

The Royal Marsden NHS Foundation Trust

The Royal Marsden - Sutton

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

Good 

Services for children and young people

Good 

End of life care

Good 

Outpatients and diagnostic imaging

Requires improvement 

Chemotherapy

Outstanding 

Radiotherapy

Outstanding 

Adult solid tumours

Good 

Haematology

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Marsden Hospital NHS Foundation Trust is split over two principal sites, in Chelsea and Sutton, and 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 Royal Marsden Sutton hospital has 106 patient beds.

Overall we rated this location as good. We rated both the radiotherapy and chemotherapy services as outstanding. This was because the radiotherapy service was a patient centered service; care was provided in line with national standards, with radiotherapy services participating in national and international research programmes. Within the chemotherapy service, patients were provided with individual care in a timely and appropriate manner. Staff provided patients with both internal and external opportunities to emotionally cope with both their condition and treatment. Staff often went out of their way to ensure patient care went beyond their remit as healthcare professionals.

We further rated the hospital as outstanding for the key question of caring. Staff across all professions and grades were observed to be compassionate and truly championed the practice of putting patients needs first and foremost.

Our key findings were as follows:

- There was an open and transparent approach to incident reporting. Staff were encouraged to report incidents and learning from incident investigations was largely embedded.
- The hospital had taken action to minimise risks to patients but had not implemented the World Health Organisation safety checklist in the outpatients department.
- Most staff followed infection prevention and control procedures to minimise the risks of patients acquiring infections. All the wards/clinical areas we visited were clean and well maintained.
- Medicines, including chemotherapy, in the majority of areas were managed safely with the support of pharmacists. The storage of controlled drugs in the outpatient department was improved during the inspection.
- Staff had access to all the equipment they needed to keep patients safe. Resuscitation equipment was checked daily.
- Patients who presented unwell to the hospital were always seen by a nurse or a doctor however the hospital did not have a dedicated acute oncology service.
- Staff were aware of the safeguarding procedures including action to take to protect children and adults but not all staff had completed the required training.
- There were sufficient nursing and medical staff to provide safe care for patients.
- Space in the outpatients department was limited and insufficient to cope with the increasing number of patient. On some occasions staff found it difficult to find an area to care for unwell patients.
- Staff had ready access to and followed protocols and guidelines driven by national guidelines and best practice.
- Departments, such as radiotherapy, were involved in the development of best practice guidance for paediatric radiotherapy.
- The hospital participated in national and local research. The quality of care was monitored through a programme of audits.

Summary of findings

- There was a good culture of multidisciplinary team working involving a full range of health and social care professional and underpinned care and treatment.
- Patients had their pain regularly assessed and managed effectively.
- A full range of food and drinks were available to meet the differing needs and preferences of patients. Dieticians and speech and language therapists were available to provide advice and nutritional support.
- Patients were cared for by highly competent staff who were encouraged and supported to continue with their professional development.
- Documentation of consent was good. Children were involved in giving consent when they were at an age to have a sufficient level of understanding
- Patients and carers were overwhelmingly positive about the care they received from staff. Our observations indicated a caring and compassionate approach in the delivery of care.
- Patients told us they were treated with dignity and respect and involved in decisions about their care and treatment. Staff worked creatively to engage children through the use of play sessions.
- Staff valued patients as individuals and we were told of examples where staff had gone beyond expectations to provide individual care.
- Services were designed to provide emotional support to patients and carers with had access to counselling and spiritual support.
- Services were planned to meet the needs to local people and there were processes for patients to access care for non-cancer related health problems in other hospitals.
- Patients were treated in a timely manner and largely within national access standards, however some patients were not referred to the end of life care team in a timely manner.
- Services were designed to meet the individual needs of patients including support for patients who had dementia or a learning disability.
- Information leaflets were available in English and in other languages on request. “Easy read” copies of the trust’s information leaflets were available.
- Overnight facilities were available for parents in services for children and young people.
- The hospital received few complaints and tried to resolve problem before they escalated to a formal complaint.
- Many of the clinical services were well led with good governance and risk management processes to monitor and evaluate care and report performance back to staff and to the trust board.
- Staff were proud to work at the hospital and we saw the trust’s values reflected in their work.
- Leadership was visible and supportive with effective working relationships between managers and clinicians.
- The culture of the hospital was centred on the needs of patients and promoted the delivery of high quality, person-centred care.
- There was good engagement with staff who felt valued and their work was appreciated. Although staff in the outpatients department felt their service was less of a priority than other services

We saw several areas of outstanding practice including:

Summary of findings

- Hospital staff from all professional backgrounds provided care, therapy and treatment that reflected the most recent evidence from international and national research findings, and from local audits and pilot studies.
- There were exceptional opportunities for staff development, which contributed to a highly skilled and competent workforce.
- Nursing and therapy staff had the commitment and time to provide person-centred care that often went the 'extra mile'
- The introduction of ambulatory care had managed to reduce patient bed stays and improve patient experience.
- In radiotherapy the development of best practice through constant innovation and change of practices and the way in which these were shared nationally with other departments.
- Management of the paediatric patient pathway with consideration to the needs of children through the traumatic radiotherapy pathway. This included the interactions with staff, the play sessions before radiotherapy and the way in which they were engaged throughout the process.
- The contribution made by the radiotherapy physics team to engage with school children to pursue a career in medical physics and the recognition of the department as a result of its contribution with the annual schools science conference.
- The children and young people's service sent families flowers on the first anniversary of a child's death and sent families cards for five years after a child's death.
- A youth support worker provided activities, games and other media to engage and occupy young people while in hospital.
- The process for both site specific and technique multidisciplinary meetings across both the Chelsea and Sutton sites linked through the use of technology and a shared understanding of the process by all parties.
- The accreditation the radiotherapy department has received from ISO 9001/ 2008, IPREM, HEE, and the academy of healthcare sciences for training.
- The plethora of research and publications released having an impact on both national and international practice including the development of the Heartspare for breast radiotherapy (which has been rolled out nationally).
- The trust had the largest paediatric inpatient drug development programme in the UK. The programme was set up with the objective of improving survival rates for children and young people with cancer.
- The rapid access and diagnosis service provided a one stop shop for patients with suspected cancer .
- The use of patient information prescriptions which provided patients with information about their condition, using sources approved by the Department of Health.

Importantly, the trust must:

- Implement and embed surgical safety checklists in the outpatients department

In addition the trust should:

- Continue with their redevelopment plans for the outpatient department.
- Provide an acute oncology service in line with best practice guidance.
- Ensure that extravasation and cytotoxic spillage kits in all clinical areas are checked in accordance with trust policy.
- The hospital should improve the compliance with the high dusting audit and ensure that process are in place for all clinical areas to be cleaned appropriately.

Summary of findings

- Ensure that staff always follow effective hand hygiene practice including the use of alcohol gel when caring for patients.
- Ensure systems for controlling access to medicines in the outpatient department are secure at all times.
- Take steps to ensure clinics are not overbooked and there is sufficient medical staff available to reduce the time patients wait to be seen in clinic.
- Reduce delays in referring patients, where appropriate, to the end of life care service
- Develop a consistent approach across the trust for recording and logging cadaver storage temperatures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Services for children and young people

Rating

Good



Why have we given this rating?

We rated services for children and young people Royal Marsden Hospital Sutton as overall good overall because:

- Children, young people and their families were unanimously positive about the care they received.
- Sensitive emotional support was provided to children, young people and their families.
- There was a children's psychology care service and bereaved families were offered a post bereavement meeting to discuss their child's care and treatment and ask any questions.
- There were enough nurses and doctors with the right skills and knowledgeable and experience to care for children and young people.
- There was an effective system for learning and reporting from incidents. The majority of incidents reported between February 2015 and February 2016 were graded as either low harm or no harm.
- The service had reported no serious incidents during the preceding twelve months leading up to the inspection. There was robust evidence that where such incidents had previously been reported, actions had been taken to mitigate the risk of such incidents being repeated.
- All of the areas we visited were clean and spacious and entrances were secure.
- Although the service did not have a paediatric intensive care unit, children or young people who required intensive care were transferred to St George's University Hospitals Foundation Trust without compromising safety.
- The service used the Paediatric Early Warning Score (PEWS) to monitor children and the

Summary of findings

National Early Warning Score (NEWS) whose condition changed or deteriorated. Staff we spoke with were aware of the action to take should a child or young person's condition deteriorate and this was supported in the patient notes we reviewed.

- A specialist telephone helpline was available for 24 hours seven days a week for children and young people and health care staff who were looking after them once they had been discharged. Call details and actions taken were recorded on the patients' electronic patient record. This process was audited on an annual basis to ensure that information was recorded and actioned appropriately and that appropriate communication between relevant persons had taken place.
- Care and treatment was provided in line with best practice and by a multidisciplinary team involving nurses, doctors, therapists, social workers and an activities coordinator. Staff told us “we work as part of a team”.
- There were some audits but information about outcomes was limited.
- Pain was monitored using age specific tools and a range of options for controlling pain were available including analgesia, physiotherapy and relaxation therapy.
- A dietician supported children and young people to maintain a healthy diet before, during and after treatment.
- Children had access to play areas and toys and books and for young people there were separate social areas where they could to play pool, watch TV, make a snack or play games.
- For children or young people with a learning disability a needs assessment was carried out and staff worked closely with their families. Their care was reviewed at a weekly meeting along with plans to support them in the longer term.

Summary of findings

- There was a clear vision and set of values which staff were aware of.
- There was a strong clinical governance structure with mechanisms for reporting upwards and providing feedback to staff. Risks were reviewed and managed effectively.
- Staff spoke positively about the local management team, they were visible and supportive along with the trust executive were visible. Support was available to help staff cope with the emotional challenges of the work.
- Children and young people and their families were involved in developing the service through a range of consultations. Staff felt valued by the hospital and were passionate about caring for children and young people.
- Staff described the hospital as a “learning organisation” which saw incidents and complaints as a way to improve the service. Staff felt valued by the hospital and were passionate about caring for children and young people.
- Staff spoke positively about their managers and the senior team. They felt they were visible and approachable and staff were proud to work at the hospital.

However:

- The Royal Marsden CYP service shared care with multiple POSCUs, posing a challenge to information sharing and governance. The configuration of services and their governance across the network should be reviewed.

End of life care

Good



We rated the end of life care (EoLC) services at The Royal Marsden Hospital Sutton as ‘good’ overall because:

- The specialist palliative care team (SPCT) were highly skilled and knowledgeable to meet the needs of patients and work cohesively with ward staff.

Summary of findings

- They provided a seven day 24 hour service and demonstrated a multidisciplinary approach to delivering patient care.
- There was an open and transparent approach to reporting and learning from incidents and staff were aware of safeguarding procedures and how to recognise if someone was at risk or had experience abuse. The SPCT provided training and education to other staff in the hospital including junior doctors, nurses and porters.
- Care and treatment was delivered in line with best practice such as NHS guidance Priorities for the Care of the Dying Person and One Chance to get it Right – developed by the Leadership Alliance for the Care of Dying People (LACDP). It also referred to the NICE quality standards for end of life care.
- The SPCT worked closely with the acute pain service and many patients we spoke with said their pain was well controlled.
- The majority of 'Do not attempt cardiopulmonary resuscitation' forms we reviewed had been completed in full.
- We saw patients were treated with dignity and respect and all staff provided compassionate care. Patients and their families were involved in discussions and decisions about their care and treatment.
- Facilities were available for relatives to stay overnight, either on fold-out cots by the patient's bed or in specific accommodation.
- Patients had access to emotional support from two registered mental health nurses and a consultant psychiatrist, although due to increasing demand patients sometimes had to wait up to six weeks for this support.
- A new clinical leadership model had recently been introduced to strengthen the leadership and improve accountability for quality and reporting to and from the trust board. Senior staff were positive about the changes as they felt it would improve access to therapies and psychological support for patients.

Summary of findings

- The trust had an end of life care strategy supported by an action plan and key milestones.
- Many staff had worked at the hospital for a number of years and told us there was a flattened hierarch and an open culture in which everyone's opinion was considered.
- Staff engagement was good with quarterly forums where staff could share their experiences with colleagues.

However;

- For some patients there was a delay in referral to the service. 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.
- Body store fridge checks were not retained, and there was a lack of consistent approach across the trust sites for this.
- There was a lack of quiet or private space on some wards for grieving relatives.

Outpatients and diagnostic imaging

Requires improvement



We rated the outpatient and diagnostic imaging service at The Royal Marsden Hospital Sutton as requires improvement overall because:

- Surgical procedures were being carried out in the OPD however staff were not using the WHO safety checklist.
- There was no acute oncology service. Although there were areas to care for patients who presented or who became unwell they were also used for clinical procedures. This meant that staff sometimes had difficulty finding an area to care for unwell patients and had to care for them in clinic rooms until an inpatient bed could be found or the patient was transferred to another hospital.

Summary of findings

- Systems for controlling access to medicines in the OPD 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.
- The trust was aware of the capacity problems in the OPD but had only recently taken started to take action to address them. Plans included a new outpatient department within the Centre for Clinical Care and Research.
- A transformation project had been established to improve performance and patient experience but was still in the early stages.

