conflict resolution, equality and diversity, health and safety and moving and handling.
- Staff told us mandatory training was delivered using a combination of on-line and face-to-face learning packages.
- Monthly performance reports included information for managers about staff for example mandatory training, appraisal, sickness, and vacancy rates.
- Administrative staff had a designated member of staff responsible for ensuring all mandatory training was booked in for all staff and were up to date.
- Good local records were kept in diagnostic imaging and staff told us they were always encouraged to attend training. Compliance rates for mandatory training in diagnostic imaging was consistently above the trust targets.

## Assessing and responding to patient risk

- If a patient became unwell in the outpatient department staff used an escalation procedure, which meant transferring them to the clinical assessment unit, from where they either returned home or were admitted. Staff were familiar with the escalation process and how to access support from acute oncology and critical care outreach staff. The national early warning score (NEWS) was used for monitoring a patient whose condition deteriorated.
- Allergy status and venous thromboembolism (VTE) risk assessments were completed in the outpatient

department and the relevant low molecular weight heparin (LMWH) was prescribed if required. We saw evidence of this in the patient drug charts reviewed during the inspection.

- The outpatient records we reviewed all contained a range of risk assessments for example patient's risk of acquiring an infection and nutritional assessments.
- 90% of staff in the outpatient department had completed mandatory training in risk awareness.
- Invasive surgical procedures were carried out in the outpatient department. Information about the procedure and the clinician who carried it out was entered on to the patient's electronic record. The service was not using the World Health Organisation (WHO) surgical checklist for recording information about these procedures. This did not meet the recommendations by national bodies including NHS England.
- The hospital had an internal medical physics department who were contactable for any support required. They also provided advice on radiation protection for medical exposures in radiological procedures. This was in line with IR(ME)R guidance. Staff told us the support given was excellent.
- The diagnostic imaging department had named Radiation Protection Supervisors (RPS), who provided advice when needed, and to ensure patient safety and minimise radiation risk. They were adequately trained within requirements. There were currently four RPS's on the Chelsea site. The RPS staff attended a Radiation Protection meeting every six months to discuss the latest guidance on radiation protection requirements.
- We looked at a range of Radiation Protection audit reports. Compliance with IR(ME)R 2000 had been met and no recommendations were required.
- Dose reference levels (DRL) were evident for all x ray rooms and doses were optimised to give the lowest possible dose to patients whilst maintaining good diagnostic quality. The DRLs in CT were set at below the national average. This meant the patient would routinely receive a lower dose. Staff told us that dose optimisation meetings were held twice a year to look at the protocols and agree safe and best practice.
- A radiation safety policy was provided to staff, which included the Ionising Radiation Medical Exposure Regulations (IRMER) procedures. There was also a protocol for the management of contamination,



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monitoring and spillage of radioactive material, and a procedure for the disposal of radioactive waste. Comprehensive records were kept on the disposal of radioactive waste.

- We saw the Society of Radiographers 'pause and check' policy was implemented to comply with the IR(ME)R Operator checks.
- We saw local rules were available for all staff to follow in the imaging areas we visited.
- Diagnostic imaging used an adaptation of the WHO safer surgical checklist for all interventional procedures. Staff audited the checklists for compliance and quality. A six-month audit between July and December 2015, which sampled 30 records, showed the service had achieved a 93% compliance rate.

## Nursing staffing

- We saw an analysis of the number of planned versus actual staffing levels for the Chelsea outpatient department, which showed staffing levels dropped from 90% to 84% during the period October 2015 to January 2016 for registered nurses. The health care assistant levels improved from 57% in November to 80% in January 2016. Managers told us they covered the reduced staffing levels by using agency phlebotomy staff, releasing healthcare assistants to support registered nursing staff. There were 13 whole time equivalent trained nursing staff posts, eight healthcare assistant posts, including phlebotomists, and 17.3 administration staff. All these posts were full when we inspected.
- The trust was not using an acuity tool to calculate the number of staff required to support outpatients. However, a skill mix review for staffing was being carried out in the in outpatient department as part of the trust's outpatient transformation project. The aims of the project were to link staffs' skills to the tasks required in clinic.
- There were 35 specialist nurses at the Chelsea site. A further seventeen CNSs worked across both the Chelsea and Sutton sites.

## Medical staffing

- We spoke with three junior medical staff who said they had joined the trust to increase their knowledge about cancer treatment in a specialist centre. They felt supported by senior medical staff and specialist nurses.

They said they thought there could be more junior medical staff but the advanced nurse practitioners were very knowledgeable, and able to provide patients with the care they needed.

- Medical staff was provided by the specialty running the clinics in the outpatient department. There was a range of medical staff from consultants to junior doctors. On occasions, clinics were provided by junior medical staff without consultants present for example if the consultant was teaching.
- The trust employed 166 consultant medical staff and 236 doctors in training. A large proportion of these were involved in seeing patients in the outpatient department.
- A policy was in place, which stated medical staff must provide six weeks' notice of leave or other absences to allow in order that clinics could be re-organised. Clinic administration staff told they sometimes reduced the number of patients attending if the clinic was not fully staffed doctors. The outpatient department monitored the number of clinics, which were cancelled or reduced as a result of medical staff not being available.
- Two locum consultant posts had recently been recruited to for radiology to address the current shortage.

## Radiology staffing

- There were adequate levels of radiographer staff with a recent recruitment drive being successful in recruiting staff. There were 42.8 radiographers, three healthcare assistants and five registered nurses. There were 17 radiologists working across the Chelsea and Sutton sites.
- Agency staff were used in a limited capacity. All agency staff received an induction before starting work in the service. There were no agency staff in nuclear medicine.

## Major incident awareness and training

- The trust's major incident policy was available on the intranet. This included easy-to-follow action cards for the members of staff with specific responsibilities. There were tested back-up arrangements for possible failures of electronic and telecommunications systems. There was a telephone line operating on a separate system from the main telephone lines, and a major incident bags in different parts of the hospitals with walkie-talkies.

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- There was a print out of outpatient department patients as a backup for the electronic record. Each department had their own business continuity plan in case of a major incident.
- There was evidence of business continuity plans for diagnostic imaging. Senior staff told us how the department had been evacuated several years ago due to a fire and how the diagnostic imaging procedures were transferred to the Sutton site.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate the effectiveness of the outpatient and diagnostic imaging service. We found the following;

- Staff in the outpatient department and diagnostic imaging were using evidence based guidelines to inform the way services were provided.
- Patient's pain was assessed and adjustments made to their medicines when required. Patients were referred to professional staff who specialised in pain management if their pain was difficult to control.
- Services in outpatients were provided by staff who had good access to education, and received supervision and appraisals from their managers.
- There was effective multidisciplinary assessment and treatment planning, with access to a wide range of specialists to provide advice and support.
- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice, including the National Institute for Health and Care Excellence (NICE) guidelines.
- Consent to care and treatment was obtained in accordance with legislation and guidance.
- Staff worked collaboratively to meet patients' needs in a timely manner and diagnostic imaging staff were part of multidisciplinary team meetings.

### Evidence-based care and treatment

- We asked nursing staff in the outpatient department about the use of evidence based guidelines and they told us these were easy to locate on the trusts intranet. They said they were informed when new policies and guidelines were introduced or when existing guidelines

were updated. For example, there were guidelines on recognising and treating patients who may have developed sepsis, a serious condition which required urgent treatment.

- Staff in diagnostic imaging had access to evidence based protocols and pathways based on NICE and Royal College guidelines. Relevant clinical guidelines, technology appraisals, interventional procedures, quality standards, and diagnostic guidelines were all available.
- Staff involved in diagnostic imaging demonstrated an understanding of their role with regards to the IR(ME)R regulations and protected patients from the risks of unnecessary exposure to radiation. We looked at the RPA reports, which showed compliance with radiation regulations.
- Diagnostic reference levels (DRL) were monitored and audits of the levels completed. The staff in the department had regular contact with the radiation protection advisor. All staff we spoke with were aware of the DRLs within their particular modalities.
- Representative doses for an average sized adult receiving nuclear medicine (NM) and positron emission tomography (PET) procedures were given by the Administration of Radioactive Substances Advisory Committee (ARSAC). The NM department referred to the ARSAC 'Notes for Guidance on the Clinical Administration of Radiopharmaceuticals and Use of Sealed Radioactive Sources' held electronically on the intranet with paper copies also available in the NM and PET department.
- All the equipment in the NM department was less than three years old and staff told us this gave them the opportunity to deliver a high quality service, using the latest research techniques.

### Pain relief

- There was a pain service, which outpatients could access. The service was provided by two part time pain consultants (anaesthetic consultants), an advanced pain trainee, a part time research fellow, and three Clinical Nurse Specialists (CNSs). The service saw a total of 333 outpatients at Chelsea and there were 357 ad hoc out-patient contacts and 490 telephone follow up calls by CNS's.
- Patients returning to clinic usually brought their own pain relief medicines. Pain was discussed as part of the

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consultation with the patient, and medical staff would make any changes required. Patient received a prescription, which they could collect to take home before they left.

- An audit of the pain management telephone reviews provided by clinical nurse specialists was carried out to test the feasibility of a formal nurse led telephone pain clinic. A baseline audit of all patient calls was conducted over an eight-week period from 23 November 2015- 22 January 2016. The audit examined the reasons for the calls to assess how a pain advice service could be provided.
- Clinical teams could also refer patients to the specialist pain team if required, and patients could often be seen on the same appointment by the pain clinical nurse specialist or a doctor.
- Patient's pain was assessed on initial referral using the London cancer alliance holistic needs assessment.

## Nutrition and Hydration

- Records showed patients height and weight was recorded. A national nutritional screening tool was used for patients where nutrition and hydration was a risk, for example head and neck and upper gastro-intestinal cancer patients.
- Specialist dietetic support was available if patients required additional support, and patients were sometimes seen on the same day as their appointment.

## Patient outcomes

- The trust participated in a large number of national audits for example the lung and bowel cancer audits.
- Staff carried out audits throughout the radiology department. Audits included review of the out of hour's process, did not attend rates, as well as clinical based ones, such as cord compression in MRI.

## Competent staff

- The number of nurses who had received an annual appraisal in the year April 2015 –April 2016 had fallen from 75% to 60%. However, appraisal rates had increased for health care assistants from 0% to 50% during the same period. Appraisal rates for other staff in the outpatient department including administrative staff had improved from 75% to 100%.
- New nursing staff we spoke with told us they received five days induction training, which was intensive but very helpful. They told us the knowledge gained at induction was assessed by senior staff against a

checklist of knowledge and skills required by staff working in the department. One member of staff said they had to repeat training they received previously whilst working for another organisation. They said they did not mind because the trust wanted to ensure staff skills met the trust's standards, which they understood.

- A local induction plan was in place for all new staff starting within the diagnostic imaging department. The CT induction pack was an excellent example of ensuring competency.
- The OPD had introduced a system for checking the competency of new agency staff who provided the blood taking service. When agency staff started, a assessor checked the first five-10 bloods they took to ensure they were able to provide an effective service.
- The trust offered band 5 nurses, with no previous cancer experience, access to a cancer course, and foundation courses in cancer care. Most senior nurses had completed a master's degree in caring for patients with cancer.
- We spoke with three nurses who told us they enjoyed working at the trust and wanted to specialise in oncology. They said they had joined the trust because of the number of education opportunities on offer and the range of career opportunities.
- As required by the regulations, there was an up to date electronic list of people approved to request x-rays or CT/MRI's. All referrers undertook an induction course to cover the IR(ME)R requirements.
- Continual professional development was encouraged throughout the diagnostic imaging department and a number of staff were currently undertaking post-graduate training. Staff told us they were able to access in-house courses including IV cannulation and accessing ports. Ports are inserted under the skin and can be used to deliver chemotherapy treatment. We looked at the competency booklets. One staff member told us the training was of an extremely high standard.
- We saw that all employed radiography staff were registered with the Health Care Professions Council (HCPC). Managers checked the registration of their staff regularly.

## Multidisciplinary working

- Nursing staff in the outpatient department told us multidisciplinary working was very good, both in the

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clinics, and the multidisciplinary team meetings. Staff worked well together to ensure they saw all the patients who attended, and tried to minimise waiting times and delays.

- Consultant medical staff told us patients care was discussed and planned by multidisciplinary teams (MDT), which were well organised by the patient navigators. Consultant medical staff, junior doctors discussed the diagnosis and treatment options. Specialist staff, such as pharmacists, and oncologists were also involved.
- The outpatient teams also worked closely with palliative care colleagues. The patient's clinical nurse specialist supported patients when they were referred to the palliative care team.
- We saw records of four MDT discussions. The patient's history, diagnosis, and stage of disease was discussed. Test results were reviewed, and we saw patients were asked to complete different consent forms for each chemotherapy regimen. Patients were seen in outpatient clinics prior to chemotherapy commencing. Information about chemotherapy treatments was full and clear. This included information about side effects, and what to do in an emergency.
- The trust provided one-stop multidisciplinary breast service clinics in the Rapid Diagnostic & Assessment Centre (RDAC). The Rapid Diagnostic Clinics included radiology provision, a one-stop assessment service for those patients with a suspicion of cancer. Some patients received a diagnosis on the same day depending on their condition.
- Diagnostic imaging staff attended multidisciplinary meetings such as those for breast cancer. One member of staff told us attendance at these meetings was the 'highlight of the week.' Staff felt they were invaluable for their work.
- Radiologists liaised with staff at other trusts, and could refer patients with complex or specialist needs, such as head injuries.

## Seven-day services

- The outpatient department operated between the hours of 8am to 7pm five days a week. CT and MRI scanning was available 8.30am to 8pm five days a week and from 9am to 5pm on Saturdays.
- A workforce review was being undertaken in outpatients to identify how the working day could be extended as part of the trust's transformation programme.

- The diagnostic imaging services were available seven days a week with a combination of regular opening times, extended working hours and on-call services.

## Access to information

- Outpatient staff could access the information they needed using the trust's electronic record system. Diagnostic imaging staff told us and we saw they had access to trust policies and procedures on the intranet.
- There was a board in the outpatient department with the names and photographs of staff on duty. A comprehensive photographic board detailing all staff members and their roles was visible in diagnostic imaging.
- Diagnostic imaging records and reports were available electronically, which made them promptly and readily accessible to staff at both Royal Marsden sites.
- Electronic access to radiology results was available across the hospital. Clinicians undertook training to use these systems and could find patient information quickly and easily.
- Explanatory leaflets were available to assist diagnostic imaging staff to explain procedures and investigations to patients including a full range of nuclear medicine tests such as PET, bone density and bone scans.
- Information boards were displayed around the diagnostic imaging department giving specific information to patients and staff such as referral to treatment targets.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A specialist nurse described the importance of being clear with patients and checking they understood any procedures, risks, and possible long term effects as part of the process for obtaining consent.
- The service used The London Cancer Alliance patient passport for people with a learning disability. This was a means of providing hospital staff with information about the patients preferred means of communication. This included any particular anxieties or fears they might need support with whilst attending clinic. A consultant told us about a multidisciplinary team meeting they had held to plan the care of a patient with a learning disability. They had involved a wide range of staff and people who knew the patient to plan their care.
- We spoke with a clinical nurse specialist (CNS), who had worked with the staff from a community home to develop a care plan for a person who did not

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understand the nature of their condition, and was not able to consent to treatment. We saw records of decisions, which had been made in the person's best interests. The person's mental capacity had been assessed, and an extensive multidisciplinary discussion had been held to develop their care plan. Information about the process of developing and agreeing the care plan was clearly recorded.

- Diagnostic imaging staff demonstrated confidence and competence in seeking verbal and written consent from patients. Staff told us the usually obtained verbal consent from patients for simple procedures such as plain x-rays. Staff obtained consent for any interventional procedures. Carers were encouraged to escort their relative to appointments where needed to offer support. A patient told us the staff had been good at explaining what was happening to them before asking consent to carry out the interventional procedures.
- Diagnostic imaging staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity; they demonstrated a knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).

## Are outpatient and diagnostic imaging services caring?

Good



We rated the outpatient and diagnostic imaging service at the Royal Marsden, Chelsea as good for caring, because:

- Patients we spoke with in outpatients were unanimous in their praise for the staff. They gave us many examples of the spontaneous way staff supported people from helping them get dressed to offering a hug when someone was upset. Patients told us everyone was kind from senior medical staff to admin staff.
  - Throughout the inspection, we witnessed good care being given. Patients were kept informed at all times and emotional support was given to both patients and staff.
  - Staff behaved positively to provide the best possible care for their patients. It was evident the patient experience was a central element to the delivery of care.
- Patients told, and we saw without exception the staff were friendly, kind and approachable. One patient said, "It is the staff that make a difference here."
  - Staff demonstrated a good understanding of the privacy and dignity needs of their patients.
  - We observed staff being respectful at all times.

## Compassionate care

- We visited the outpatient department on a very busy day. We observed senior staff monitoring what was happening in clinics to make sure they identified patients who might need support. We observed one member of staff who identified a patient who was upset. They took the patient to a quiet area and spent time supporting them until they felt able to go home.
- Radiographers, medical staff, healthcare assistants, and administration staff worked as a team to ensure and their patients received a good service in diagnostic imaging. Reception staff respected patients' privacy when they were checking personal details on arrival to the diagnostic imaging department.
- The outpatient department used the friends and family test to obtain patient feedback about the service. The latest friends and family feedback figures provided by the trust for the six months from October 2015 to February 2016 showed the highest score for out-patient services was February 2016, which scored 4.85 (95% likely to recommend); 4.93 (100% likely to recommend) for January 2016. The lowest score was in October 2015, which scored 4.97 (97.4% likely to recommend). The diagnostic imaging department was not using the Family and Friends test, but had plans to introduce it.
- Positive comments were made to us about the experiences patients had when attending the service. One person we spoke with in outpatients told us, "Once when their relative felt unwell the nurse went and got their prescription from pharmacy without being asked." Another patient said, "The staff here are very helpful if they see you are having difficulty they help you. I was struggling with a dressing and the nurse noticed and helped me." They said, "This is a very scary place for people but the staff make it less scary."
- One patient said, "Staff give me a hug when they see I am tearful it makes such a difference." A relative told us, "If we are here for a long time staff offer us sandwiches." One patient said, "I didn't want radiotherapy but the staff in outpatients built my confidence so that I could go through with the treatment." Other comments



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included; the outpatient admin staff know you and treat you like an old friend and about a consultant who had called the patient personally in person to inform them of their operation date.

- Another patient said, “Staff are charming and attentive. If I ask where a department is they don’t just tell me they take me.”
- We spoke with three patients and one relative in the main diagnostic imaging department. All said that staff were friendly and with a very caring attitude. One patient in diagnostic imaging told us they had to travel a long way for the appointment but it was a “fantastic” service.
- A relative we spoke with felt their family member had been treated with great dignity and respect in diagnostic imaging. Staff confirmed that the patient would have a chaperone attend when intimate examinations were performed, or if requested.
- We saw one negative comment about diagnostic imaging from a recent survey where the patient wished the staff would smile more. The comment was dealt with, and staff reminded to smile. We saw this in action during the inspection.
- We heard diagnostic imaging staff introducing themselves when dealing with patients and relatives and all patients were greeted in a friendly manner by all the staff they came in contact with. Patients told us staff in diagnostic imaging were caring and professional.

## Understanding and involvement of patients and those close to them

- A specialist nurse in outpatients told us it was their role to develop a holistic care plan based on the outcomes the patient wished to achieve. They spent time getting to know the person and provided information to help them understand the choices, and options available to them before reaching a decision. They described how key providing information was to their role. They had developed a short film on a particular cancer, which patients could take home after their consultation and diagnosis. The patient could share the information with their family, and discuss the implications of the treatment as part of the process of reaching a decision.
- Patients and their families were given time to ask questions. One patient told us they felt well informed at all times during their MRI scan.

## Emotional support

- The trust used a distress thermometer as part of the holistic needs assessment process and we saw examples of these, which had been completed on patients’ electronic records.
- A clinical nurse specialist (CNS) told us they encouraged patients to access information on websites with good information and could direct them to local help and support groups. They used a ‘concerns thermometer’ to identify and record patients concerns. We saw examples of care plans, which had been created on the trusts electronic records system, where they had recorded the patient’s worries and concerns.
- We saw the results of a survey of patients with sarcoma, which showed the majority of patients felt they were treated as a person rather than as a set of symptoms, and felt they had received emotional support during their outpatient consultations. The survey showed the majority of patients preferred to be supported by a specialist nurse, followed by a preference to have access to face-to-face counselling. A small number of patients preferred on line support groups and telephone counselling.
- Another CNS told us they contacted the person’s GP to inform them about the outcome of the patients clinic visit particularly if there had been a decision had been made not to continue active treatment, or if the patient required access to services provided locally.
- Psychology services had developed a training programme called Cancer and the Family for healthcare professionals, to enhance their supportive care for families.

## Are outpatient and diagnostic imaging services responsive?

Good



We rated the outpatient and diagnostic imaging service at the Royal Marsden, Chelsea as good for responsive, because:

- The Chelsea outpatient service consistently met the two-week wait referral standard for breast cancer including symptomatic referrals.



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- Clinical nurse specialists provided holistic care planning and provide patients with information about the choices available to them and the risks.
- The diagnostic imaging department was providing access to tests and results in a timely manner, including one-stop clinics for several specialities, which reduced the number of appointments a patient needed.
- Staff made sure services could meet the patient's individual needs. There was good support for patients with a learning disability in diagnostic imaging. There was access to interpreters for patients whose first language might not be English.
- The service recorded concerns and complaints and used this feedback proactively to improve service provision and quality.
- Diagnostic investigations and procedures were organised to meet patient need. Teams worked together to try and ensure investigations and consultations happened on the same day.
- Radiographers had been trained and were competent in some extended roles such as cannulation and accessing patient ports. This had enabled work to be undertaken more efficiently.
- The nuclear medicine service had started a new service for a specific group of patients that had reduced the scan time to 30 minutes as opposed to a previous time of several days.
- 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.

However;

- Several patients told us they had to wait sometimes up to two hours to be seen in outpatients. Patients were understanding but wondered if improvement could be made to reduce the time they had to wait.
- The waiting area was very busy and was not a pleasant environment for patients to wait for long periods of time. Outpatient managers were aware of the issues and had made some changes to improve patient's experience.

## Service planning and delivery to meet the needs of local people

- Referral data showed the Chelsea outpatient service consistently met the two-week wait referral standard for breast cancer including symptomatic referrals.
- The trust was working with local GPs in the Clinical Commissioning Group to improve the appropriateness of referrals for diagnostics.
- Nursing staff in outpatients planned the care patients' received to meet their individual needs. This included patients who had a learning disability and might not understand the nature of their condition and the treatment options available to them.
- There was access to translation services. Patients could book this themselves or make arrangements through their consultant's secretary.
- Signage to diagnostic imaging services was clearly displayed throughout the hospital.
- 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 a waiting 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 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.
- A patient told us they arrived at 8.45 for a blood test. They said the staff were inexperienced and were unable to find the correct forms. They said more experienced

# Outpatients and diagnostic imaging

staff arrived half an hour later and knew where everything was. They said the delay put everything back including when they saw their consultant because of the delay in obtaining the results.

- We spoke with two patients waiting to be seen in clinic. One patient told us they were unhappy about having to travel to Sutton hospital for a DEXA scan. They said they found it hard to believe this facility was not available on the Chelsea site.
- We spoke with patients about waiting times. One patient had been attending every day for treatment for several weeks. They said in all that time there had only been one problem. They had waited over an hour to see their consultant after treatment. They said, "Staff realised and made sure it had not happened again. He said was going to send an email to the trust saying how good the staff are and how upset they were when they overheard patients complaining."
- A patient told us they spent large amounts of time waiting for blood tests, results or to see their consultant. They said the electronic noticeboard advised patients about delays. They said the nurses also announced how late the clinics were running which helped patients understand what was going on.
- One patient said, "It's frustrating I end up waiting for two hours it doesn't matter what it says on the screen. Last time it said the clinic was running an hour and 30 minutes late but I ended up waiting two hours."
- Another patient said their local hospital had referred them in August 2015 but they had not received their appointment until November, which they said was too long to wait.
- There were nurse co-ordinators in outpatients whose role was to try and keep clinics running on time.
- The Royal Marsden NHS Foundation Trust received a high number of referrals from other hospitals as well as local GPs. The overall split between referrals from other hospitals and referrals from GP was approximately 50:50 although the ratio increased to 84:16 for referrals proceeding to treatment.
- Operational standards are that 95% 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 98.1% of non admitted patients started treatment within 18 weeks, achieving the operational standard.
- 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 commenced their treatment in any setting within 31 days of the decision to treat was 100% for breast, 100% for skin, 97.1% for urology, 97.1% for lower gastrointestinal and 100% for lung.
- The percentage of patients who commenced treatment within 62 days of urgent referral from their GP 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. These figures applied to the whole trust not just the Chelsea site and included patients treated in a range of setting not just the outpatient department.
- 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. We attended a meeting where staff reviewed breaches. There had been delays with diagnostic tests. The problem was successfully identified and rectified.
- We found that patients received x-rays and scans in a timely manner and these were reported promptly. Diagnostic waiting times for this trust had performed consistently better than the England average. Over 70% of CT examinations were reported on the same day.
- Waiting times for patients accessing diagnostic imaging were monitored. Across all modalities, 89.85% of patients waited less than 30 minutes, 4.5% waited for up to one hour, and 5.6%.

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- We saw a report, which showed that between October and December 2015, 0.6% of clinics were cancelled. The figures were 0.5% for the previous six months. The main reasons for the cancellations were doctors on annual leave, doctors attending conferences, doctor attending a meeting, study leave, and unexpected emergency. 16% of patients waited longer than 30 minutes to see their doctor. One week's audit of start times in clinics showed 8% started late.

## Meeting people's individual needs

- Staff in the outpatient department made every effort to meet people's individual needs. We spoke with people attending the services and they provided a range of comments. One person told us staff were very keen to put their relative on a clinical trial but they had not put them under any pressure. They had the opportunity to have a long discussion about it with the research nurse. In the end they were not suitable but they were pleased to be considered. A patient said they had a blood test, which showed they needed treatment. Their doctor from the clinic had rung them with the result and told them to go to their local A&E and ask for a potassium infusion. They said they were impressed their doctor had contacted them.
- Staff told us they could always access translation services and there was an Arabic advocate they could access. Patients were able to book an interpreter themselves or could request this through the consultant's secretary.
- On the day of our inspection, two lifts to the outpatient department were out of order. One was repaired that day but one had been out of action for a week. Two patients told us the lifts were often out of action when they attended clinic.
- Patient waiting areas in diagnostics were comfortable and well equipped although the interventional suite was cramped for space. This had been highlighted on their local risk register
- We saw there were sufficient numbers of wheelchairs available for patient's to use in the outpatient department.
- Patient information leaflets were on display in areas close to the consultation suites. These included booklets on chemotherapy and radiotherapy – your questions answered, on the trusts duty of candour policy – 'Being open in the event of a patient safety incident', information about the trusts help service and information about a range of treatments provided. There were also leaflets about dealing with the side effects for treatment for example hair loss, diet and a guide to services in the community.
- A specialist nurse told us it was their role to develop a holistic care plan based on the outcomes the patient wished to achieve. They spent time getting to know the person and provided them with the information they needed to help them understand the choices and option available to them before reaching a decision. They said it was important patients had sufficient time and information before deciding on a treatment option, which could have a considerable impact on their life.
- We asked managers about identifying and meeting the needs of patients with dementia in the outpatient department. They were aware of the needs of people with dementia but there were no dementia champions or champions for other groups of patients with particular needs, for example patients with a learning disability. They said they would raise any concerns with the trust's safeguarding lead, who was responsible for ensuring patients with special needs were met.
- Some people in outpatients felt the waiting areas were impersonal, and there could be more information available about support groups. Other people told us they appreciated the café being available in the middle of the clinic. They said it made everything feel more normal and they did not have to go looking for refreshments before they set off on their journey home.
- We saw the diagnostic imaging department had a comprehensive range of patient information leaflets about the examinations before attending the hospital.
- We saw posters in diagnostic imaging clearly displaying information about accessing translation services if required.
- The staff we spoke with in diagnostic imaging demonstrated a good understanding of the needs of patients with dementia and learning disabilities. We were assured the patient who may be distressed or confused would be treated appropriately. The MRI team told us they would text any deaf patients if this was their preferred way of communication. Patients were also directed from the appointment letter to call the radiographers directly if they have any questions rather than phone reception. Radiographers greeted patients in the waiting areas and escorted them to the relevant changing area and procedure room.

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- Patients we spoke with were very positive about the diagnostic imaging services.

## Learning from complaints and concerns

- A number of complaints received by the trust related to appointment delays and cancellations in outpatients, (20%). These were not broken down by location. Managers told us they were aware of patients' concerns and were working to address them. They told us the outpatient transformation project had identified those clinics with the greatest scope for improvement.
- Leaflets informing patients how to make complaints were available in diagnostic imaging waiting areas.
- Staff in outpatients and diagnostic imaging told us they received feedback about complaints in the staff meetings and we saw records of these discussions in the staff meeting minutes.