However:

- Staff in both the outpatient and diagnostics imaging service were caring and involved patients and their carers in discussions about their care and treatment.
 - At the time of the inspection the OPD had experienced a high vacancy rate but temporary staff were used to fill the vacancies.
 - There were adequate levels, with relevant skills and experience, of radiography staff and a recent recruitment drive had been successful in recruiting more staff.
 - Staff in OPD and diagnostics and imaging had access to, and used, evidence based guidance.
 - Clinics were organised so that patients could access services together for example breast and plastic surgery clinics were organised on the same day.
 - Diagnostics and imaging provided a rapid diagnostic service for breast, skin and urology cancers.
 - The trust was aware of the capacity problems in the OPD but had only recently taken started to take action to address them. Plans included a new outpatient department within the Centre for Clinical Care and Research.
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Summary of findings

- A transformation project had been established to improve performance and patient experience but was still in the early stages.

Chemotherapy

Outstanding



We rated the chemotherapy service at the Royal Marsden Hospital Sutton as outstanding overall because:

- Patients were provided with individual care in a timely and appropriate manner. Staff provided patients with both internal and external opportunities to emotionally cope with both their condition and treatment. Staff often went out of their way to ensure patient care went beyond their remit as healthcare professionals.
- There were processes in place for reporting of incidents and staff could clearly outline the reporting system used by the trust. Staff reported incidents and the trust ensured there was a system in place to learn from incidents and improve practice including regular meetings for staff.
- There was an open culture of incident reporting and learning from these incidents was disseminated to all staff through regular meetings. We found that staff felt confident about being candid with patients.
- We found that the measures used by the chemotherapy service for preventing and controlling infection met national guidance.
- There was a bespoke chemotherapy prescribing system and specialist pharmacists. The service took part in national and local audit programmes and there were procedures in place to ensure that the correct medicines were provided in the correct location.
- Staff were aware of the escalation policies around safeguarding concerns, mental capacity act and deprivation of liberties. Deteriorating patients received a speedy response.

Summary of findings

- Patient treatment plans were decided in effective multidisciplinary meetings. Patients told us that they had their pain managed and this followed national guidelines.
- The service supported staff with access to training and supervision for competencies. There was a programme of staff led audits regarding clinical practice.
- Dietitians were on hand to provide regular support to patients. Nurses and housekeepers offered patients food and fluids regularly.
- The trust's performance in the FFT was consistently higher than the England average. Patients told us that they felt very involved in the decisions regarding their care and treatment. Patients were assessed holistically and psychological support was available on request.
- The service was responsive to the needs of people using it. The trust understood their limitations regarding not having a critical care unit on site. To lessen the risk there were processes in place to ensure that patients requiring emergency care had access as soon as possible. The service proactively managed discharges.
- Patients were provided with written up information concerning their treatment plans and had access to a key worker. There was a minimal amount of complaints. The Patient Advice and Liaison Service (PALS) investigated and fed-back learning to the staff dealt with formal complaints effectively.
- Staff were aware of the vision and strategy for the chemotherapy service. Quarterly governance reports were published and available to staff on the ward. Staff could name members of the executive team and felt there was a friendly and approachable governance structure. The culture of the service was one of openness and staff felt supported by their teams and team leaders.
- Generally staff were very proud to work at the trust and within the chemotherapy division.

Summary of findings

Radiotherapy

Outstanding



We rated the radiotherapy service at The Royal Marsden Hospital Sutton as overall outstanding because;

- There was a clear culture of providing safe care and incident report and learning from incidents was embedded in the service.
- Staff were aware of safeguarding procedures for both adults and children.
- There were enough radiographers, physics and engineering and medical staff to provide a safe service.
- Many staff were up to date with all aspects of mandatory training.
- Equipment was checked and maintained and there was a replacement programme for equipment.
- Care and treatment was delivered in line with national guidance and best practice and the service led nationally on the development of best practice guidance particularly in paediatric radiotherapy.
- The service provided a range of treatments including stereotactic body radiation therapy (SBRT), which is a highly focused radiation treatment that gives an intense dose of radiation concentrated on a tumour, while limiting the dose to the surrounding organs.
- Intensity modulated radiotherapy (IMRT) is known to provide better outcomes and the percentage of IMRT delivered by the service was significantly higher than other services.
- Staff were supported to develop their knowledge and skill and all staff has either had an appraisal or had one booked. There was good multidisciplinary working involving a range of staff.
- Patients and families were overwhelmingly positive about the service. They told us staff were compassionate and gave examples of where they had gone the “extra mile”.
- Staff treated patients as individuals and recognised the importance of building a relationship with them. Patients were involved in decisions about their treatment and given information about the risks and benefits of treatment.

Summary of findings

- To help children become familiar with the processes involved in radiation and had several play sessions before their treatment started. Play specialists and their parents were involved in helping children become accustomed to the environment.
- The service was responsive to the individual needs of patients and patients received their treatments within national targets.
- The service had dementia champions and was directly involved in the development of the trust's dementia strategy and the trust's dementia board.
- Following an audit of the suitability of the radiotherapy department signage had been improved along with more clocks to help patients orientate themselves.
- There were separate waiting areas for children and adults and the service recognised that young people needed their own area and had secured funding to develop a waiting area for young people.
- The leadership of the service was outstanding. There was an innovative strategy which staff were aware of. Staff could describe the trust values and we saw evidence of them translated into practice.

Adult solid tumours

Good



We rated adult solid tumours service at The Royal Marsden Hospital, Sutton as good because:

- The service had trained staff and taken action to minimise risks to patients. Staff were aware of the incident reporting procedures and told us learning from incidents was shared with them.
- There were sufficient staff, with appropriate skills and expertise, in post to care for patients. Clinical areas were clean and tidy and staff adhered to infection prevention and control procedures.
- Medicines and controlled drugs were managed in line with best practice and controlled drugs were stored in locked cupboards on the wards.

Summary of findings

- Care and treatment was informed by evidence based practice and staff contributed to national and international research and the trust performed well in national audits.
- Patients received prompt and effective pain relief and staff had access to the consultant led acute and chronic pain support team.
- Patients were very positive about the way staff cared for them and we observed positive and responsive interactions. The focus was on the individual needs of patients and staff often went the “extra mile” to meet them.
- The trust scored well on the Cancer Patient Experience Survey, being in the top 20% for many statements.
- The hospital worked well with commissioners and other local NHS trusts to plan and provide care for patients.
- Referral to treatment times were the same or better than the England average.
- Additional staff could be deployed to support patients with a learning disability or who were living with dementia.
- The leadership of the service was good with a strong emphasis on learning, involving staff and patients and improving the quality and safety of care.
- Staff told us they were treated equally regardless of their gender or ethnicity and were proud to work for the trust.
- There had been an improvement in the training and support for junior doctors.
- Formal service level agreements were in place for some services e.g. cardiology and others were being reviewed with providing hospitals.

However:

- There was limited contribution from non-consultant staff to multidisciplinary review of patients’ needs in some specialties.

Haematology

Good



We rated the haematology service at The Royal Marsden Hospital, Sutton as good because:

Summary of findings

- Ambulatory care proved to be a valuable innovation both in terms of enabling patients to benefit from more time at home and reducing hospital costs.
- Staff were enthusiastic to work at the trust and within their division. There was a culture of openness and staff said their managers supported them. The vision of the service was embedded into practice on the unit.
- The environment was clean and staff complied with infection prevention and control procedures.
- There were clear arrangements for responding to whose condition deteriorated including if they developed sepsis.
- Staff were aware of the signs of potential and actual abuse and knew what action to take.
- There were sufficient staff with the right skills and expertise to care for patients.
- Staff used national and local guidance to care for patients and the transplant unit had been accredited by the Joint Accreditation Committee of the International Society for Cellular Therapy (JACIE).
- Weekly multidisciplinary meetings took place to review patients care and treatment.
- Patients told us the food was good and where needed support was given with eating.
- Patients received appropriate pain relief and staff through a range of methods and analgesia and they also had access to psychological support.
- There was good multidisciplinary team working with all staff contributing at multidisciplinary team meetings.
- We observed staff treating patients with kindness and compassion and care was individualised with patients saying they felt “at home” on the ward.
- Patients’ care was coordinated with care for non-cancer conditions provided at other hospitals.

Summary of findings

- The ambulatory inpatient care (AMBIN) service for transplant patients enabled patients to be cared for at home with frequent visits to the unit for review.
- All patients were allocated a key worker who acted as the point of contact for patients and answer any questions they had.
- Patients with a specific need, such as a learning disability had their care tailored to meet their needs. Patients at risk of falling were provided with non-slip socks and an interpreter service was available for patients for whom English was not their first language.
- The service received very few complaints
- Quality and safety meetings took place and the risk registers were up to date.
- Staff described the culture as “open” and said their managers and senior managers within the trust were visible and approachable.

However;

- Space on the wards was limited and there was no relative’s room on the haemto-oncology unit.
 - Junior doctors had limited time to attend training due to their workload.
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The Royal Marsden - Sutton

Detailed findings

Services we looked at

Adult solid tumours; Haematology; Chemotherapy; Radiotherapy; Services for Children and Young People; End of life care; Outpatients & Diagnostic Imaging

Detailed findings

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Background to The Royal Marsden - Sutton

The Royal Marsden Sutton Hospital is one of two locations, which make up the Royal Marsden NHS Foundation Trust. It is located within Sutton in south west London, approximately five miles from central London. There are 106 general and acute beds at Royal Marsden Hospital Sutton.

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 Sutton location we reviewed seven core service areas, as follows:

- Adult solid tumours
- HBMT
- Chemotherapy
- Radiotherapy
- Services for children and young people
- 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.

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?

Detailed findings

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 6 May 2016.

During our inspection we spoke with 68 patients and relatives/friends, who provided feedback on their experiences of using the hospital services. We looked at patient records where it was necessary to support information provided to us.

Whilst on site we interviewed more than 160 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 - Sutton

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

The hospital provides a full range of diagnostic and treatment services, including surgery, services for children and young people, chemotherapy, radiotherapy, HBMT, End of life care and outpatients and diagnostics. The hospital did not have an acute oncology service.

The London Borough of Sutton is in south west London and forms part of outer London. It has a population of 191,123. The proportion of both younger people aged 0-19 years and those aged 35-44 years is higher in Sutton compared to the national profile, while the birth rate and

the population of young children (0-4 year olds) is lower compared to London or England. In 2011 79% of people living in Sutton were of white ethnicity. This is lower than England (85%) and higher than London (60%).

Deprivation: At borough level Sutton ranks 196 out of 326 boroughs (where 1 is the most deprived and 326 is the least deprived).

The health of people in Sutton is generally better than the England average. It has some of the lowest avoidable mortality rates (people dying before the age of 75 years) compared to London and England. Cancer remains the biggest single cause of death in those under 75 year olds,

Detailed findings

and the proportion of cancer deaths has increased over the last five years. Over the same time, the proportion of deaths from circulatory disease reduced and there was a small decrease in deaths from respiratory conditions.

Activity

The hospital has 106 inpatient beds including two level 2 critical care beds and 31 paediatric beds and 83 day case beds. The hospital employs 152 (FTE) staff. Between 2014 and 2015 the trust had 9,842 inpatient admissions and 190, 117 outpatient attendances.

Key intelligence indicators

Most of the following information was produced at trust level only.

Safety

- Between January 2015 and February 2016 25 serious incidents were reported by the trust. Of these 20 were related to pressure ulcers.
- For the same period 3,454 incidents were reported to NRLS which is higher than the England average. Of these only one caused severe harm or death to the patient.
- There were 42 cases of C. Diff reported in the trust in 2015.
- In 2015 25 pressure ulcers, 11 falls with harm and six catheter urinary tract infections were reported

Effective

- In the 2015 Bowel Cancer Audit the trust performed better than London Cancer Alliance and England average for data completeness and readmission rates, but has a higher mortality rate.
- In the 2015 Prostate Cancer Audit the trust performed better than England average for most screening completion rates.
- The trust performed better than the England average in eight out of ten measures on the UK Radiotherapy Equipment Survey 2013.

Caring

- Family and friends test scores for the trust were greater than or similar to the England average for January – December 2015. The scores ranged from 95 – 95.5%.

- In the 2013/14 cancer patient survey the trust score was in the top 20% of trusts for 9 of indicators (bottom 20% for four indicators and in the middle 60% for remaining questions).
- The hospital scored better than the England average for three of the four domains in the Patient led Assessment of the Care Environment (PLACE). It scored just below the England average for privacy and dignity and well being.
- From the 2015 CQC inpatient survey the trust scored better than other trusts for all of the questions.

Responsive

- The trust received 118 complaints in 2015.
- The bed occupancy has been below the national average since quarter 2 2014/15.
- From February 2015 – January 2016 referral to treatment times have been above the national average for outpatients receiving consultant led treatment.
- Between September 2015 – December 2015 98.3% of patients with suspected breast cancer were seen in two weeks by a specialist following referral by their GP. The figures for blood malignancies including leukaemia were 100%, 93% for head and neck cancer, 100% for upper gastrointestinal, 93% for sarcoma, 96% for urological cancers (not including testicular).

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%
- From June 2012 – September 2015 the trust sickness absence rates have been consistently lower than the national average.
- 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.

Detailed findings







Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

Services for children and young people

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

Information about the service

Children and young people's (CYP) services are provided by Royal Marsden NHS Foundation Trust. The service is in the trust's cancer division. The Royal Marsden Hospital (RMH) treats all types of childhood cancer in the 31 bed Oak Centre for Children and Young People in Sutton, a modern, purpose-built facility that is one of the largest comprehensive children's cancer centres in Europe. The Oak Centre sees almost 600 inpatients and more than 5,000 day patients every year. There are also two critical care beds for children and young people at the RMH site in Chelsea.

The clinical service is provided by a multidisciplinary team of paediatric oncologists with on-site access to radiotherapy, diagnostic imaging and pathology; as well as specialist cancer and paediatric nursing, therapies including physiotherapy, and pharmacy expertise. Children requiring intensive care would be transferred by the South Thames Retrieval Service (STRS) to St George's Hospital (SGH) paediatric intensive care unit (PICU).

The trust is part of the South Thames paediatric oncology Joint Principal Treatment Centre and provides this service in partnership with St Georges Hospital. It is also the South Thames Principal Treatment Centre for Teenage and Young Adult Cancer - this service is provided across both sites of the trust across. The service links with 16 paediatric oncology shared care units (POSCUs) in a network model to provide care to children in South London, Kent, Surrey and Sussex. The current commissioning arrangements and framework for the provision of children's cancer services had been in place since 2011. The trust currently linked

with some 16 paediatric oncology shared care units (POSCU) across South London, Kent, Surrey and Sussex. As part of this inspection we have not visited the various POSCU's, but have carefully considered the governance arrangements and model of care associated with the children's cancer services across the region.

- McElwain Ward is an 18-bed unit, providing inpatient facilities for children aged 1 to 16 years old.
- The Teenage Cancer Trust Unit (TCTU) is a nine bed inpatient ward, offering purpose-built facilities for teenagers and young adults with cancer aged 16 to 24 years old.
- The Outpatient and Day Care Unit has 22 beds/chairs for patients requiring day case admissions and outpatient clinics.

We visited children and young people's (CYP) services on 19 to 22 April 2016. We talked with 20 children, young people, parents and carers. We spoke with three managers and over 20 staff. We observed how people were being cared for in day clinics and as inpatients; and reviewed care or treatment records of 12 children and young people who used services.

Services for children and young people

Summary of findings

We judged children and young people's (CYP) services were good because:

- We found there were arrangements to ensure children and young people were protected from abuse and avoidable harm, and there were systems to report, investigate and learn from safety incidents and near-misses.
- We found care and treatment was based on current guidance and best practice and there were arrangements to monitor the standards of care. Children, young people and their families told us they were treated with kindness and empathy and their dignity was upheld. CYP services were arranged to respond to children and young people's individual needs and could be accessed when they were required.
- People were truly respected and valued as individuals and were empowered as partners in their care. Feedback from children, young people and their families was continually positive about the way staff treated people. People thought staff went the extra mile and received care that exceeded their expectations. There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity
- We found that services were well-led, and there was a positive culture across CYP services. There was a clear vision; set of values; and a strategy which staff were engaged in and identified with.
- There were robust governance systems that ensured information flowed freely between the various levels of management, including the executive team and front-line staff.
- There were high levels of staff satisfaction across all staff groups. Staff were proud of the organisation as a place to work and spoke highly of the culture.
- There was also an established programme of research, and drug development, and there was a clear proactive approach to seeking out and embedding new and more sustainable models of care.

However we found:

- Staffing was a challenge due to children and young people's services being under resourced and dependent upon the goodwill of staff.
- Some staff told us information sharing between Royal Marsden children and young people's services and POSCUs was a challenge due to different information technology systems being used across the network.

Services for children and young people

Are services for children and young people safe?

Good



We rated the service as good for safe. This was because:

- There were good methods of reporting, investigating and learning from incidents, which were well understood by staff we spoke with, and were embedded in their daily work. There were plans to deal with a major incident or events that would disrupt the delivery of care.
- We saw there were processes and systems that protected patients from the risk of infection, and the risks associated with equipment used in their care and treatment. There were safe systems of medicines' management
- There were adequate numbers of suitably qualified, skilled and experienced staff to meet children and young people's needs; and we noted staff completed their mandatory training. Safeguarding children and young people was given sufficient priority.
- Records were found to be accurate, comprehensive and current and they supported the delivery of safe care.

Incidents

- The CYP service used service dashboards to monitor harm free care. We viewed the dashboard performance report from April 2015 to March 2016. This benchmarked the service performance against the trust's health care targets. We saw that in most instances the service was exceeding the trust's targets in regards to clinical quality and safety. The scorecard indicated the number of incidents reported had exceeded the children and young people's service target of 157, with 171 incidents being reported in the period. It is important to note that this higher than expected number of incidents should not be considered negatively; the number of incidents reported would suggest that there exists an open and transparent culture amongst staff in regards to incident reporting and should be considered as a positive finding.

- The majority (96%) of incidents were classified as either low or no harm. The service had not experienced any incidents which met the threshold for reporting as a serious incident during the time period of January - December 2015.
- The children and young people's service used an incident reporting system widely used in the NHS. We found incidents were consistently reported across teams; and staff used the reporting system appropriately.
- We saw records were kept regarding all safety incidents and near misses reported in CYP services. These included details of the incident and how and why it occurred. We saw that actions to mitigate against recurrence had been formulated and noted these were appropriate to the incident described.
- The strategic executive information system, (STEIS). Incidents were monitored by the matron and children's lead nurse for trends.
- Incidents were reported using an electronic reporting system which also provided reports for managers on reporting activity and incidents. All staff we spoke with were aware of the system and told us they were confident in its use. Staff indicated they felt empowered to report any type of safety incident or near miss that might affect patient safety.
- Staff told us they understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns. Staff confirmed they received feedback on incidents that took place in other areas of the service as well as their own. Staff and managers told us they were satisfied there was a culture of reporting incidents promptly within community services.
- We saw the notes of team meetings and safety huddles which demonstrated incidents were analysed, lessons were learned and practice or process changes were discussed with and communicated to staff. Staff we spoke with told us that the discussion and consideration of safety events was frequently part of their routine
- A standard agenda was used for staff team meetings and learning from incidents was discussed and shared with staff at those meetings.
- Incidents were standard agenda items at monthly 'Royal Marsden and St George's Hospitals clinical governance meetings.' These were monthly meetings attended by a staff representative from each CYP service area as well

Services for children and young people

as RMH staff working at St George's Hospital (SGH). The minutes of these meetings showed incidents were discussed at the meetings. Where incidents had been reported a full investigation had been carried out and steps were taken to ensure lessons were learnt. Action plans were produced following investigations. These were monitored and tracked to completion at subsequent meetings.

- Safety alerts were sent to clinical leads by email. The alerts were reviewed by the clinical leads for their relevance and shared with staff by email or discussed at team meetings. Safety alerts were available to staff in team folders on the trust's shared computer drive.
- There is a statutory duty of candour (DoC) imposed on all providers of services to 'provide to the service user and any other relevant person all necessary support and all relevant information' in the event that a 'reportable patient safety incident' occurred. Staff and managers we spoke with were aware of and able to explain the 'duty of candour'. We viewed staff training records and saw that 88% of nursing staff and 100% of HCA's had up to date training in the duty of candour. We did not see any examples of the service having used the DoC. The matron told us, "It's about being open and honest and offering a sincere apology." The Trust also had a DoC panel that reviewed DoC incidents which parents would be invited to attend.
- A serious incident in April 2011 relating to shared care between the Royal Marsden and other hospitals in the South Thames Network had led to a coroners' report. The trust demonstrated it had learnt from the incident and action had been taken to mitigate the risk of such incidents being repeated
- Staff told us they did not hear about low level incidents from paediatric oncology shared care units (POSCUs). However, in the event of a moderate incident at a POSCU the consultant would telephone the Royal Marsden Hospital consultant to inform and discuss. Staff reported that if there was a serious incident in a POSCU, representatives from Royal Marsden Hospital would attend the hospital and be involved in the incidents analysis. Further, learning from incidents formed part of the annual POSCU update programme facilitated by the Royal Marsden. It was acknowledged by the leadership team that further improvements in incident reporting would be useful in order that wider service improvements could be made across the network. Following our inspection the service told us a

reduction in the number of POSCUs would improve the flow of information from POSCUs into the PTC. The executive team reported that regular engagement meetings which included quality as an area of topic, facilitated by commissioners of services had ceased and so there had been limited insight in to the quality of care provided by third party providers.

Safety Thermometer

- Royal Marsden Hospital's (RMH) children and young people's (CYP) services had a good level of safety performance over time. The service participated in the National Safety Thermometer programme; this is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. We saw that Safety Thermometer monthly results were prominently displayed in all the wards we visited.
- Safety Thermometer data submitted by the trust, covering the period from February 2015 to April 2016, showed there had been no harm in regards to the children and young people's safety thermometer reported in the period.

Cleanliness, infection control and hygiene

- Overall we found the CYP services were compliant with the "Code of Practice on the prevention and control of infections and related guidance" issued by the Department of Health in 2010.
- The trust was found to score about the same as other trusts, 92%, in question 26 of the children and young people survey 2014, "how clean do you think the hospital ward was."
- Mandatory training records dated April 2016 showed that 88% of nursing staff and 100% of health care assistants working on McElwain Ward and the TCTU had completed mandatory Infection Prevention and Control (IPC) training. This was either close to or above the trust target of 90%. Staff told us they also had 'antimicrobial awareness days', (antimicrobials are agents that kill microorganisms), to supplement mandatory training in IPC.
- There had been no reported cases of meticillin-resistant staphylococcus aureus (MRSA), or clostridium difficile (C. diff) in the previous 12 months.
- We saw the facilities where patients were treated were visibly clean and hygienic. We saw cleaning schedules which clearly set out how and when premises and their equipment should be cleaned.

Services for children and young people

- We observed contracted cleaners from the trust's private cleaning provider were carrying out cleaning activities across all wards and departments.
- Infection control checks of clinical areas against The Hygiene Code were carried out weekly by the ward sisters with a validation check monthly by the matrons. We saw monthly audit results for McElwain Ward and the TCTU were displayed on patient facing dashboards on the wards. We viewed the results for April to May 2015 these demonstrated the cleaning standards were monitored to ensure they met national specifications.
- We observed the clinic environments had supplies of personal protective equipment (PPE) which staff used appropriately.
- We observed adequate hand-washing facilities and supplies of hand sanitizer for staff and the public to use. We saw hand hygiene compliance was audited on a monthly basis. We reviewed the results on the ward for April to May 2016, these did not raise any concerns. The results from hand hygiene audits were displayed on all wards and departments.
- The importance of all visitors cleaning their hands was publicised. At the time of our visit, children's and young people's services were achieving compliance standards of 100% for hand hygiene, with the exception of November and December 2015 when McElwain Ward had 90% compliance.
- We noted disposable curtains were used and were changed at the recommended six-monthly intervals.
- We saw clinical and domestic waste was segregated and that waste bins were covered and operated by foot pedal. We observed contaminated clinical waste awaiting collection was stored securely and safely in a locked metal store. This ensured that there could be no unauthorised access or interference with this hazardous material.
- "Sharps" waste was disposed of in appropriate receptacles which were properly labelled. Overall, we found the conditions of the "Health and Safety (Sharp Instruments in Healthcare) Regulations 2013" were being met.
- The ward areas provided a safe environment for children and families which were effective for cleaning and maintenance. All the areas we visited were clean and free from clutter. We saw housekeeping staff cleaning on the wards and in the departments throughout our visit.
- McElwain Ward had a supply of toys that could be cleaned safely. Play specialist staff told us that toys in the children's ward were cleaned by them as part of their role. We viewed the McElwain Ward toy cleaning schedules which demonstrated that play specialists cleaned toys regularly and these were up to date. Play specialists told us toys were cleaned using a UV sanitiser prior to being taken to children in isolation and cleaned again when they came out of the child's isolation room. Play rooms were checked regularly with furniture and floors being cleaned daily. Soft toys and blankets were for single use only.
- Isolation rooms were equipped with anterooms. Each room had colour coded poster on the door highlighting the infection prevention and control procedures that would be required to provide individualised safe care to each occupant. Isolation rooms had urine testing facilities in bathrooms so that staff did not have to remove urine from the isolation room to test it. Equipment such as stethoscopes were kept in the room, to minimise the risk of infections being carried outside the isolation room.
- We observed domestic staff cleaning an isolation room which had been vacated by a child on McElwain Ward. Staff had access to a state of the art ultraviolet (UV) sanitiser which was used to reduce the risk of infections and we saw the room being stripped for cleaning.
- The RMH infection prevention and control team had an established audit programme for reviewing infection control and cleanliness in clinical areas. The RMH infection and prevention report 2014-2015 reported children and young people's services were fully compliant with National Institute for Clinical Excellence (NICE) standards for infection control. McElwain Ward had regularly achieved the RMH 98% compliance standard.
- Children, young people and parents told us that they had no concerns regarding the cleanliness of premises. One said the TCTU was, "always spotless."
- McElwain Ward had eight isolation rooms. Each isolation room also had an anteroom as an aspect of infection prevention and control procedures, this was room attached to the entrance of an isolation room where staff and visitors carried out infection prevention and control procedures to minimize the risk of spreading infections.