## Are outpatient and diagnostic imaging services well-led?

Good



We rated the outpatient and diagnostic imaging service at the Royal Marsden, Chelsea as requires improvement for well-led, because:

- Staff and managers in diagnostic imaging had a vision for the future of the department, and were aware of the risks and challenges the service faced. Teams were motivated and were involved in planning extended and new services.
- Staff in the outpatient department were involved in the transformation project, and told us they hoped this would result in reducing clinic overruns and the length of time patients waited before being seen.

However,

- There was no strategy for developing outpatient services. More services were being delivered in the outpatient department but the department was cramped with no more clinic space available for expansion. There were no plans to relocate the department or make significant improvements to the waiting area, reception area and clinic rooms.

- A transformation project had been set up however the work was in its early stages and focused on operational issues, which affected the effective management of the clinics.
- There was concern about the sustainability of the diagnostic imaging service due to capacity and demand issues, and also the lack of space to be able to expand. The interventional service was small and cramped.

## Vision and strategy for this service

- A strategy for the future of outpatient services had not been developed. Some staff told us it felt as if the business units did not appreciate the impact on the outpatient department when changes to pathways were implemented. The trust was working towards expanding capacity in the outpatient and diagnostic services to respond to increasing patient demand, improving access and reducing waiting times. There were plans to extend the working hours in radiology in Chelsea. The trust was also working as part of a collaborative with other hospitals to develop seven-day services.
- The outpatient waiting area, clinics and reception area were all cramped. The trust recognised this was an issue but here were no plans for relocating the department.
- The trust recognised that changes in cancer pathways would result in more patients being treated in outpatient settings. The trust had set up an outpatient transformation project to identify the opportunities for developing new models of follow up care, which could free up capacity in the outpatient clinics to see more new referrals. The project had been established for over a year. However, the work was still at an early stage and focused on those areas where there were particular concerns about referral to treatment times or the length of time patients waited in clinic to be seen, for example in gynaecology and urology.
- The use of technology such as telephone or video follow up consultations was beginning to be explored. Some specialist services such as sarcoma had already been introduced this to reduce the distance patients had to travel.
- The transformation project was considering improvements to patient's experience by reducing clinic attendances through more tailored support to patients. Medical and nursing staff told us the only way they could cope with the volume of patients was to work longer hours but felt this was not sustainable in the longer term.

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- A clinic utilisation study and capacity and demand study was in progress but had not yet been completed.
- A five-year development plan had been developed for radiology, which addressed the issues of capacity and demand. We spoke with senior staff who told us a feasibility study was being looked at with the estates department to find a solution to expand the interventional service.
- Senior staff from nuclear medicine (NM) were looking at expanding their service if further space could be gained from the current interventional suite.
- Staff we spoke with in diagnostic imaging felt empowered by the process of planning the extended CT and MRI services.
- Diagnostic imaging managers told us it was important to have the staff involved in strategic working and planning.
- The assistant practitioners utilised in NM offered a valuable contribution to the smooth running of the busy service.
- We saw the diagnostic imaging department had an updated risk register in place. Staff discussed risks in their departmental meetings, and were aware of the actions taken to reduce these.
- The trust provided us with a generic risk assessment of the risks in the outpatient department. The risks identified were not specific to the outpatient department and the mitigating actions were general and not specific. For example, local security arrangements were rated as the highest risk but it was not clear what the issues were or how these might affect patients.
- Audit systems were used to measure the quality and accuracy of work carried out within the diagnostic imaging department. This included audit half days for staff to attend.
- CT radiographers were following NICE guidance on reducing the risk of acute kidney injury, and carried out compliance audits. The use of an iSTAT machine (portable blood analyser machine) helped reduce the risk of the inappropriate use of contrast media.
- Good governance processes were established for radiation safety monitoring and all staff reported that the Radiation Protection Advisory (RPA) Service gave excellent input and support. The RPA provided support and guidance in all aspects of risk assessment.
- There were clear lines of accountability across the diagnostic imaging department.

## Governance, risk management and quality measurement

- Information about achieving outpatient clinic waiting times standards was included in the integrated governance report produced for monitoring the quality of services. The number of cancelled clinics and patients not attending was monitored quarterly by the Board.
- A clinical scorecard incorporating trends for incidents had also been developed. We saw an example of a pilot, which had been developed but was not yet fully in use. The scorecard monitored key clinical indicators for each clinical business, which was discussed by clinical staff and managers at clinical business unit meetings.
- Governance arrangements were established for the diagnostic imaging clinical business unit (CBU). Senior staff attended quarterly divisional meeting including a radiologist for medical input. The divisional meeting reviewed incidents, risks, staffing and performance within the radiology service.
- Staff were given feedback about incidents and lessons learned comments, compliments and complaints at monthly staff meetings. We observed the minutes of these meetings where relevant information had been discussed.

## Leadership of service

- The outpatient and diagnostic imaging departments were managed as part of the Clinical Services Division. The Head Of Patient Support Services managed the outpatient services on both sites, reporting to the Deputy Director of Clinical Services. The Director of Clinical Services was responsible for fourteen clinical services and reported to the Chief Operation Officer, who provided executive leadership for outpatient services. Most clinical departments had a clinical and managerial lead but there was no clinical lead for the outpatient department. However, following the inspection, the trust informed us that clinical leadership of the outpatient service was devolved to the clinical business unit Clinical Directors. The Head of Patient Support Services worked with each of the business units in the cancer services division to plan their use of the outpatient department.



# Outpatients and diagnostic imaging

- An Outpatient Operational group met monthly to review the performance of the outpatient department and any governance issues, which were fed into divisional meetings. Feedback from these meetings was provided to the sisters in outpatients by the Head of Service. A divisional meeting with extended membership was held every three months, which the outpatient matrons attended where incidents, risks, staffing and performance was discussed.
- We found competent staff managing each of the diagnostic imaging clinical areas we visited. Staff told us they had confidence in their leadership. Modality leads were visible and approachable and we observed good interactions between managers and their staff.
- Nursing staff in the outpatient department told us their managers provided effective leadership. They were able to raise concerns and felt managers listened and resolved issues wherever possible.
- The radiology service was well led by a team of highly specialist, competent radiologists, and radiographers, and they had managed to continue a quality service in the face of service demand pressures.
- Managers supported staff to carry out continuous professional development activities, complete mandatory training, attend appraisal and complete specific modality competencies. Senior nursing staff told us they felt supported by the trust and able to raise issues and concerns affecting the outpatient department.

## Culture within the service

- Staff we spoke with told us they were well supported with training, had the opportunity to meet with their manager often for one to one meetings, and the culture within their department was open. They said the only pressure they felt was to ensure the large number of patients they saw each day had a positive experience of visiting the outpatient department.
- One staff member in diagnostic imaging said the culture was one of, "Genuine care" and another, "I love working here." All diagnostic imaging staff we spoke with described a positive working environment and the strength of teamwork. There was a good level of morale across the diagnostic imaging team and many of the staff we spoke with had been there for many years.

- Good working relationships and support networks had been built with other local hospitals and the research institutions. Staff felt they could raise concerns and would be listened to.

## Public engagement

- We saw examples of patient survey's, which had been carried out to find out more about patients experiences, for example in the sarcoma service survey. This had been carried out in 2015. Results indicated; 66% of patients felt they had received sufficient information about what to expect when they attended clinic. Of the responses, 70% of patients felt they were able to adequately discuss their worries or concerns. Further, 18% of patients were seen on time, with 22% were seen within 30-60 minutes of their clinic appointment time, and the majority of patients were given a choice of appointment time.
- An 'always events' group had been set up involving patients in discussing improvements they would like to see implemented in clinics. The first meeting was held in January 2016. The outpatient transformation team wanted to involve patients in identifying areas for improvement.
- An audit study of patient experience had been piloted in the CT department in Sutton and was to be further rolled out across all modalities on both sites. 92% of patients (115) patient had responded to the survey. The results showed 97% of patients were happy with the information they received prior to their scan and 90% said their radiographers had been very helpful and polite. The service planned to provide patients with more information about the process for receiving the results of scans.

## Staff engagement

- Staff in outpatients met daily to discuss the organisation of the clinics. They told us they felt involved in plans to improve outpatient pathways through the outpatient transformation project.
- Senior staff in diagnostic imaging told us they sent out regular emails to the staff and the staff confirmed this was a good method of communication.
- Radiology staff contributed to the writing of standard operating procedures (SOPs), and these were also written in collaboration with other clinicians across the hospital.



# Outpatients and diagnostic imaging

- Staff felt the consultation and planning for the extended hours had been a good experience and gave them ownership of the new working arrangements.
- Outpatient nursing staff met monthly to discuss issues relating to running the department such as new appointments and staff training.

## **Innovation, improvement and sustainability**

- An outpatient transformation project was underway across the trust. The project was reviewing the management of activity in the clinics, making improvements to clinical processes and reviewing the skill mix of staff. The project plan showed multidisciplinary follow up clinics were being planned for all patients following their first outpatient appointment, the involvement of palliative care in the outpatient department was being considered and the patient journey through poorly performing outpatient clinics was being reviewed.
- Advanced practice was evident in the radiology department with radiographers doing IV cannulation and port access procedures and breast ultrasound.
- The diagnostic imaging department was going through the process of the Imaging Services Accreditation Scheme (ISAS) and the application was planned for completion in September 2016.
- The diagnostic imaging department had implemented a 'whole body' scanning technique for patients with bone marrow cancer which reduced the need for multiple x-rays of the individual bones and was more accurate for diagnosis of the condition.
- The CT department had installed a portable blood analyser machine, which could give staff access to laboratory results within minutes rather than hours. This helped reduce the time needed to get blood test results for patients requiring contrast medium injections.
- A large proportion of interventional radiology procedures had been previously outsourced to a nearby NHS provider. These had now all been brought back in-house and the service was working well.
- The radio-pharmacy department had purchased a specialist generator used to extract a positron-emitting isotope for the creation of specialist PET scans

# Chemotherapy

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

## Information about the service

The Royal Marsden Hospital NHS Foundation Trust in Chelsea provides a specialist tertiary service for patients diagnosed with cancer and treats private patients both from the UK and overseas, and patients in the local area. The hospital has a strong national and international reputation for both treatment and research, including in chemotherapy treatments and drug trials.

Chemotherapy is provided on a day case basis for 90% of patients with solid tumours requiring treatment. Two medical day units administer all Systemic anti-cancer therapies including chemotherapy, monoclonal antibodies, supportive therapies, and blood transfusion. They provided a cannulation service and insert peripheral lines, as well as providing flushing and dressings for these. There is telephone triage for patients.

Granard House Day Unit caters for private patients. It has 18 chairs and 4 consulting/treatment rooms. The unit treated 8698 patients in the year from January 2015 to December 2015. It is open Monday to Friday 08.30 to 19.00.

The MDU for NHS patients has 29 chairs and treated 22278 patients in the year from January 2015 to December 2015. The services are open 8.30 am to 8 pm, Monday to Friday.

Each unit has its own pharmacists.

Inpatient wards take patients based on their tumour group. Most wards have a few patients receiving chemotherapy treatment, for example those who are unwell because of

their cancer or those needing intensive daily chemotherapy and observation. There are two wards for private patients: Granard House and Wiltshaw Ward. There are six NHS wards.

A Clinical Day Assessment Unit (CAU) is open Monday to Friday from 8 am to 5.30 pm for both NHS and private patients presenting with troublesome symptoms due to cancer treatment or disease. About 59% of patients attend by appointment, for example for elective transfusion or other day case procedures such as chest drain insertions. The unit has eight trolleys, five chairs, and an isolation room for any patient who is potentially infectious. About 280 patients attend each month.

An 'Acute oncology service' (AOS) within CAU carries out assessments and investigations to form a prompt and timely treatment plan to avoid admissions and reduce length of stay. The AOS has been established in line with the National Cancer Action Team's published measures for Acute Oncology (2011) as a specialist provider – Hospitals with Specialist Oncology Beds and Outpatient Chemotherapy without Accident and Emergency Services. Patients becoming unwell out of hours are advised to contact the Clinical Site Practitioner for triage.

Most Haemato-oncology patients were treated at Sutton Hospital. Intensive chemotherapy of the kind needed by such patients was not currently administered at the Chelsea site. There are two dedicated isolation rooms for the most immune-compromised oncology patients in the private Wiltshaw Ward. Three more isolation rooms are due to open later in 2016, when an in-patient haemato-oncology facility for private patients is planned to open.

# Chemotherapy

During the inspection we spoke with 12 patients and nine family members or friends. We also spoke with over 40 doctors and nurses at all grades, as well as with domestic staff, an occupational therapist, physiotherapist and dietitian, complementary therapist and pharmacists. We observed interactions between patients and staff and reviewed 10 care records. We reviewed data received from the trust before the inspection, and data we requested after the inspection to help corroborate our findings.

## Summary of findings

We rated the chemotherapy service services at The Royal Marsden Chelsea as good for safety, effectiveness, responsiveness, and leadership. We rated caring as outstanding:

- Chemotherapy drugs were prepared in an aseptic (germ free) environment, prescribed through an electronic prescribing system. Drug administration was monitored safely, and patients were made aware of potentially life threatening side effects that could occur between treatments and knew what action to take.
- There was a strong culture of multidisciplinary working between nurses, specialist nurses, doctors and allied health professionals. Patient treatment was decided in multidisciplinary meetings (MDTs) and there was regular in-depth MDT patient review.
- There were clear arrangements for responding quickly to patients with possible neutropenic sepsis both within the hospital and for those admitted to A&E departments in other trusts.
- There were established non-cancer pathways and agreements with other hospitals for patients needing treatment for other conditions such as respiratory and neurological conditions. There were formal agreements with some other hospitals where patients were treated for non-cancer related conditions.
- Services were organised to meet people's treatment needs in relation to their cancer. They also took into account patients wider holistic needs for spiritual and psychological support and for relaxation. Staff treated patients as individuals.
- Patients told us staff at all levels were courteous, thoughtful and kind in their dealings with them, in many small ways that went well beyond the administration of treatment. The number of compliments far exceeded the complaints.
- The atmosphere of the units was calm and welcoming and patients we spoke with and their families were full of praise for the sensitivity staff showed to their feelings and concerns and to the needs of some patients for emotional support in coping with their treatment and condition.

# Chemotherapy

- Nurses recognised the uniqueness of each patient, and the diversity of patients, and responded appropriately with support and advice as required.
- There was an open culture of reporting and learning from incidents and near misses without blame and patients were protected from avoidable harm because staff understood the risks of treatment and the nature of incidents
- Both the chemotherapy day units, the clinical assessment unit and some wards were modern and welcoming and we observed high standards of cleanliness
- Staff were clear about the vision for the trust's services to be leaders in cancer care. They shared the objectives of the wider trust to provide safe, effective and high quality care to all patients. All those we spoke with were proud to work for the hospital and would want their friends and family to be treated there should the need arise.
- There was a very wide range of information available to patients to supplement what they were told by clinical staff, including films for patients to help them look after their CAVD devices. Information was available in other languages.
- An acute oncology pathway for patients who became unwell out of hours was managed by clinical site managers.

## Are chemotherapy services safe?

Good



We rated the chemotherapy service at The Royal Marsden Chelsea as good because:

- There were adequate numbers of trained staff to care for day patients attending for chemotherapy and other day medical treatments.
- Patients were protected from avoidable harm because staff understood the serious potential risks of chemotherapy treatment and the nature of incidents.
- Chemotherapy drugs were prepared in an aseptic (germ free) environment, prescribed through an electronic prescribing system. Drug administration was monitored safely, and patients were made aware of potentially life threatening side effects that could occur between treatments and knew what action to take.
- There were clear arrangements for responding quickly to patients with possible neutropenic sepsis both within the hospital and for those admitted to A&E departments in other trusts.
- Medicines were stored safely, separately from other medicines.
- Incidents were reported, effectively investigated and we saw changes made as a result in several cases.
- We observed high standards of cleanliness, and clinical waste including chemotherapy waste was disposed of safely.
- There was sufficient equipment, well maintained to provide safe and effective care.
- Although the hospital did not have capacity to admit all its own patients who became unwell as a result of chemotherapy treatment there were sound arrangements for passing on information to receiving hospitals when patients were admitted to other hospitals and following up their progress.
- An acute oncology pathway for patients who became unwell out of hours was managed by clinical site managers.

However;

- The pharmacists in the aseptic unit told us they were often working beyond their capacity.
- There was no evidence of temperature monitoring in rooms where medicines were stored.

# Chemotherapy

## Incidents

- There was a positive reporting culture. Incident reporting was through DATIX web based electronic reporting system to which all staff had access.
- All staff we spoke with said they reported incidents, including near misses, and received feedback on action taken both directly and in meetings. The medical day unit reported 110 incidents during 2015, of which, 46 were rated low and 64 very low. 66% of incidents were medication related.
- The ward sister investigated all low and very low harm incidents and the Matron reviewed these. Incidents resulting in moderate harm, and selected incidents of low harm were investigated by a panel. There had been no incidents of serious harm in chemotherapy day centres.
- Staff told us some incidents were allergic or hypersensitive reactions to chemotherapy. Although staff were prepared for these with certain treatments, they would still report them to the nurse in charge, and record them as incidents, including noting length of patient recovery time.
- Staff said they would always consider whether PALS needed to be involved. Trends and themes of incidents were analysed and benchmarked against national data. An example was that several incidents of extravasation had occurred when the anti-cancer drug, Paclitaxel, was given as an injection or infusion into the vein. (Extravasation is the escape of medicine from the vein causing damage to surrounding tissue, which can cause necrosis and ulceration and required prompt action from staff to minimise damage). Nurses were trialling a different gauge needle to try to reduce the occurrence, as well as using film dressings. Staff told us that incidents had reduced.
- Staff received feedback on incidents via e-mail and discussions at weekly ward meetings, as well as through the trust-wide email “message of the week”.
- We saw examples of inpatient pressures sores investigated under the SI process with appropriate root cause analysis, recommendations and action plan.
- Doctors discussed in-patient incidents at morning handovers. These were documented for the clinical governance team, and contributed to performance statistics.
- The Medical Advisory Committee considered results and action plans following serious incident (SI) investigations.
- Pharmacists discussed incidents and near misses weekly, including any intrathecal (IT) chemotherapy medication errors. (Intrathecal drug administration is by an injection into the spinal canal rather than through a vein).
- The Multidisciplinary Executive Medicines Safety Group reviewed medicines incidents and errors monthly. The main recent medication incidents had been dose delays, dose omission, wrong infiltration, and allergic reactions to drugs. Learning from these incidents was shared with staff across the organisation through local governance meetings such as ward sisters meetings and trust wide email termed “message of the week”
- Safety alerts received externally that required action were circulated to managers who updated their staff on changes that needed to be made. A nurse gave us an example of a change to the storage conditions for a drug called Oxaliplatin that now had to be refrigerated.
- Chemotherapy Mortality and Morbidity (M&M) meetings took place once a month to consider recent deaths and their primary causes and discuss whether they could have improved patient outcomes. Learning points were identified following discussion of selected cases and a summary review was sent to consultants following the meeting.

## Safety thermometer

- The standard NHS Safety thermometer tool was not relevant to services for day patients; however, a medicines safety thermometer to show harm free care had been piloted and would be rolled out during 2016.
- Staff told us safety issues were discussed at unit meetings. Ward staff reviewed falls, pressure ulcers, urinary tract infections in patients with a catheter and new venous thromboembolisms (blood clots) on each inpatient ward.

## Duty of candour

- We saw evidence of staff training on the duty of candour.
- Staff we spoke with understood the duty of candour. A nurse gave an example of a near miss in relation to an injection. She had explained what happened and apologised to the patient. She reported on the incident reporting system. The patient record was annotated to record who informed the patient of the incident and the date.

# Chemotherapy

## Cleanliness, infection control and hygiene

- There were link nurses for infection prevention and control in all clinical areas. All areas we visited were clean and tidy. Patients told us they were impressed with cleanliness.
- The trust policy was to screen all new patients for Meticillin Resistant Staphylococcus aureus (MRSA) and a Carbapenemase Producing Organism (CPO). (MRSA is a bacterium that can be present on the skin without causing infection but can be a common cause of infections. A CPO is a bacteria found in the gut, which can be a common cause of some infections like a urinary tract infection.)
- Hand hygiene was monitored monthly and results were displayed in patient areas. The scores in the MDU and CAU were 100%. We observed good hand hygiene practice during our inspection. All trolley bays in the CAU had individual washbasins, soap and alcohol gel. Staff told us the infection control team also conducted hand hygiene audits. The trust aimed for a compliance score of 95%.
- Good hand hygiene practices were taught in mandatory training sessions to all staff, with emphasis on the '5 moments of hand hygiene' as supported by the World Health Organisation (2006) and the EPIC3 guidelines (2014).
- Only trained chemotherapy nurses administered cytotoxic drugs. They were aware of the vital importance of safe handling of chemotherapy drugs and complied with trust policies and best practice in using personal protective equipment such as gloves and aprons. Staff transporting chemotherapy drugs carried them in yellow, padded, leak-proof cytotoxic bags, labelled with additional information on storage temperature. The nurse receiving the bags signed for them, with the time of delivery added to the electronic system. The tracking system was visible across the trust.
- All staff we spoke with knew the safety procedures for dealing with cytotoxic spillages, the decontamination of surfaces and individuals, the use of the Cytotoxic Spillage Kit (CSK) and the purple cytotoxic sharps bin to disposal of cytotoxic contaminated materials and equipment. Staff knew to seek a review from occupational health if they were at risk of contamination.

- Staff were able to explain the additional precautions for dealing with body fluids that might be contaminated with cytotoxic matter, double flushing of sluices and toilets and the need to consider incineration of heavily soiled bed linen.
- Domestic staff we spoke with that cleaned wards and units said they were aware of the health risks associated with cytotoxic drugs and cytotoxic waste.
- We saw an audit of patients identified as Clostridium difficile toxin positive (April to September 2015) who were all receiving chemotherapy and therefore at risk of infection. The audit identified factors increased patients' risk, such as being artificially fed, or having radiotherapy or surgery in addition to chemotherapy. This learning was cascaded to staff trust wide.

## Environment and equipment

- Both medical day units were bright, modern and welcoming. The atmosphere of the hospital both on the units and the wards was calm and efficient.
- Link nurses were responsible for medical devices in their area. Where there were changes in usage, practice educators were responsible for updating staff.
- There was sufficient medical equipment, for example intravenous pumps and subcutaneous drivers, to maintain safe and effective care. All medical equipment was tested and calibrated annually or more often if required. Records were kept centrally. If any equipment was involved in an incident, it was removed from use and sent to clinical engineering for testing.
- All new equipment purchased was approved for purchase by the Clinical Product Review Committee and procurement, taking account of recommendations from the National Council for Clinical Excellence (NICE).
- Equipment was cleaned after patient use and labelled clinically clean.
- Staff only administered chemotherapy in designated areas: the medical day units or inpatient wards. All these areas contained resuscitation equipment, drugs for the management of emergencies – cardiac arrest and anaphylaxis, an extravasation kit, a cytotoxic spillage kit, and eye wash with access to running water.
- The policy required resuscitation equipment to be checked daily. We noted a few days had been missed in the MDU. However, drawers were tagged so it would be



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evident from the broken tag that an item had been removed. Staff told us missed checks would be picked up and staff would receive reminders to be more conscientious about checks.

## Medicines

- The pharmacy team in the trust were leading a national project across in England on dose banding of chemotherapy medicines. The outcome of this project would standardise chemotherapy doses, which would mean most chemotherapy medicines could be batch produced, improving efficiency, and reduction in wastage.
- The trust used a bespoke electronic chemotherapy prescribing system that had been developed in agreement with NHS England. It had in-built safety systems ensuring all relevant information relating to the individual patient journey and treatment pathway were centrally held. This had significantly reduced errors. Managers reported this had reduced errors and made it easier to collect data. Staff completed paper charts for patients on clinical trials.
- Only authorised prescribers, on the trust register prescribed chemotherapy. Pharmacists required training and accreditation to be added to the register. The trust used a London Cancer Alliance training programme. Staff told us any change in procedure or practice required some retraining for all staff working in the Aseptic Services Unit, as well as reading and signing the new or amended standard operating procedure. A consultant pharmacist independent prescriber was involved in chemotherapy prescribing, as well as other supportive therapies in paediatric medical day unit. A recent prescribing audit carried out by the unit showed that prescribing done by NMP was 100% accurate compared to those done by medical doctors.
- Specialist pharmacists provide clinical support to doctors in the medical day outpatient clinics to facilitate accurate and effective prescribing and manufacturing of chemotherapy doses which reduces error, patient waiting time, and improves patient experience. All staff involved in handling cytotoxic drugs such as purchasing and receipt of goods, packaging, storage, and transportation followed the management of health and safety at work regulations 1999 and other health and safety guidance. We saw evidence of appropriate handling of chemotherapy medicines, including delivery by the porter, receiving by nursing staff and storage of chemotherapy medicine
- Pharmacy staff did not release chemotherapy drugs to nurses on wards or on the MDU until medical staff had confirmed satisfactory results for patient's blood tests. Some patients due to receive specific anti-cancer drugs such as Carboplatin needed extra tests, for example, tests of renal function before pharmacists could prepare the drug. Sign off was by a trained oncology pharmacist.
- The workload in the aseptic pharmacy was high. For capacity reasons, the pharmacy outsourced preparation of some chemotherapy drugs to a private pharmaceutical company. However, a large number of drugs were prepared in house in the licenced aseptic unit (ASU), particularly drugs that had to be used very soon after preparation. There were 18 aseptic production trained pharmacists preparing drugs for the MDUs. They also prepared intravenous (IV) drugs for patients on the wards. Nine pharmacists worked on drug trials. Staff coded drug preparation status as red (pending), amber (made), and green (dispensed).
- Turnaround time for emergency drugs was 40 minutes to one hour. Normal turnaround for non-clinical trial drugs was two hours.
- The ASU could take orders up to five days in advance, these were checked at the time of preparation, and again when the patient's blood had been checked prior to treatment. As dose reductions were very common, there was often wastage as staff needed to remake the drug to the new formulation.
- Except in specific listed emergencies, staff only administered chemotherapy during normal working hours.
- Inpatients and outpatients obtained drugs to take home from a contracted-out pharmacy dispensary service on site. The pharmacy used the trust computer operating systems that increased patient's safety especially when dispensing supportive chemotherapy medicines. Separating this dispensary from the main hospital pharmacy had resulted in reduced waiting times for outpatients.
- Medicines were stored securely in the pharmacy adjoining the day unit. However, intravenous (IV) fluids,

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although in a locked room, were not themselves in locked cupboards. There was a plan for installation of cabinets with biometric access. This was on the risk register.

- On wards, access to cytotoxic drug storage areas was limited to authorised staff, and the storage areas displayed cytotoxic warnings. Cytotoxic drugs were stored separately from other drugs. All cytotoxic drugs taken to wards were for the use of named individuals only.
- We saw signs on display about dealing with cytotoxic waste. Spillage kits were available in all wards and other relevant locations for chemotherapy drugs and for blood. Between April 2015 and March 2016 there had been one cytotoxic spillage at Chelsea.
- Staff checked and recorded fridge and freezer temperatures in the MDU, although not every day in either case.
- Some nurses were able to prescribe drugs such as antibiotics and fluids under Patient Group Directions, before a doctor arrived.
- Some cancer treatments were very expensive. There was a scheme where patients could share the cost of some treatments.
- We did not see any evidence of room temperature monitoring in clinical areas where medicines were stored, although no staff mentioned that rooms ever became too warm.

## Records

- We checked 10 sets of notes of patients undergoing chemotherapy and found clear documentation of allergies, weight and height, assessments and NEWS scores. Staff documented end of life plans and any conversations to which duty of candour applied in patient records. Staff recorded any significant toxicity reaction to chemotherapy treatment.
- Most patient notes were kept electronically, although on wards there were bedside paper notes.
- Patients and their GPs received written copies of their end of treatment record after a chemotherapy cycle.

## Safeguarding

- Safeguarding training was mandatory for all staff. All healthcare staff were trained at level 2 and all administrative staff were trained at level 1. Training was every two years.

- All staff we spoke with knew the name of the safeguarding lead and the process for reporting concerns about the protecting patients from abuse or avoidable harm, including reporting the concern as an incident.

## Mandatory training

- We checked nurse training records and found most staff had completed their regular mandatory training updates. Mandatory training covered basic life support skills, prevention of blood clots, blood transfusion, conflict resolution, health, safety and the duty of candour, and, for some staff, emergency planning. Two staff were due an update on Infection prevention level 2 and we saw evidence that this training was booked.
- An electronic system used a traffic light system to notify staff and managers when training was due.
- Mandatory training in chemotherapy was required for all staff involved in prescribing, reconstituting, dispensing, and administering chemotherapy. The trust maintained a register of named medical and non-medical staff that were reviewed as competent to prescribe chemotherapy.
- All nursing staff undertook medicines management training each year. Medical staff had this training on a three-year cycle.

## Assessing and responding to patient risk

- A consultant Oncologist / Haematologist took the initial decision to initiate treatment in adult patients following discussion at the relevant multi-disciplinary team (MDT).
- Before chemotherapy treatment, staff discussed potential side effects with patients such as the risk of colitis, dehydration, or reduction of thyroid function, including impacts on pregnancy or fertility. Patients were time to reflect on the options and decide on treatment.
- Royal Marsden patients who became unwell at home with possible neutropenic sepsis were advised to telephone RMH. All patients we spoke with said staff had told them about self-care relating to chemotherapy including signs of neutropenic sepsis which might occur some days after treatment. (Sepsis is a whole-body reaction triggered by an infection and may occur when white blood cells are low because of anti-cancer treatment. It is a serious condition, which can be life threatening).
- Telephone triage at RMH followed a flow chart dependent on the symptoms the patient reported. Staff

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recorded the patient's details and symptoms on a triage template. They maintained a log of the advice to patients, whether the event was referred to their consultant and if RMH was unable to admit the patient because of lack of beds or because the patient lived too far away, whether patient information had been sent to the receiving A&E department.