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Environment and equipment

- We found the premises we visited were modern, spacious and well maintained.
- Entrances to all children and young people's ward areas were secure, entry was granted by a member of staff via an intercom for visitors during the day and at night. On the TCTU and McElwain Ward access was granted by a ward clerk at reception during the day and by ward staff at night. CCTV was used to monitor entrances at all children's wards.
- We looked at records which showed equipment was identifiable and traceable, and service dates were recorded. For example, we saw records from McElwain Ward which demonstrated how specific Flow meters, these are instruments for use with medical gases, were tracked and their last and next service dates were recorded to ensure that they were maintained in line with manufacturers' recommendations. We noted the service dates were current. We also saw the anaesthetic machine had been serviced regularly every six months and servicing records were up to date.
- All staff reported adequate access to equipment. We reviewed a number of items on the wards and saw they had been recently inspected. For example, we checked a neuro-stabilisation trolley in the surgical theatre. We found this had been checked weekly and records were regular and up to date.
- Equipment on the inpatient bays and isolation rooms was checked on a daily basis. We viewed six 'daily equipment checklists' on McElwain Ward and the TCTU for the week commencing 11 to 18 April 2016, we found these were completed and signed by staff who had completed the checks.
- Clean equipment had an 'I am clean' sticker applied when it was cleaned. Staff told us they only used equipment from the storage area.
- Age-appropriate resuscitation and emergency equipment was available for staff across children's and young people's services. We found resuscitation equipment on McElwain Ward, TCTU and Day Care Unit was checked on a daily basis and records of checks were up to date.
- McElwain Ward and the TCTU had a dedicated radioisotope rooms, these were rooms used exclusively for the treatment of children or young people requiring iodine therapy. The service informed us the rooms could be used by other patients if there were no patients requiring radioisotope therapy. Staff explained that the

rooms were lead lined as the scanning process involved small amounts of radiation. There were clear procedures on the door of the rooms to provide guidance on safe practice for staff. Staff also had radioactive monitoring badges to ensure they were not exposed to harmful levels of radiation. Parents were provided with radiation monitoring badges. The rooms had viewing windows where staff and parents could monitor a child or young person's treatment.

Medicines

- Medicines that needed to be stored in a 'fridge' to ensure they remained in optimal condition were kept in designated 'fridges'. We saw the temperature was checked daily and that a log was maintained to record this.
- The RMH had a divisional pharmacist for CYP services who staff could liaise with and ask for advice. The pharmacist worked across all the ward and department areas. The pharmacist also regularly attended the paediatric clinical governance meeting and junior doctors meeting.
- There had been a total of 60 medication incidents on McElwain Ward between 11 April 2015 and 22 March 2016. There had also been 60 reported incidents at the Teenage Cancer Trust Unit (TCTU). All reported incidents were judged to be "low harm" or "very low harm" to children or young people. Where incidents had been reported a full investigation had been carried out and steps were taken to ensure lessons were learnt.
- The lead paediatric pharmacist was a practising non-medical prescriber (NMP), involved in chemotherapy prescribing, especially for day cases, as well as other supportive therapy. A recent audit found NMP prescribing was 100% accurate.
- Pharmacists were described as, "Fantastic" by staff. Staff told us pharmacists provided lots of patient facing and prescribing activities.
- We observed that correct parameters, such as current weight and surface area, being used to calculate appropriate medication doses.
- Although most junior doctors working in the unit were ST3, their prescribing was assessed during a two week induction period. This involved spending time with the pharmacist, and completing a medicines competency assessment book before they were allowed on the register to prescribe chemotherapy. Competence assessments, including observations of practice, were

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conducted before doctors could go on the intrathecal register, (intrathecal chemotherapy is a treatment in which anticancer drugs are injected into the fluid-filled space between the thin layers of tissue that cover the brain and spinal cord). Following the inspection the trust told us they were allocated trainees by the Deanery and at the time a maximum of two doctors were of ST3 level.

- There were a number of guidelines and protocols covering a range of chemotherapy related complications and reactions. We viewed the protocol for children and young people, 'At risk of complications related to the administration of chemotherapy'. This gave staff clear and comprehensive guidance on the actions staff should take prior to the administration of chemotherapy, during administration, and post administration. The protocol was attached to the patient chemotherapy administration record, and provided staff with immediate guidance on administering treatment.
- Pharmacy staff had good awareness of protocols and guidelines. For example we asked pharmacy staff why 0.45% saline was being used when the NICE recommendation was 0.9%. Pharmacy staff showed us the national chemotherapy guidance for forced hydration was 0.45%.
- Pharmacists were involved in training for staff on the ward and POSCU nurses.
- The pharmacy team had designed a paediatric palliative care pack, 'end of life box', for oral medicines to be used in the home; this included controlled drugs (CD). There was a system for checking that medicines in the box were in date.
- Proformas were used for prescribing and pharmacy dispensing, with additional drugs being added when needed. We found the proformas to improve patient safety.
- We viewed symptom plans for intravenous (IV) and subcutaneous (SC) medications for use in hospice care. These were also used to provide information for GPs and community nurses.
- Pharmacists told us prescribing was paper based. Staff told us paper charts were still needed as they were still used in the community. However, the service was moving towards electronic prescribing for all chemotherapy

- We spoke with a 14 year old patient and their parents. They told us they had received appropriate information about their medicines and side effects and were happy with the information provided.
- The service used e-chemo, and electronic prescribing system. This was a virtual ward that provided the facility to send prescriptions to POSCU hospitals via NHS.net.

Records

- We saw CYP services used a paper light system, this was a mix of paper and electronic patient records, (EPR). Patients' electronic records were managed in accordance with the Data Protection Act 1998. We viewed 12 sets of paper based notes on the wards and the Day Care Unit; we found them to be accurate and legible. Children and young people's chemotherapy treatment records were recorded on the EPR including whether or not chemotherapy had been completed, if not completed the reasons for this were recorded.
- The service had introduced 'family held records' for shared care for children and young people to take with them, and to produce at appointments with other services, for example, their G.P or local hospital. Patient held records were individualised and contained risk assessments specific to the child or young person. For example, blood count and treatment records. Records also contained guidance for staff on managing the identified risks, such as infections and complications related to the administration of chemotherapy. Some risk assessments also contained flow charts of the procedures to be followed if a particular risk developed, such as pressure sores.
- The trust had conducted an audit of patient held records to determine whether they were frequently being used by parents as a source of reference. The trust identified that approximately 50% of parents were routinely using the records, and identified that in the main, records were up to date and included the latest blood results which had been sent to the family by the Trust. The trust acknowledged the need to further enhance the use of the records in order that they were user friendly. The trust was collaborating with the North London children's principal treatment centre to improve the patient held records, including consideration to a move towards electronic records.
- The service used a situation, background, assessment, recommendation (SBAR) tool, which is a structured method for communicating critical information that

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requires immediate attention and action contributing to effective escalation and increased patient safety. Staff told us SBAR was audited regularly. The service operated a 24 hour advice and enquiry line which had been introduced following concerns raised by the Coroner in which telephone queries had not been recorded. A system was in place for all queries from patients and external trusts to be recorded; there was oversight of this process via the clinical nurse specialists who reviewed the call log daily to identify calls where recurrent queries regarding specific children may be raised. An escalation process was in place to ensure that queries which were high priority were referred to a dedicated clinician (Registrar or Clinical Nurse Specialist) without delay. Audits existed to ensure that where queries were referred to individuals that relevant SBAR documents were logged on to the electronic patient system. In addition, where the hospital received queries from external providers or parents/carers, these patients were discussed twice weekly as part of the grand-round facilitated by the duty consultant paediatrician to ensure appropriate advice and treatment plans could be organised.

- McElwain Ward and the TCTU used an 'intentional rounding tool' in inpatient records. This ensured children and young people who were inpatients were checked regularly to ensure they were comfortable and their pain was being managed. A record of the checks was kept.
- Children and young people were supported by RMH for up to five years.
- Patients remain in acute follow up for 5 years from the end of treatment. The service added following our inspection that there was a comprehensive risk-based long term follow up (survservice for children that signposted children from the end of treatment to the appropriate service including: community, local hospital or the survivorship service at Royal Marsden.
- Children and young people received individualised post treatment care plans and follow up appointments. Care plans contained a summary of all the treatments they had received together with any complications they had experienced, the care plan also contained information on any possible side effects as a result of treatment. This acted as a potted history for clinicians that might review the care plan at a future date, as well as empowering children and young people to understand their treatment and recovery process.

- The CYP service regularly audited patients' records. Information displayed on the TCTU found 100% compliance with the recording of children and young people's allergy states. This reduced the risk of staff inadvertently administering care or treatment that may cause an allergic reaction to children and young people with allergies.
- Information governance was part of the trust's mandatory training. Staff told us they had received information governance training. The staff training spreadsheet recorded most staff mandatory training, including information governance, was up to date. For example, on the TCTU 88% of nursing staff and 100% of health care assistants (HCA) had up to date information governance training; on McElwain Ward the figure was 92% of nursing staff and 100% of HCA's; on the Day Care Unit the figure was 89% of nursing staff and 100% of HCA's.
- Booklets explaining patients' rights to access their medical records were available on all the wards. The trust's website also carried information on people's rights to access their records under the Freedom of Information Act 2000.

Safeguarding

- RMH had a safeguarding team who lead on safeguarding children and child protection. The trust employed 2.1 whole time equivalent (WTE) named safeguarding nurses for children; as well as a 0.4 WTE named doctor for children's safeguarding. Staff told us the safeguarding team at RMH in Sutton also worked closely with local authority social workers and social worker's from a charity that worked with children and young people with cancer, and had an office on McElwain Ward. Staff told us they could speak with social workers if they had any queries in regards to safeguarding due to their proximity.
- The Chief Nurse was the executive lead for safeguarding children and chaired the safeguarding board, which reported to the RMH Board on safeguarding issues.
- There was a system of safeguarding governance meetings in place. For example, we viewed minutes from the 'safeguarding children and adults committee meeting', 2 November 2015, these recorded that female genital mutilation (FGM) reporting would be mandatory from February 2016.
- The children and young people's safeguarding named nurses managed complex safeguarding cases and

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worked collaboratively with other health and social care organisations. The safeguarding named nurse also worked with wards and departments, raising awareness and offering advice and support where necessary. Staff we spoke with understood their safeguarding responsibilities and knew what to do if they had concerns. Staff told us they would liaise with the safeguarding named nurse if they had concerns.

- Safeguarding children's supervision was formally provided to specialist children's staff who were providing care to vulnerable children. Staff told us safeguarding supervision was available upon request to all hospital staff.
- Clinical staff and therapy staff had access to level 3 safeguarding training in line with the 'safeguarding children and young people roles and competencies for health care staff; intercollegiate document', (RCPCH, 2014). The staff mandatory training spreadsheet dated 8 April 2016 recorded 42% of qualified nursing staff had completed level three enhanced safeguarding training. The figure for the TCTU was 82% and the Day Care Unit was 74%. The Trust target was 90%. However, we viewed the safeguarding training programme which demonstrated training sessions were in place to ensure staff across the service were trained to the appropriate level in safeguarding.
- All staff working in CYP services also received mandatory training in safeguarding vulnerable adults. We saw that on McElwain Ward 92% of nursing staff and 100% of HCA's had up to date training; on the TCTU the figure was 76% for nursing staff and 100% for HCA's[on the Day Care Unit the figure was 79% for nursing staff and 100% for HCA's.
- Comprehensive safeguarding policies and procedures were available to support staff. This included referral pathways for children's safeguarding. The 'child protection and safeguarding children' policy was reviewed in February 2016. We found the reviewed document reflected inter-agency guidance 'Working Together to Safeguard Children.'
- RMH had comprehensive guidelines for staff in regards to female genital mutilation (FGM). We saw RMH regularly provided information to the Health and Social Care Information Centre (HSCIC) on cases of FGM.

Mandatory training

- The children and young people's staff training spreadsheet indicated that across CYP services there

was compliance with mandatory training updates. From viewing the mandatory training spreadsheet for CYP services we saw staff had access to a rolling programme of training, including both adults and children's basic life support.

- The mandatory training spreadsheet recorded that nursing staff on McElwain Ward had between 58% and 100% compliance against a trust target of 90%. The lowest rate in McElwain Ward was 58% for conflict resolution. The highest rate for McElwain Ward was 100% for blood transfusions: Nursing staff on the TCTU had compliance of between 71% for conflict resolution and 94% for blood transfusions: Whilst nursing staff on the Day Care Unit had compliance of between 32% for conflict resolution and 100% for safeguarding children levels one and two.
- The trust used an electronic training record that provided staff with easy access to their training record and issued prompts when training was due to be updated. The system was also used as a governance tool to provide managers and the learning and development team with information on the levels of compliance with mandatory training in teams and across the trust.
- Staff we spoke with confirmed they were up to date with training, or had dates to attend scheduled training where their training was due to be updated. Staff told us they were supported to attend their mandatory training by their managers and they received reminders by email when it was due.

Assessing and responding to patient risk

- In case of an emergency within the children and young people's inpatient area, the paediatric resuscitation team would attend. We found 30% of children and young people's staff were trained in advanced paediatric life support (APLS) or European paediatric life support (EPLS). This included a mix of staff including: nurses, advanced nurse practitioners, anaesthetists, consultants, speciality doctors, and junior doctors. Staff demonstrated how staff skills were considered when organising the staffing roster, to ensure there were appropriately trained staff on every shift.
- This service did not have an intensive care unit. Staff told us they responded early to a child who appeared to be deteriorating. Children and young people who required intensive care would be transferred to St George's Hospital (SGH) paediatric intensive care unit

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(PICU), which was part of the South Thames Network. Staff told us, “The majority of children are transferred before being ventilated, because if a child is deteriorating we act early.” An audit in to the transfer of patients who required intensive care during 2015 identified that eight children out of 22 required ventilation and inotropic support out of a total of 625 admissions over the whole year.

- There were protocols in place for children and young people requiring care in a PICU. The child or young person would be transferred via the South Thames Retrieval Service (STRS). This involved a full handover from RMH staff to the STRS staff in attendance, who would make an assessment and plan of action for treatment and stabilisation, prior to transporting a child or young person to the SGH PICU. Staff told us they would call STRS prior to transferring a child for advice and to discuss whether the child needed STRS transfer.
- There was detailed guidance available to staff for children or young people who needed to be transferred in the trust policy, ‘Transfer of adult and paediatric patients between wards, departments and other hospitals.’ Out of hours (OOH) the on-call anaesthetist and a doctor would stay with a child who appeared to be deteriorating until the child could be safely transferred by the South Thames Retrieval Service to SGH. The Oak Centre had its own ambulance entrance which meant children and young people could be transported directly to and from the centre, thus avoiding the main hospital.
- Following concerns raised by families and through the trust feedback system, changes were made to how and when children referred for intensive care could be transferred back to the Royal Marsden Hospital at Sutton. All children who had been referred for intensive care were stepped down to a ward at SGH for a period of no less than 24 hours before they were transferred back; this allowed the clinical team an opportunity to review the child once they had been stepped down, to ensure they were clinically stable. Following our inspection the service informed us St George's Hospital was staffed by an attending paediatric oncology consultant from Royal Marsden and a hospital specialist employed by Royal Marsden with support from four advanced nurse practitioners (ANP). Three of these were employed by SGH and one was employed by RMH and worked across the sites. The ANPs were trained by the oncology team at RMH and located at SGH from 9.00am to 5.00pm Monday to Friday, and at weekends for the ward rounds. They were also available for advice 24 hours a day and for patients to be reviewed by on-call consultant. During 2015, 6 children required multiple transfers (at least two transfers) between the RMH and SGH (3 children required three transfers and 3 children required two transfers).
- Between 2000 and 2015 there had been a total of: 255 (includes both emergency and routine transfers for ongoing care) transfers to SGH; 48 transfers to the Evelina Hospital; four transfers to Royal Marsden's Chelsea site; 14 transfers to Kings College Hospital; seven transfers to Great Ormond Street Hospital; one transfer to the Brompton Hospital; and one transfer to other hospitals. There had been no deaths prior to transfer since 2005. The overall mortality rate for children who were transferred between 2000 and 2015 was 16%. The mortality rate for children transferred in 2015 was 3% (1 child). Sepsis was the most frequent indicator for transfer during 2015.
- The service had introduced a paediatric early warning score (PEWS) system on the children's wards, this was based on the NHS Institute for Innovation and Improvement PEWS system. The service had also introduced a national early warning score (NEWS) for young adults on the TCTU, this was based on the Royal College of Physicians NEWS system. The early warning systems helped to identify children and young people who were at risk of deterioration. We saw that early warning scores were supported by a ‘Situation, Background, Action, Review (SBAR)’ tool which supported staff to escalate concerns to senior colleagues in a structured and explicit way.
- We spoke with staff on both McElwain Ward and the TCTU and found they were aware of the appropriate action to be taken if patients scored higher than expected with early warning tools. We reviewed 12 sets of notes and saw where higher scores had been recorded, action had been taken to escalate concerns, or the rationale for not escalating had been documented.
- In surgery we found guidance on the World Health Organization (WHO) 5 Steps to Safer Surgery checklist was consistently followed. This was a checklist that confirmed the surgical team had completed specific phases of operating tasks before proceeding to the next phase of an operation.

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- Staff told us there was no paediatric surgeon on site at RMH after 6.00pm. Children and young people experiencing complications after 6.00pm would need to be transferred to SGH to access a surgeon. The service informed us patients over the age of 16 years could have surgery at the RMH Chelsea site under adult services. Patients aged up to 18 years could have surgery under a paediatric surgical team. Patients aged 16 and 17, the most appropriate surgical team would be involved (either RMH or SGH depending on diagnosis and the nature of the problem). Paediatric general ear nose and throat (ENT) surgery was performed at SGH, whilst paediatric thoracic surgery was performed at the Royal Brompton Hospital. Paediatric neurosurgery was performed at either SGH or at Kings College Hospital.
- Children under one or with significant co morbidity e.g. syndrome, cardiac lesion, difficult airway or mediastinal mass are managed at an alternative centre with on-site PICU facilities.
- We viewed the children and young people's safety dashboard dated December 2015. The dashboard was red, amber, green (RAG) rated. The service had received a 'green' rating indicating children and young people had received appropriate observations during the audit period.
- The South Thames Retrieval Service provided training twice a year for RMH staff on the retrieval and transfer of a critically ill child.

Nursing staffing

- Senior nursing staff told us there were no nursing vacancies at the time of our inspection. Staff told us CYP services had high rates of staff retention and did not have any problems attracting new staff. We viewed the 'nurse metrics dashboard' dated April 2016. This recorded the nursing vacancy rate in children and young people's services as -1.8%. This meant the service did not have any nursing vacancies. The staff turnover rate for staff with less than 12 months service was 0%. The number of permanent staff with over 12 months service was 8.4%, this was lower than the Trust target of 10%.
- Senior nursing staff said the main risk to nurse staffing was maternity leave. Staff told us this was due to the demography of the nursing staff maternity leave was proving a challenge. This was an identified risk on the RMH risk register. The risk register also identified actions the children and young people's service were taking to mitigate this risk, including a training package for new nurses that were covering maternity leave.
- Staff told us between October 2015 and January 2016 there had been a vacancy rate of 15%. However, this had been managed effectively due to lower occupancy rates. There was on-going recruitment to nursing positions, including advertising in professional journals, and an international recruitment campaign resulting in the recruitment of two international nurses. Following our inspection, the trust informed us the vacancy rate had dropped in both McElwain Ward and TCTU by the time of the inspection to 9%.
- Staff told us there were sufficient nursing staff to ensure shifts were filled in line with their agreed staffing numbers. The safe staffing dashboard was displayed in all the wards we visited. This showed details of the required levels of staffing, and actual levels present on each shift. Staffing levels were adequate, as was the required skill mix at the time of our visit. The matron demonstrated an online acuity tool which was used three times a day to assess the required staffing levels for day, evening, and night shifts as well as staffing for the following day. We found staffing levels conformed to the Royal College of Nursing (RCN) guidance 'defining staffing levels for children and young people's services' 2013. Staffing rotas' for March to April 2016 confirmed that staff had access to a band 7 nurse at all times in any 24 hour period.
- McElwain Ward, the Day Care Unit and TCTU used a daily bed occupancy flow chart to estimate the number of nursing staff and skill mix required to maintain safe staffing numbers on wards. Senior staff told us staffing requirements were reviewed on a daily basis, depending upon the needs of children and young people on the unit and would flex up or down in response. We saw that between October 2015 and January 2016 during the day the TCTU had between 88% actual nurse staffing in December 2015, up to 101% in January 2016. At night the staffing levels in the same period were between 91% in November 2015 and 85% in January. McElwain Ward had between 83% and 93% nurse staffing levels between October 2015 and January 2016. At night the figures were between 90% in December and 94% in October and January.

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- Staff told us the ratio of nursing staff to children and young people was two to one on wards for oncology, and three to one others.
 - During our inspection staff were very visible, particularly on McElwain Ward. Senior nursing staff told us the service did not use agency staff due to the specialist nature of the care provided, as staff must have or be undertaking relevant and appropriate training and experience in oncology and chemotherapy care. RMH had bank nurses to cover staffing shortages. Nurses we spoke with told us they had been asked if they would like to join the bank, but added that it wasn't compulsory to join the bank. Staff described the bank staff as "robust."
 - Nursing staff on McElwain Ward and the TCTU had a twice daily hand over. Staff were not to be disturbed during hand overs as this was classed as protected time. Nursing handovers occurred at each change of shift. On McElwain Ward and the TCTU the nurse in charge who had the overall co-ordinating role, received a detailed handover from their counterpart. We viewed a McElwain Ward handover sheet and saw that staffing for the shift was discussed, as well as any high risk patients or potential issues.
 - The Day Care Unit had introduced three advanced nurse practitioners (ANP) due to the high volume of children and young people requiring day care services. Senior staff told us this had a positive impact on the time children, young people and their families had to wait before receiving care and treatment.
 - The service also employed eight WTE health care support workers (HCA): Three WTE worked on McElwain Ward; three WTE on outpatients and the Day Care Unit; and two WTE worked on TCTU.
- Medical staffing**
- At the time of our inspection the actual medical figures were: 7.3 WTE consultants; 3.3 WTE specialty doctors; 2.0 WTE drug development fellows, (plus one vacant post); 5.4 WTE specialist registrars, (plus 2.6 vacant posts). Consultants and specialty doctors were fully staffed. Staff told us the service was actively recruiting to fill vacant medical positions by advertising.
 - Resident medical cover was provided by paediatric trained medical staff with a minimum seniority of ST3 level, these are doctors training in speciality. There were eight posts, (five trainees and three trust grades, doctors in a non-training post), on a 24 hour rota for seven days a week. Additional senior medical cover was provided in the Day Care Unit and McElwain Ward by a speciality doctor for each area.
 - In-hours on call consultant cover at the RMH site and OOH's cover was shared between seven consultants. Four consultants also participated in the paediatric oncology daytime attending rota at SGH.
 - There was a named anaesthetist who was responsible for paediatric anaesthesia. The lead anaesthetist regularly attended the Thames Paediatric Anaesthesia Group (PAG) meeting (local network), developed close links with the South Thames Retrieval Service (STRS) and attended the national Association of Paediatric Anaesthetists Linkman meetings as APAGBI link.
 - Overall, 13 Consultant Anaesthetists provided regular sessions in paediatric anaesthesia.
 - The on-call named consultant rota was staffed by paediatric oncologists who provided inpatient care as a part of their timetable during normal working hours. The medical staff rota provided medical cover 24 hours a day, seven days a week. We reviewed the medical staffing rota for April 2016. There was an on-call consultant OOH's. We found staffing levels were in accordance with the rota. There was a system for both locum staff and internal staff to cover staff absence or holidays. Medical staff told us the children and young people's service only used locums who had worked at the service previously and were familiar with the team and protocols.
 - Staff on the Day Care Unit told us the recruitment of three advanced nurse practitioners (ANP) had assisted the junior doctors on the unit during the daytime. Staff told us the recruitment of ANP's was due to RMH having had difficulties in recruiting sufficient numbers of junior doctors due to a national shortage. ANP's were not in use in the evening or at night.
 - Staff also told us they were under resourced in regards to medical staff, and they were in the process of making a case for the recruitment of CNS's to provide further support for medical staff. Staff said this did not compromise patient safety, but did involve a lot of goodwill from medical staff to ensure rotas and clinics were covered, and increased the risk of medical staff burning out.
 - Each day there was a paediatric oncology consultant for SGH who reviewed all percutaneous trans-hepatic cholangiogram patients daily. (This is an X-ray of the bile

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ducts). The consultant sometimes delegated responsibility for morning ward rounds to a RMH middle grade on one or two occasions per week. However, the consultant would liaise closely with the middle grade doctor. The attending consultant saw all new inpatients within 24 hours of arrival. New outpatients were seen by a consultant in the daily consultant on-call clinic or in their regular clinic.

- There were twice daily children and young people's safety huddles, these were at 9.00am and 3.30pm. Safety huddles were led by a consultant paediatric oncologist. We attended an afternoon safety huddle and saw staff discussing both medical and nursing staffing levels for the night shift as well as staffing levels for the next day.

Major incident awareness and training

- Staff were aware of the trust's business continuity policy, senior staff understood their roles and responsibilities within a major incident. Staff told us there were children and young people's staff allocated to assist in the event of a major incident.
- The risk and reliance manager prepared staff to respond to a major incident and worked with the site management team to assess current risks. Clinical site practitioners (CSPs), were 'bronze commanders', and received annual practical training in responding to a scenario. We looked at the major incident policy on the intranet, which 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. We were told staff were encouraged to attend major incident training.

Are services for children and young people effective?

Good



We rated the service as good for effective. This was because:

- We saw national guidance from the National Institute of Health and Care Excellence (NICE) and professional bodies was complied with and staff showed awareness of relevant guidance in their work.

- The Oak Centre was one of the largest children and young people's comprehensive cancer centres in Europe.
- We found the overall quality of care was monitored through audits, which informed the development of local guidance and practice.
- Staff were supported through face-to-face meetings with their manager and through an annual appraisal which generated a personal development plan for each individual. Staff were encouraged and supported by the organisation to gain additional qualifications. The children and young people's service had the most nursing staff with Doctorates (PhD) in the UK. There were robust systems to ensure professional staff remained registered with the relevant professional body.
- We found patients could access all professionals relevant to their care through a system of integrated multi-disciplinary teams; and patients' care was co-ordinated and managed.
- There were systems to gain children and young people's consent prior to care and treatment.