- The hospital used a standard fax transfer for patients referred to A&E to ensure that all relevant information was passed over promptly. If the patient knew which A&E they were going to then the fax was sent when the advice to attend A&E was given to the patient.
- Staff told us patient information for patients admitted to Emergency Departments for neutropenic sepsis was transferred promptly because electronic prescribing facilitated access to treatment information. Staff emailed the treating RMH consultant/CNS to alert the treating team for follow up and check appropriate care the next working day.
- The Royal Marsden had driven local AOS teams with a common one-hour door to antibiotic pathway for A&E presentations, with internal mechanisms to review patients by RMH led oncology team in 24 hours. Internal pathways were routinely audited and discussed at meetings of the London Cancer Alliance. The forthcoming Macmillan hotline would allow the hospital to gather data prospectively about calls to the AOS and put in place a call back to inform immediate and subsequent outcomes prospectively for all patients.
- Of the 81- 109 RMH patients admitted to network trusts monthly, some 17-19% were admitted due to sepsis of any cause. Ten patients a month were admitted to the Royal Marsden for the same reasons.
- The trust guideline for the management of Adult Neutropenic sepsis followed the NICE guidelines on prevention and management of neutropenic sepsis in cancer patients (2013) and guidelines from the Infectious Diseases Society of America (IDSA). Increasing awareness, identification, and treatment of sepsis and reducing death from it were the focus of a Safety Improvement Plan for 2015-2018, which included increased awareness and education for patients and staff, and use of the Sepsis Six bundle (blood cultures, lactate measurement, oxygen, fluids measurement, early antibiotics and urine output monitoring).
- Antimicrobial patient group directions (PGDs) had been updated and it was planned to promote the use of neutropenic sepsis PGD training to increase the number of nurses able to administer antibiotics on PGDs following recognition of sepsis.
- Audits showed a significant improvement during 2015 in the proportion of patients with sepsis who had received antibiotics within the one-hour target. This had improved from 41% to 94% in the period January to December 2015. An audit of a specific chemotherapy regimen that caused a higher incidence of sepsis had led to a review of the regimen, with a consequent reduction in sepsis rates. The AOS was only available Monday to Friday from 8.30am to 5.30pm. The CAU was also open 8am to 5.30pm. Out of hours, defined as any time between 17:00-09:00 Monday to Friday; and 24 hours on Saturday and Sunday, Clinical Site Practitioners dealt with enquiries.
- We saw clear standardised arrangements for telephone triage and managing patients out of hours. We saw an oral systemic anti-cancer therapy (SACT) checklist for site practitioners to go through with patients. Patients taking oral chemotherapy attended as outpatients to collect their medication. Medicines reconciliations and patient counselling for oral chemotherapy were carried out by qualified technician especially during the first and second cycle of chemotherapy treatment.
- Staff assessed all chemotherapy patients before each treatment. This included checking any weight change (because the dose of chemotherapy is based on the patient's body mass index). Blood tests checked patients' red blood cell (RBC), white blood cell (WBC) and platelet count. If their RBC was too low, they might need a blood transfusion to prevent treatment from pushing these down to a dangerous level. Blood tests also checked how well the kidneys and liver were working, as this could lead to more side effects from the chemotherapy. If the blood counts were too low, patients would be advised to return another time for a repeat blood test to assess their fitness for chemotherapy. Patients with or at risk of hypercalcaemia (high levels of calcium in the blood) were tested for blood calcium levels. Patients saw a doctor to discuss their test results and review their health.
- Some patients were treated with drugs not yet licensed for general use but administered as part of a clinical trial. Doctors gave patients information about the trial

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and its alternatives. They assured patients they would observe them closely to make sure they were not in any danger. Staff carried out extra tests, such as biochemistry and tumour markers, to safeguard patients from possible side effects associated with a new treatment. Trial drugs were only given to named patients on the list for that trial. Doctors warned that new treatments could have side effects or risks that they were not expecting, and if patients took part in randomised trials they would not be able to choose which treatment to receive. Patients had to be assessed as fit enough to take part in a trial and were closely monitored during the trial for side effects. A pharmacist said many drugs used in trials had been approved by the Food and Drug Administration in the USA, even if not yet approved by NICE.

- Chemotherapy administration sheets were printed within an hour of being needed, and with version control, which was a good control to avoid the wrong chemotherapy drug being given. The Electronic chemo prescribing system showed whether a print off has already been made.
- We observed that nurses carried out appropriate checks before administering chemotherapy. We saw that a full initial administrative check was done by two nurses, and this was followed by another check fifteen minutes after initiation. A green card was placed on the infusion stand at the start of the infusion to alert staff to carry out 15 minute checks including observing the IV catheter sites for signs of swelling or inflammation, the rate of infusion and whether the patient showed any adverse symptoms. Nurses advised patients to notify them immediately about any symptoms of concern. This helped prevent extravasation. Patients were given a telephone number to ring if side effects of treatment occurred when they were at home.
- Nurses used National Early Warning Scores, (NEWS) to measure respiratory rate, oxygen saturations, temperature, blood pressure, pulse rate and level of consciousness, to identify deteriorating patients. The team had access to the Acute Oncology Service, a team of staff who supported patients attending the CAU or presenting with oncological emergencies. The Critical Care Outreach team was available for emergencies.
- The Multinational Association for Supportive Care in Cancer (MASCC) Risk Index was used to identify low-risk patients (score  $\geq 21$  points) for serious complications of febrile neutropenia (including death, intensive care unit

admission, confusion, cardiac complications, respiratory failure, renal failure, hypotension, bleeding, and other serious medical complications). The MASCC study is an international collaboration to derive and validate a scoring system to identify low-risk patients for complications of febrile neutropenia.

- Specialist registrars were contactable for chemotherapy problems and SHOs for medical problems. Clinical Nurse Specialists (CNS) for particular cancers were available, but consultants rarely came to the MDU. In the private day unit, the patient's consultant generally reviewed their own patients undergoing chemotherapy.
- If outpatients or relatives became unwell in the hospital, staff informed the site manager and called 999 to take the person to the nearest Accident and Emergency Department.

## Nursing staffing

- Nurse staffing levels on the MDU were at full establishment during our inspection. A matron oversaw the unit. There were 15 nurses, all chemotherapy trained, and nine healthcare assistants. Healthcare assistants were responsible for monitoring vital signs, clinic support, and phlebotomy. Each nurse looked after the patients in three chemotherapy chairs, which was in line with the national benchmark.
- Managers told us they used bank staff but not agency staff on the unit because. Chemotherapy trained nurses were not usually available from agencies. Managers said they were considering building some headroom into staffing to ensure there were enough chemotherapy-trained nurses, and nurses trained in ultrasound cannulation.
- The Granard House MDU had an establishment of 15.95 full time equivalent staff. Nine nurses were chemotherapy trained.
- An Advanced Nurse Practitioner supported by two nurses and a healthcare assistant led the CAU.
- All wards had some chemotherapy-trained nurses. The number varied according to the tumour type covered in the ward and the likelihood of patients needing to receive inpatient chemotherapy. Chemotherapy trained nurses on wards said enough patients received chemotherapy on wards for them to maintain their skills.
- The units held weekly meetings where staff discussed incidents and ways to improve practice.

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- There were challenges on staffing when staff were sick. Senior staff were considering building headroom into staffing figures to cover this.
- There were also challenges to maintaining staffing numbers the aseptic pharmacy and ensuring staff kept up to date with the pace of change in chemotherapy.
- Ward handovers took place at shift changes. We observed three ward handovers and saw comprehensive handover notes, including highlighting incidents. At handover the nurses in charge reviewed staffing in the light of patient acuity and reported any shortfalls to the morning bed manager meeting. Some patients were on wards because of side effects of chemotherapy, others because of infection. Such patients were as far as possible accommodated in single rooms. Single rooms on the private wards were sometimes used for NHS patients for infection control reasons.
- In the private wards handover information was recorded by the night nurse in charge. Staff were not clear why this was done as paper handover sheets were also available for all staff.
- The advanced nurse practitioner role was being developed in the trust to support medical staff.
- There were Clinical Nurse Specialists (CNS) on the pain team. They supported the whole hospital.
- Research nurses were involved in the day to day running of studies in clinical trials including recruiting patients, treatment and monitoring and supporting the patients on studies.
- A specialty doctor was assigned to each MDU. Nurses told us consultants did not routinely come to the Medical Day Unit. Registrars and Specialist registrars were contactable for chemotherapy problems and SHOs for medical problems.
- Two medical oncology consultants worked the hours of one whole time equivalent (WTE), in the acute oncology service (AOS). They were supported by another doctor, and a part time advanced nurse practitioner. They carried out ward rounds daily Monday to Friday, and took part in morning handovers with pharmacy, the clinical site practitioner, discharge co-ordinator, the clinical care outreach nurse, and the specialist registrar on call overnight.
- Out of Hours on-call junior doctors and clinical site practitioner could admit patients to a ward, seeking consultant advice by telephone. AOS staff would review these patients next day.
- Some locum doctors were used, including locum consultants. We saw a recruitment plan to attract more trust grade doctors. There were no gaps at Chelsea on the junior doctor medical rota.
- Doctors had to follow a series of competencies in systemic chemotherapy before they could prescribe.
- In the Granard House MDU, consultants saw patients more often. They were supported by department based speciality doctors and junior training grade doctors (SHO and registrar).
- The pain team, available to the whole hospital had three part time consultants, and an advanced pain trainee. There was a vacancy for a part time research fellow.

## Medical staffing

- Consultants worked by tumour type and were supported by a specialist registrar or trust grade doctor and a trainee. There were at least two consultants for each modality of treatment within each tumour type.
- Doctors in training that we spoke with said the workload was varied and manageable. Not all doctors worked on the wards, some worked in clinics and clinical trials only. Team working was effective. The rota was flexible and current rotas were published on the intranet. Doctors told us there was weekly oncology training and centralised training days, and we saw the teaching timetable for the current year.

## Major incident awareness and training

- The matron was a member of the major incident planning committee and had attended major incident training in the last six months.
- Shift coordinators told us they were clear about escalation plans in the event of incidents, however not all staff were aware of the major incident or business continuity plans. Staff told us major incident guidance was available for all staff on the intranet.



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## Are chemotherapy services effective?

Good



We rated the effectiveness of chemotherapy services at The Royal Marsden Chelsea as good because:

- Patient treatment was decided in Multidisciplinary team meetings (MDTS). There was a daily MDT handover and a regular in-depth MDT patient review.
- Staff had access to induction, training and appraisal systems.
- There was evidence of local clinical audits and action required at unit level.
- There were effective systems to ensure staff maintained their skills as well as opportunities for development.

However;

- Some of the SACT data reported by the service was incomplete and did not include all clinical data

### Evidence-based care and treatment

- 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.
- Staff were aware of evidence based practice and NICE guidelines, and told us they were notified of updates to these. There was a clinical protocols review schedule and all protocols were on the intranet. A few protocols were now due for review. Nurses said senior staff notified them when national or local guidelines changed.
- Many policies were based on the Royal Marsden Hospital Manual of Clinical Nursing Procedures, 2015 that was also used nationally.
- The pain team worked jointly with other pain teams in nearby trusts so they could learn from each other. They followed British Pain Society guidelines for acute pain, chronic pain & cancer pain.
- All chemotherapy was prescribed according to recommended practices with a written protocol containing indications, drug, dose, route, cycle length, and frequency, length of treatment, monitoring requirements, and requirements for dose adjustments. Staff recorded deviations from protocol in patient notes and on the e-prescribing system. We reviewed the Chemotherapy Treatment Policy and had no concerns.

- Named staff were responsible trust wide for ensuring patients safety when drugs were given to patients through injection into the spine and were not confused with drugs intended for delivery through the vein. We saw that only trained staff whose names were on the trust intrathecal register were allowed handle intrathecal medicines from dispensing to administration. The trust's intrathecal chemotherapy safe administration policy was in line with standard recommendations in national guidance in Health Service Circular, HSC 2008/001 and the rapid Response Report NPSA/2008/RRR004 relating to intravenous vinca alkaloid administration.
- Peripherally inserted central catheters (often called PICC or PIC lines or CVADs) are a form of intravenous access that can be used for a prolonged period (e.g., for long chemotherapy regimens). Nurses in the MDU inserted these using ultrasound and ECG guidance in line with best practice. Patients given a type of catheter inserted completely under the skin, known as a port or portacath had these inserted by a doctor or radiologist using local anaesthesia or conscious sedation.
- The trust scored well in the National Lung Cancer Audit for Small Cell Lung Cancer patients having chemotherapy.
- The trust had a formulary listing pharmacy-stocked medicines, which was used to promote evidence-based cost-effective prescribing. A drug and therapeutic committee (DTC) oversaw and approved any amendments to the formulary and implementation of relevant NICE and other national guidance.
- Up to 30% of patients were on clinical trials of chemotherapy regimens.

### Pain relief

- Staff told us they used a pain scale to assess patients' pain. A non-medical prescriber on the unit could provide analgesia but when necessary would escalate concerns to the medical team or, if the patient's needs were complex to the pain team.
- The role of the pain team for both acute and chronic pain management was trust wide, both NHS and private patients.
- The pain team could also referred patients to other health care professionals if specific needs were identified, such as psychological support or advice on relaxation such as through yoga or massage.



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- The pain CNS also provided education for staff: formal study days and informal ad hoc teaching to ensure all clinical staff had sound foundation knowledge of pain assessment and management.
- The pain service could also provide telephone advice and review patients when they attended the hospital for other appointments. Five patients we spoke with mentioned how well staff managed their pain.

## Nutrition and hydration

- Food and drink were provided on the day units. The dietitians approved the content of snacks.
- When patients first attended the hospital staff carried out a nutritional assessment and this reassessed this at subsequent attendances, particularly if there was weight loss. Patients were weighed each time they attended for chemotherapy treatment. If they were losing weight, dietitians could advise on eating well, including supplements such as calorie loaded drinks.
- Red serviettes were used to identify patients that needed assistance with nutritional needs.

## Patient outcomes

- The trust administered chemotherapy regimens for all major tumour sites. They contributed to national audit programmes such as the Systemic Anti-Cancer Therapy (SACT) Dataset that covers patients receiving cancer chemotherapy in or funded by the NHS in England.
- Treatment plans were based on best practice and all patient care was documented on their individual records. Treatment for many patients would not only involve chemotherapy, but might involve surgery, radiotherapy, symptom control or palliative care depending on their needs at the time.
- The main measurable outcome of cancer care is long-term survival, but the trust considered that soft outcomes such as the quality of patient experience were also very important.
- Trust wide figures showed that between October and December 2015 5.7% of patients died within 30 days of receiving chemotherapy. Over an eight year period there had been a 2% reduction in deaths within 30 days of treatment.
- Unexpected deaths were low, about 0.6%.
- The trust also contributed to the National cancer waiting times database, and the Cancer outcomes and services dataset, although some of their clinical data was incomplete.

- On wider outcomes for different types of cancer, results, where published, were around the national average.

## Competent staff

- New staff had a trust and individual induction. Staff told us their induction had been very useful. After induction, all nurses had to pass a medicines management and Patient Group Directions Test. They also attended training and completed workbooks on administering intravenous drugs. Nurses could begin chemotherapy training after qualification and nurses were able to practice as soon as they had been assessed competent. They repeated skills testing for chemotherapy after a year and thereafter they completed self-assessments annually.
- Nurses we spoke with reported good access to training outside mandatory training. A number of staff we spoke with mentioned the availability of regular training opportunities. Much training took place in programmes, modules and study days in Royal Marsden school and but external training was also available, for example through the London Cancer Alliance.
- Practical work was assessed by the team of educators who covered areas such as venepuncture, cannulation, and IV training. Practice educators also worked practically on the MDU to keep their skills up to date. Staff were responsible for ensuring they achieved and maintained competences such as cannulation and venepuncture by carrying out a minimum number of procedures in a month, in accordance with NMC Code (2015).
- Several nurses told us of external training opportunities funded by the trust for their wider development.
- There were mentorship schemes for nurses and six-weekly clinical supervision for staff.
- MDU staff were trained and assessed on all medical devices used within the day units.
- Nurse educators worked practically too, to maintain their clinical skills.
- Doctors in training told us they had high quality in-house training and study leave before examinations. Monthly research clubs, a journal club, trials meetings and tissue research results meetings were held, and they could attend 'paper rounds' where consultants discussed patient progress and treatment plans. Clinical forums took place bi-monthly.
- All staff we spoke with confirmed they had had appraisals. Trust wide appraisals were on target at 85%.

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## Multidisciplinary working

- There was a strong culture of multidisciplinary working. Multidisciplinary teams (MDTs), based on tumour types, and decided on patient eligibility for systemic therapies (chemotherapy). Some of the patients considered had been referred from other hospitals for pioneering treatments. 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. Video conferencing was used with the trust's Sutton hospital. Investigations were decided and outcomes were recorded live. MDTs had a designated lead. There was good multidisciplinary attendance (pathologists, CNS, consultants and junior doctors). Junior doctors took the notes. MDT outcomes were recorded directly into the trust's electronic MDT system so each outcome appeared within each patient's record immediately on completion.
- 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.
- At ward level there were daily handovers attended by nurses and therapists to review the treatment plans of inpatients and there were weekly MDT meetings on wards
- Specialist pharmacists provided clinical support to doctors in the medical day units to facilitate accurate and effective prescribing and manufacturing of chemotherapy doses that reduced error, patient waiting time and improved patient experience.
- Some inpatients were transferred out to other trusts for medical treatment not directly related to their cancers, for example for specialist respiratory or renal care. Formal service level agreements had been developed with neighbouring trusts for the main non-cancer clinical pathways and there were arrangements to update patient records on transfer to another trust.
- There was access to for patients to psychiatric and psychologist input, supported by nurse practitioners.
- A clinical psychologist was available to support staff monthly.

## Seven-day services

- The Medical Day Units were open Monday to Friday, although after a bank holiday they opened on Saturdays so patients did not lose a week's treatment.
- The aseptic pharmacy was open on Saturday mornings. There was no out of hours aseptic pharmacy cover. In emergencies, staff could obtain medicines prepared at Sutton pharmacy. There were no clinical pharmacy services on Sundays but there was a pharmacist on call.
- Out of hours, physiotherapy was provided for respiratory patients only.
- Acute pain was managed by Critical Care Outreach out of hours when the pain team were not on duty.

## Access to information

- Staff were aware of trust wide protocols, such as medicines policies and procedures for the treatment of patients suffering febrile neutropenia as a consequence of chemotherapy, and where to find them. The intranet was easy to access and staff were able to show us how to find policies.
- Protocols and treatments were the same trust wide.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were familiar with the trust's consent policy.
- A wide range of regimen specific consent forms clearly listed the potential risks and their likelihood for each 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. If there was a change in a patient's chemotherapy regimen consent was taken a second time. (A chemotherapy regimen defines the drugs to be used, their dosage, the frequency, and duration of treatments and combination with other chemotherapy drugs). We saw signed consent forms in patient notes including for blood transfusion.
- 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.

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- Staff we spoke with were aware of the needs of dementia patients and those of patients suffering delirium and confusion. They understood capability assessments and best interest's decision-making. All patients aged 70 or above were screened for dementia.

## Are chemotherapy services caring?

Outstanding



We rated chemotherapy service services at The Royal Marsden Chelsea as outstanding for caring, because:

- The staff went out of their way to ensure the atmosphere within the hospital was one which promoted calm and reassurance.
- Patients told us and we observed that staff at all levels were courteous, thoughtful and kind in their dealings with patients undergoing chemotherapy, in many small ways that went well beyond the administration of treatment.
- The atmosphere of the units was calm and welcoming. Patients were full of praise about the sensitivity of staff, their understanding of their feelings, and the needs of some patients for emotional support in coping with their treatment and condition.
- Nurses recognised the uniqueness of each patient, and the diversity of patients, and responded appropriately with support and advice as required.
- Patients were given clear information, with as much or as little detail as they wanted, in order to understand their treatment.
- All staff we spoke with had a clear understanding of and empathy for the holistic needs of patients and their families. They went out of their way to provide help and support both patients and those close to them.
- Patients were encouraged to access supportive therapies.

## Compassionate care

- We observed numerous respectful and compassionate interactions between staff and patients, with staff treating each patient as an individual and making time to talk with them.
- Patients we spoke with were full of praise for the helpfulness and kindness of staff. More than one patient

who had had chemotherapy in other hospitals said staff in this unit were always pleasant and welcoming, and seem to have more time to take interest in their wellbeing beyond just the administration of treatments

- Friends and Family test results for the medical day unit showed 95.3% of patients recommended the service in February. (Response rate 85 responses which was a relatively small number of attendees).
- Patients and their relatives were hugely complementary about staff, saying they always had time to listen and give support and encouragement to patients. Patients told us staff never seemed rushed and always seemed to have time to listen to their views.
- Nurses recognised the uniqueness and the diversity of patients and responded appropriately.
- Patients told us: "It's the best hospital I have ever been in" and "one day I did not feel like eating the food offered so the nurse went to get me a sandwich instead". We spoke with three patients who had been attending the hospital over several years, who said "they are a cut above other hospitals", and "no staff here are ever rude, from the cleaners to the top consultants, everyone is courteous and helpful", and "The Marsden way is fantastic, a model for other hospitals".

## Understanding and involvement of patients and those close to them

- 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 said staff shared as much or as little information with them as they wanted. A patient told us "the staff are unbelievable in always making time to talk to us, giving all the time we need – I have not a single concern".
- All patients were allocated a key worker who supported them in coordinating their care and promoting continuity. The key worker was usually a CNS or a research nurse. Patients told us they valued having a constant named point of contact during their care who could provide support and answer questions or concerns by liaising with health professionals,

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- Doctors considered patient choice an important component of the decision making process, and seek to ensure patients understand the benefits and side effects as well as the level of uncertainty.
- Staff encouraged relatives or friends who wanted to know more, to understand their loved one's treatment and how to support the patient.

## Emotional support

- Nurses were very skilled at handling patient anxiety and putting patients at ease. Patients told us staff were friendly and reassuring.
- It was clear that staff had a good understanding of the problems with self-esteem and adjustment that were common to some cancer patients and conscious of the distress patients and their families might experience at times. Staff had training on the Sage and Thyme model to help them recognise psychological distress and to listen and provide support to patients.
- Nurses assessed patients holistically to identify the need for any additional psychological, social, or spiritual support. Complex issues where a patient had symptomatic anxiety could be referred psychological medicine. Trust wide 391 patients were seen by the psychological support service between October and December 2015.
- Nurses and key workers could direct patients to relevant support groups, both within the hospital and beyond, as well as to websites.
- A Chaplaincy Team provided spiritual and religious care, primarily to inpatients, their relatives/carers, and staff, whether or not the person had a religious faith. They could also put patients in touch with spiritual support across a range of faiths.
- Staff were supported by the provision of confidential services to support their emotional wellbeing in response to referrals from managers, occupational health, or self-referral.

## Are chemotherapy services responsive?

Good



We rated chemotherapy services at The Royal Marsden Chelsea as good for responsiveness because:

- There was a very wide range of information available to patients to supplement what they were told by clinical staff, including films for patients about caring for CAVD devices.
- There was some flexibility in appointment times to meet the needs of patients who were working or had care responsibilities. Patients also had an option having their blood tests, consultation and treatment on a single day (known as one stop) or of attending the medical day unit on two separate days, one for assessment, and one for treatment.
- Services were organised to meet people's treatment needs in relation to their cancer, as well as their wider holistic needs for spiritual and psychological support and for relaxation. The trust had set up formal arrangements for liaison with some of the other London hospitals where their patients were treated for non-cancer related conditions.
- There was clear information and additional culturally appropriate support services for international patients receiving private treatment.
- Compliments far outweighed complaints about chemotherapy services. Staff acknowledged written complaints within three days.

However;

- There was room to improve patient waiting times when they attended for chemotherapy. We saw that work was taking place on this.

## Service planning and delivery to meet the needs of local people

- Pre-treatment appointments enabled patient to prepare for their chemotherapy and associated treatments such as blood transfusions, blood tests, injections and other intravenous therapies.
- A Help centre was located in the Ambulatory care centre. This combined the traditional Patient Advice and Liaison Service (PALS) and the Patient Information Service. The two services provide different kinds of information, support, and advice to patients, their families and friends, and staff involved in their care. This was staffed all day during the week, and staff were pro-active in offering help to those browsing. PALS staff visited wards and talked to patients and relatives.
- The centre had booklets on a wide range of cancers, chemotherapy induced symptoms, services available to support the effects of living with cancer and dealing with

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its emotional effects. These were in several languages such as Russian, Polish, Arabic and Portuguese. Some were written in association with the MacMillan cancer charity, and approved by Royal Marsden. Information about The trust could translate patient information into other languages usually within a week. They could also supply information in different media to meet special communication needs.

- For patients on clinical trials comprehensive written information was provided, including the phase of the trial. Clinical trials might be to find out the most effective dose of a drug (Phase 1 trials), which cancers respond best to different types of drug at what dose and frequency of treatment (Phase 2 trials) and the effect of treatment on a cancer and how long effects last, as well as side effects and long term problems (Phase 3). Patients were given written information about this.
- Staff had access to leaflets for patients who were receiving specific treatments or in specific situations, for example 'Strong Opioids (painkillers) – What you should know', an 'Infiltration information leaflet' or Venepuncture and Cannulation for patients at risk of developing Lymphedema of the arm.
- The Help Centre also had information about support groups, for example an African and African Caribbean support group.
- All patients who had chemotherapy were given a yellow chemotherapy alert card with a list of serious symptoms particularly a temperature (38°C /100°F or higher), shivering or chills and shortness of breath or breathing difficulties that might need immediate A&E attendance. The card gave the name of the trust, contact details for the treating consultant or, out of hours, the Clinical Site Practitioner. Consideration was being given to an Alert Wristband for patients who might attend Emergency Departments.
- The environment was clean, and well signposted. Patients remarked on the calm colour scheme.

## Access and flow

- Patients had timely access to assessment, and once a treatment approach had been agreed the waits to begin treatment were about a week. Waiting times for clinical trials could sometimes be longer.
- When patients attended for chemotherapy treatment there could be long waits on the day between having the initial assessment and treatment. The waiting area was not large.

- All chemotherapy appointments necessarily include a number of steps before administering chemotherapy: blood tests, patient observations, consultation with a doctor to assess patient health and test results, rechecking weight to adjust doses within safe parameters, then chemotherapy preparation by pharmacy. For patients on clinical trials there could be additional of stage of checking with the drug company. These safety checks were essential because 46% of chemotherapy doses were altered as a result of these checks. The benefit of the checking process was that only six wrong doses were delivered in the last year out of 93,817 administered, equivalent to 0.00006% of doses administered.
- Patients had an option of attending on two separate days, one for assessment, and one for treatment to reduce the waiting time. About 42% of patients chose to attend the "two stop" option, mainly those living nearby. Patients could be offered overnight accommodation to ensure chemotherapy started on time on the second day.
- The trust target was for not more than 5% of patients to wait more than four hours for their chemotherapy treatment following their blood tests and initial assessment by a doctor. This was just missed in the Granard House Day Unit where 6% of patients were seen outside this time. The figure for the main MDU was 13%. Between April and December 2015 the chemotherapy waiting times from patient's arrival in clinic to the start of their treatment showed that 67% waited around 2 hours, and others waited three to six hours. Patients were able to go elsewhere while awaiting treatment, which they appreciated. Staff paged them when their treatment was due.
- Staff audited waiting times as part of an effort to improve patient flow and reduce waiting times as far as was consistent with safe delivery of services.
- A multidisciplinary Quality Improvement project group for pharmacy had been set up. This group was continually monitoring patient waiting times and implementing an improvement programme to reduce these.
- The CAU provided supportive treatments such as antibiotics and blood transfusions to allow patients to recover before planned treatments. The unit also



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provided an 'overflow' facility for blood transfusions for the rest of the hospital. Once a week they carried out chest drains. They also carried out ascetic drains (drainage of excess fluid from the abdomen).

- It was a challenge to meet the 62 days waiting time target for treating all patients referred urgently by GPs because most referrals were from hospitals to the Royal Marsden as a tertiary centre. The most unwell patients were seen within seven days. Newly diagnosed patients who had surgery elsewhere were seen within two or three weeks to discuss and prescribe. Overall, about 77% of patients were treated within this timescale.
- The Granard House MDU was busiest on Tuesdays and Thursdays because of the presence of specific consultants those days. Unpredictable delays could be caused by issues with cannulation or catheter occlusion. Not many patients required admission and transfer to CCU was rare. 72% of patients were treated within three hours of arrival at the clinic.

## Meeting people's individual needs

- Staff gave patients written information including their regimen details, treatment plan, and arrangements for monitoring. The hospital did not use chemotherapy patient diaries. Staff advised patients to keep all treatment records and discharge letters from the hospital in a folder that they should take with them if admitted to A&E.
- Doctors and nurses warned patients about common side effects and the action to take in the event of nausea, vomiting, and fatigue. At each appointment, they asked patients about any problems or side effects that had occurred since their previous cycle of treatment.
- Staff provided light refreshments for patients attending as day patients. The nutritional content of snacks was checked by a dietician.
- Patients could bring a friend or relative to sit with them during their treatment.
- The Medical Day Unit opened on a Saturday after a bank holiday closure, to enable all patients to receive timely treatment.
- Various evidence-based complementary therapies were available to help patients with pain and with relaxation, for example, acupuncture, a six-week yoga course, massage, and reflexology. These could help patients cope with stress and anxiety, relieving pain and lifting mood. We spoke with patients who had benefited from these services which were free to NHS patients. Music and art therapy were also available.
- Hairdressing was available for inpatients. All patients at risk of hair loss could order an acrylic wig from an onsite service. There was a prescription charge set by Department of Health: £67.75. If patients want greater choice, they were given details of other suppliers.
- Scalp-cooling treatment was available to reduce hair loss. Patients were warned that this added to the length of the visit.
- Staff also told female patients about a programme of free beauty workshops - Look Good Feel Better, which took place monthly.
- For patients with specific needs such as mobility, hearing or sight impairment or needing a translator, arrangements for support such as bringing in an interpreter or therapist for the deaf could be arranged.
- Some staff were dementia champions. Some nurses told us about work in progress to consider improvements to signage to help dementia patients and the use of patient TV screens as an orientation tool. A 'This is me' passport was being made available in pre assessment, PALS and outpatients.
- There was scope to adjust appointment times to ensure patients who were working or had child care responsibilities could attend at times that suited them.
- There was a service for patients to discuss and choose the right central venous access device to meet their needs.
- Patients could refer themselves for adult psychological support Monday to Friday between 9am and 5pm.
- The chaplaincy had contacts with representatives of a different faith groups to enable patients to seek support. There was a multi-faith chapel and a separate prayer room
- The chemotherapy preparation unit had invited all nurses in the MDU to spend a day in the manufacturing unit. This gave insight to processes involved in making up and dispensing treatment regimens, and ensured they could explain the processes involved to patients. This improved patients experience and reduced patient complaints.
- The trust had produced three short films to support patients and carers to undertake own care of CVADs at home to reduce need to travel to hospital.



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- Translation services were available in a wide range of languages for both NHS and private patients.
- A significant proportion of international private patients spoke Arabic. Arabic interpreters and advocates were able to attend meetings with clinicians between 8am and 8pm on weekdays. The Arabic coordination service helped arrange appointments, coordinate care with other consultants if patients needed this, help with billing arrangements, and advice on accommodation.
- A complimentary Arabic or other international newspaper was available to these patients as well as Middle Eastern magazines, Arabic and other international TV channels. Patients spoke highly of the advocacy service and the interpreters who ensured patients fully understood their treatment. There was a booklet available for nursing and other staff to help them with simple phrases in Arabic.
- International patients could be treated on private wards when they had cancer-related health concerns. This was because they generally did not have a GP. If admitted to hospital through A&E (accident and emergency department) then although immediate treatment was free, they would be charged if they were then admitted to hospital. Such patients would be re-patriated to the Royal Marsden once they were stable.
- Patients attending the private medical day unit were required to provide evidence of insurance or, if embassy sponsored, a letter of guarantee before treatment could begin. There was an international patient's team that coordinated embassy sponsored admissions.

## Learning from complaints and concerns

- Compliments far outweighed complaints. Overall between October and December 2015, 493 letters of praise had been received.
- All complaint letters were acknowledged within three days.
- There had been one written complaint in December 2015 about waiting times, no others since then. Staff were aware of the number of informal complaints about waiting times in the day units and were considering ways of addressing these such as delivering some chemotherapy treatments by injection at home.
- As regards services for private patients, complaints both formal and informal were considered weekly and any learning from complaints was circulated by email. We saw evidence of high levels of patient satisfaction.

## Are chemotherapy services well-led?

Good



We rated chemotherapy at the Royal Marsden, Chelsea as good for well led, because:

- Staff were clear about the vision for the trust's services to be leaders in cancer care.
- They shared the objectives of the wider trust to provide safe, effective and high quality care to all patients; to minimise patient waiting times and to provide a positive experience for patients.
- There was a strong learning culture right through the service and a no blame culture for reporting incidents and near misses.
- Leaders at all levels were visible to staff and approachable and staff at all levels told us communication was good.
- We observed the trust values in action in staff behaviours.

## Vision and strategy for this service

- Staff were aware of the overall published strategy for the trust to provide the best possible person-centred care, and the role of chemotherapy services within this. There was a focus on clinical and operational sustainability and a search for ways to localise care where possible.
- Day services were projected to grow by 22% by 2018/19. The recently modernised facilities would not be able to meet this demand so consideration was being given to developing satellite facilities, a mobile chemotherapy unit and developing more home based services. Additional pressure came from earlier diagnosis and patient expectations of quicker access and referral.
- Space was a constraint at the Chelsea hospital. There was a longer-term plan to increase the size of the pharmacy unit but no scope to increase the number of inpatient beds for emergency admissions. Within the Royal Marsden during the first quarter of 2016 data showed 29 admissions with suspected neutropenic sepsis managed over 3 months with 45% of the admissions at the Chelsea site.
- Staff said they had been involved in developing trust values and we saw these values reflected in staff

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behaviours. It was evident that staff were confident in their roles, proud of their contribution, open if something adverse occurred and calm and compassionate with patients.

## Governance, risk management and quality measurement

- The cancer services division, in common with other divisions had a monthly scorecard against which to monitor trends in workforce indicators. An MDU scorecard was used to monitor activity levels including appointment and treatment waiting times and chair use. Key chemotherapy indicators were reported to the wider public in the Integrated Governance Monitoring Reports.
- There were weekly MDT meetings to discuss complex patients and gather opinions about treatment of patients.
- We saw a risk register for the division. There were no high level risks in the MDUs. The risks that were reflected in this register were about medical staffing and the lack of SHO support for registrars. Doctors raised this issue with us as a risk, and one of the actions being taken was to develop more ANPS to provide support. Staff we spoke with were aware of the trust risk register and of local risks within the unit.
- Audits, incidents, and complaints were reviewed and escalated as necessary. As the hospital was relatively small, the committee structure was not complex. Incident categories such as falls, pressure ulcers, and medication errors/incidents were monitored by trust level committees. For example, the Executive Medicines Safety Group (EMSG) reviewed medication incidents from across the organisation every month.
- Quality Improvement (QI) meetings took place every two weeks with a focus on identifying areas for improvement, agreeing how to improve or address blocks and then to measure the impact of any improvements made.
- The hospital was participating in the national sign up to safety initiative to increase awareness, identification and treatment of sepsis and reduce death from it; to reduce harm from medication errors and from pressure ulcers.

## Leadership of service

- Staff in the medical day unit reported they had very effective support from the Matron, from the Unit manager and the practice educator. They said the Director of Nursing was visible and always willing to advise and help.
- Doctors reported good leadership from consultants.
- The small size of the hospital meant most staff knew each other and this helped communication. However managers used a number of other communication channels – email, the intranet, posters in wards and day units, RM magazine and information on the intranet and the internet.
- Ward and unit meetings took place weekly and were minuted, so staff not present at a meeting could catch up with any points they had missed.

## Culture within the service

- Staff reported that the working atmosphere was friendly and supportive. Many training opportunities were available, often paid for or part paid for by the trust, for staff who wanted to develop. However, there was no discrimination against staff who wished to continue working at the same level
- Staff told us they had discussed and understood the principles of the duty of candour in training and staff meetings. They understood staff should be proactive and not wait for a complaint.
- The Duty of Candour had been the topic of a Schwartz Round (an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim was to offer staff a safe environment in which to share their stories and offer support to one another)
- Weekly divisional meetings and team meetings on unit ensured staff were well informed and actively engaged with their units.
- Nurses were committed to the 6 C's of Compassion in Practice: care, compassion, courage, communication, commitment and competence and this was evident in their interactions with patients, and in teamwork.
- Staff sickness had been 2% over the past year for the MDU and staff turnover was 7.6%. Staff turnover was higher in the Granard House MDU at 17% but sickness was lower at 1%. The overall sickness rates were lower than the England average of 4%. Turnover, although a problem affecting all London trusts, was lower at the Royal Marsden than at other London hospitals.

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## Public engagement

- The hospital had a strong reputation with the public both locally, nationally and internationally.
- A large number of volunteers from the local community supported the hospital in many departments. The Friends of the Royal Marsden provided services that enhance the well-being of patients and staff including running refreshment bars and shops, providing non-medical assistance in wards and raising funds for medical equipment and provision of amenities for the added comfort of the patients.
- The Royal Marsden Cancer Charity was active and successful charity raising the profile of the hospital.
- Patient feedback was sought on patient information booklets e.g. CVAD and chemotherapy. Patient champions contributed to hospital decision-making about services, for example home treatment for low risk high volume treatments to free up chair space.
- The multidisciplinary executive medicines safety group included a patients' representative.

## Staff engagement

- All the staff we spoke with were proud to work in the hospital and would want their family and friends to be treated there if the need arose. Some staff we met had joined the hospital following family involvement as patients.
- An annual Staff survey was carried out to review scope for improving working lives and areas of good practice. We saw that performance in the 2015 survey showed the trust were average on 16 measures and better than







average in seven. Actions taken as a result were to develop a programme of health and wellbeing events to help staff, continue good management practices to ensure all staff have regular high quality appraisals reinforce expectations about behaviours and promote a workplace advisor service, and holding listening events throughout June 2015.

- There was also a Staff Friends and Family survey that showed 74% of those working in the trust would recommend it to Friends and Family as a place to work and 97% as a place to have medical care.
- Senior staff engaged with clinical staff at open meetings and visits to clinical areas.
- The national staff survey was discussed at the Quality Assurance and Risk Committee.
- The Royal Marsden School on the premises reflected the culture of staff development which staff told us was central the learning and research ethos of the hospital.

## Innovation, improvement and sustainability

- The bespoke E-Chemo system which had improved safety in prescribing and dispensing.
- The staff were proud of recent successes in immunotherapy had some success. Research was taking place on predicting and preventing toxicity or autoimmunity, which was the biggest roadblock in these promising treatments.
- The development of the new role of advanced nurse practitioner had the potential to provide good support for doctors in training.

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

## Information about the service

The Royal Marsden Hospital (RMH) Radiotherapy (RT) service was managed as one service but radiotherapy treatments were delivered on the two hospital sites, Sutton and Chelsea. The RMH plays an integral part in the London Cancer Alliance (LCA), which supports integrated cancer patient pathways to drive improvements in patient outcomes. Radiotherapy is commissioned centrally by NHS England.

The South West London host population for the Royal Marsden Hospital is 1.528 million but the total population served for specialist services is 2.38 million.

From April 2015 to March 2016, the radiotherapy service delivered 6,699 completed courses (episodes) of Radiotherapy, and there were 73,283 attendances (one visit by a patient to receive RT) across both sites.

There are eleven linear accelerators (radiotherapy machines) available for clinical use cross-site with three in clinical use at Chelsea. One linear accelerator is currently being replaced. Brachytherapy is available to deliver interventional radiotherapy. A stereotactic unit is used to deliver stereotactic ablative radiotherapy (SABR).

The service was staffed by three main professional groups led by a senior management team. These included clinical oncologists, therapeutic radiographers and physicists, all of whom contribute in the multidisciplinary working along the patient's radiotherapy pathway. The

radiotherapy service has a Quality Management system (ISO9001:2008), which was re accredited for a further three years by the British Standards Institution in March 2015.

During the inspection, we spoke to staff that included clinical oncologists, radiographers, administration staff, engineers, physicists and radiotherapy aids. We reviewed records, protocols, and standard operating procedures. We also spoke with 10 patients and one relative and looked in five sets of treatment records.

This report relates to the service delivered at the Chelsea site. No children are treated at this site.

# Radiotherapy

## Summary of findings

Overall we rated the Radiotherapy service at the Royal Marsden, Chelsea as outstanding, because:

- Safety was embedded across all areas involved in the radiotherapy pathway from the maintenance of equipment to the delivery of accurate complex radiotherapy treatments.
  - Incident reporting played a major part in the safe and effective delivery of the service. Clinical, non-clinical and radiation incidents were reported through the appropriate mechanisms, investigated and learnings were shared across all multi professional groups of staff.
  - The department submitted radiotherapy error reports (RTE) to Public Health England (PHE) Towards Safer Radiotherapy data set. This disseminated learning from RTE's across the radiotherapy community to influence local practise and improve patient safety.
  - The clinical equipment available in the pre-treatment, physics planning, and treatment areas allowed high standards of treatments to be planned and delivered. This included Intensity Modulated Radiotherapy (IMRT), Image Guided Radiotherapy (IGRT) and Stereotactic radiotherapy. All of which followed national recommendations as best practice to deliver improved outcomes to patients.
  - The radiotherapy service was a major contributor to local and national clinical trials with 33 trials open. With this high level of engagement, the department supported the implementation and evaluation of new radiotherapy techniques such as adaptive radiotherapy and IMRT.
  - All professional groups of staff were very well supported by the trust through mandatory and continuing professional development training, (CPD). High percentages of staff had postgraduate qualifications, which enriched their knowledge, allowing high levels of care to be delivered.
- There was a comprehensive system for ensuring and measuring competencies, which supported the continuing development of all the staff groups. There was a strong multidisciplinary teamwork, which supported improved patient pathways.
  - Electronic patient records and a quality management system ensured staff could access clinical information, protocols, and procedures to support the delivery of evidenced based good care.
  - We observed staff being caring and compassionate to patients, relatives and all staff groups. We observed patients being treated as a person and not a group of symptoms. All relatives were actively included, with patients' consent, in the patient centred care delivered.
  - The service performed well against the 31 day waiting time standard for definitive and subsequent treatments. Data confirmed all patients were seen within 20 minutes of their scheduled treatment time unless unforeseen circumstances developed. All patients started their radiotherapy within the time constraints recommended in the Manual of Cancer Standards.
  - A strong, visible, and approachable senior management team led the service with a strong governance structure, which ensured a safe and effective service. Staff felt fully supported and presented at national and international conferences with the work they were undertaking across the service.

# Radiotherapy

## Are radiotherapy services safe?

Good



We rated radiotherapy services at The Royal Marsden, Chelsea as good for safety, because:

- There were effective and robust systems and a protocol to protect patients from harm. The directorate understood risks, had a clear picture of safety across services, and was focused on improvement. The department submitted data to the 'Towards safer Radiotherapy' dataset, which benchmarked their incidents against other radiotherapy providers nationally.
- The radiotherapy service operated a quality system (QS), which monitored that radiotherapy was delivered as intended and in accordance with protocols. The QS was accredited to the ISO 9001:2008 quality standard. The hospital was able to demonstrate a multidisciplinary approach to achieving accreditation across physics, radiotherapy and oncology. For radiotherapy, ISO 9001 involved assessment of clinical protocols, standardisation of treatment delivery, quality assurance, dosimetry, patient safety and quality. The service was reaccredited in May 2015 for a further three years.
- Staff took an active role in delivering and promoting safety, learning, and improvement. When things went wrong, staff were open and transparent with those affected.
- Environmental safety was assured through regular monitoring and on-going checking of issues such as infection control, equipment maintenance, and compliance to Ionising Regulations (Medical Exposures) Regulations 2000.
- Patients' care needs were assessed, planned, and delivered in a way that protected their rights and maintained their safety. The department had processes to review patients regularly to identify when patients felt unwell. This enabled staff to provide increased support.
- We found staff attendance at mandatory training was good and staff were knowledgeable in how to safeguard and protect vulnerable patients.

However;

- The drawers to the resuscitation trolley located in the pre-planning and Cyber knife waiting area were not locked. As a result there was easy unsecured access to intravenous drugs. We noted the oxygen cylinder had expired in 2014.

## Incidents

- We found there was an electronic system for reporting and recording clinical and non-clinical incidents. All staff we spoke with across the radiotherapy service were aware incidents should be reported and were able to follow the process chart "Using Datix to report Radiotherapy Non-conformance's and Incidents". This ensured the correct data was collected immediately. However, radiographers told us they would always gain support from a senior radiographer to input the incident into the electronic system.
- There were effective mechanisms for learning lessons from incidents and for ensuring actions were taken to reduce the risk of similar incidents occurring in the future. Staff told us incident learning took place with the team involved directly and immediately, then at the weekly communications meetings. These were attended by a radiographer of any grade (one from each unit), who then reported back to their team. Minutes were taken and circulated from these meetings. Incidents were also discussed at the monthly staff meetings.
- Staff were able to tell us of an incident where the linear accelerator gantry was moved automatically from the outside of the room and where the edge of the patient was touched. This machine function had been disarmed to prevent similar situations occurring in the future to maintain patient safety.
- In 2015/16 a total of 85 incidents were reported. The majority were coded as low/no harm. Between July and December 2015, 44 incidents were reported. Incidents were coded using the 'Towards safer Radiotherapy' classification system which allows comparable coding across other radiotherapy services. Of the 44 incidents, 39 were classified as 'very low' and five were classified as 'low'. The incidents were reviewed and discussed at the Multi-Professional Team Quality Assurance (Radiotherapy) Committee (MPT QART) as part of root cause analysis and the implementation of corrective actions was taken.



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- We reviewed the minutes from three 2016 MPT QART committee meetings and saw incidents were discussed and corrective actions implemented. Minutes of all meetings were circulated and copies were kept within the Quality Assurance department.
- The radiotherapy service manager told us the trust circulated all the serious incidents for senior staff to look review. If there were any good learning points that could apply to Radiotherapy then they shared them or acted on them. We were told learning from a medication incident resulted in the introduction of a red chair in the treatment control area. The radiographer sitting in the red chair was not to be disturbed during the delivery of a treatment. We observed this was being followed.
- As part of the Quality System (ISO 9001:2008) incident trend analysis was undertaken regularly and reports sent to the heads of service. We reviewed a report and saw the grade and severity of the incident was coded along with the part of the patient pathway where the incident occurred. Since 2013/14, the number of incidents reported had increased. This demonstrated a positive reporting culture and an increased staff understanding of the process.
- One of the Medical Physics Experts (MPEs) reviewed any incidents relating to the dose of radiation received by patients. An analysis of the error/incident was undertaken. The MPE and the patient's consultant were both required to have reviewed and signed off the response to the incident.
- The radiotherapy service reported incidents as required following the Ionising Radiation (Medical Exposures) Regulations 2000 (IR(ME)R). These reports were made to the IR(ME)R team at the Care Quality Commission (CQC). The service had no reports currently open. IR(ME)R incidents were discussed at the Medical exposure committee which took place quarterly. We reviewed the minutes and saw incidents were discussed and corrective actions taken.
- We observed duty of candour information leaflets called 'Being open' were available as guidance to patients and carers in the event of a patient safety incident. This included information on how patients would be kept informed during an investigation and the support available to them and other bodies they could report any concerns to.
- Staff told us they were open and transparent with patients and their relatives should anything go wrong. Staff we spoke to were aware of the duty of candour

policy and were reporting and recording incidents in line with the hospital's policy. Medical staff we spoke to told us they had received training and felt the duty of candour was well embedded across the service.

## Cleanliness, infection control and hygiene

- The radiotherapy sub waiting areas had new seating and tables due to a recent refurbishment of the department. The surfaces and floors were covered in easy to clean materials, which allowed high levels of hygiene to be maintained throughout the working day. Staff told us cleaners came in the evening and cleaned the floors, sinks, and high level cleaning.
- The Brunel treatment suite was visibly clean. Staff reassured us that changing cubicle and machine/equipment were cleaned in between patients. We observed staff clean down the equipment and the use of hand gels between each patient contact. Curtains in the service user changing cubicle had recently been changed.
- The waiting area for pre planning and cyberknife treatment appeared visibly clean. A toilet-cleaning checklist confirmed the toilets were monitored and cleaned three times a day. The toilets were checked at 6.40pm the day before the inspection.
- One of the operational superintendent radiographer's duties was to be the point of contact for all the infection, prevention and control (IPC) procedures within the department. Hand hygiene audits were undertaken weekly on the treatment units, 20 observations were made. We reviewed recent audits and saw the radiographers were consistently 100% compliant.
- Weekly electronic IPC audits were undertaken which covered the cleaning of the equipment and the saving lives dashboard. In a recent report, we saw the radiographers are 100% compliant. However, if the teams were not 100% compliant an action plan was developed and implemented followed by a re audit.
- We saw staff were bare below the elbows in line with the trust's policy. We observed personal protective equipment (PPE) was available, including plastic aprons and gloves.
- The pre-treatment cannulation room 'I am clean stickers' were seen on the chair/trolley. The disposable curtains were within six months (previously replaced 19/01/2016). In other areas of the department, we saw 'I am clean' stickers allowing staff to be confident the equipment had been cleaned.

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- Radiographers in the pre-treatment area were able to describe the process in place when patients who had communicable diseases needed planned for their treatment. Patients were CT scanned at the end of the day to ensure appropriate cleaning could be done afterwards
- Hand gel was seen on the walls throughout the radiotherapy department. However, there did not appear to be any information surrounding these to encourage service users/staff to use these.

## Environment and equipment

- Physics engineering staff told us they were alerted to any safety issues related to the equipment. Regular updates and customer bulletins from suppliers, Public Health England (PHE) and the Medicines and Healthcare products Regulatory Agency (MHRA) ensured any equipment safety issues were promptly dealt with.
- The PHE safety newsletters were sent to all staff. Any issues were discussed at the MPT QART, weekly communications, and staff meeting. We reviewed minutes from these meetings and saw safety issues were discussed.
- There was a clear maintenance programme. Major radiotherapy equipment was serviced and quality assured to meet the Institute of Physics and Engineering in Medicine (IPEM) National guidelines. We reviewed the schedule and saw maintenance and quality assurance was scheduled every three months for the next year. One and a half days per month was allocated to perform quality assurance by the physics team. This ensured the radiation delivered was consistent with previous deliveries and accurate treatments were delivered. Service records of the CT scanner were seen showing regular maintenance on a three monthly basis by the supplier.
- Physics staff told us all radiotherapy equipment, including the machine that delivers brachytherapy, had service contracts in place. In house engineers maintained the equipment on a day-to-day basis; however, contracts ensured the supplier maintained the equipment regularly and there was access to parts, which kept machine down time to a minimum.
- All machine downtime was recorded and monitored and was less than 2%. Decisions around whether a machine needed more maintenance time would be discussed at the quarterly Radiotherapy Liaison and Quality Circle meetings. A yellow folder was available on the treatment units to highlight any issues with the equipment. This was checked daily by the engineers, and corrective action could be taken at the end of the day or wait until the next service. Radiographers would check the log daily before treating patients.
- The resuscitation trolley in the pre planning and cyberknife waiting area was readily accessible. Records showed this had been checked on a daily basis from 15/04/2016. We requested the previous checking records and found daily checking had been carried out over the preceding months. The defibrillator was checked with the user strip seen. However, concerns that oxygen was out of date (expired 20/11/2014) were noted. The trolley drawers were not locked, and therefore access to intravenous drugs such as adrenaline and fluids was unrestricted. All consumables/drugs within the trolley were in date and well stocked.
- There were three Linear Accelerators available for routine use with a fourth linear accelerator being replaced. During this period of refurbishment the radiographic staff were working extended days to prevent waiting times developing and to ensure patients' treatments were uninterrupted during machine service and quality assurance days. Physics staff performed servicing and quality assurance out of hours and at weekends.
- National guidance recommends providers should ensure each linear accelerator was in operation for a maximum of 10 years and the replacements were planned in a timely manner. Reviewing the equipment inventory one linear accelerator was installed in 2004 with a second installed in 2006. The radiotherapy service manager told us capital equipment priorities were reviewed on a quarterly basis. Radiotherapy priorities were integrated into the trust's rolling capital equipment programme. Although the programme to replace the linear accelerators were running behind schedule, there were no concerns about the reliability or functionality of the machines.
- There was recognition of the risks associated with equipment failure and equipment nearing the end of its life cycle. This was annotated; the impact assessed and control measures in place on the hospital's risk register. The pre-treatment CT scanner was on the risk register along with the cooling and plumbing of the building.
- Physics engineering staff 'ran up' the treatment units each day; a process, which involved bringing them up to operational readiness. The radiographers would

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perform the daily quality assurance checks prior to the first treatment. Radiographers completed a training workbook before undertaking the running up of equipment when on-call.

- Within the department, there was a steep ramp down to the radiotherapy waiting area. A handrail was only available on one side of the corridor. We reviewed the risk assessment, which was on the facilities risk register and saw actions to mitigate the risk including the purchase of two electric wheelchairs. We were told they operated a four-person system when required to take a hospital bed or wheelchair down and also made use of the porters when doing so.
- A senior physicist told us there were not sufficient planning terminals; however, this would be rectified when the new linear accelerator came into service.
- A recovery area was available in the radiotherapy outpatients department for any patient who felt unwell during the visit. Outpatient nurses supported the care needs of the patients while in this area.

## Medicines

- Patient group directives (PGD's) were in use for the delivery of contrast agents administered within the pre-treatment area. A PGD is a written instruction to help administer medicines to patients in planned circumstances. A contrast agent is a dye used to make interior body parts visible on x-rays.
- Stocks of contrast (not in heater) were stored within a locked cupboard in the CT scanner room. This followed national guidance and meant the contrast was being kept safely.
- The CT contrast heater was situated in the CT scanning room where access was restricted. A limited amount of contrast was stored in the heater. Temperature was set at 37°C, cross calibration of temperature was seen for the months of March and April 2016 on the wall adjacent to the machine (no earlier records were available as staff stated this heater was new).
- Appropriate arrangements were used for recording information pre and post contrast delivery. The records of administration stated the name of the contrast and dose delivered. Records we looked at were completed appropriately and followed hospital policy.

- Staff told us they left the cannula in-situ if any concerns/risks were identified when administering contrast. For minor reactions, they would call the consultant or for serious life threatening (anaphylaxis) they would put out a crash call.
- If a patient required medication, the radiographer could access either the clinical oncologist or the Clinical Nurse Specialist (CNS's) who would review the patient and prescribe the required medication.

## Records

- The radiotherapy department operated a paper heavy system with all pre-treatment and treatment documentation in paper files. We saw numerous separate documents and IT systems in use. Staff managed the systems well. We observed all patient identifiable documentation was securely locked away when not in use and overnight.
- All computer terminals were locked when left unattended. This prevented un- authorised access to patient identifiable material.
- All radiotherapy procedures and treatments were subject to a series of well-defined checks to comply with IR(ME)R legislation. We observed in the pre-treatment and physics planning robust systems of cross checking were in place. This was also observed prior to the delivery of treatment by the treatment radiographers. Checklists were used to check all the appropriate documentation was present. However, there was an opportunity to rationalise all the documentation in use.
- We checked a sample of five treatment sheets and saw they were appropriately signed and checked. Under IR(ME)R, radiographers are classed as operators and therefore "personally responsible for their contribution to the patient's treatment". Checking and signing shows compliance to the legislation.
- We observed the pre-treatment checks undertaken for a patient who was receiving radiotherapy for the second time. All documentation including the consent and prescribing of the treatment were completed correctly.
- Radiographers could access the electronic patient records (EPR) to check any patient information; however, staff told us they could not input into EPR. One of the operational superintendents told us they were able to input into the records, and did so if any relevant patient information developed during the patient's radiotherapy pathway.

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- Radiographers undertook daily reviews of the patient prior to their treatment. If patients had no symptoms or issues, nothing was documented in the treatment sheet; however, if the patient had any symptoms such as sore skin, this was documented on the treatment sheet along with the actions taken. This information was reviewed at the weekly audit meetings.
- IR(ME)R states the employer must have a list of individuals entitled to be 'operators or practitioners'. We saw records which confirmed who were practitioners and operators, which staff could easily access. On the pre-treatment and treatment documentation the person prescribing the treatment had to specify if they were acting as an operator or practitioner so complying with IR(ME)R legislation.
- The radiotherapy service operated a quality system (QS) which monitored that radiotherapy was delivered as intended and in accordance with protocols. The QS was accredited to the ISO 9001:2008 quality standard. Documents held in the quality management system were available for staff to access. Documents were password protected.

## Safeguarding

- We reviewed the training records and saw safeguarding training was up to date. Records showed 99% of staff had completed adult safeguarding training (two staff had not completed the training). Safeguarding training for children level 1 and level 2 was also 99% compliant with one staff member required to complete the training. Staff completed the eLearning module every three years.
- Staff were aware of procedures for consent where patients lacked capacity and ensured the correct consent form was used. One radiographer, who had an extended role, was in the process of being trained to perform consent.
- Staff we spoke with understood their responsibilities for safeguarding and knew what to do if there was a concern. One radiographer we spoke to was able to describe a recent safeguarding referral, which was made to the local Authority by the clinical oncologist. The referral was investigated and the person received the prescribed course of radiotherapy.

## Mandatory training

- As part of the learning and development programme a web based system was used to inform staff about their

mandatory training. A report was regularly run for the department with one of the superintendent radiographers overseeing the radiographers programme.