Evidence-based care and treatment

- We found care complied with relevant guideline issues by the National Institute of Health and Care Excellence (NICE), as well as through other forms of evidence such as trust audits. We found staff demonstrated awareness of relevant guidance and referred to it in their daily work, for example, the matron for children and young people's explained how the CYP service's model was compliant with NICE guidance 'Improving Outcomes in Children and Young People with Cancer (2005)'.
- The Royal Marsden Hospital was a member of the London Cancer Alliance (LCA), an integrated cancer system working across south and west London. The LCA was clinically-led and had the responsibility for delivering specified care pathways for different tumour sites and pathways for delivering safe and effective care. The children and young people's service worked to the LCA children's cancer multidisciplinary team operational policy, October 2014.
- Clinical guidelines were updated annually and ratified by the Network Group and the London Cancer Alliance. The joint paediatric oncology group (JPOG) monitored the implementation of NICE guidance on chemotherapy as outlined in the operational policy.

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- Staff told us a gap analysis was completed for all new NICE guidance and this was returned to the 'quality and safety' team.
- We saw that children and young people's care plans referred staff to the relevant policy or procedure, this enabled staff to find the relevant guidance on the trust's intranet. Staff on McElwain Ward and the TCTU demonstrated how they would access policies and procedures on the intranet. Bank staff were known to the service and also had access to the trust intranet.
- We saw from reviewing a range of monthly joint RM and SGH clinical governance committee meeting minutes, dated from November 2015 to January 2016, that updates to policies and procedures or new guidance were standard agenda items at the meetings.
- NICE guidance recommends children and young people with cancer should be offered the chance to take part in research trials. The service had an established programme of research trials, working in partnership with other organisations including the Institute of Cancer Research.

Pain relief

- Pain was assessed and managed appropriately. We sampled a few patient records and observed age-specific tools in use across CYP services and the appropriate national guidance was followed. Patients were given analgesia, as required, and staff monitored whether the analgesia had adequately relieved the pain. For example, the service used the 'Face, Legs, Activity, Cry, Consolability' (FLACC) scale to measure and assess pain for children between the ages of two months and seven years or older children and young people that were unable to communicate their pain. This involved staff in assigning a score to children's observable behaviour to assess their pain and provide appropriate pain relief.
- CYP services were found about the same as other trusts in question 41 of the children and young people survey 2014, "do you think the hospital staff did everything they could to help your pain."
- The pain team offered children and young people support with pain management and strategies for coping with pain. Children and young people were referred to a pain clinic if they were experiencing pain. The pain clinic offered a range of pain management strategies, including medicines, physiotherapy, relaxation therapy, acupuncture and massage.

- Appropriate equipment was available including equipment for patient-controlled analgesia (PCA). The lead anaesthetist for children was involved with the children's pain strategy.
- The play specialist team were available in each ward and department, and provided distraction technique therapy for children undergoing a variety of procedures. Play specialists described numerous distraction therapies and techniques they used to help reduce children's pain and distract them from painful procedures.
- Parents we asked confirmed that staff ensured their children were not in pain.

Nutrition and hydration

- The children and young people's service had a specialist dietitian for teenagers and young adults. The dietitian provided information to ensure young people maintained a healthy diet before, during and after treatment. The dietitian also assessed young people's nutritional risks and requirements throughout treatment to ensure young people's diets met their body's needs. The dietitian recommended the most appropriate forms of nutritional support from a wide range of drinks, supplements and alternative feeding methods for children and young people requiring nutritional support.

Patient outcomes

- Information about the outcomes of children and young people's care and treatment was routinely collected and monitored via internal audits. The outcome of audits of observation charts and fluid balance charts were recorded monthly on the paediatric dashboard.
- RMH was one of the largest UK bone marrow transplant units for patients with malignant disease. The Bone Marrow Transplant Team performed a wide range of transplants from different donors, including umbilical cord transplants. The hospital was accredited by the Joint Accreditation Committee of the International Society for Cellular Therapy and the European Group for Blood and Marrow Transplantation (JACIE) in 2009 and reaccredited in 2014. The team was supported by a "state-of-the-art" stem cell laboratory for the storage of bone marrow stem cells, and provided care for a wide range of malignant diseases. One of the major strategies at The Royal Marsden was to provide care that would minimize acute and long-term complications.

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- Senior staff told us they were in the process of reviewing the children and young people's audits. Staff told us they recognized they could do more formal audits and this was due for discussion at a governance meeting in June 2016.

Competent staff

- We saw records that showed 100% of staff had attended a corporate induction programme.
- All nursing staff were trained in paediatrics as well as cancer care.
- We were shown records that indicated competencies relevant to staff roles had been developed and there were systems to ensure competency was demonstrated and reviewed. We looked at competency assessments in McElwain Ward and noted they were comprehensive, complete and up-to-date. For example, the practice educator had developed an algorithm that set out specific competency framework for each area of the service.
- The lead consultant paediatric oncologist specialised in: solid tumours, (these are tumours that do not contain any liquid or cysts; and soft tissue sarcomas, cancers that develop from cells in the soft, supporting tissues of the body). The lead consultant also specialized in targeted therapies, (these are types of chemotherapy that attack cancer cells while doing less damage to normal cells); as well as novel drugs, (these are new drug therapies designed to treat cancers).
- Nursing care was provided by a range of specially trained clinical nurse specialists (CNS). These were nurses who were experienced in caring for children and young people and also had specialist knowledge and skills in: particular types of cancer, such as brain tumors; or specialist skills and knowledge in specific area of care, such as symptom management.
- A band 7 ward sister was a qualified practice educator. The ward sister told us they were responsible for developing the skills of new staff, as well as supporting experienced staff with their skills development and continuous professional development. Staff we spoke with confirmed the practice educator provided daily teaching for nursing staff following morning handovers.
- There was a named chemotherapy nurse for the clinical chemotherapy with responsibility for training in chemotherapy administration, as well as ensuring staff administering chemotherapy were trained and assessed for competence.
- Junior medical staff received training in chemotherapy as part of their induction and were signed off by their educational supervisor as being competent to prescribe and take consent for chemotherapy. The only chemotherapy administered by medical staff at RMH was intrathecal chemotherapy, as standard chemotherapy was a nurse-led service. Competency based training was provided to all medical staff who administered intrathecal chemotherapy.
- The South Thames Retrieval Service provided training twice a year for RMH staff on the retrieval and transfer of a critically ill child.
- The 'nursing metrics report' for April 2016 showed appraisal rates for the service were 90.2%, this was better than the trust target of 85%.
- Most staff were up to date in medical competency assessment. For example, 100% of staff were trained in the use of sphygmomanometers, a tool used to take blood pressure; and 100% of nursing staff were trained in using syringe pumps.
- All the staff we spoke with told us they had access to regular one to one supervision as well as clinical supervision. For example, a CNS at the paediatric palliative care team told us, "We never work in isolation. There is a lot of team and managerial support." We viewed the matron's diary and saw monthly one to one supervision sessions with CNS's and senior sisters were booked in advance.
- We were shown two examples of monthly one-to-one meetings between staff members and the matron. Supervisions covered a wide range of issues relating to the management and development of the service and team, updating on clinical and corporate issues, and discussions on personal performance and development.
- Staff told us there was a process to assure the organisation that its registered staff remained registered with relevant professional bodies. Staff told us they were advised when trust records indicated their registration was due for renewal and re-registration was verified by the trust.
- Staff told us they were supported to gain further qualifications relevant to their role. We saw that senior nurses held specialist qualifications. We spoke with a number of staff who had been supported to complete Masters degrees and Doctorates (Phd).

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- Registered therapy staff told us they were up to date with their Continuing Professional Development which was necessary for them to remain on the Health and Care Professionals Council (HCPC) register. They told us they felt supported by the organisation in their CPD.
- Therapy staff told us they felt well supported by the trust with study leave, opportunities to do research, writing articles for publication, teaching, and receiving support to gain additional qualifications.
- Overall, junior doctors across children and young people's services reported they had very good training and support from their senior consultants. However, some middle grade doctors told us it was difficult for them to attend the junior doctors' forums due the pressure of clinical work.
- Medical trainers were given study leave to attend regional teaching days.
- Patients we spoke with expressed confidence in the skills and competence of those caring for and treating them.

Multidisciplinary working

- Care was provided by a multidisciplinary team (MDT) including specialists in cancer types. This included medical consultants experienced in paediatrics and consultants experienced in teenage and young adults services; consultants experienced in palliative care and complex symptom care; a nurse consultant in teenage and young adults cancer care; dietitians; physiotherapists; occupational therapists (OT); psychologists; CLIC Sargent social worker; TCTU activity coordinator; speech and language therapists (SALT); CNS's; teachers; and a hospital chaplain.
- The children and young people's MDT included experts in the field of paediatric oncology, paediatric surgery, specialist melanoma physicians and surgeons, specialist nurses and other health professionals. Staff told us the service also worked closely with the adult gynaecology and testicular teams at RMH. This ensured children and young people had access to a wide range of medical and surgical treatment.
- Children and young people's service were involved in a range of MDT meetings to ensure children and young people's treatment and care plans were in accordance with recommended clinical guidelines, these included late effects MDT meetings and solid tumour MDT meetings. There was a weekly MDT meeting attended by the RMH paediatric consultant who worked on-site at SGH. The meeting was also attended by radiology staff. The meetings were three way video linked to staff working at SGH and RMH Chelsea site.
- Staff told us they did not have regular MDT meetings with POSCU hospitals. However, following our inspection the service told us staff from RMH attended paediatric oncology shared care units (POSCU) MDT as necessary and some POSCU used videolink to connect with the regular weekly solid tumour MDT. The shared care coordinator and consultants visited an MDT in each POSCU annually.
- We saw there were effective systems in place to ensure good communication and understanding between pharmacy staff other professionals in the MDT.
- The lead consultant paediatric oncologist collaborated with the Institute for Cancer Research's 'sarcoma molecular pathology team' to provide relevant clinical input into its work and to also translate its outcomes in the clinical setting.
- The service had a nurse consultant who was funded by the Teenage Cancer Trust charity. The nurse consultant told us their role was to develop services for teenagers and young people across London.
- Therapists ran a weekly inpatient 'Jigsaw' group on McElwain Ward for pre-school children; this was an MDT group involving input from occupational therapists (OT), physiotherapists and speech and language therapists. Staff told us this gave young children as normal an experience of therapeutic activities as possible.
- The consultant in paediatric palliative medicine worked closely with the Shooting Star CHASE hospice. The consultant was also an executive committee member of the Association of Paediatric Palliative Medicine (APPM) and part of the Paediatric Palliative Care Formulary Group. The consultant was also a member of the medicines for children research network (MCRN).
- We observed the paediatric palliative care team arranging a joint visit with a community children's nurse (CCN). We saw the team discuss with the CCN the need to ensure care was appropriate and not intrusive for the young person or their family.
- A CNS told us, "We all work as part of the service; nurses, doctors, ANP's, therapists. We all work as a team."
- A paediatric anaesthetist told us RMH staff worked very closely with the paediatric surgeons at SGH. The

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children and young people's matron and head of department held bi-monthly MDT meetings at SGH. The matron told us senior staff were flexible and could attend SGH when needed.

- MDT meetings for palliative care were held at the GP's surgery, as the GP surgery would be the main palliative care setting, and staff at the GP surgery would be the professionals who would liaise with the family if a child or young person was deceased.
- A teacher at the McElwain Ward school room told us they attended regular MDT morning handovers with clinical staff and therapists. The chaplaincy also attended morning handover meetings.
- The playroom was shared by children using the Day Care Unit and McElwain Ward aged under eight years. The playroom was supervised by a play therapist between 8.00am and 8.00pm. However, the room was open 24 hours a day for supervised play with either parents or nurses when play specialists weren't on duty. The room had a wide range of toys, books, and creative play equipment. The room also had a projector system that encouraged children with exercises, games, and simulated outdoor activities. For example, children could play 'kicking up leaves'. The playroom also had a varied activities programme including art and music activities.
- A play team was able to provide qualified play specialists and play assistants to children's services seven days a week. The play team were informed of all planned admissions at handover, and were involved in multidisciplinary ward rounds, as necessary.
- Staff told us any district general hospital could telephone the service's 24 hour advice line for guidance or advice.
- There was an on-site haematologist who dealt benign tumors, malignancies would be dealt with by the haematologist at SGH.
- Children and young people's services provided a mandatory four day foundation oncology programme for POSCU staff, to ensure POSCU staff were equipped with oncology skills. Competence was assessed by their local POSCU.
- The lead paediatric oncology consultant and matron attended bi-monthly MDT meetings at SGH, the

meetings were attended by SGH staff. However, there were no regular MDT meetings with staff from other POSCU hospitals in the Royal Marsden Hospitals network.

Seven-day services

- McElwain Ward was staffed to provide chemotherapy at any time during the day or night seven days of the week. A consultant paediatric oncologist was available for 24 hours a day on McElwain Ward. The TCTU consultant cover out of hours (OOH) would be provided by the on-call consultant on McElwain Ward to paediatric patients. Older young people on TCTU under adult teams were managed through the standard adult on call procedures.
- There was a consultant paediatric oncologist available at SGH seven days a week for children and young people that had been transferred from the hospital.
- Staff had access to a lead nurse or ward matron for twenty four hours, seven days a week, via an on-call rota.
- Physiotherapy services were available from 8.30am to 5.00pm Monday to Friday. However, a 24-hour on-call service was available seven days a week for emergency, such as chest, physiotherapy.
- Staff told us children and young people had access to the department of diagnostic radiology for scans and X-rays 24 hours a day for seven days a week.
- The Paediatric Patient Advice by Telephone for Care at Home, Hospice and Hospital (PATCH) service was a 24 hours a day, seven days a week specialist telephone advice service for children and young people and their families, as well as for healthcare and allied professionals. There was a single number for all external enquiries. The "Oak Centre of Children and Young People 24hr Communication Policy" outlined the telephone advice service that was available. Professionals within and outside the trust had access to the line for specialist information to support patients who were receiving ongoing treatment for cancer, in particular designated shared care centres and community teams who provided care closer to home.
- Children and young people had emergency access 24 hours a day, seven days a week to X-ray and CT scans. There was 24 hour access to pathology services: biochemistry, blood transfusion, haematology and microbiology. There was also an extended day service for acute leukaemia investigations.