- We reviewed the radiographers training records. These showed the overall the majority of radiographic staff mandatory training was up to date. However, the physics departments showed the majority of training was still in date but was due to be updated in the very near future.
- Staff told us Advanced Life Support (ALS) training had depended on the number of available trainers and sessions. This had been limited recently but more sessions were now scheduled. We observed that four radiographers were out of date with their basic life support training.
- The department included mandatory radiation protection training and yearly IR(ME)R updates for staff, however this was not yet on the trust's system.

## Assessing and responding to patient risk

- Patients on treatment were reviewed regularly by the clinical oncologist. Radiographers performed daily reviews prior to the patient receiving their treatment. This meant patients who might deteriorate or have reactions to their treatment could be managed in a timely way. We observed a radiographer escalating a concern to the oncologist regarding a patient who was experiencing skin problems.
- The radiotherapy service manager explained to us that risk assessment(RA) were carried out for individual patients whose treatment were different for whatever reason and for new techniques introduced into the department. An example recently was when a patient required a technique, which was not normally performed at Chelsea. A RA was completed, which resulted in staff training and staff from Sutton transferring to Chelsea to support the treatment.
- Under IR(ME)R patients must be correctly identified before an exposure to radiation takes place. We observed staff followed good procedures to identify the correct patient before taking the patient into the treatment room and before the exposure was made. We saw verbal identification checks (name, address and date of birth) undertaken.

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- In the pre-treatment area staff told us procedures were in place to check the pregnancy status of the female patients to comply with IR(ME)R. Staff told us if there was any doubt a pregnancy test would be carried out before any exposures to radiation took place.
- Systems were used in the pre-treatment department to check if patients had previously undergone radiotherapy. This allowed staff to request information from other radiotherapy departments to ensure previous treatment areas were taken into consideration when planning the patient's new treatment.
- All radiotherapy treatments and CT scans were protocol driven, which ensured all patients received care and treatment that followed best practice standards. For example, in the pre-treatment area we observed scan details were documented at the end of each scan so, if in the future, there was a need to review the information, patients' individual scanning details could be retrieved.
- The radiotherapy service operated an out of hour's on-call system for patients who required urgent radiotherapy. There were clear on-call arrangements and procedures in place. We observed patients requiring urgent radiotherapy were CT scanned as part of treatment planning. This supported best practice guidelines.
- The radiotherapy service undertook radiation risk assessments annually for all the equipment in the department, or when new equipment arrived. Undertaking risk assessment ensured both patients and staff were not placed at risk from stray radiation. We reviewed the cyberknife risk assessment and saw no radiation risks were identified on its last assessment.

## Therapeutic Radiographer staffing

- The Chelsea department was made up of 32.60 whole time radiographers. The radiotherapy services manager, pre-treatment radiographer and two posts covering learning and development covered cross-site. Student radiographers were trained within the department. Radiotherapy aids helped with administrative duties.
- A safe radiotherapy service was dependent on an appropriate number and skill mix of staff. Staff we spoke to felt staffing levels and skills mix was appropriate for the numbers of patients treated and complexity of

treatments delivered. We observed four staff, of varying grades, present on each of the linear accelerators. Staff told us the establishment posts were lean when benchmarked against other centres.

- The service used all staff flexibly, working between 8am and 7pm in a shift system on service days or during the present linear accelerator replacement.
- The operational superintendent told us they have four band 5 vacancies at present. These posts would be filled when the present cohort of students qualified. To support this gap and support extended days the department had two long-term agency members of staff.
- Two new extended role band 7 radiographer posts had been developed. One post was to insert gold grains for prostate radiotherapy and the second was a urology post.

## Radiotherapy Physics staffing

- Establishment post numbers were lower than IPEM recommended levels, but continued to provide the required service. Peaks in demand were managed by working extended days.
- The radiotherapy physics service was made up of physicists and dosimetrists. This skill mix gave the department a wide range of knowledge and skills that complimented each other.
- The department was a training centre for the training of specialist trainee physicists (four placements) and the postgraduate diploma physics practitioner training (three dosimetrist placements). The team had developed joint clinical and research posts. Currently four staff were in these posts
- The physics team was made up of 14 physicists and three dosimetrists. No vacancies existed at present. A senior physicist told us there was sufficient staff with the appropriate skill mix to cover the complexity of the work undertaken in the department, even when staff were absent.
- Two new dosimetry posts were developed to outline organs at risk to support the medical specialist trainees.

## Medical staffing

- The medical workforce was made up of consultant clinical oncologists who were able to specialise in all the major cancer sites. There were sufficient consultant and



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registrar grade doctors to provide the level of care and speciality knowledge to prescribe treatments. One consultant told us the flexible working attitude of the trust had resulted in more women consultants.

- There were six clinical oncologists who worked cross-site. Specialisations included lung, breast, neurology, and skin. Eight consultant clinical oncologists were based at the Chelsea department specialising in tumour sites such as head and neck, urology, sarcoma and gynaecological cancers.
- The consultant oncologists were supported by 21 trainee doctors. However there were five vacancies at present which left gaps in the rota. Gaps in the rota were filled by locum staff. An on-call rota was in place, which consisted of consultants and junior staff. The rota covered patient queries out of hours plus urgent radiotherapy.
- The radiotherapy service manager told us the trust were undertaking a workforce review due to the national shortage of junior doctors and were looking at other workforce models including specialist radiographers to cover gaps in the medical workforce.

## Business Continuity Plan

- The radiotherapy service had a business continuity plan to enable radiotherapy to maintain its critical functions during an emergency situation, and provided support to the wider trust as required. We reviewed the plan and saw it comprehensively covered essential activities that need to be maintained, non-essential activities and contact details of staff and outside support.
- One operational superintendent we spoke to told us training for such a situation had been given by the trust and they were aware of the gold, silver, and bronze chain of commands system.
- Staff we spoke to told us they received up-to date contact details for the plan annually.

## Are radiotherapy services effective?

**Outstanding**



We rated the effectiveness of the radiotherapy department at The Royal Marsden, Chelsea site as outstanding because:

- Patients care and treatment was individually planned in line with current best practice, guidelines, and

legislation. The department led nationally for the development and implementation of best practice through involvement in an array of local and national clinical trials resulting in improved patient outcomes. Techniques developed by the radiotherapy staff were regularly audited and assessed at a local and national level to ensure improvement in outcomes was achieved.

- The department submitted data to the national radiotherapy data set and was able to demonstrate they continuously met national quality indicators. As an active member of the London Cancer Alliance (LCA) integrated cancer pathways were used, which followed national guidance and best practice. Data submitted was benchmarked against three other radiotherapy providers within the LCA.
- Patient centred care and treatment was supported through multidisciplinary teams undertaking weekly audit meetings, which covered all tumour sites. All patients new to radiotherapy, and on treatment were reviewed by the multi professional team. Every staff member was able to comment or raise concerns on the treatment being delivered.
- We found the training for staff was excellent with newly qualified staff being well supported. Staff delivering care for patients had undertaken training relevant to their roles and completed competence assessments to ensure patient safety. Thirty percent of staff had post graduate qualifications, which kept their knowledge and skills up to date and relevant to deliver best practice care. Staff received an annual performance review and had opportunities to discuss and identify learning and development needs through this review.

## Evidence-based care and treatment

- The NHS commissioning clinical reference group stated Intensity Modulated Radiotherapy (IMRT) was the gold standard of care. IMRT uses linear accelerators to deliver safely and precisely radiotherapy to a tumour while minimizing the dose to surrounding critical and normal tissue. Within the radiotherapy service patients with a variety of tumours including sarcomas, head and neck, urological and gynaecological cancers were treated with this modern technology.
- The National Cancer Action Team identified that at least 24% of patients receiving curative radiotherapy should



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be offered radiotherapy using IMRT. The National Clinical Analysis & Specialised Applications Team (NATCANSAT) monitored levels of IMRT in England on behalf of NHS England.

- In the last quarter of 2015/16, the department was delivering IMRT to 44.2 % of patients, an increase from quarter three, where 37.9% patients were receiving curative radiotherapy by IMRT. The current rate of IMRT did not take into consideration the stereotactic work, which was less than 15 fractions (a fraction being a daily treatment). In quarter four of 2015/16 an additional 107 episodes of IMRT were delivered but not included in the national data set.
- We reviewed IMRT activity data and saw that 85.2% of patients with Head and Neck cancers received IMRT with the remaining 14.8% having standardised conformal radiotherapy as this delivers an acceptable and often better delivery of radiation dose for certain cancers including lymphomas and facial bones. Activity data demonstrated a wide range of patients were able to benefit from this gold standard technique. The England average for this period was just over 40%.
- To improve the accuracy of each radiotherapy treatment delivered Image-guided radiotherapy (IGRT) was used across a variety of patient treatments. In the last quarter of 2015/16, approximately 40 – 45 % of all radical treatments over 15 fractions were delivered with IGRT, this did not include the stereotactic patients who also received IGRT.
- The stereotactic units allowed the delivery of very accurate high doses of radiotherapy to patients with small tumours. A maximum of six patients were treated daily as treatment times varied between 30-90 minutes. 180 patients benefited from this treatment in 2014/15.
- To support the stereotactic unit with an increasing brain cancer workload (45% of patients treated in 2014/15) the department was treating, on its newest linear accelerator, some stereotactic patients. This treatment delivery was more suitable for some patients as treatment times were shorter with the same improved outcome.
- The radiotherapy service was integrated into the Radiotherapy group of the London Cancer Alliance (LCA), along with three radiotherapy partners: Imperial, Guys and St Thomas's and Mount Vernon. This integrated service provided comprehensive, integrated cancer pathways based on best practice and national guidance.

- We reviewed a variety of the clinical protocols including head and neck, breast and lung. All treatments were delivered within an evidence-based approach and according to locally agreed protocols within the LCA.
- To keep protocols up to date the service had a clinical protocols review schedule. We reviewed the schedule and saw 12 out of 59 protocols reviewed were overdue. We saw corrective actions were in place to mitigate and ensure protocols were updated.
- A brachytherapy suite was available to deliver High Dose Rate (HDR), interventional radiotherapy to patients with gynaecological cancers. In 2015/16 a total of 167 patients were treated on the unit. This practice was in line with National Institute for Health and Care Excellence (NICE) Interventional procedure guidance 160.
- Appropriate verification systems (checking systems) were routinely used to ensure accuracy and correct alignment before patients started radiotherapy and regularly during their treatments to ensure any changes in the daily set up were compensated for. For example, imaging and in-vivo dosimetry. This meant patients were receiving accurate treatments throughout the course of treatment, which resulted in improved outcomes.

## Pain relief

- Staff were able to explain to us in detail that if patients were experiencing pain, they would seek advice from the medical teams and get the patient reviewed prior to receiving their treatment. For urgent pain relief appropriately trained outpatient nurses and site practitioners could dispense and administer controlled pain medication if necessary.
- One of the operational superintendent radiographers was trained in the delivery of Entonox, which was used by patients receiving brachytherapy. The clinical oncologist prescribed the Entonox. Delivery was documented on the patient's prescription card. A PGD was in place to support this process.

## Equipment

- In the pre-treatment area there was a dedicated radiotherapy planning CT scanner, which all patients visited prior to receiving any radiotherapy in order that the treatment area could be accurately localised. All

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scans were protocol driven to ensure consistency. Staff told us positioning lasers were being placed in the diagnostic PET scanner room as a backup if the planning CT scanner broke down.

- Staff told us if a patient required radiotherapy to alleviate symptoms and within one month of their CT scan, they required more radiotherapy the original scan would be used. This prevented over irradiation of the patient and effective use of the equipment.
- A virtual simulation suite comprised of four computer terminals. Computed Tomography (CT) data of individualised patients was sent to the software terminals where the patients' scan data could be used to localise the area to be treated and place the necessary treatment fields in position. This improved the patient's experience (as they were not present during this process) and more accurate treatments were delivered as has been reinforced by recent research studies.
- The department had three linear accelerators all of which provided IGRT and Intensity Modulated Radiotherapy. Stereotactic radiotherapy and brachytherapy units were also in routine use. These new technologies all contributed in improving outcomes and survival and complied with national guidance.
- Treatment planning software was of the highest specification and the physics team were able to get software updates regularly as part of their contract. The senior physicist we spoke with told us they were able to decide when they required updates in the software, which would add functionality and further improved the quality of radiotherapy delivery.
- The senior physicist was able to describe to us the variety of planning systems in use. All planning computers were attached to back up batteries. This meant if there was any loss in power, no data would be lost.
- Electronic Portal Imaging Dosimetry (EPID) was standard for quality assurance for treatment plans. This was performed in real time and was used to check IMRT plans prior to the patient attending for treatment. This meant there was minimal disruption to patients' treatments resulting in an improved patient experience.

## Nutrition and hydration

- We reviewed a variety of patient information leaflets, which gave clear instructions to patients regarding when

they could eat or drink prior to their pre-planning and treatment appointments. During pre-treatment discussions with patients, the radiographers were able to give advice on eating and drinking during treatment.

- Patients on the radiotherapy pathway had access to dietitians and speech and language therapists. A referral could be made by staff at any time.
- There was access to free drinks and fresh water in the pre-treatment and outpatients waiting area in radiotherapy. Fresh water was available in the treatment sub waiting areas.

## Patient outcomes

- Up to date technologies and techniques, for example IMRT, stereotactic and CT scanning were used in the pre-treatment and treatment areas. This had resulted in the delivery of more accurate treatments. Smaller areas were treated which resulted in a better quality of life, with fewer side effects for patients.
- In RT, data was collected around both the 30 and 90-day mortality figures for patients having completed a course of radical or palliative RT. No national benchmark exists at present for providers to benchmark their service against other providers. In 2015/16 the Chelsea department reported 1% of patients died within 30 days of receiving radical RT and 12 % of patients receiving palliative RT
- For the 90 day mortality figure in 2015/16 the Chelsea department reported 2.5% of patients died within 90 days of receiving radical RT and 30 % of patients receiving palliative RT. The radiotherapy service manager was able to describe patients in clinical trials who would have this data collected within the trial. An example was described regarding a patient who had been entered into an international Lung Trial and who died sooner than expected after RT. The case was fully investigated by the trials team in Europe and the criteria that made the patient eligible for the trial was checked.
- Two clinical Oncologists from RMH led the PARSPORT trial, which compared conventional radiotherapy to IMRT in head and neck patients. We reviewed the research data, which demonstrated that IMRT allows the salivary glands to be spared during radiotherapy. This has shown to prevent patients having dry mouth late side effects. This side effect was present when

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conventional radiotherapy was delivered in this group of patients. By using IMRT to this group of patients, the quality of life had been improved as long term side effects have been prevented.

- The IMRT and anal cancer trial (with accompanying chemotherapy) looked at the toxicity between conventional conformal radiotherapy and IMRT. Before the use of IMRT patients experienced significant side effects following RT. Research data has shown a reduction in acute skin damage and follow up questionnaires (over 3 years) have 'shown that patients are either stable, improving, indicating no progressive change in bowel or sexual dysfunction.' The data supports a reduction in the acute side effects with data on late effects still being collected. The data results was allowing oncologists to provide patients with real information regarding their functional outcomes after treatment allowing patients to be better informed to make decisions around their care.
- For patients with localised prostate cancer two recent national randomised control trials (CHHiP and RT01) collected both physician and patient reported outcome data to compare side effects following treatment. The data has shown improvements in long lasting side effects in the CHHiP trial, which suggests patients benefit substantially from improved treatment methods that use IMRT and hypofractionated RT, which was used in CHHiP in comparison to the RT01 trial, which used conformal radiotherapy without hypofractionated RT. At five years gastrointestinal side effects were found in 14% of CHHiP patients and 33% in RT01 patients. By delivering IMRT and hypofractionated RT in patients with localised prostate cancer it was shown to reduced side effects and improve patient's quality of life. This trial data has resulted in a change in clinical practice across the department to ensure all patients benefit from the research findings and are treated using IMRT which is now hypofractionated.
- The radiotherapy services were involved in local and national clinical trials, which evaluated new radiotherapy techniques including IMRT and adaptive radiotherapy (changing the radiotherapy plan after treatment has started). We reviewed the radiotherapy trials list and saw 33 trials were open across the department, covering a variety of body sites including lung, head and neck, neurology and urology. There was good recruitment to trials, which contributed to improved outcomes through developing new treatment techniques.
- We spoke to a research radiographer who told us that during trials patients completed Patient Reported Outcomes Measures (PROMS) questionnaires, which helped to monitor the effects of treatment. A baseline questionnaire was completed and then further questionnaires at specified intervals. This allowed staff to monitor the effects of treatment and support patients in any areas highlighted. PROMS data was not used to benchmark services against other providers at present.
- Across the service, we observed staff from radiotherapy and physics were actively involved in the development of new treatment techniques. We saw that in the last two years eight radiographers undertaking postgraduate education were making a large contribution in this area. All pilot studies were taken through the trust's ethic committee and all had to be worthwhile and clinically relevant. We saw one pilot undertaken was, "a comparison of closed face and open faced masks for head and neck patients" (to support claustrophobic patients). This contributed to improving the patient experience during a course of radiotherapy.
- Stereotactic radiotherapy is an important alternative to invasive surgery, especially for patients who are unable to undergo surgery. It also allows patients with hard to reach tumours to have a treatment option available to them, which was not previously available. We observed patients with multiple small brain tumours were receiving stereotactic brain treatments rather than conventional whole brain radiotherapy. This had resulted in an improved quality of life for this group of patients, which had been reflected in recent research trial data.
- Skin reactions and early radiotherapy effects were monitored during treatment using the radiation therapy oncology group (RTOG) scoring, which was undertaken by the radiographers. This allowed staff to assess ongoing care needs, recovery needs at the end of treatment and follow up needs.
- Following the completion of the heartspare trial, patients were now receiving treatment during a Deep Inspiration Breath Hold technique. This technique was introduced to reduce the amount of cardiac tissue in the radiation field and reduce radiation damage to the heart

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for patients having breast or chest wall radiotherapy, particularly the left breast. The introduction of this new technique offers patients improved outcomes by preventing late radiation effects.

- IGRT allowed the frequent imaging of the patient during a course of radiotherapy for the purpose of improving the precision and accuracy of the delivery of treatment. Radiographers were able to identify, after taking an image, if the treatment area was still correct or needed correcting before treatment. For example, patients may be required to refill their bladder if it is found to be too small on the image taken prior to treatment. This helped to improve outcomes as a more accurate treatment was delivered and side effects were minimised.
- A pilot was being undertaken where patients were offered ultraviolet ink marks, which are invisible to the naked eye. This was instead of black permanent markers to support the accurate positioning of patients receiving breast cancer treatment. This meant on the completion of the treatment no markers were visible to the patient to remind them of the experience.
- Independent checks on the dose calculations on the treatment units were undertaken with a commercial system. This verified the calculated dose matched that planned and delivered, significantly reducing the risk of operator error.

## Competent staff

- The radiotherapy department had appropriate job descriptions for all disciplines of staff. On-going checks ensured continuing registration with professional bodies. We reviewed the registration records of the radiographers. All staff were registered with the Health and Care Professions Council.
- New employees undertook both the trust (four days) and departmental induction. One junior doctor we spoke with told us the induction process was excellent. For the first two week's observations took place in the clinic followed by the signing off of their log book by their academic supervisor.
- There was a back to work induction programme for radiographers who were returning from long-term sick or maternity leave. This included, for example, new techniques that had been introduced during their

absence, as well as staff communication emails and audit information. Staff completed the necessary competency workbooks and their signing off before delivering care.

- Agency radiographers we spoke with told us they had completed a trust generic induction form, which contained some policies and procedures and a department induction of two weeks. The workbook had to be completed and signed off. Supervision was given in the first month. This gave assurance that agency staff had appropriate induction, training, and competencies to undertake their role.
- The training of staff on new equipment was performed by the supplier's applications teams. This ensured staff received the highest quality training on new equipment and the techniques the equipment could perform. Staff told us if radiographers had not worked on a piece of equipment for six months they must complete a competency workbook before delivering treatments.
- The department used excellent competency workbooks across all treatment disciplines. These were in paper format; however, work was being undertaken to place these on line and use a more interactive interface. The lead education superintendent radiographer was able to demonstrate the training matrix which showed members of staff who had completed which competency workbooks.
- The radiotherapy service manager told us education budgets were allocated annually to ensure staff in all clinical areas had access to further education and study opportunities. Across the department, the radiographers demonstrated high levels of skills and knowledge, which was backed up by their academic achievements. The number of radiographers who held a post-graduate award was 30%. These awards were supported by the trusts study leave programme. Two radiographers in the management team held doctorates with a further two working towards their doctorates.
- The radiotherapy service supported continuing professional development by cross-site lectures and journal clubs. One junior doctor told us the journal clubs and teaching by the consultants in protected time was excellent and took place on a regular basis.
- The physics team had developed the practise of joint clinical and research posts. Currently four staff were in post. This helped to ensure staff were kept up to date with latest research and how research could influence the model of clinical care delivered.

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- The trust's medical director told us 95% of the consultant oncologists had up to date appraisals. We reviewed two consultants' appraisals and saw they followed national guidance. We were told five oncologists were due revalidation in the next six months.
- All staff must read the local rules and risk assessments annually. These were required to be signed off by staff in order to comply with IR(ME)R. There was mandatory annual update of IR(ME)R responsibilities for all radiographers.
- Staff told us they received annual appraisals. We reviewed the appraisals of different staff members and saw they were in line with national guidance.

## Multidisciplinary working

- We observed strong team working at all levels of the service. This was demonstrated by the number of multidisciplinary meetings, which took place. These were used to discuss the various aspects of delivering a safe, effective service. Meetings included the radiotherapy strategy group, cross-site radiotherapy departmental audit meeting, and the liaison and quality circle meetings. These meetings brought doctors, physicists, and radiographers together to discuss the safe delivery of the service.
- A variety of multidisciplinary team (MDT) meetings were held across all the tumours sites. We observed the stereotactic MDT, which was via video link across both hospital sites. We observed good attendance at the meetings, which was documented and included a range of professions, including various grades of medical staff, radiographers, physicists, radiologists, pathologists, and nursing staff. One junior doctor told us the MDT process was an excellent training experience.
- At the stereotactic MDT cases were discussed systematically including all new referrals and patients on treatment. Patients were seen in the afternoon clinic to get the results of the MDT discussion. Where a patient was not felt suitable for the treatment direct communication with their referring consultant would take place. This prevented patients travelling from afar only to be told the treatment would not be suitable for them.
- Non-local patients receiving stereotactic treatment would have any follow up at the referring hospital. This had improved the patients' journeys by preventing

repeated visits to the hospital. There was good communication processes between the referring hospital and the stereotactic team to provide the best possible experience for the patient.

- Weekly audit meetings took place across all the tumour groups. These acted as a form of quality assurance as well as a peer review process. One oncologist told us these meetings were excellent as they signed off plans, checked areas being treated, and the development of an end of treatment plan. We observed the neurology meeting where patients receiving radiotherapy and new patients were discussed by the team delivering the care, which included doctors, clinical nurse specialists, and radiographers.
- Each oncologist was prepared to sign off another consultant's treatment plan. This avoided delays for the patient. It demonstrated a strong team working relationship between medical staff.

## Seven-day services

- The radiotherapy service was operating extended days during the replacement of one of their linear accelerators. The department was operating from 8am to 7pm, Monday to Friday. The service used all staff flexibly, working a shift system when machines were taken out of patient use for services, quality assurance, and upgrades to equipment.
- The service provided an on-call CT and virtual simulation service for Metastatic Spinal Cord Compressions at the weekends.
- CT planning scanners were serviced at the weekends. All software upgrades for linear accelerator and planning systems were scheduled for weekends when possible.
- There was an on-call system during the weekend for urgent access to radiotherapy. This included two treatments and one pre-treatment radiographer. There was a named consultant rota for out of hours contact along with junior doctor support.
- If access was required to support services such as pharmacy the on call pharmacist would be called in to support. The site practitioners were available to support out of hours.

## Access to information

- All staff across the radiotherapy service had access to the quality management system, which allowed staff to refer to protocols and standard operating procedures. Staff told us there were enough terminals available.



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- Staff all had access to the electronic patient records (EPR) and the radiology picture archiving and communications system (PACS). This meant staff could access information in order to support them in the delivery of safe care. We observed good use of EPR and PACS during the weekly audit meetings.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told all staff attends Mental Capacity Act mandatory training and completed an eLearning module every three years. The topic was covered regularly during weekly communications meetings.
- Staff were issued with and were able to show us the Principles of the Mental Capacity Act 2005 credit card size prompts. Staff we spoke with understood the Mental Capacity Act and were able to describe the appropriate steps.
- Patient consent to treatment was obtained at the clinical consultation phase. Patients confirmed their consent at scanning and prior to treatment.
- All radiotherapy consents included consent for imaging and data to be used for teaching and future audit/research. All radiotherapy complex trials follow trial protocols for consent.
- Radiotherapy had six-dementia champions across-site who supported the consent process for dementia patients, their carers, and the clinicians.
- Staff attended deprivation of liberty safeguarding (DoLS) mandatory training and completed an eLearning module every three years.
- A short DoLS PowerPoint presentation had been prepared by a team of radiographers and saved on the shared drive for quick access and review.

## Are radiotherapy services caring?

Outstanding



We rated radiotherapy services at the Royal Marsden, Chelsea as outstanding, because:

- The patients we spoke with during the inspection told us they were treated with dignity and respect, and had their care needs met by caring and compassionate staff. We reviewed the information submitted by patients to the LCA patient questionnaire and saw the feedback was extremely positive which confirmed our findings.

- We observed patients being treated in a professional and considerate manner by staff. All the staff we spoke with were enthusiastic about the service they provided to ensure patients received good-quality care that they would want their own families to receive.
- Patients and relatives reported feeling involved in planning their care and treatment and told us they received good information about their conditions from the clinical oncologist and the radiographers delivering their treatment, which meant they felt fully informed.
- Emotional support to patients and relatives was offered through the Trusts psychological services or through the radiographers who performed the daily reviews. A Clinical Nurse Specialist was allocated as the patient's key worker and was available for support when needed during the radiotherapy pathway.

## Compassionate care

- The department was involved in the London Cancer Alliance (LCA) radiotherapy patient experience study, which covered all areas of care from consent to the delivery of care and treatment. The data received was benchmarked against three other radiotherapy providers in the LCA. In the 2015 survey, 156 patients (100%) rated their care as excellent or very good across both departments, which were the best rating across the LCA providers.
- The trust had a dignity and privacy policy, which was read by all staff during their induction period. On the LCA experience study across both 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 with 156 patients taking part in the survey for the RMH.
- We observed the workings at the radiotherapy reception desk and saw staff were able to build up a relationship with the patient and family as many were attending daily over a six week period for their treatment. Staff spoke to patients in a kind and respectful way and helped direct patients to the sub waiting areas. This was confirmed in the LCA survey, where 97% of patients felt they were treated as a whole person at the radiotherapy reception desk. 156 patients answered this question across the departments. The RMH had the highest percentage across the four providers in the survey.
- One patient told us they were, "privileged to be in their hands and that from day one, their key worker was very



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calm and kind.” Another patient told us they, “had been attending the hospital for one and half years, and couldn’t say anything negative. They felt reassured and safe every step of the way.”

- Other patients we spoke with expressed a high level of satisfaction with their care and treatment. One patient told us, “the staff were very nice and helpful,” and another commented that staff were, “respectful and kind,” and the, “staff and the service” were exceptional.
- One patient told us the staff were like ‘a second family.’ If they were unwell, the radiographers would get someone to review them. They were never left feeling unwell. Staff reported a good relationship between radiographers and consultants. This was observed when escalating a concern regarding a service user receiving treatment in the department.
- We were able to review a recent email from a patient who had just completed their treatment. The patient praised ‘the skill of the staff, understanding, courtesy and kindness and their positive outlook has been awesome and such an invaluable help through a difficult period.’ This sentiment was reflected in the patients we spoke to during the inspection.
- One member of staff was seen to make a particular effort to maintain rapport with a patient, stating they would escort the patient to the ‘linac’ to ensure there was the same face as from previous treatment sessions. All staff we observed taking patients into the treatment rooms conducted themselves in a professional manner whilst being caring and empathetic. Caring and empathy was embedded in the staff and was seen when staff interacted with patients and their family. One patient told us the staff were, “very caring and helpful and we get to know them so well.”
- Throughout our inspection, we observed patients being treated with compassion, dignity, and respect. We observed a senior member of staff on two occasions speaking to relatives and patients. The member of staff demonstrated excellent communication skills and was caring and empathetic whilst remaining professional.
- We observed an array of thank you cards from patients, all expressing their gratitude for the care they received during their treatment. Between October and December 2015, 65 letters or cards of praise were received by the service.

- During a weekly audit meeting, we observed the team discuss the holistic needs of the patients. This demonstrated the person was being treated as a whole person and not a group of symptoms.