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- The resuscitation team were available 24 hours a day, seven days a week for children or young people being transferred to other hospitals. Anaesthetists were trained in both adults and paediatric intubation. Staff told us it was very rare that children or young people would be intubated prior to transfer.
- Parents told us they could access to staff at weekends if they wished to speak with staff. A parent told us, "Staff are always available at weekends."

Access to information

- Staff told us they could access information they needed to deliver effective care and treatment in a timely and accessible way. For example, blood results were updated daily.
- Patients were provided with patient held records and these were carried with children and young people when they moved between teams and services, including at referral, discharge, transfer and transition.
- Children and young people had individualised paper based records in the handover rooms. These contained children and young people's care plans and risk assessments, including skin integrity, falls risks and nutrition.
- We found patient information was easy to find. All nursing records including daily notes were held on the EPR. Observations including NEWS and PEWS charts were kept next to children and young people's beds, together with records of children and young people's weight, intentional rounding charts, drug charts and fluid balance charts.
- The EPR contained MDT notes, for example, we saw one young person's notes had information from the haematology team and bio-chemistry team.
- The EPR would flag any issues in regards to patient risk including information on safeguarding. The EPR would also flag if a child or young person had an infection and provide staff with information on the type of infection to ensure staff were aware and took appropriate infection control measures. The EPR also flagged children and young people's allergy status to ensure staff were aware of any risks allergies may pose.
- Staff told us they had timely access to laboratory results and information needed for children and young people's ongoing care. However, a few staff members told us the trust's electronic information technology (IT) system and hospital Wifi could be unreliable.

- Primary care colleagues received timely and accurate discharge information in order to support the patient in accordance with the 'primary care standards for children's surgery', (The Royal College of Surgeons, 2013), by working in accordance with the London Cancer Alliance protocols and Pan-London guidance. Staff told us discharge summaries were sent to GP's within 24 hours of a child or young person being discharged to ensure continuity of care in the community. GPs could speak to a consultant or registrar on the telephone if they required information that could not be provided by the 'paediatric advice by telephone for care at home, hospice, and hospital' (PATCH) team.
- However, staff told us they used different computer systems to SGH, and this meant staff had to remember to document contacts. Staff also said different systems across the PTC and POSCU network could be a challenge.

Consent

- We saw children and young people's consent to care and treatment was documented and signed on all the patient's records we viewed. Consent information was also recorded on children and young people's EPR. Records we viewed confirmed young people receiving chemotherapy or their parents had signed a consent form prior to starting a course of chemotherapy.
- Parents were involved in giving consent to examinations, as were children when they were at an age to have a sufficient level of understanding. Staff we spoke with were aware of Gillick competence, this is a decision whether a child, 16 years or younger, is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff told us they would always speak with a child and encourage them to involve their parents where appropriate; but would respect the rights of a child deemed to be competent to make a decision about their care or treatment.
- We saw staff spent time with children, young people and their parents to ensure they understood their care and treatment. We observed how staff talked and explained procedures to children in a way they could understand.
- Staff told us they would always gain consent from children, young people and parents or caregivers before involving them in clinical trials. Staff told us there were standard operating procedures (SOP) in place in regards to patient consent for clinical trials. We viewed the SOP

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for the 'allocation of patients to trials in the drug development unit', 30 June 2014. The SOP gave clear guidance to staff on gaining consent and actions staff should take if a patient declined involvement in clinical trials following a discussion of their willingness to take part. One young person we spoke with was involved in a clinical trial and said they were consulted about their involvement and their family had given consent.

Are services for children and young people caring?

Outstanding



We rated the service as outstanding for caring. This was because:

- We found children and young people's service demonstrated outstanding standards of caring. This was because patients and carers we spoke with were overwhelmingly positive about their experience of care and treatment, and feedback gathered by the hospital showed high levels of satisfaction.
- We observed staff responding to people with kindness and compassion. Patients told us they were treated with dignity and respect, and that they were involved in the planning and delivery of their care to the extent they wished to be.

Compassionate care

- Children, young people, and families we spoke with were overwhelmingly positive about the care and treatment they received. Words and phrases such as, "This place is amazing, it's second to none," "This has been a positive experience," "You can't fault the staff," "They are brilliant here," and, "World class," were used extensively in their feedback.
- The trust had implemented the friends and family (FFT) survey. We reviewed FFT data from December 2015 to April 2016. The children and young people's service scored an average of 100% from respondents in the category of recommending the service.
- Throughout our inspection, we observed positive interactions between staff, parents and children. We saw staff responding in a considerate manner with children, young people and their families in all of the areas we visited. A parent of a child who was an inpatient told us,

"They are really caring, at another hospital I stayed in they woke me to change my child's nappy; here the nurses told me to sleep and they did the nappy change. I slept throughout the night."

- We observed a number of examples of compassion and kindness shown by staff across all the departments and ward areas. For example, we saw a nurse explaining in accessible language what she was doing, why she was doing it, and what she would do next to a child receiving chemotherapy on the Day Care Unit.
- Parents we spoke to told us they had been treated with respect and compassion by the staff and praised staff for their attitude and approach. A young person on TCTU told us, "They are all really nice. They can't do enough for you."
- The children and young people's service sent families flowers on the first anniversary of a child's death and sent families cards for five years after a child's death. Staff told us it was important in recognising families' loss and to acknowledge the relationship that had existed between the child and their family and the hospital.
- We saw children and young people's privacy and dignity was respected by staff drawing curtains when providing intimate care or treatment.
- Play specialists worked with nursing staff on McElwain Ward to ensure that children and young people were not left unsupervised for prolonged periods when they didn't have a parent or carer visiting.
- Play specialists organised a monthly party on McElwain Ward with party food, to provide families with children receiving inpatient care the opportunity to meet and socialize.

Understanding and involvement of patients and those close to them

- All of the parents we spoke with told us they felt involved in planning and making decisions about the care and treatment of their child. For example, one parent commented, "The staff are always professional and lovely."
- In the 2014 children's survey the Trust performed better than other trust's for two of the "caring" questions and "about the same" as other Trusts for other questions. For example, question 50, "were you given any written information, for example, leaflets about your child's condition or treatment to take home with you." 97% of the survey respondents had confirmed they had

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received information. We found children, young people and families had access to a wide range of information on cancer, its treatments, affects and side effects. Information was available on all the wards and units we visited

- In the children and young people's survey the trust was found about the same, 100%, as other trusts in question 7, "do you feel that your child was safe on the hospital ward." The Trust scored 100%, this was better than other trusts, for question 8, "did you feel safe on the ward."
- In the children's survey the Trust also performed better than other trusts, 89%, for "caring" question 30, "Were you encouraged to be involved in decisions about your child's care and treatment."
- There were posters on all the wards and departments explaining the colour coding of staff uniforms to enable children, young people and their parents to identify clinical, housekeeping and administrative staff. There were also posters on the wards explaining the role of the keyworker.
- We viewed a PALS service 'viewpoint action plan' for April to September 2015. This was based on comments children, young people and their families had raised via viewpoint cards on the wards. This demonstrated how the CYP service had addressed issues raised about services. For example, a parent had raised an issue about the lack of play specialists on McElwain Ward at weekends. In response the service had approached a charity in regards to funding for an extra play specialist at the weekends; and were awaiting a decision.
- Paediatric pharmacy had produced written information for all medicines, to enable children, young people and families to understand their medicines. The information leaflets had been produced in collaboration with parents and signed off by PALS.
- A youth support worker provided activities, games and other media to engage and occupy young people while in hospital. This included organizing social and recreational outings and events for young people up to the age of 24 and helping young people to resume activities such as school and college, as well as supporting young people to maintain or rebuild a social life between or after treatment. For example, events included trips to concerts, pamper days, shopping trips, outings to restaurants and bowling. We saw a range of

free events for young people with cancer being publicised on the TCTU. The TCTU also had a weekly events calendar on the noticeboard, this included a quiz night and a visit to a concert at the Royal Albert Hall.

- Play specialists told us they spoke with every child on the Day Care Unit and McElwain Ward about play activities for the day. The McElwain Ward noticeboard had information on wish granting organisations and how families could apply for a subsidised holiday break with their children. A child commented, "The playrooms are great. The nurses are fun. I feel OK when I have an LP (lumbar punch) because everyone looks after me so well."

Emotional support

- Children and young people had access to a range of therapies to support their physical, mental, and emotional wellbeing. These included: six sessions of acupuncture by referral from the clinical team. Children and young people could self-refer or be referred by the clinical team for art therapy. Massage therapy and reflexology was available to assist children and young people in coping with anxiety or to help lift their moods. Outpatients could receive four one hour sessions, but there was no set limit for children and young people who were inpatients. Children and young people could self-refer for massage therapy and reflexology or could ask the clinical team to refer them. A therapist was available on-site Monday to Friday from 9.00am to 5.00pm. There was a waiting list for outpatients, but inpatients would usually be seen on the day of referral or the following day.
- The Teenage Cancer Trust funded a nurse consultant that was employed by the trust. An aspect of the nurse consultant's role was to provide support for teenagers and young adults through their cancer journey. For example, we saw details of a Facebook group that had been set up for young people to offer peer support. The group was monitored by the nurse consultant to ensure it was used appropriately and young people's privacy was maintained.
- Bereaved families were offered a follow up post-bereavement appointment with their child's consultant, to enable families to discuss their child's care and treatment and ask any questions they may have had in regards to the death of their child.

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Are services for children and young people responsive?

Good



We rated the service as good for responsive. This was because:

- Children and young people's services provided cancer diagnosis, cancer treatment expertise, psycho-social support and non-surgical cancer therapy to ensure children and young people received truly joined up working that was responsive to patients' individual needs.
- Services were planned to ensure they were responsive to children and young people's needs. Systems were used to monitor service capacity and demand for services.
- Referral, admission and discharge processes for children and young people were effective. There was provision to ensure essential services were available out-of-hours, and there were no major issues with waiting lists.
- The design of the Oak Centre created a variety of different spaces which contributed to children's and young people's comfort and engagement.
- Consideration was given to the needs of children and young people with complex needs and for those where English was not their first language.
- Feedback from children, young people and families was actively sought and acted on. Complaints were investigated and responded to. Staff were made aware of the issues raised by complaints and where appropriate changes were made as a result.

However,

- Due to the limited availability of paediatric intensive care services, there was a requirement for children who deteriorated or who required intensive support to be transferred to a neighbouring trust. Improvements were required to ensure that the process of transferring patients between services was managed effectively, including the management of patient and family expectations.

Service planning and delivery to meet the needs of local people

- The model of care was based on the London Specialist Commissioning Group model. This entailed RMH and SGH functioning as a unified 'Paediatric Oncology Primary Treatment Centre (PTC)'. This meant the service provided cancer diagnosis, cancer treatment expertise, psycho-social support and non-surgical cancer therapy; whilst SGH provided paediatric specialist services, including paediatric intensive care, paediatric surgery, neuro-surgery and paediatric infectious disease specialist care. Staff told us they had, "very good" relationships with local hospitals that operated as POSCU's in accordance with the model of care. However, staff told us they would, "love to reconfigure POSCU." This had been reviewed at a strategic clinical network group in 2015.
- It was recognised by the leadership team and the wider children's cancer network that consolidation of the POSCU network was necessary if the overall quality of children's cancer care across London and neighbouring counties was to be enhanced. The RMH team considered that the overall number of POSCUs was too high, and that careful consideration had been given to the ideal number of shared cared units. The leadership team had devised a model of care and a draft proposal, in consultation with colleagues from the North London PTC which would have meant that whilst there was an overall reduction in commissioned POSCUs, there would have been an opportunity to increase the level of service provided. At the time of the inspection, the majority of the 16 POSCU's were accredited at level 1; the RMH team aspired to see an overall reduction to around eight POSCUs but with them all being level 3 accredited.
- The matron told us that not all young people were designated their local general hospital as their POSCU. The matron said the 'shared care' model and principle of age appropriate services delivered locally had created dilemmas for a few young people as they had not been allocated their local hospital as their POSCU. However, the matron added that the majority of young people were treated at the hospital.
- The clinical service was provided by a team of paediatric, clinical and medical oncologists with on-site access to radiotherapy, diagnostic imaging, pathology, specialist cancer nursing, symptom care and pharmacy expertise. The clinical service at SGH was provided by

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paediatric oncologists, employed by RMH to provide on-site cover at SGH in and out of hours. SGH provided a level 1 shared care service for PTC patients in the South Thames area, including Kent, Surrey and Sussex. Non oncology services were linked to the RMH oncology team at SGH and provided services for children and young people on an oncology pathway.