## Understanding and involvement of patients and those close to them

- We spoke with patients at all stages of their radiotherapy pathway. They told us they felt involved in their care and in decision making about their treatment. Patients told us the oncologists had explained their diagnosis, and they were aware of what was happening with their care and treatment.
- One relative we spoke with felt they were kept fully informed and the information given was tailored to fit the patient’s needs. For example the patient receiving treatment, “does not always want to know all the detail but is happy with the treatment and knowing the risks and side effects.” Staff facilitated information in accordance with the patient’s wishes.
- Staff told us they involved relatives after consent was given by the patient. Families liked to see the equipment, and staff were happy to facilitate this.
- 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. This was the highest percentage across all the providers with 156 patients answering this question. We reviewed the patient information leaflets and saw the information given was informative and clearly written. The department had produced a wide array of information from bladder preparation to the breath hold technique, which meant patients could review the information prior to their hospital visit at their leisure. Patients were told of the risks, benefits and alternatives by the consultant oncologists during outpatient clinic consultations and this could be discussed with radiographers at any time during treatment
- In the LCA study 79% of patients felt they could speak about any worries to a member of staff. 153 patients answered this question across the departments. This was reflected slightly differently by the patients we spoke to who felt fully informed. Patients told us if they had any worries staff would respond and sort any issues out for them immediately. Across the LCA survey, the RMH did not perform the best in this question.

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## Emotional support

- All patients had access to psychological support during the course of their oncological treatments. The team made the decision on how many sessions the patient required. Relatives could also book sessions with the team, for example partners, siblings or whole families.
- During the radiotherapy pathway, the key worker remained the Clinical Nurse Specialist (CNS). The CNS attended the weekly audit and MDT meetings, getting regular updates on the patient's progress.
- All radiographers attended Sage and Thyme training. This gave them the skills to carry out level 1 psychological assessment and support to distressed patients. One of the superintendent radiographers was a trainer on the course and provided support to patients who were very anxious.
- We observed that emotional support was embedded in the total care delivered at all times. All patients we spoke with felt very supported, and all their anxieties and concerns were addressed in a calm and caring manner.
- Radiographers could contact the chaplaincy if requested by a patient. One patient told us they had a strong faith, which was supported by visits from the hospital chaplain.
- Support groups were available to patients. Two groups we were told about were the pre-treat group for men with prostate cancer and breast exercise and support class. During the inspection, a prostate seminar took place for new patients prior to radiotherapy. Radiographers spoke at the seminar to inform patients on the treatment and alleviate any fears that may exist.
- As part of a prostate and breast cancer trial a mentoring scheme had been introduced to help, reassure, and support patients entering into the trial. A handbook was available to guide both the mentors and patients. The scheme was linked to information governance to protect both parties.
- The needs of local people, commissioners, and stakeholders were taken into consideration when planning services. The 31 day cancer targets were being met by the radiotherapy service and were continually above the national standard.
- All patients requiring radiotherapy received it within best practice guidelines and no patients treatments were rested unless in exceptional circumstances. National guidance identifies the more gaps in treatment the worse the outcome; treatment gaps are more detrimental to the patient outcome than a short delay in initiating the course of radiotherapy.
- Following evidence based research trials techniques and treatment pathways were promptly introduced into clinical practice to allow patients to receive up to date innovative treatments. This had included the introduction of hypofractionated radiotherapy in prostate cancer and breath hold treatments in breast cancer.
- No formal complaints had been received by the service in the last three years; however, we saw processes were in place to manage any formal complaints in an effective, timely manner. Comments made by patients about the service were acknowledged and we saw patients comments had influenced the department design and care delivered.

## Service planning and delivery to meet the needs of local people

- Data from the National Clinical Analysis & Specialised Applications Team (NATCANSAT) showed in the year 2015/16, there were 6,699 episodes of radiotherapy delivered to 4,979 individual patient's patients and there were 73,283 attendances for radiotherapy. Completed courses of radiotherapy had increased slightly since 2012/13, however, as treatments become more complex, the time taken to prepare and delivery treatments maintains the level of activity on the linear accelerators.
- The numbers of attendances had dropped in 2015/16 from the previous year. This was the result of more stereotactic and hypo fractionated (more radiotherapy per fraction, but fewer fractions.) radiotherapy delivered. Research from the CHHIP trial, (looked at delivering radiotherapy for prostate cancer in fewer, higher dose treatments) found outcomes were the same for early prostate cancers when the patient received 20 fractions (daily treatments) of radiotherapy compared with the

## Are radiotherapy services responsive?

Outstanding



We rated radiotherapy services at the Royal Marsden, Chelsea as outstanding for responsiveness, because:

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old regime of 37 fractions. This has released time and more patients could be treated; however, as treatments became more complex more time was needed to accurately deliver the treatments.

- In June 2015 NHS England funded the 'Commissioning through Evaluation process' where the trust received the contract to treat patients with stereotactic ablative radiotherapy (SABR). The contract allowed the department to treat patients with a variety of tumours including oligometastasis (few tumour spots in one organ.) spine and lymph nodes. Between June 2015 and March 2016, a total of 63 individual patients were treated under the contract.
- NHS England expects an increase in activity for patients with brain cancer to be treated via stereotactic radiotherapy. Due to the limited capacity on the unit, additional hard and soft ware had been purchased, which allowed stereotactic radiotherapy to be delivered on one of the linear accelerators. This helped to support the expected increase in activity and allow more patients to have access to this treatment.

## Access and flow

- NHS England monitored the proportion of patients receiving radiotherapy as the first treatment of choice and as a subsequent treatment. These should be delivered within 31 days of the patient agreeing to receive radiotherapy. For radiotherapy delivered as a first treatment, the national standard is set at 96%. Between April 2015 to and January 2016, 98.2 % of patients met this standard. Over the period, this equated to nine patients who did not meet the standard. Each patient who fell outside the standard would be investigated to find out the reason for missing the standard.
- For Radiotherapy as a subsequent treatment, the national standard is set at 94%. Between April 2015 and January 2016, the department was achieving almost 98.6%.
- At the daily radiographers forecast meetings, the capacity and demand of the service was discussed. If there was an indication that a waiting list was developing, steps would be taken to flex the workforce by introducing extended days and if necessary work a Saturday. Over the working year, the department ensured they worked the necessary 239 days to provide an effective service. Peaks in demand were managed through overtime.

- In 1993 the Joint Council for Clinical Oncology (JCCO) defined targets for waiting times for radiotherapy. Radiotherapy can be delivered as a curative treatment (radical), a treatment to alleviate symptoms (palliative) and as an urgent treatment. The JCCO targets are no longer measured; however, the department monitored their waiting times against these targets to ensure they were delivering effective care.
- Between April 2015 and March 2016, 98.2% of their patients started radical radiotherapy within 28 days of the referral being made. Over the same period, 100% received palliative radiotherapy within the 14 day target and 99.5% of urgent treatments were delivered within 48 hours. These comply with the Manual of Cancer Standards.
- Patients attending for treatment each day would have an allocated appointment time. We reviewed data that showed all patients were seen on time or within 20minutes of their appointment time. This was confirmed in the LCA patient questionnaire where the department achieved 99% of appointments on time or within 30 minutes.
- We saw the department had contingency plans and arrangements for the management of patients during periods of staff shortage and machine maintenance and breakdown. Staff told us no patients had their treatment interrupted unless exceptional circumstances developed. Data confirmed no category one patients (patients with the tumour types for which there is evidence that prolongation of treatments affect outcomes and who are being treated radically with curative intent) had their treatment interrupted during their course of treatment.

## Meeting people's individual needs

- We saw the radiographers were able to be flexible in changing appointments to meet individual people's needs.
- All patients received individual care and treatment based on their own personal scans, resulting in treatment that was tailor made for them. All treatments were based on national guidelines and radiotherapy protocols. However if treatment was prescribed off protocol this was discussed at the weekly audit meetings, where staff could question decisions.
- Prior to the patient visiting the pre planning area an information proforma was completed which highlighted the specific needs of the patients from their medical

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notes. This included information on whether an interpreter was required, do they have any hearing or visual impairment, if transport was required and whether a pacemaker was in place. This meant treatment could be organised and delivered around the specific needs of the patient before they arrived.

- Three radiographers had recently undertaken training to become 'dementia champions'. Staff told us that whilst they were completing an information proforma they identified a patient with early onset dementia. This was flagged with the dementia champion who would complete a "this is me" booklet with the patient and family on their first visit. This was then available to all staff to ensure individualised care was delivered and any requirements were put in place before treatment started.
- The Royal Marsden Hospital had a help centre. This provided information to patients attending for radiotherapy and other cancer treatments.
- Private patient's whose first language was not English had advocates to help them through the process. NHS patients had access to the 'Big Word' for face to face, written and telephone translation. An interpreter would be available during the consent process and during the pre-treatment and treatment phases. This service was available out of hours.
- The trust had a chaperon's policy, which offered a chaperone to patients during examinations and treatment. We were told some patients expressed a wish not to be treated by male radiographers. If a patient expressed this, then steps were taken to ensure female radiographers were available to deliver the treatment. A flexible workforce approach was available to meet the patient's needs.
- Patients with hearing impairments had access to the hearing loop system, which was available at the radiotherapy out patient's reception.
- Complementary therapies were available for all patients across the trust. Reflexology was available as well as referrals for acupuncture. There was a 'looking good feeling good' programme, which female patients could register on.
- Quiet areas were available to break bad news. These were found in the patient information area and the radiotherapy treatment area.

- The trust had accommodation available to support patients and relatives who travelled long distances to receive treatment. The unit had six to seven rooms with twin beds. These were available Monday to Friday.
- Very limited car parking was available. Six spaces could be reserved for patients via the facilities department. The majority of patients we spoke with used public or patient transport. No issues were identified with the patients we spoke with.
- A variety of information leaflets were available in the out patients and radiotherapy receptions and pre-treatment waiting area for patient and relatives. These included Macmillan cancer information booklets along with Royal Marsden information, which included Radiotherapy - your questions answered, your guide to support, practical help and complementary therapies and clinical trials. Coffee and hot drinks were available. Water was available across all sub-waiting areas.
- The hospital's website also provided information, and signposted to further sources of information and helpful advice.

## Learning from complaints and concerns

- The radiotherapy service manager told us they had not received any formal complaints about the service apart from a long-standing complaint, which was lodged with the department in March 2013 with a report from the Parliamentary Health and Service Ombudsman (PHSO) received by the trust in November 2014. This resulted in the trust re writing their CCTV policy and updating patient information booklets. A further complaint was lodged with the Information Commissioners Office in March 2016 but no further action was required by the trust. The outcomes from this complaint had been shared nationally with all other radiotherapy providers. On a monthly basis, the service report the number of complaints received and the number up held to the Radiotherapy Specialist Data Set.
- Any formal complaints would be investigated by the superintendent radiographers. Feedback about complaints would be given to staff at the weekly forecasting and monthly staff meetings.
- Radiographers told us the complaints policy was easily accessible on the intranet. Radiographers told us if a patient was unhappy they would speak to the patient

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during their daily visit. One patient, we were told, did not like the terminology used such as 'move left a little' so the radiographers changed it to 'come to me'. The patient was happy with the change implemented.

- If the staff felt they could not deal with an issue raised staff they would direct patients to the 'Patient Advice and Liaison Service'. Throughout the department 'Viewpoint' forms were available to complete and collection points were in place where any comments, suggestions, and complaints from patients could be placed. A patient information booklet was available to guide the patient through the process.
- Patients were encouraged to comment on the care they had received. One comment made by patients was that they did not like the positioning of the toilets within the department. Staff took this on board and during the recent refurbishing of the department, the toilets were moved.

## Are radiotherapy services well-led?

**Outstanding**



We rated the radiotherapy services at the Royal Marsden, Chelsea outstanding for well led, because:

- The radiotherapy department operated an effective governance structure with robust clinical governance and reporting arrangements in place. Risks were identified and acknowledged and action plans were put into place to address them. Care was evidence based and action plans were constantly reviewed.
- There was a strong senior management team, who staff said were approachable and visible. Staff knew their reporting responsibilities and took ownership of their areas of influence. All staff spoke with passion and pride about the service. Staff reported the culture of the service made them feel valued and respected.
- There were systems to ensure patients were heard and listened to and the service actively engaged with the public through school, student days, and meetings. Staff engagement was through meetings, surveys and communications.
- All healthcare professions across the service were actively involved in research resulting in an array of articles, presentations, posters, and abstracts, which

had been published by national professional journals. Staff regularly trained staff from outside radiotherapy providers on new innovative techniques and developed training videos.

## Vision and strategy for this service

- The radiotherapy service had no medium or long-term strategy; however, they had a service development strategy that covered 2016/17. Members of the senior management team we spoke to said as technology was moving so fast they had developed a short-term strategy. High-level strategic priorities were agreed at the quarterly Radiotherapy Strategic Group, whose membership consists of representatives from clinical and research services.
- Work streams from the Radiotherapy Strategy Group were aligned to the trust's strategic priorities through quarterly performance review meetings with the divisional director for clinical services and the deputy divisional director for clinical services and business unit lead.
- The service development strategy was cascaded to staff via the monthly clinical oncology consultants group, the lead physicist's meetings, as well as monthly superintendent radiographers meetings, weekly communications and staff meetings. Staff we spoke to told us they learnt about the strategy at their staff meetings.
- Four challenges were identified in the 2014/15 annual report, which included workforce, capital equipment, and information technology and research infrastructure. These were the areas the radiotherapy strategy group had chosen to oversee in the coming year. We did not see a work plan with work stream, timelines, and responsible persons in place.
- The radiotherapy strategy group aimed to create and deliver more models of advanced practice/specialist radiographers and physicist posts. In December 2015, radiographer led palliative planning for whole brain and bony lesions were delivered cross-site utilising the knowledge and skills of an experienced workforce in pre-treatment.
- The lead clinical oncologist and the divisional lead for clinical services were members of the trust executive board.



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## Governance, risk management and quality measurement

- The radiotherapy service was certified to the ISO9001:2008 quality standard by the British Standards Institution (BSI) and assessed by an external auditor twice a year. We found no issues had been raised in the last two inspections. The service has been ISO accredited for more than 15 years.
- The department, twice a year, undertook cross-site Radiotherapy Departmental Audit meetings to support compliance with the ISO 9001:2008 quality standard. The governance structure demonstrated that the audit processes were robust and ensured compliance with the standard and maintained a continuous cycle of improvements. Internal audit activity was submitted and reported in the Integrated Governance report.
- The department submitted monthly data to the national radiotherapy scorecard monitoring targets, for example, national performance targets, patient experience and clinical quality. This allowed the service to be benchmarked against other radiotherapy providers nationally.
- We looked at the governance structure. A variety of multi- professional meetings took place across the service including the multi professional quality assurance in radiotherapy team (MPTQUART), the Medical Exposure committee (MEC) and the Radiotherapy Liaison and Quality Circle meeting. These groups covered a variety of areas including new trials, clinical work streams, technical developments and governance issues related to IR(ME)R. All these meetings fed into the trust's Integrated Governance and Risk Management committee. These groups ensured a comprehensive clinical and operational oversight at divisional and departmental level.
- The integrated governance and risk management committee was chaired by the chief nurse, and met monthly to oversee patient safety issues. The quality lead for ISO attended this committee and submitted the radiotherapy report.
- The radiotherapy service manager attended the monthly Nursing, Radiology, and Rehabilitation Advisory Committee. All trust policies were discussed and approved. Incidents and complaints were discussed to share learning across all the directorates.

- A department risk register was in place. Local risks were recognised, recorded and mitigated. We saw that the ten year old radiotherapy CT scanner was on the register.
- We observed that Towards Safer Radiotherapy recommendations were embedded into the service.

## Leadership of service

- The radiotherapy service was led by a strong leadership team, which included the lead clinical oncologist, principle physicist and the radiotherapy service manager. The management team were able to tell us the integration of the operational service teams and research teams had resulted in a better understanding between the teams of the challenges experienced when delivering a service and integrating research. This new collaboration and understanding had led to joint physics posts and funding for equipment.
- The service had academic strengths as an undergraduate radiographer training centre and nationally accredited scientists training programme (STP) training centre. The service had strong links with education, teaching opportunities and a source of newly qualified radiographers and physicists.
- The department had an excellent research reputation and links with Institute of Cancer Research (ICR), which had resulted in staff from all professions involved in publications, presentations, teaching on courses, awards and prizes won.
- Links with postgraduate education and trust study leave support had resulted in large numbers of staff gaining MSc level education. Over 30% of the radiographer current workforce has MSc level post-graduation education.
- Radiographers had recently submitted publications to the British Journal of Radiology and Radiology, some of which had been published and several in manuscript form for submission. We saw three publications supported the development of radiographers training. At this year's College of Radiographers conference three radiographers gave presentations with another radiographer speaking at the Swiss Society for Radiation Oncology on breath holding techniques in breast cancer.
- Staff told us a high volume of patients were entered into National Cancer Research Institute (NCRI) badged trials. The Clinical and Translational Radiotherapy Research Working Group (CTRad) was set up in 2008. Its objective



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was to develop a portfolio of high quality radiotherapy and radiobiology trials. Physics had several Clinical trial QA physicists (externally funded) who performed national accreditation for clinical trials (both internal and external).

- Physics staff had received awards in 2015/16 to support them in developing their skills and knowledge. Research grants had been awarded along with funding for doctorates.
- Staff told us they felt supported by the directorate's management team who were all visible throughout the working week within the department. Staff told us they felt valued and respected and worked in a very supportive environment. They described a clear leadership of the service in which they had great confidence. Staff described an organisation that they felt proud to be part of.
- In a previous report from the medical deanery, issues regarding medical trainees had been raised. The department had addressed the issues and had implemented consultant-training sessions. We spoke to some medical trainees. There was positive feedback from trainee doctors who had been on placement in the department. They said they had been made to feel part of the team and staff ensured that they were fully involved in all aspects of patient care and treatment.

## Culture within the service

- There was a culture of quality and safety, which ran through the department at all levels of the service. Quality and safety were placed at the centre of the service and was part of the everyday work undertaken. Staff were committed to their work and to provide high quality care for patients. We observed, during the inspection, strong team working, and a culture of mutual respect. We saw staff communicating well within the different professional groups and we saw that people respected each other's professional contribution to the patient pathway.
- Staff we spoke with were proud to work within the radiotherapy department, they were very positive about the high quality care and treatment they provided for patients and were proud to work for the trust. They described the trust as a good place to work and that it had an open culture.
- Staff told us they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents.

- Staff had access to support services. This was of value following complex cases where staff needed to talk about their experiences. Schwartz rounds took place monthly. All staff were invited to come along and talk about their experiences. A patient's story was told followed by a discussion exploring issues raised by the story.

## Public engagement

- The service encouraged patient engagement through the use of 'Viewpoint' comment cards. Patients were able to comment on the care they had received.
- The radiographers recently attended 13th Schools Science Conference at the University of Westminster London to advertise a career in radiotherapy. They also attended local careers events in schools.
- The physicist teams introduced medical sciences to schoolchildren via talks and visits. The team were also involved in the Health Education England (HEE) Reach out for Healthcare science initiative.
- The trust had a patient and carer advisory group (PCAG). Previous patients and current patients supported projects where the views of patients supported better services. Within the radiotherapy department patients who had undergone radiotherapy for prostate and breast cancer treatment were used to mentor new patients.

## Staff engagement

- Staff engagement and keeping staff up to date with what was happening across the department and trust was via emails, which were colour coded depending on the importance of the message. Changes in practice were shared cross-site and if a process was changed then this was documented in the quality system and an email sent to the staff.
- Staff meetings took place monthly; however, on a daily basis communication updates took place daily on the treatment machines before the day's work began. Weekly forecasting meetings also took place to engage staff.

## Innovation, improvement and sustainability

- The trust actively encouraged innovation and service development. Within the radiotherapy service, innovation and service development were at the core ensuring that research developments were rapidly translated into clinical practice for the benefits of the patient. This was demonstrated following the Heart

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spare trial where breath hold techniques were compared to spare the heart from the effects of radiation during left sided breast radiotherapy. The department ran three national training days for the voluntary breath hold technique and a total of 25 centres have been trained by the department.

- The radiotherapy department led nationally on various clinical trials and evaluation of new radiotherapy techniques including: PACE: a trial comparing surgery, conventional radiotherapy, and stereotactic radiotherapy for localised prostate cancer; IMPORT: a trial comparing different ways of giving radiotherapy for early stage breast cancer along with other national trials. The physicists had, and continued to provide, quality assurance support for several clinical trials including CHHIP and PACE.
- A number of the national trials were developed and implemented by RMH clinical oncologists. These included 'START', which looked at hypofractionated radiotherapy in early breast cancer, CHHIP which looked at radiotherapy to early prostate cancer in fewer, higher doses. HYBRID, which looked at hypofractionated bladder radiotherapy with or without IGRT and PACE.
- The radiographers were actively involved in their role development. This led to the introduction of specialist radiographer posts including the insertion of gold grains for IGRT in prostate radiotherapy and a urology specialist radiographer supporting reviews, consent, and information. A dosimetrist post was supporting 'organs at risk' outlining to take the pressure of the medical trainees.
- Staff across the disciplines provided MSc teaching, and ran courses for external education of MDT's in oncology. The radiotherapy physics team undertook a variety of annual courses for both national and international delegates. This included IMRT/IGRT training, radiation protection and advanced radiotherapy treatment techniques.
- The Trust was involved in the NHS England Vanguard programme, which was to enable emerging leaders to deliver improvements in quality and productivity. The senior management team were unsure how this programme would influence radiotherapy at this stage.
- Service improvements initiatives were actively implemented across the service. These included the implementation of interstitial needles for brachytherapy, streamlining of routine QA, which was risk assessed and the upgrade of a linear accelerator to deliver volumetric modulated arc radiotherapy. This type of treatment delivers radiotherapy by rotating the gantry of a linear accelerator through one or more arcs with the radiation continuously on which helps to reduce treatment times and improves the patient's experience.
- The department supported the training of undergraduate radiotherapy students (65 students) on two pre-registration BSC pathways, one for full time students and one part time, which allowed them to recruit students that would otherwise be unable to contemplate attending university.
- The department continued to drive the implementation and evaluation of new radiotherapy techniques such as adaptive radiotherapy and IMRT by leading national trials. This required considerable start-up input from physicists and oncologists and the development of advanced radiographer skills to deliver complex Image Guided Radiotherapy.
- To sustain an effective high quality service requires resources. With the predicted increased activity for commissioning through evaluation, the stereotactic workload was being addressed with a business case for some additional staff in the pre-treatment area and to support the administrative and clerical activities.
- The complexity of treatment planning had increased. This would have to be maintained and was likely to increase as innovative treatments are developed and the possible increase in activity of radical patients following the commissioning drive to introduce early testing and the diagnosing of cancer. The workforce and technologies must keep up to date. It will therefore be a challenge for the service to keep the skilled workforce to deliver the increasing number of complex treatments.
- There were challenges around the timely funding of the equipment replacement programme for major radiotherapy equipment. With the department having eleven linear accelerators, two CT scanners and planning terminals there was considerable challenges for the trust to meet the national recommendations on the life cycle of the equipment.
- With the department being at the forefront of innovative treatments the lack of a National Tariff for emerging technology, such as MR Linac and Brachytherapy could place the department at a financial disadvantage, and prevent the development of these innovative treatments.

# Adult solid tumours

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

## Information about the service

Solid tumours at The Royal Marsden Hospital Chelsea, comprises of, urology, gastrointestinal, breast, gynaecological, head and neck, sarcoma, melanoma, lung, plastic surgery, skin, thyroid, neuro oncology and other rare cancers. As a recognised centre for the treatment of cancer, The Royal Marsden provides a specialist tertiary service for complex surgery and treats patients referred from all over the country and abroad.

Surgery makes up part of cancer services, with the chief of surgery reporting to the divisional director. Theatres are part of the clinical services. The chief of surgery, lead for clinical oncology, lead for medical oncology and director of medical education report to the medical director.

The Royal Marsden Trust, as well as its Chelsea hospital, has one further hospital in Sutton and a site in Kingston. There are seven operating theatres at The Royal Marsden, Chelsea and 4969 operations took place in 2015. They operate Monday to Friday with additional emergency cover, if needed at the weekends. The recovery area has 14 bays. The Royal Marsden is the only NHS trust in England to have the latest da Vinci Xi robot for prostate cancer. The trust provides specialist anaesthesia for upper gastrointestinal, major liver resections and head and neck cancers as well as major intra-abdominal and retroperitoneal sarcomas.

The Royal Marsden solid tumours services offers private care for national and overseas patients. In 2014 to 2015 financial year, The Royal Marsden received £78 million of

private patient income, which was re-invested in care and services for NHS patients. The Royal Marsden now operates the largest private care business of any NHS organisation.

There are seven wards in total; five are divided into tumour type. Burdett Coutts is a male only ward for gastrointestinal and genito-urinary treatment. Ellis Ward is female only, for treatment of breast, gynaecological, urological and gastrointestinal. Wilson Ward is a male and female ward for patients with sarcoma, melanoma, head and neck, lung and haematology cancers. The private wards of Granard House and Wiltshire Ward cater for patients with surgery and medical treatment. Both Horder and Markus Wards specialise in inpatient oncology, chemotherapy and medical needs.

During our inspection, we inspected the perioperative pathway, from pre-assessment, admissions, through to wards. We looked at service provision for both inpatients and day care patients. We inspected the pre-assessment area, surgical admissions, operating theatres and recovery area. We visited five solid tumour wards: Burdett Coutts, Ellis, Wilson, Granard House and Wiltshire Ward. We inspected both NHS day care surgery and private care surgery units and the endoscopy suite. We visited the clinical pre-assessment centre which provided specialist “acute oncology service”, for patients with symptoms requiring prompt assessment and treatment.

We spoke to 13 patients, observed their care and treatment and looked at 15 care records. We spoke to over 49 members of staff. These included surgeons, consultants, matrons, clinical leads, nurses, junior

# Adult solid tumours

doctors, surgery practice facilitator, the estate manager, porter and cleaning staff. We also reviewed national and local data and performance information about the trust and considered this when making our judgements.

Prior to the inspection we received data from the hospital, some of which was combined with the Sutton site hospital. We, therefore refer to this data as 'trust' information.

## Summary of findings

We rated the solid tumours service at The Royal Marsden Hospital, Chelsea as good overall, because:

- The solid tumour services at The Royal Marsden Chelsea had good safety performance, with few serious incidents.
- Staff reduced risks for patients by assessing and responding to risk. There was a strong focus on surgical safety in theatres and a high level of awareness and knowledge of the best ways to keep patients safe.
- There were sufficient staff with a range of skills and expertise, and staff were encouraged to develop.
- Theatres and wards were clean and there were safe practices to minimise the risk of infections arising.
- Hospital staff contributed to evidence-based practice through participating in research and evaluating their work. They made sure patients received care and treatment that reflected the most recent evidence.
- There were good multidisciplinary team input between surgeons, doctors, nurses and other members of staff to provide a safe patient pathway of care.
- There were good surgical outcomes for the complex high-risk surgery undertaken at the trust, and the trust performed well in national audits.
- Specialist surgery, using the latest equipment and advanced practices were available to patients.
- Patients received timely effective pain relief.
- The trust demonstrated continual improvement, with comprehensive auditing and projects.
- We saw staff being compassionate, kind and caring to patients across the whole trust.
- The trust scored well on the Cancer Patient Experience Survey, being in the top 20% for many statements.
- The trust supplied an extensive range of accessible therapies for patients.

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- The use of enhanced care pathway plans for patients and the involvement of staff in designing these.
- Patient flow from admission, to theatre, then on to the ward and finally to discharge was managed effectively and ran smoothly.
- The service was fully accessible to patients with disabilities.
- There was a clear strategic plan and staff demonstrated a shared vision with the trust.
- There was effective leadership, which provided strong support to staff. Leaders were visible and staff felt they were approachable. Matrons and clinical leads were present and supportive of their staff.

## Are adult solid tumours services safe?

Good



We rated the solid tumours service at The Royal Marsden Hospital, Chelsea as good overall, because:

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- There were sufficient staff with a range of skills and expertise, and staff were encouraged to develop.
- Theatres and wards were clean and there were safe practices to minimise the risk of infections arising.
- Hospital staff contributed to evidence-based practice through participating in research and evaluating their work. They made sure patients received care and treatment that reflected the most recent evidence.
- There were good multidisciplinary team input between surgeons, doctors, nurses and other members of staff to provide a safe patient pathway of care.
- There were good surgical outcomes for the complex high-risk surgery undertaken at the trust, and the trust performed well in national audits.
- Specialist surgery, using the latest equipment and advanced practices were available to patients.
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# Adult solid tumours

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## Incidents

- The surgery services reported two serious incidents in the year preceding our inspection. One related to a retained swab and another to an incorrectly inserted portacath, (This is an implanted venous access device for patients who need frequent or continuous administration of chemotherapy). Each incident included a detailed chronology of events, root cause analysis, contributory factors and recommended actions. Trust serious incidents were investigated with a panel of senior clinicians and discussed at the governance board meetings. The retained swab enquiry included stakeholder involvement in a comprehensive investigation, which concluded that it was a serious incident. Lessons learnt from the investigation highlighted a need for duty of candour to be at the forefront for all patient incidents. In response to the incident, clear bowls for swab counts were introduced in theatres.
- There were good structures in place for the reporting of incidents. Evidence showed there were effective systems to share information and outcomes of investigations. Learning was cascaded down to staff through e-mails, meetings, and one to one sessions.
- Ward staff demonstrated they knew how to report incidents on their electronic system known as Datix. The process was easily accessible and simple to complete. Staff said feedback was timely and relevant.

- Staff in Ellis Ward told us incidents were investigated by the sister. Feedback was given to the individual staff member and they were encouraged to write a reflective statement. Staff shared updates and learning at ward meetings.
- Safety concerns were discussed during the Theatre Audit Day of 25 September 2015. Topics discussed for prevention of incidents included, stocking equipment of the resuscitation trolley to stop shortages and ensuring sharps and intravenous bags were disposed of correctly.
- Senior surgery services staff discussed incidents at the Royal Marsden Anaesthetic Audit meeting of 25 November 2015. For instance, a pressure ulcer incident, regarding a patient moved from theatre to the critical care unit (CCU), was mentioned. Nasogastric tube insertion advice was given to help staff in the prevention of more incidents of this kind. During the meeting, staff were made aware to be more vigilant. The incident discussed demonstrated good multidisciplinary team effort between CCU and theatre staff.
- Mortality and morbidity discussions took place in the Surgical Audit Group meetings. Surgeons, doctors and the anaesthetic department discussed complex surgery cases. All deaths were discussed at the meetings; however, we noted that these meetings were only attended by medical staff and were not multidisciplinary.

## Duty of candour

- Staff were able to identify and describe duty of candour. A nurse described it as being 'open and transparent' and 'accepting responsibility, when things go wrong'.
- Staff told us it was about apologising and involving the patient and family in the process that followed.
- Staff were able to show us where to find the duty of candour policy on the trust intranet.
- The hospitals incident and root cause analysis tool included a section on duty of candour, contractual requirements, detailing when an apology was made, letter sent, and date patient or next of kin was notified. We saw a number of examples when the trust had used this tool.
- The trust ranked third in the NHS England Learning from Mistakes League, which lists trusts for openness and transparency. It was in the top 20% of trusts in England in the NHS staff survey of 2015 for staff rating of the fairness and effectiveness of procedures for reporting



# Adult solid tumours

errors, near misses and incidents The trust had a better rate of reporting incidents than the England average, but reported fewer incidents that caused harm to patients.

## Safety thermometer

- The NHS safety monitor is a national tool for measuring, monitoring and analysing patient harm and harm free care. It provides a monthly capture of data on new pressure ulcers, catheter and urinary tract infections, falls with harm to patients and venous thromboembolism (VTE) incidents. The trust collected data on all incidents of harm, harm free care, and reported this via the patient facing board. The trust collected data on all incidents of harm, harm free care, and reported this via the patient facing board.
- Wards displayed this information in the form of the patient facing dashboard. For example, Wilson Ward for the month of March/April had 91.7% harm free care. They had one, hospital acquired infection of *Clostridium difficile* (C diff) and no Meticillin- Resistant *Staphylococcus Aureus*, (MRSA) incidents. They had eight incidents, which included falls and pressure ulcers. Hand hygiene results were below the trust's recommended level at 85%. The Matron told us this was being addressed during team meetings. The type of incidents was not clearly defined but a more detailed breakdown was displayed in the staff office.
- For the month of March/April 2016, both Wiltshire and Granard House Wards completed 100% for their hand hygiene results.

## Cleanliness, infection control and hygiene

- Surgery services and clinical wards we visited were clean and tidy. Areas were clutter free and well organised.
- An external company was contracted to clean theatres and wards. Daily morning and evening cleaning was provided. Once a month theatres received an intensive clean. There was a dedicated cleaner of theatres. The team leader checked all areas once a day. Weekends were covered by an on call service after each surgery session.
- The matron and sister regularly audited the cleaning and supplied regular feedback to services.
- Surgery services had a dedicated specimen room. We observed staff handle surgical specimens in a safe manner wearing personal protective equipment.

- All elective patients for surgery were screened for Meticillin Resistant *Staphylococcus Aureus* (MRSA). There were procedures to isolate patients where necessary in accordance with the infection prevention and control (IPC) policy.
- There were facilities to isolate patients if needed, and signage was used to inform staff and visitors not to enter without taking the required precautions.
- Infection and control (IPC) policies and procedures were easily accessible via the trust intranet. Staff were able to show us the policies and were able to name the IPC link nurse.
- Non-scrubbed staff were not allowed to enter operating theatres, and signs were displayed to say this.
- Sterile equipment was labelled clean when in store or not in use. A third party provider supplied the decontamination of surgical instruments service. There were three deliveries per day, morning, afternoon and evening. There was an accelerated and priority service available if the trust required it. There was a robust reporting of unacceptable cleaning standards, and the trust had monthly meetings with the provider and quarterly decontamination committee meetings, attended by the delegated decontamination person. Penalties were applied for poor performance of the service. There was full traceability of instruments from processing to use of the tray.
- Prior to inspection, we reviewed hospital data on compliance for the month of December 2015 and January 2016. In theatres, for both months, there was 100% compliance for pre-operative actions to avoid surgical site infections, urinary catheter care insertion, central venous catheter care and peripheral intravenous cannula insertion.
- In line with hospital policy, we observed in both theatres and wards staff adhering to the 'bare below the elbow', to enable effective hand washing.
- Staff had good access to handwashing and drying equipment and we observed staff washing hands in between patients and handling of equipment. Handwashing gel facilities were clearly accessible at the entrance of wards, throughout, and in surgical areas.
- The integrated governance report for Jan – March 2016 demonstrated that overall hand hygiene compliance for the Chelsea site was 76%.

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- We observed sufficient supplies of personal and protective equipment available for staff, in both theatres and wards. Access to gloves, aprons and antibacterial wipes was easy and we saw staff using them appropriately.
- Waste segregation was in line with the Department of Health (DoH) 2011, safe management of waste. We saw waste collection staff secured clinical sacks with a tag, which was in line with policy. We spoke to the staff member who collected waste. They said they felt involved and up to date with all decisions made on waste segregation and collection within the trust.
- Syringes and other single use disposable equipment were disposed of in sharps bins. These were clearly labelled, not overfilled and stored safely to avoid spillage.
- On wards, purple sharps containers were available for the disposal of cytotoxic (chemotherapy) waste.
- Staff were able to locate cytotoxic spillage kits on the wards and knew how to use them.
- The sluice rooms were clean, clutter free and stickers were placed on items to clarify they were clean.
- Side rooms, toilets and shower facilities were tidy and seen to be clean.
- The surgery services team were proactive in decolonising all patients, to avoid surgery site infections.
- Surgical staff working in theatres followed NICE guidelines CG74, surgical site infection, prevention and treatment of surgical site infections 2011.
- Laryngoscope blades were single use and the handles were cleaned with anti-bacterial wipes. Theatres often ran audits and swabbed the handles for extra cross infection precautions.
- We saw posters on cross infection and hand washing, on walls in the wards throughout the trust.
- Infection prevention and control was part of mandatory training for all staff. We saw in training figures supplied, the overall trust compliance rate for October to December 2015 was 85% against the trusts target of 90%.
- There were seven surgical theatres at Chelsea. Access was good throughout, with space to accommodate disabled patients needs and bariatric trolleys. Recovery was spacious with 14 bays and was clutter free.
- We visited the in house services and estates. They have five engineers and one administrative staff. They covered all maintenance of equipment, seven days a week, 24 hours a day. They had a clear pathway for out of hours and sufficient spare equipment was readily set up for use.
- Staff training for equipment, was given at their induction to the trust and training was updated during regular audit days.
- All anaesthetic equipment was tagged and serial numbers were logged making it easy to track and locate.
- Theatres had new anaesthetic monitoring equipment, including ultrasound technology for safe vascular access and placement of regional local anaesthetic blocks.
- Intubation endoscopes were single use and disposable.
- In theatres, resuscitation equipment was located in three places and staff knew where to access them. Staff checked and signed logbooks daily, to ensure equipment was present and functioning.
- In clinical wards, resuscitation equipment was available with security tabs present. All necessary daily checks were logged and signed in books.
- The NHS day surgery unit had 11 patient trolleys. The private day surgery unit had six. There was enough room between bays to accommodate patient relatives. They each had a private consulting room.
- All medical equipment was serviced by in-house services. Manufacturers covered the servicing of robotic equipment. A link person was appointed for medical devices.
- All plant, air handling and water safety lines were carried out by the estates, in line with health Technical Memorandum (HTM) 03-01 specialist ventilation in healthcare premises 2007 and HTM 04-01 A&B control of legionella.
- Bariatric equipment was available in theatres and operating tables took up to 250kg in weight. Technical equipment was available to support individuals when required.
- Staff told us they had sufficient equipment to deliver safe care.
- As of March 2016, the planned preventative maintenance of equipment was 93%. The 7% outstanding was for minor equipment.

## Environment and equipment

- The wards at The Royal Marsden Chelsea were spacious, quiet, clean, and clutter free with the exception of Wilson Ward.

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- There were two main generators and four transformers. Three of the transformers were automatic and one was manual for critical care access.
- Equipment in clinical areas had been serviced, and portable appliance tested (PAT) safety stickers displayed the date the next test was due. Information supplied by the trust pre-inspection, showed the service records of syringe drivers in theatres.
- In wards, large equipment requests were managed by the matron or sister, presenting valid business cases to senior managers. For example, in pre-assessment staff audited the waiting times for patients to have their blood pressure taken by staff. The results, together with the business case allowed staff to purchase additional patient monitoring equipment, which had reduced the waiting time for patients.
- There was a sufficient supply of clean linen and single use equipment, such as, needles, syringes, suction tubes and oxygen masks. They were neatly displayed and none exceeded expiry dates.
- The medicine safety thermometer was included in the patient facing dashboard. On Granard House Ward, we observed medicine reconciliation being 100% and allergy status 100%. The trust contributed this information into the national data set with the intention of signing up to the chemotherapy safety campaign.
- The trust used an electronic prescribing system that had an inbuilt safety system ensuring all relevant information relating to the patients pathway of care was centrally held.
- It was formalised practice for the clinician administering the drug to draw it up. The anaesthetist drew up the drugs to be used during a procedure and the operation department practitioner (ODP) drew up drugs in an emergency during the operation. All ODPs were appropriately trained in medicine administration. Theatre practitioners and some nursing staff were trained in intravenous drug administration, their competency checked and their names put on a register.
- Theatres had a new biometric drug storage facility. The system was able to provide an audit record, by recording who had accessed the facility. Any incidents could be traced back to the staff member involved. Staff were able to show us how the system worked.
- We observed three patient medical records on Burdett Coutts, two on Ellis Ward and two on Wilson Ward and several notes in theatre. All of the records we looked at contained medicine name, dose, and the time given to patients, and staff members signatures.
- Drug fridge and chemotherapy fridge temperatures were monitored in line with national guidance. Drug fridge logbooks were correctly completed with all information recorded and with no gaps.
- Staff on clinical wards had access to the medicine room using electronic swipe keys. All cupboards inside the drugs room were locked.
- Ward staff were specially trained in the administration of chemotherapy drugs as well as general drugs. However, 90% of administration for chemotherapy was provided in outpatients.
- Staff on Wilson Ward told us of a new system adopted to alleviate the risk of falls in patients. Certain medicines that could cause delirium were given a red sticker warning, which, was put into the patients electronic record and placed on the drug chart, next to the patient's name. Staff were then able to identify those patients that were at risk

## Medicines

- Medicines were stored safely and managed well within theatres and wards. We observed pharmacy staff on Burdett Coutts and Wilson wards, checking medicines and controlled drugs. We saw good interaction between ward nurses and pharmacy staff in checking supply and updates of medicines.
- Medicines were stored neatly and displayed well. Expiry dates were correct and good stock rotation ensured the most current date of expiry medicines were used first.
- We observed two members of staff administering medicines to patients. The staff wore red aprons with visible 'do not disturb' signs to ensure no interruptions. We heard staff ask patients their name and if they had any allergies before giving them their medicines.
- Medicine policies were available on the trusts intranet. Staff was given detailed training as part of their mandatory training. The overall trust compliance rate for clinical staff from October to December 2015 was 83%. Medical staff's compliance rate was 89% against the trust target of 90%. Some nursing and theatre staff took further training in intravenous administration of drugs and some ward staff were trained in the administration of chemotherapy drugs. Team managers kept a record of staff competencies in the management and administration of medicines. There was a register of staff competent to administer drugs intravenously.

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- Staff indicated delayed discharge medication affected the patient's timely discharge, but there had been a slight improvement since Boot's pharmacy has started to dispense medication.

## Records

- The clinical areas used a mixture of electronic patient records and paper documentation. The records viewed were clear and provided detailed information of the patient's pathway of care. Pre-assessment information was included. Notes indicated if patients had chemotherapy prior to surgery and the relevant blood checks required were listed.
- In total, we viewed 15 patient notes from the wards, theatres, day surgical units and clinical assessment unit. Paper copies of patient's notes were stored in secure trolleys on the wards. Records were not left on display in accordance with the Data Protection Act 1998.
- We found medical notes contained detailed risk assessment and enhanced care pathways. For example, patient's notes from breast reconstructions gave enhanced recovery checklists, a daily guide to checks required and a clear structure for staff to follow.
- Records for patients were detailed according to the complexity of their illness. For example, we viewed a comprehensive patient record, which included endoscopy suite pathway of care and endoscopy observation chart and numerous notes on chemotherapy medication given prior to surgery. All had clear notes written and signed by various staff from across different departments.
- We followed a patient through treatment from surgical assessment to theatre and through to recovery. The notes were electronic and easy to access. They were clear to understand and contained consent. However, the anaesthetic record was electronic but was not linked to the e-notes process and therefore not integrated with the pre-operative assessment.
- Information governance was part of mandatory training. Staff were 91% compliant against the trusts target of 95% for October to December 2015.
- Nursing assessments were completed on records, including vital observations and early warning scores, falls assessments, assessment for pressure areas (water flow score), VTE assessment and nutritional status, Malnutrition Universal Screening Tool ( MUST), and drug charts.

## Safeguarding

- The trust had a policy in place for safeguarding that was embedded in the culture. This policy was available on the trusts intranet along with Deprivation of Liberties Safeguards (DoLS).
- Staff received safeguard training as part of their mandatory training. Senior staff members were trained to level two or three. The compliance rates for staff from October to December 2015 were 89% for adult safeguarding level one, and 73% for level two. For children's safeguarding, the compliance rates were 87% for level one, 88% for level two and 89% for level three. The trust target was 90%.
- Staff in clinical areas had a clear understanding of what safeguarding was. They knew how to identify a safeguarding issue and how to escalate. Staff were aware of who their safeguarding lead was.
- Staff on Wilson Ward were able to describe a recent safeguarding incident and the protocols they followed. In this case, the Divisional Nurse Director kept in regular contact with the staff member involved to provide guidance and support. The staff member was able to explain the escalation process and the reporting of the incident.

## Mandatory training

- The Royal Marsden Chelsea monitored mandatory training, and staff were to complete their training using the electronic system WIRED. Staff demonstrated how the system worked. A red, amber and green system was used to identify topics that were completed. Staff said they found the system easy to use. Examples of training topics covered included, consent awareness, infection prevention and control, safeguarding, fire awareness, information governance and medicine management.
- The hospitals target for completion of mandatory and statutory training was 90%. Theatres, Ellis and Burdett Coutts Ward achieved targets over 90%. Other wards were within reach averaging between 80 to 90%.
- Mandatory training figures for clinical staff, supplied to us indicated that the overall trust compliance rate from October to December 2015, for VTE and pressure ulcers was 85% against the trusts target of 90%. Medical staff scored lower on 71%.

## Assessing and responding to patient risk

- The Royal Marsden, was committed to the NHS 'Sign up to Safety', a campaign aimed to deliver harm free care for every patient, every time, everywhere. The trust had

# Adult solid tumours

pledged to three safety priorities. The first, increasing the awareness, identification, treatment of sepsis and reducing avoidable death. The aim was to eliminate all avoidable deaths by severe sepsis by 2018. Sepsis figures viewed, demonstrated the trust had made an improvement to reduce their sepsis rates. The Information Governance Report (IMG) from October 2015 to December 2015 showed only 41% of patients received antibiotics within one hour of recognition of septic shock. The IMG report from January 2016 to March 2016 showed this had increased significantly to 94%. In theatres, a sepsis pathway was under development.

- The trust other pledges were, reducing harm in medical errors and reducing harm from pressure ulcers.
- In theatres, for the prevention of pressure ulcers, sacral dressings were used for long surgery cases. This was in line with National Institute for Health and Care Excellence (NICE) CG179, prevention and management of pressure ulcers.
- Care bundles were in place for the insertion of urinary catheters aseptically in line with Royal College of Nursing (RCN) Catheter Care 2012.
- In theatres pressure relieving equipment was available for all complex lengthy surgery. Patients were risk assessed using the recognised water low score. The patient's body temperature was maintained using air warming devices. All fluids were warmed prior to use. Plans to trial humidified patient warming system for robotic and laparoscopic surgery with anaesthetic support were being reviewed.
- In recovery, the Salim score was used. This involved a robust care pathway, where anaesthetic criteria were used to identify how deteriorating conditions were monitored and addressed. The staffing ratio was one staff to two patients and all staff had immediate life support training. Physical signs of airways, breathing and consciousness were assessed. We reviewed two patients' notes. Both sets documented the assessments had taken place and results recorded
- The majority of surgical patients were sent to the high dependency unit due to the complexity of their surgery.
- A scoring system, known as national early warning score (NEWS) was used to measure patient's vital signs and identify patients who were at risk of deteriorating.

Observations were recorded and monitored in accordance with, National Institute for Care and Excellence (NICE) guideline CG50 'acutely ill patients in hospital'.

- Nursing staff were aware of the escalation process and would call a doctor if concerned. Nurses told us responses were swift from doctors and the outreach team.
- We observed a nursing staff catch-up meeting, which took place in Burdett Coutts Ward in the morning. Staff provided updates on patient conditions and any concerns were discussed. In addition to this, we observed a staff handover. We heard detailed medical up to date information on patients and their general comfort. For example, the lead sister provided information on a patient that needed to 'be turned' every two hours to avoid skin pressure.
- Assessment criteria were used to respond to patient risk. We saw evidence in patient records of the malnutrition universal screening tool (MUST), safer skin care (SSKIN) and venous thromboembolism (VTE) in use.
- Anaesthetist staff met The Association of Anaesthetists of Great Britain and Ireland (AAGBI) requirements on resuscitation certification. A number of anaesthetists within the department were qualified advanced paediatric life support and advanced life support instructors, and taught these courses at The Royal Marsden Chelsea and other institutions.
- On clinical wards Situation, Background, Assessment Recommendation (SBAR) was discussed. This was a structured method of communicating critical information that required immediate attention, which ensured effective escalation and increased patient safety.
- The surgery service staff completed safety checks, before, during, and after surgery as required by the 'five steps to safer surgery' - the NHS Patient Safety First Campaign adaptation of the World Health Organisation (WHO) surgical safety checklist. We found good evidence of compliance during our inspection. However, the audit gave results in February 2016, of 76% compliance in debriefing. As a result, staff were given more training and instructions on debriefing. Our meeting with senior surgery staff confirmed problems with the recording of the debriefing electronically. Staff were aware and a robust monthly audit of the safety checklist was in place to ensure improved compliance.



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- We followed a patient through a surgical procedure in main theatre. All the WHO checklists were completed comprehensively and recorded in patients notes.
- Projects led from surgery services, included national safety standards for invasive procedures. The aim was to promote safer consistent standards, by introducing the five steps to safer surgery, particularly the brief and de-briefing stage in other environments outside of theatre. For example, endoscopy, interventional radiology and vascular access

## Nursing and theatre staffing

- Ward managers and surgery staff used acuity measures to manage safe staffing levels. Lead sisters reviewed handover sheets to make decisions on staffing levels and bed management. We attended an afternoon staff huddle meeting, involving multiple wards and departments. Staffing levels and bed management were discussed for the next day. The meeting was well organised and effective. Staff worked as a team to reach solutions.
- Staffing data for clinical wards showed that in January 2016, the average planned staff on duty for day staff was 94.2% and night staff 97.7%.
- The clinical lead anaesthetist told us a robust international recruitment campaign drive had been successful and staff were due to start in August of this year.
- Theatres used bank staff, who were familiar with procedures and policies. The clinical lead anaesthetist staggered staff shifts throughout the day to ensure there was adequate cover, especially for overrun theatre lists.
- There was a higher number of band 6 nursing staff at The Royal Marsden Chelsea, due to the specialist care required for oncology patients. For example, on Wilson Ward, the ward establishment was one band 7, 11 band 6, and four band 5 and 0.9 whole time equivalent (WTE) band 3 and 0.6 WTE band 2 staff members.
- We found long serving staff members in each clinical setting with a wealth of experience in oncology that was shared to the newer members of staff.
- We observed effective nursing handover processes. Two scheduled handovers took place every day in clinical wards at 8am and 8pm. A further 'catch up' meeting took place at 11am in Burdett Coutts Ward.

- We saw effective procedures for the handovers, with individual patient's risks being assessed and detailed information shared. Nurses told us the meetings were crucial in helping them deliver the right care for the patient.
- The latest figures we received for October to December 2015, showed us the sickness rate in clinical services was relatively low amongst the trust at 3.06% The vacancy rate was low at 5.2%.
- During our inspection, all wards were safely staffed with nurses and nursing assistants. Staff told us they felt happy with the plans to recruit more staff and the use of bank staff when they were required.
- Patients were happy with staffing levels. They told us they were regularly seen, and staff were always readily available.

## Medical and surgical staffing

- The medical staffing mix for surgery services was different to that of the England average. Consultant level was similar at 42%, while the register group was at 50% and junior doctors were lower at 5% compared to the England average of 12%. Overall, the medical staffing mix was more senior than that of the England average, due to the specialist clinical nature of the trust.
- There was 24-hour consultant cover, and staff were happy with the level of doctor involvement and access when required.
- Senior staff told us the trusts aim was to work towards a 'full time surgeon to Marsden policy', whereby, all surgeons worked solely for the trust full time.
- Arrangements were in place for emergency cover. The trust told us that surgeons did not live more than 30 minutes from the hospital.
- Doctors in training in theatres told us they felt well supported by consultants. They received good training advice and feedback.
- The Advanced Nurse Practitioner role was introduced to manage medical patients with gastrointestinal and urology cancers.

## Major incident awareness and training

- The hospital had a major incident plan, which was accessible by all staff. It was comprehensive and gave steps for staff to take in such events, for example, notification of major incident definition tree for staff to follow. The trust used a three-tier command and control system of gold, silver and bronze for major incidents.



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- The hospital had a risk and resilience officer, who staff could contact at any time.
- Fire training was incorporated into the hospitals mandatory training. The Royal Marsden major incident policy was utilised for snow, information technical problems and the junior doctor strike.

## Are adult solid tumours services effective?

Good



Overall we rated solid tumours services at The Royal Marsden, Chelsea as good for effective because:

- Robust continual auditing, for improvement in patient care, was evident throughout surgical services.
- Numerous projects and research were in place, to improve the outcomes of cancer, with cohesive involvement from staff.
- There were good outcomes for patients, despite the complex high-risk surgery that took place.
- A high standard of training and development was available for all levels of staff.
- Surgical services performed well in national audits
- There were strong multidisciplinary working relationships, ensuring the patients treatment ran smoothly.
- Care was delivered in line with national guidelines.

### Evidence-based care and treatment

- From observations and patients records, we confirmed The Royal Marsden followed National Institute for Health and Care Excellence (NICE) guidelines. Some examples of guidelines followed were NICE CG74 surgical site infection in theatres, NICE PU 179 pressure ulcer care. Other guidelines followed included; the Association of Anaesthetists of Great Britain and Ireland (AAGBI) 2014, out of hour's anaesthesia, AAGBI 2012, immediate anaesthetic recovery, Royal College of Nursing (RCN) 2012, in catheter care, and Health Technical Memorandum (HTM) 04, control of legionella and HTM 03, specialised ventilation for healthcare premises.
- The Joint Advisory Group on gastrointestinal endoscopy accredited the endoscopy suite.
- During our inspection, staff were able to access and show us policies and procedures on the trusts intranet.

- The hospital reviewed NICE guidelines regularly. NICE published 17 items of guidance, which were presented to the trust. Two items were seen to be relevant and eight items were under review. The clinical lead managed the implementation of new guidelines and regulations.
- The trust contributed to the evidence-base for cancer care and treatment by participating in local and national research. The trust was involved in the 100,000 Genomes Project. In collaboration with other trusts, The Royal Marsden trust was leading the cancer element of the partnership. They had been collecting and decoding the genomes of patients. The project was dedicated to understanding changes in the genome to get a better idea of how the disease develops, to make future treatments more effective. The project was still developing during our inspection.
- The Royal Marsden contributed to a landmark study that demonstrated improved survival for patients with operable gastric cancer, if they were given chemotherapy before and after their surgery.
- The Royal Marsden was a contributor to a national trial in endometrial cancer, assessing the role of both radiotherapy and extended surgery, with lymphadenectomy, after a conventional hysterectomy.
- We saw Difficult Airway Society guidelines followed in theatres and difficult airway trolleys displayed posters of algorithms for staff to follow if required.
- Staff used The Royal Marsden manual on clinical nursing procedures. This manual was nationally recognised as the definitive guide to nursing skills and had provided essential knowledge for over 30 years.
- Clinical services used enhanced recovery care pathways. They were a key tool for patient care. Staff were actively involved in devising and updating plans. We reviewed the endoscopy suite pathway of care and the bowel and urinary stoma pathway for newly formed stomas. These gave detailed, post-operative care and listed actions and observations to be taken, each day by staff. The Royal College of Surgeons had endorsed the enhanced recovery plan for upper gastrointestinal cancer, devised by staff at the trust.
- Pre-assessment staff had been involved in developing a pre-operative delirium pathway, to identify patients at risk. Colleagues from other departments were working on the post-operative part of the delirium pathway.

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- All professions were involved in an extensive audit programme, participating in local, regional and national audits. The trust clinical audit committee authorised the audit programme and reviewed audit results.
- The trust acted upon outcomes of audits. In theatres, the tissue viability audit resulted in the purchase of a new pressure ulcer-relieving mattress.
- The minutes of the surgical audit group included reference to the quarterly review of 30 day unplanned readmissions & return to theatre, case reviews of surgical deaths and complications, local audits and national reports.
- Other projects led from surgery services, included national safety standards for invasive procedures. The aim was to promote safer consistent standards, by introducing the five steps to safer surgery, particularly the brief and de-briefing stage in other environments outside of theatre. For example, endoscopy, interventional radiology and vascular access.

## Pain relief

- Staff managed the assessment and control of patient's pain well in clinical areas.
- Patients told us staff were quick to respond to their pain. Patient records showed that pain relief was prescribed, and given to patients when requested.
- Audits seen prior to inspection demonstrated the trust had an effective system for measuring patient's pain satisfaction. Pain was assessed using a pain-scoring tool, with 10 being the highest score. We did not see any records with a patient score of 10.
- A pain team was available at The Royal Marsden hospital. A link person was available for theatre recovery if required. Staff in theatres had competency-based training in the use of epidurals and PCA pumps. Theatres were running a project on improving pain management.
- Ward staff had an epidural study day. The pain link nurse provided updates to all staff and care nurse practitioners provided teaching on pain management by request.
- The 'Abby' pain scale was used for patients living with dementia and those who were unable to communicate. Pain was assessed by monitoring, psychological, behavioural and physical changes. Staff told us this was an effective tool.
- Consultant anaesthetists, discussed pain relief with patients for major surgery at the pre-admissions stage of their treatment.

## Nutrition and hydration

- The hospital used the Malnutrition Universal Screening Tool (MUST) to monitor patients who were at risk of malnutrition. At pre-assessment, the nutritional screening tool was completed and sent to the dietetics department for triaging and follow up referral when required.
- On wards, we found staff followed the MUST screening tool and we observed recordings in patient's records. All patients had a nutrition assessment on the day of admission and staff were guided by the score for when to take appropriate action. Staff reviewed this weekly.
- The dietetics and speech and language team (SALT) assessed patients who had special dietary needs or had difficulties swallowing food. Staff recorded food intake when this was indicated.
- In theatres, we viewed two patients' records and no MUST scores were indicated. Staff were aware and told us an action plan was in place for improvement and implementation.
- Patients were given IV fluids pre surgery, intra and post operatively, until the patient was transferred to the critical care unit or day surgery. Fluid balance monitoring was recorded in patient's records.
- Patients were provided with a "fasting before operation" leaflet, which supplied instructions such as, hospital arrival time and the last time to eat or drink.
- Patients with percutaneous endoscopic gastrostomy (PEG) feeding tubes were provided with a consulting room for privacy.
- There were protected meal times on wards. Staff felt it was challenging at times, as relatives were reluctant to leave especially if patient support was required from other staff members. However, staff said they would include relatives as much as possible.
- A white board on wards, showed the patients that required help with meal times. This information was supplied in handovers to other staff.
- Food allergies were highlighted on admission and recorded in patient's notes.
- Enteral and parenteral nutrition was given to patients unable to have oral nutrition. Staff were able to contact the speech and therapy language team for additional support.

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## Patient outcomes

- The Royal Marsden used the new state of the art da Vinci Xi surgical robot. This allowed surgical staff to use advanced technology on patients, enabling them to cut and manipulate tissue, without the need for open surgery. We were told that benefits for the patient had included, smaller scars, less pain and blood loss, shorter stay in hospital and recovery time, but we were not provided with detailed information. The Royal Marsden was, amongst the largest provider of robot surgical procedures for prostate cancer in the UK. They had also used robot surgery for other tumour types, which included bladder and salvage prostatectomy for recurrent cases.
- The latest figures we saw from the Information Governance (IMG) Report January 2016 to March 2016 showed the hospitals 30 days death rate following surgery and anaesthesia was 0.9%, which represented 29 deaths out of 2564 patients.
- The National Bowel Cancer Audit 2015 showed that The Royal Marsden had a higher 90-day mortality rate at 4.9%. For other criteria within this audit the trust performed an average score. The trust performed on an average basis for the Prostate Cancer Audit 2015 and the trust was below the England average for the National Lung Cancer Audit 2015. The Royal Marsden participated in several national audits. It must be noted that The Royal Marsden was one of a number of tertiary trusts and which are rarely the 'first place seen'. Therefore, it was not possible to compare outcomes for certain targets.
- The trust was amongst the top performers for several areas and the top 10 sites for the National Emergency Laparotomy Audit (NELA). They scored well for pre-operative risk documentation, a consultant being present in theatre, direct access to the critical care unit and a low rate of missing times for decision made to operate and booking for theatre.
- The trust performed better than the England average in the bowel cancer audit for cases discussed at multidisciplinary meetings (MDT), patients seen by a clinical specialist nurse and a CT scan reported.
- We reviewed The Royal Marsden High Risk Cancer Surgery – Outcomes and Risk Prediction March 2016 for the Clinical Quality Review Group. This gave an overview of outcomes for patients who presented with more co-morbid conditions. Patients who were older and

- frailer. The hospital focussed on 138 elective surgery cases. The objective was to understand whether the surgeries had good clinical outcomes and that patients received the appropriate treatments.
- Of the 138 cases, 10 (7.2%) were turned down from other hospitals and centres. Four patients were turned down due to the complexity of the surgery, three patients were seen to be medically unfit by other hospitals and three were seen to be medically unfit and that their surgery was too complex.
  - The hospital used various tools to reach their conclusions. These included National Surgical Quality Improvement Program (NSQIP) surgical risk calculator, NCEPOD surgical outcome tool, P-POSSUM scoring and The Charlson Comorbidity Index.
  - Of all the 138 patients, the predicted mortality at 30 days was 3.80%. The Royal Marsden's actual rate was 1%. The predicted serious morbidity was 92%. The hospitals actual figure was 72%. Other outcomes included 0% for 90-day mortality rate for pelvic extenuation work, (Radical surgical treatment, which removes all organs from a person's pelvic cavity) .This was the lowest rate in the UK.
  - The outcomes of second opinions from other hospitals and centres included 100% survival at 30 days and 80% survival at one year.
  - The outcomes were good due to the systems they had in place to identify high-risk patients. These included comprehensive care pathways plans, the high-risk patient pre-operative multidisciplinary team (MDT) meetings, critical care admission for all patients and the cutting-edge surgery and anaesthesia and post-operative MDT care.
  - Surgery services participated in a multi-centre prospective audit, which related to incidence of postoperative pneumonia, following oesophagostomy and gastrectomy surgery. We did not see the outcome results of this audit.
  - New data collected from the trust, showed that low bi-spectral and mean arterial pressure readings did not influence morbidity in cancer related surgery. This new additional information was submitted to the European Society of Anaesthesia.

## Competent staff

- Medical appraisal and re-validation was comprehensively covered within The Royal Marsden appraisal policy and medical appraisal procedure. The

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policy covered all aspects of the re-validation process and provided a step- by -step guidance to achieve the General Medical council (GMC) re-validation. Discussions on re-validation took place in staff appraisals.

- In theatres and wards, there was a robust investment in staff development and learning. Staff were encouraged and supported to study for qualifications in specialist areas, and given time to complete courses. Many staff we interviewed were in the process, or had, completed master degrees. On Burdett Coutts Ward, four staff members had their mentorship and another three had completed and were awaiting confirmation. Oncology at degree level and higher was offered to staff.
- In theatres, the health care assistant staff had the opportunity to develop to registered nurse or operating department practitioners (ODP). Registered nurses and ODP's were able to develop to surgical practitioner or advanced nurse practitioner roles.
- Staff were given 18 days study leave per year.
- New nurses felt supported in their training. As well as mandatory training and induction, they attend the 'new cancer programme' one day a month, where they rotated within different departments.
- Senior staff told us bank agency staff had received local induction training.
- All junior doctors attend a one-day trust mandatory training day and one day critical care training.
- Staff spoke highly of the hospitals support and investment in their learning. New staff praised the hospitals learning culture.
- Newly qualified staff reported a supported learning environment on clinical wards
- There was good completion of annual staff performance appraisals in the surgery service.
- At the time of our inspection, information from the trust showed that consultant appraisal rate was 90% and specialist registrars 100%.
- Advanced nurse practitioners (ANP) were available to support nursing staff with decision making clinical competencies and expert advice. The role was a development route for nurses who wished to further their career, after taking extensive specialist studies. ANP had vascular access clinics at the hospital whereby they were able to assess patients.

- The anaesthetic department had developed the use of theatre crisis simulation at the Chelsea hospital. There had been two simulations in 2015, including a scenario of a major haemorrhage, which was screened live to over 200 staff.

## Multidisciplinary working

- There was an effective multidisciplinary working environment within surgery services. We found evidence of multidisciplinary inputs throughout the patients care pathway. We observed good multidisciplinary input from staff on the wards.
- There was good access to support from palliative care team, occupational therapists, physiotherapists and the pharmacy and pain team.
- Due to the complexity of the patient's illness, multidisciplinary input was vital. From patient's records, we saw involvement from endoscopy, radiology, medicine and chemotherapy specialists at a high level. Medical notes were comprehensive and enhanced care pathway plans were detailed.
- On clinical wards, the physiotherapist and occupational therapist team met every morning Monday to Friday at 8.45am together with nursing staff. The discharge team joined every Thursday to discuss patient pathways.
- We observed two high level MDT meetings for urology and head and neck. Patients outcomes and treatments were discussed in detail and we found the meetings were constructive and informative.

## Seven-day services

- Theatres operated a full service Monday to Friday, with emergency on-call out of hour's service available when required at weekends.
- Consultant surgeons were on call for out of hour arrangements and they lived within 30 minutes of the hospital. Anaesthetists were available 24 hours, seven days a week and this was consultant led.
- On clinical wards, the medical team viewed patients at weekends.
- Out of hours support services included, pharmacy, physiotherapy, occupational therapy and imaging were available.

## Access to information

- There was sufficient number of computers for staff to access in theatres and wards.
- Authorised staff were able to access test results electronically.

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- Manual guidelines were kept in staff ward offices and were easily accessible.
- Test results and patient's medical notes were readily available.
- Ward information, such as, patient feedback and safety information was displayed near the entrance to wards.
- Enhanced recovery care pathway forms for each solid tumour type, was available in staff offices.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us the staff explained treatment clearly and asked consent before treatment started. All patients we spoke to had been given information and had signed their consent form.
- Consent forms were tailored to patient treatment. Complex treatment required more detailed consent forms. For example, we viewed the consent details for laparoscopic prostatectomy. The consent booklet was very comprehensive, detailing consent for digital video images of the procedure for urology. Risks involved were listed, as too were the benefits. There were provisions for an interpreter to provide a statement and a witness to sign.
- There was a hospital policy for consent and staff were able to tell us the content.
- Staff were able to explain The Mental Capacity Act and identify those patients that required extra support. One to one care was provided to patients living with dementia and patients that required extra help.
- Senior staff told us they involved patients' family members and carers, social services, and the clinical team in MDT meetings to reach agreed decisions.
- Deprivation of Liberties Safeguards (DoLS) had increased at the trust. Nine applications were made with the trust from October to December 2015. A programme of information and training sessions throughout the trust have helped raise staff awareness.
- Information provided, showed us that 78% of medical staff had completed consent awareness mandatory training, against the trusts target of 90% for October to December 2015.
- During our inspection, we followed a patient through their journey of treatment from pre-admissions, to theatre and through to recovery. We saw staff obtain consent from the patient and the risks and treatment was explained fully to the patient.

- Patients who could not speak English were provided with an interpreter or advocate for consent.

## Are adult solid tumours services caring?

Outstanding



Overall, we rated adult solid tumours services at The Royal Marsden Chelsea as outstanding for caring because:

- Staff showed a high level of compassion and care for patients, and patients told us, staff were kind, professional and caring.
- Staff anticipated patients' needs and recognised their individual requirements. Staff often went the extra mile to ensure these needs were met.
- We saw staff communicate with patients in a friendly and polite manner.
- Patients were treated with dignity and respect at all times. We found the trust performed better than the England average in national patient surveys in many of the questions relating to how caring staff were.
- There was a full range of therapies available to assist patients in meeting their emotional needs.
- The psychological needs of patients was fully considered, and interventions reflected an holistic approach to meeting their needs.
- The trust performed well in the Friends and Family Test.

## Compassionate care

- All patients we spoke with praised the care and treatment they had received from staff. Direct comments from patients included: "amazing", "10 out of 10", "everyone from the door in, is professional, they know their job and I think they'll help anyone".
- Other patient comments included: "care is wonderful here", and, "the surgeon rang my daughter half way through my operation, to say how it was going".
- Comments from Ellis Ward included: "couldn't ask for a better hospital", "care has been marvellous, they take their time and explain things clearly".
- On Wilson Ward, two patients told us the care was brilliant, medicine was given on time and the call bell was answered quickly.
- We saw examples of above and beyond compassionate care shown to patients. A younger patient told us staff often offered porter assistance, so he could be taken out



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of the ward, for a change of environment. The patient told us, staff were happy to accommodate him whenever he wanted to leave the ward and always provided private time for him and his family.

- We saw thank you cards displayed in wards from patients, expressing their gratitude for care.
- There were hourly observation checks on the wards, where staff ensured patients pain, comfort and other needs were met.
- We saw staff at pre-assessment help patients with luggage and helped them to their appointment.
- The response rates for the Friends and Family Test was relatively good. From January 2016 to March 2016, 97% of inpatients indicated they would recommend the trust against the national average of 96%. However, the response rate was lower than the national average.
- The trust performed better than the England average in national patient surveys in many of the questions relating to how caring staff were. For example, in the cancer patient experience survey of 2014, the trust performed better than the England average in the percentage of patients who said they were always treated with respect and dignity (89%).
- The trust scored higher than the England average on a majority of topics for the patient led assessments of the care environment (PLACE).
- In theatres, we observed staff care for patients in a professional manner. At all stages of the patient's procedure, they were treated with dignity and respect. Nurses, anaesthetic staff and surgeons were kind to patients and clearly explained different stages of their treatment.
- 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.
- Patients told us nursing staff came to the bed to handover between shifts and they were made aware of who their nurse would be responsible for their care.
- We made many observations of staff interactions across areas we inspected. Staff were attentive to patient's needs and were polite and kind, for example, in pre-assessment; patients were not rushed and were offered refreshments while waiting.
- We followed a patient's surgical pathway from admission, to the surgical assessment unit, through to theatre and recovery. The surgical team gained consent at admission. The process of treatment was explained

clearly to the patient and the surgical area was marked. The patient's admission was staggered to fit in with the surgical theatre list and to avoid a lengthy wait for the patient. The patient was able to have water until they left home. The anaesthetist and ODP met the patient on arrival at theatre to introduce themselves and explain the treatment to the patient. When surgery was completed, the patient was taken to recovery.

- The patient was treated with dignity and respect. Treatment was explained at all stages of their journey. The patient's notes showed an enhanced care pathway plan for their discharge.

## Understanding and involvement of patients and those close to them

- Patients on surgery wards and in the day surgery unit told us pre-assessment staff explained the risks and benefits of the treatment and provided information about after care support.
- Patients we spoke to told us their treatment had been explained fully and they had been involved in the process throughout.
- Patients commented that consultants were approachable, spoke to them on an even level and answered all questions.
- Relatives were very pleased with the staff. They felt involved in decisions and kept updated of their relative's treatment plan.
- Staff arranged travel for patients who lived far from the hospital and made travel arrangements for patient's families. Several patients commented that staff had done this for them on several occasions when they had felt unwell.

## 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.
- The Psychological Support Team responded to patients with significant distress associated with their cancer. They provided assessment and intervention when necessary and onward referral. Their work included supporting staff and other professionals within the trust.



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- A chaplaincy service and multi faith prayer room was 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 adult solid tumours services responsive?

Good



Overall, we rated adult solid tumour service at The Royal Marsden Chelsea as good for responsive because:

- Patient flow from admissions, through theatres and onto to wards was satisfactory and bed availability was managed well.
- Theatre lists were co-ordinated to ensure minimal cancellation.
- The hospital was supportive to patients who needed extra care and had services in place to assist.
- Discharge was planned in advance and multidisciplinary involvement, allowed effective support for patients.

However;

- Wilson Ward was very cramped and lacked space for patient privacy.

## Service planning and delivery to meet the needs of local people

- The Royal Marsden Trust was part of the Vanguard New Care Models programme and worked closely with other hospitals and public health, primary care services, tertiary care and community care hospices. The aim was to improve cancer survival, quality and patient experience.
- To ensure theatre lists were fully populated, the theatre schedule lists for elective patients were managed two weeks in advance.

- The trust saw patients from all over the country. They had good communication channels with clinical commissioning groups to meet patient demand.

## Meeting people's individual needs

- Learning disability link nurses were available to provide support between clinical and ward areas.
- Patients with disabilities were able to request "buddies" to help them through their treatment. The 'buddies' provided one to one support and ensured patients had extra time at appointments.
- Patient passports were supplied to those individuals who had additional communication needs. The passport provided immediate and important information for staff on patient's requirements.
- We saw and heard patient's specific needs were discussed at staff handovers.
- Language translation posters were displayed in the private wards to accommodate overseas patients.
- An onsite Arabic advocacy service for Middle Eastern private patients was available. The advocates co-ordinated interpretation services, consultant appointment times and care plans. They were available weekdays 8am to 8pm and 10am to 4pm at weekends.
- Complimentary Arabic magazines and television service were available, and a 24 hour dedicated Iman was available upon request.
- Translation services were provided for other languages.
- Wheelchair access was available in theatres and wards and ramps and lifts were available for use.
- Hearing loops were supplied at all wards.
- Meal service, provided menus to meet patient's individual requirements, in terms of culture, religion, social and dietary needs.
- Colour zoning was used to assist patients in finding their way around wards. This was helpful to those patients who were hard of hearing and did not speak English.
- Staff told us the trust was developing dementia friendly wards. Patients living with dementia needs received one to one care.
- The trust had established staff training in the Health Education England, tier one dementia training. The purpose of the training was to provide better support for patients with dementia, by equipping staff with a better understanding, diagnosis, and identification of early symptoms.

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- Pre-assessment staff undertook dementia screening for patients over 75 years of age. The team comprised of two 'older persons champions'. This was in line with the government guidelines as part of the National Commissioning for Quality and Innovation (CQUIN).
- The team worked closely with family members and carers and identified extra support required when patients stayed at the hospital. A person that the patient was familiar with followed them for their surgical procedure, to help minimise confusion.
- The trust had implemented a dementia strategy, based on the SPACE five principles programme developed by The Royal College of Nursing. This was a strategy, based on the commitment to care of people with dementia in the hospital setting
- A red trays and napkins were provided at meal times, to identify, those patients that required special assistance.
- Patient's comments on food were mixed. "I've never been a big fan of the food here", and "the food is cold", while others said it was good and they were given a choice.
- An extensive choice of meal was provided to patients. Dietary, religious, cultural and social requirements were met.
- Patient's religious needs were respected. For example, women were allowed to wear burkas over theatre gowns until they entered the anaesthetic room.
- The Royal Marsden had a small number of rooms for patients and relatives at Dame Unity House in Chelsea. We were given examples of patients who had travelled from Gibraltar, allowed to use the accommodation.
- In Wiltshire Ward, we saw the designated room for bariatric patients, which included specially designed bathroom facilities to accommodate patients.
- Whilst the majority of the wards were spacious, Wilson Ward was the exception. There was no reception area and the access was very narrow. In the male section of the ward, there was a lack of privacy for the patients, as the main entrance directly faced a patient's bed. The Matron said discussions had taken place to address the problem but we did not see any formal plans for resolution.
- In pre-assessment, they had developed a project to improve patient flow, called pre-assessment, workflow and patient experience project. The aim was to improve the patient experience in pre-assessment. The trust developed short presentation videos, about the patients

operation and their time at the hospital. These videos were shown whilst the patient was waiting. They were in the process of developing new software to manage patient flow and avoid bottlenecks during the day.

- We found there was access to a range of information on the public trust website. Leaflets were readily available throughout the trust. For example, we saw leaflets on colonoscopy with in the endoscopy suite, information for patients having a general anaesthetic and surgery and information on preventing wound and chest infections after surgery. There was plenty of information for patients regarding availability of therapies. We saw diet and physical advice leaflets for patients, providing advice on how to access local exercise schemes.
- Solid tumour wards had flexible visiting times and relative rooms were available for patients and relatives to attend together for more privacy.

## Access and flow

- The flow within surgery services was managed well, with the help of enhanced care pathway plans.
- Theatre utilisation for the month of January 2016 Monday to Friday was 94.4%. Hours utilised were 1,019.6 and cancellation totalled 87 hours.
- The trust cancelled proportionally fewer surgical operations than the national average, fluctuating between 10 and 20 patients every three months. The majority of cancellations were due to patients becoming unwell pre-operatively.
- Cancellations due to lack of intensive care beds was 0.1% in the previous 18 months. This was due to effective weekly scheduling of all elective patients.
- Patient length of stay was higher than the England average. Recovery for patients was longer due to the nature of specialist complex surgery provided by the trust.
- The trust treated 82% of patients within 62 days. This is in line with the national average.
- Being a tertiary referral hospital, the trust often received late referrals from other trusts and GP's. The Royal Marsden had an agreement with Monitor regarding breach times. The trusts, along with other clinic commissioning groups, were working towards better communication channels to resolve the issue.
- Referral to Treatment (RTT) (percentage within 18 weeks) was lower than the England average of 90%, for the NHS England audit from September 2014 to January 2016, for urology at 85.2% and plastic surgery at 78.7%.

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- Theatre lists were managed two weeks in advance. Due to the complex nature of surgical cases, pre-operative checks were extensive and this allowed enough time for the checks to be completed.
- Discharge planning started at pre-assessment. High-level multidisciplinary involvement, together with enhanced care pathway plans allowed effective discharge. The patient's notes we viewed demonstrated this.
- We saw discharge arrangements, included the provision of equipment, social support and appointments arranged at other hospitals. Discharge arrangements, included the sharing of information with patient doctors and community nurses.
- The day surgery unit saw 15 to 20 patients a day. Admissions were staggered throughout the morning, which allowed time for patients social and travel requirements.
- Day surgery patients were contacted at home 24 hours after surgery, to ensure they were feeling well.
- By introducing the theatre utilisation group in November 2015, surgery services were able to improve the efficiency, utilisation and safety of the theatre lists. Staff facilitated the early identification of unused theatre sessions and these were offered to other clinical teams in a timely manner, enabling patients to have the necessary investigations prior to surgery.

## Learning from complaints and concerns

- Patients said they felt confident to speak to staff if they had an issue to raise. They knew who the matron or lead sister was.
- Clinical staff were aware of the complaints procedure and the reporting process. Staff said they did not receive many complaints.
- Burdett Coutts and Ellis Ward received one complaint each for the past year.
- The Royal Marsden had a Patient Advice and Learning Service (PALS) based at Chelsea, to resolve complaints or concerns.
- The Matron or lead sister would handle patient complaints, by offering a one to one appointment.
- Complaints were discussed in department meetings. A staff member took ownership of the complaint and completed all actions.

- Data provided pre-inspection, showed us an audit trail of complaints, actions taken and outcomes. The trust published complaints in their Integrated Governance Monitoring report, which was published every three months.
- In total, the trust received 13 NHS and one private care complaint, from October to December 2015.
- Staff gave us good examples of complaint handling and positive outcomes. Following a complaint from a patient, where blood was left in their hair after surgery, staff dealt with the matter positively. A written apology was given and a one to one meeting was arranged. In response to the complaint, patients were now supplied with theatre caps for surgery.

## Are adult solid tumours services well-led?

Good



Overall, we rated solid tumour services at The Royal Marsden Chelsea as good for well led because:

- There were clear defined strategies for solid tumours, and staff were able to demonstrate their understanding in practice.
- Leaders were visible and present, and staff were encouraged to participate in discussions to improve patient care.
- There was a strong focus on staff development and training.
- There were comprehensive and robust risk management programmes in place.
- A culture of continual improvement, research and development was embedded in the trust. Staff of all levels were encouraged to participate in finding ways of improving patient care.
- Staff felt valued, respected, and enjoyed working within solid tumours and clinical services.

## Vision and strategy for this service

- Staff across surgical services and wards, demonstrated they were aware of the trusts vision and strategy. They were able to tell us of the trusts five year plans and were aware of the 16 values, which were developed by staff.
- Information on the trusts vision was supplied, via the intranet, newsletters and staff meetings.

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- The Royal Marsden was part of the national vanguard, working together with other hospitals, commissioners, public health, primary care and other health bodies to improve cancer outcomes.
- The trust had a clear five-year surgical strategy to deal with capacity issues. They had a clear plan to develop their Sutton site and work with other partners, to utilise their space for surgical activity.
- The senior surgical team, we met during the inspection gave a clear indication of the vision of surgical services and the involvement they had in strategic decisions.

## Governance, risk management and quality measurement

- Clinical ward managers told us there were good governance arrangements in place. Staff were provided with regular reports on incidents, in their areas, survey results, complaints and staffing data.
- Senior surgical staff attended monthly surgical strategy meetings. We viewed minutes from these meetings. Topics covered, included theatre utilisation and key performance indicators (KPI's). Discussions from meetings were fed back to the chief surgeon and clinical nurse director.
- The surgical audit group (SAG) had monthly meetings. Minutes from the 24 November 2015 and 14 January 2106 meeting, showed that quality improvement models were discussed. For example we saw discussions regarding extubation strategies required for difficult airway cases and the support that was needed.
- The anaesthetist department had a clinical safety lead in post who was responsible for risk management.
- During our inspection, we visited two multidisciplinary meeting for urology and head and neck. Patient cases were discussed which involved risks and outcomes for improvements.
- Staff told us the Information Governance Monitoring Report, published every three months, was available to all staff. Numerous copies of the report were available throughout the trust, during our inspection.
- Risk registers were in place at ward level and trust level. We viewed the clinical and corporate risk registers and saw that actual and potential risks had been identified. During our inspection, surgery staff were able to identify the main risks and these collaborated with the trusts risk register.

- Staff knew how to report risks and escalate through their managers. In theatres, the clinical safety lead was responsible for managing risks.
- Prior to our inspection, we viewed quality improvement projects for operating theatres. Various projects for quality improvements were in place. For example, in November 2015, a project to improve medicine management, involved discussions on storage availability and compliancy requirements. During our inspection, we saw the new biometric medicine storage, in place, with the new key pad monitoring medicine fridges.
- Staff recognised that quality improvement was a function of their role. They told us they shared ideas for improvement with their leaders.

## Leadership of service

- Staff were able to identify their leaders locally and at board level. They told us they felt the presence of the executive team, who took part in regular walk arounds.
- The chief surgeon led the surgery services team. The anaesthetic team had lead anaesthetists to manage at ward level. There was a matron for theatres and clinical leads for scrub, anaesthetics and recovery. The nurse director met the matron and staff on a regular basis.
- Staff on the wards spoke highly of the divisional nurse director, saying they were approachable and supportive of their needs. They said there was an open door policy, which was available to staff and they found this very useful.
- Clinical staff spoke well of the Chief Executive. They said they felt inspired when they had attended one of their meetings.
- Ward managers were able to improve their leadership skills, through extensive courses offered through The Marsden learning school.

## Culture within the service

- Staff felt the hospital was open and transparent and managers shared concerns and asked for staff feedback.
- Many staff had worked at the trust for a long time, including the executive team.
- The learning culture within the trust was of a high standard. Staff were encouraged to develop and attend the Royal Marsden School, based at Chelsea. The majority of staff we spoke to had taken specialist courses and master degrees. Staff were given time to study and courses were fully funded by the trust.

# Adult solid tumours

- Several staff told us they felt proud to work for the “Marsden family”. They said their opinions were valued and taken on board. They said everyone was supportive of each other.
- The newer members of staff were able to tell us the opportunity to learn and study was of a much higher standard than that offered by other trusts.
- Staff at all levels said their direct leaders were approachable. Theatre staff were comfortable to discuss concerns with surgeons and nursing staff were able to speak of issues with their matron.
- Support staff, such as porters, housekeepers and cleaning staff said they were involved in discussions and could approach their managers with any concerns.
- During our inspection, we saw staff interacting with their leaders. Staff were comfortable with each other and friendly dialogue was exchanged, which created a relaxed atmosphere.
- The good reputation of the trust, afforded them to recruit high-level nurses and clinicians.
- In the surgery division, doctors in training told us they received good teaching and learning opportunities.

## Public engagement

- The trust worked closely with the Patient and Carer Advisory group, which was composed of patients and carers. The group worked with the trust on projects. For example, identifying a new restaurant area for patients.
- The trust published information in the form of leaflets. New leaflets produced included, information for people having a parotidectomy and the importance of getting out of bed regularly.
- The trust was involved in many conferences both national and internationally. Conferences were often held at their Chelsea site, with involvement from surgeons.
- As well as the Friends and Family test, the trust participated in the cancer experience survey.
- In March 2016, as part of Prostate Cancer awareness month, The Royal Marsden live tweeted a procedure to remove the prostate gland of a patient using the da Vinci Xi robot.

## Staff engagement

- The trust was above the national level on several responses for the 2015 NHS staff survey. For example, the percentage reporting good communication between senior managers and staff was 41.2% compared the national average of 35.4%.

- 77.5% of staff felt they were able to contribute towards improvements at work, compared to the national level of 73.2%.
- Staff attended Schwartz rounds, which were evidence-based forums, for staff to discuss all aspects of their work.
- The divisional nurse director, held drop in sessions for staff to discuss concerns. Staff told us they found these sessions very useful and good dialogue was exchanged.
- Staff were encouraged to participate in improvement projects.
- Ward agenda meetings were compiled by staff.
- Information sharing was proactive through, newsletters, e-mails, meetings and one to one meetings.

## Innovation, improvement and sustainability

- The anaesthetic service had developed a patient centred research programme focused on peri-operative critical care outcomes. Involvement came from clinical and academic groups, both from the NHS and internationally. Areas included, blood management, pre-operatively in critical care and injury associated with chemotherapy and surgery.
- For four years, The Royal Marsden had hosted the global conference on pre-operative medicine care of the cancer patient.
- In theatres, they used ‘faxitron’, an x-ray system for point of care specimen radiography, research and irradiation.
- The Royal Marsden was the only NHS trust in England, to use the latest version of the da Vinci Xi model robotic surgery.
- The trust supported a new robotic fellowship, allowing 30 multidisciplinary surgeons to train over a 10-year period. The dual console of the da Vinci Xi robot allowed trainee surgeons to participate in live surgery.
- In pre-assessment, they had developed external study days, for surgical pre-assessment. This involved the anaesthetic team, pharmacy, pre-assessment nurses and discharge team working together to share current best practices.
- The introduction of coloured caps in theatres, so staff roles were easily identified. For example, during the inspection we were given pink caps. Staff were able to identify us as visitors.
- The service had introduced the use of ‘surgimend’ mesh in breast reconstruction, which was also used by plastic colorectal and upper gastrointestinal surgeons.



# Adult solid tumours

- Quality improvement projects included the creation of oesophogogastric and urological videos to give patients and relatives an understanding of the process involved when undergoing major surgery.

# Outstanding practice and areas for improvement

## Outstanding practice

- 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.
- 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 staff were 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.
- 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 unit's 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 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 unit 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 provide tai chi, complementary therapies and meditation sessions to promote wellbeing and relaxation.

The rapid access and diagnosis service provided a one stop shop for patients with suspected cancer. Patients received their results quickly sometimes on the same day. Patients were very impressed with the speed and organisation of the service.

## Areas for improvement

### Action the hospital SHOULD take to improve

- Encourage junior doctor involvement at high level MDT meetings.
- Theatre staff should ensure de-briefing are recorded after surgical activity.
- The trust should ensure medicines are stored securely and in line with legal requirements.
- Regular checking processes of the resuscitation trolleys must ensure the drawers are locked to prevent unauthorised access to intravenous drugs and fluids.

- To meet national recommendations the Linear Accelerator replacement programme must be kept up to date.
- Ensure staff are conversant with the requirements of infection control procedures.
- Review strategies to enforce compliance with hand hygiene and infection control measures amongst clinical visitors to the critical care unit.
- Ensure staff understand security arrangements.
- Review the risk register for items that can be closed, and ensure the risk register identifies and mitigates risks related to EoLC.

# Outstanding practice and areas for improvement

- Ensure single-use disposables are managed for expiry dates.
- Develop a consistent approach across the trust for recording and logging cadaver storage temperatures.
- Ensure Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms always have dates by which they should be reviewed, and these are completed.
- Provide suitable quiet space on the wards for grieving relatives.
- Consider the introduction of formal bereavement support throughout the hospital.
- Appoint a non-executive lead for end of life care across the trust.
- The provider should review outpatient booking rules to ensure clinics are not overbooked to reduce the time patients wait to be seen.
- The provider should review the waiting area to provide additional space on busy clinic days.