- The Oak Centre was a new purpose-built facility that allowed the hospital to offer more treatments in a day care setting and to develop innovative approaches in nursing practice. Staff told us the Oak Centre meant more children and young people could be treated as day patients rather than inpatients. The increased capacity helped to avoid delays in treatments.
- There were a range of protocols in place in regards to young people receiving treatment from adult services, for example, young adults between the ages of 18-24 received adult haematology services for the treatment of blood disorders.
- The Day Care unit had eight beds and 11 chemotherapy chairs available. All had overhead television and radio access, as well as seating for parents to stay with their children during treatment.
- The Day Care Unit had introduced ANP's to address waiting times for clinics. Staff told us the Day Care Unit had also introduced structured clinics for young adults attending day care and this had streamlined the process in the unit.
- The service offered transitional clinics for late effects and for children and young people moving to adult services. The nurse consultant assisted young people with transitions in their care and treatment.
- McElwain Ward had eight isolation rooms for bone marrow treatments for cancers of the bone and immunotherapy, a treatment designed to boost the body's natural defences. All isolation rooms were equipped with television and Wi-Fi internet access.
- Children and young people had places where they could carry out normal routines. For example, all the bed spaces could be personalized, and each bed space had television and Wi-Fi internet access.
- All bed spaces had pull down parents' beds which were housed in integral lockers next to the child's bed, and could be easily accessed in the evening and put away in the morning.
- Children and young people in isolation had a 'two carers policy'. This was to minimize the risk of infection to a child or young person that required isolated care. Staff

told us siblings would not be allowed to visit a child or young person in their isolation room. However, there were private viewing windows in the isolation rooms, whereby a child or young person in isolation could see and speak to visiting siblings or friends via a 'walkie-talkie'.

Access and flow

- There had been 2373 spells in CYP services in the previous 12 months. 4% of these had been emergency admissions, but there had been no emergency admissions in the previous 12 month for children aged under one year; 28% of spells in hospital had been elective; and 68% had been day cases. The primary diagnosis groups were, 33% leukaemias. 9.4% cancer other and unspecified primary; 9.4% secondary malignancies; 8.3% cancer of the kidneys and renal pelvis.
- We reviewed the occupancy levels from April 2015 to March 2016 for the TCTU and McElwain Ward. We found that McElwain Ward had an average occupancy rate in this period of 79.5%. The TCTU had an average occupancy rate of 82.3%.
- Referrals to children and young people's services were accepted from GPs and other hospitals for the diagnosis of common and rare cancers. Referrals were reviewed prior to children and young people being given an initial assessment appointment. RMH care pathways were based on the principle that all children and teenagers with a suspicion of cancer would be referred to RMH as the PTC. RMH would make the diagnosis and direct and provide treatment.
- The pathway for a child or young person with suspected cancer was a child would present to their GP and be referred to their local district general hospital. As soon as the hospital considered the child or young person as requiring oncology services the hospital would call the Royal Marsden's 24 hour advice line. The advice line was operated by administrative staff. However, either a doctor or ANP would hold a bleep for the advice line and could be contacted by staff on the advice line. Staff told us the triage process was introduced in response to a coroner's report in 2013 and was now fully embedded.
- Staff told us telephone calls from hospitals to the service's advice line would be advised to speak to a consultant at their local hospital if the issue was an acute issue. If the issue was oncology related then the call would be logged and advice would be given on the

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basis of clinical needs. Cases were discussed at the twice weekly consultant led ward round to ensure appropriate treatment plans and advice was being provided to manage and support the child and their family.

- Care pathways were based upon the South Thames Children's Cancer Network Group 'Referral protocols and diagnosis and staging protocols, October 2014.' These provided clear flowchart guidance on plotting patients' journeys. For example, care pathways included: leukaemia; lymphoma; carcinoma and melanoma; germ cell and gonadal tumour; and bone.
- There had been 22 children and young people transferred a total of 31 times to SGH PICU between 1 January 2015 to 31 December 2015. The process was reviewed by a Royal Marsden registrar in April 2016. 45% of transfers were children and young people that had undergone bone marrow transplant. The leadership team acknowledged the need to further enhance the information available to parents and children when transfers were required. The matron of the service was devising a feedback mechanism to capture the experience of patients and their families when they were transferred in order that the process could be further improved.
- The TCTU provided care for children and young people aged 16 to 24 years. Staff told us they would accept referrals for young people and young adults up to the age of 21 years. Staff said 16 to 18 year olds had chemotherapy at RMH as this was their PTC, and in principle young people aged 19 to 24 had a choice to have chemotherapy at their "designated" hospital. However, staff said most young people chose to have their chemotherapy at Sutton.
- The palliative care team provided care for children and young people up to the age of 18 years. However, end of life care would usually be provided in a hospice or in the community. It was rare for palliative care to be provided at the hospital.
- The paediatric scorecard indicated the service were exceeding the trust's targets, by meeting 100% of cancer waiting time targets. For example: cancer two week waits; 31 day waits to first treatment; 31 day waits for subsequent treatment; 62 day waits for GP urgent referrals; 62 day screening waits; and referral to treatment (RTT) admissions within 18 weeks.
- Senior nursing staff told us 13 bed spaces were commissioned for the TCTU. However, only nine were in operation during our inspection. Staff said this was a commissioning decision to ensure there were always sufficient numbers of staff on duty to meet children and young people's needs. Staff said they would rather operate under bed capacity than work short of staff, and this did not have any impact on young people accessing inpatient services.
- Staff told us children and young people being accommodated on an adult ward was rare. In the previous 12 months there had been two young people, both aged 17 years old who had been accommodated on an adult ward. However, some medical staff told us there were insufficient numbers of inpatient beds and this had led to Day Care Unit staff spending time arranging urgent admissions for children and young people who had arrived at the unit, but who needed in-patient care.
- There were 10 paediatric lists a week for imaging and radiotherapy. Children and young people had rapid access to cancer imaging such as CT, MRI and PET scans, these are imaging procedures that use special x-ray equipment to create detailed pictures of areas inside the body. Children also had access to the hospital's cyclotron facility in the use of radiation therapy.
- There was a daily consultant-led general anaesthesia and sedation service for children and young people undergoing IT chemotherapy within a dedicated paediatric theatre. MRI scans, CT scans and radiation therapy were based close to, but outside, the operating room.
- There were regular paediatric theatre lists. These entailed general anaesthesia for infants and children undergoing minor procedures, such as the placement of long-term vascular access for cancer therapy, these are devices with a variety of uses including multi-drug chemotherapy and aspects of bone marrow transplantation. Surgical procedures were performed by paediatric surgeons from SGH.
- Minor procedures such as lumbar punctures and intrathecal chemotherapy were carried out under general anaesthetic in the day care facility at RMH. If diagnostic or interventional radiology was required under general anaesthetic this was booked at the beginning of the anaesthetic session. On Tuesday and Thursday afternoons the RMH anaesthetists worked with SGH surgeons for line insertion and removal lists.

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- The age limit for line lists was one to 18 years old, (lines are tubes that are inserted into veins of the body for the purpose of administering chemotherapy and other medicines), patients aged 18 years and above were managed through Royal Marsden adult services.
- The oncology team discussed line lists at team meetings following ward rounds. Staff told us line lists at RMH were elective and only “well patients” would receive surgery at RMH. Patients who had been transferred to SGH would receive line surgery at SGH. Staff told us there had been 194 line insertions in the previous 12 months and there had been two “low harm” incidents.
- Staff told us Thoracic tumour surgery would be done at the Royal Brompton Hospital who worked closely with surgeons at SGH and staff at RMH. Children and young people requiring transfer would be transferred in accordance with the trust policy ‘Transfer of adult and paediatric patients between wards, departments and other hospitals’ and in collaboration with the South Thames Retrieval Service.
- Post-operatively children and young people were recovered in one bay of a mixed adult and children’s recovery ward adjacent to the two main operating theatres. Staff told us sometimes there would be an adult patient in the recovery ward at the same time as a child. However, staff said it was more likely there would be only one patient at a time in the recovery ward as many of the adult operations took many hours. Staff added children and young people’s parents or carers would join them in the recovery bay “at all times” following a procedure.
- There had been four children and young people transferred to other hospitals. Three were delays and one deferred out of area to Cambridge. Staff said children or young people who were moved out of area were moved based on clinical need and repatriated as soon as possible. Staff said they always discussed this with children, young people and their families. There was also a leaflet for families for children or young people that were transferred. However, staff told us there was no specific questions in the hospital’s peer review in regards to children, young people and their families views on transfers. Staff told us the maximum rate of retrievals by STRS was 0.04%, most transfers involved febrile neutropenia, (fever).
- Staff told us families, GP’s and POSCU would be involved in children and young people’s discharge arrangements. However, staff said due to differing systems they were still faxing some children and young people’s discharge summaries. Staff said they had asked POSCU to use NHS.net for electronic discharges, but POSCU hospitals had not taken this on-board. Between April and June 2016 94.8% of discharge summaries had been added and 72.45 had been sent within 24 hours to GPs.
- Children and young people could access therapies by self-referral or referral from ward staff. However, therapy staff told us they could not provide long-term follow up once children and young people were discharged due to staffing capacity.
- The charity social work team were based in the Oak Centre and worked solely with children and young people under the age of 25 years. The social work team offered social, emotional and practical support as well as advice and information on housing and benefits.
- The Children’s Psychological Care Service was a MDT team of clinical psychologists and child psychiatrists who worked closely with charity social workers, as well as nursing and medical staff. The social workers and psychological care service offered a range of groups to support children, young people and families cope with the emotional impact of treatment. Psychiatric support was via referral from nursing or medical staff or the social work team. Young people had access to one to one counselling as well as family counselling. Referral could be arranged by staff on the ward or young people and their families could self-refer to the service. Psychiatric support would be provided for up to five years after treatment had been completed. A CNS told us, “We have to encourage young people to move on, and enable them to live their lives. The message about living life after cancer starts at cancer diagnosis.”

Meeting people’s individual needs

- Children and young person had their own named consultant. However, staff told us inpatients and urgent care children would be seen by the consultant of the week on the medical rota. The service informed us that non-urgent patients would still see their own consultant in regular clinic. Medical staff told us if the consultant of the week needed further information they would liaise with the named consultant.
- All new patients, and patients with ongoing complex needs were discussed at weekly psychosocial meetings. This was a forum for MDT members including ward staff to discuss and develop plans for the psycho-social management of vulnerable patients. For example,

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children and young people with learning disabilities had a '12 activities of living' assessment to establish their individual needs. They would also have a 'ready, steady, go' assessment to establish what support they would need in the longer term. A staff member told us, "We have had quite a lot of patients with autism and learning disability. We work closely with families and care homes."

- Children and young people had a key worker who acted as a point of contact at the hospital. Their role was to support children, young people and their families through the diagnosis, treatment and after-care process.
- Staff told us 'easy read' copies of all the trust's information leaflets were available upon request. These could be requested from either staff on the wards, the patient help centre, or patient advice and liaison service (PALS)..
- We found there was appropriate support for children and young people receiving end of life care. Staff we spoke with told us it was rare a child or young person would receive end of life care at RMH. Staff from the palliative care team said, "We don't get many babies or children, as they tend to go to the hospice." The palliative care team could provide end of life support to children, young people and their families from the point of diagnosis throughout their cancer illness. Children and young people receiving palliative care would receive care from their existing consultant or the palliative care consultant dependent upon their symptoms. A member of the children and young people's senior nursing team told us they would only discuss end of life care when there was, "Absolutely no hope, we keep hope alive as an aid to recovery."
- Parents, children and young people told us they appreciated the quality of the care environments. At 98%, the trust was better than other trusts in question 25 of the children and young people survey 2014, "does the ward where your child stayed have appropriate adaptations or equipment."
- The design of the Oak Centre created a variety of different spaces that contributed to children's and young people's comfort and engagement. Children and young people had places where they could carry out normal routines, this included age-appropriate areas where they could mix with others and quieter areas. For

example, the Outpatients Department and Day Care Unit had age specific waiting areas that were equipped with age appropriate toys including a pool table in the Day Care Unit.

- The Day Care Unit had 11 beds and 11 chairs for chemotherapy, a dedicated theatre for procedures and invasive investigations and dedicated recovery beds. Each day care treatment room had access to resuscitation equipment, records we viewed confirmed these were checked by staff on a daily basis. The unit had a procedures room where day care procedures under general anaesthetic took place, such as lumbar punctures and bone marrow aspirates, these were samples of the bone marrow. The unit also had an immediate post-operative recovery bed in a dedicated room opposite the procedure room.
- Inpatient units at the Oak Centre were McElwain Ward and the TCTU for young people aged over 14 years. McElwain Ward provided inpatient facilities for children aged 1 to 16 under the paediatric oncology service. The ward had 18 operational beds including five single rooms and a dedicated room for radioisotope therapy.
- All of the inpatient areas had facilities for a parent to stay overnight and sleep. These included pull-down beds next to the child's bed on the wards. Isolation rooms had a sofa bed so that children and young people's families could stay in the room.
- The Oak Centre had parents shower rooms for visiting parents who stayed overnight with their children on the wards. The TCTU had a visitors room with a modern kitchen and toilet for parents and visitors to use. The visitors room provided sofas for visitors to relax on. Staff said the visitors room would also be used to speak with parents away from the ward. A visiting parent who was using the room told us, "It's very good actually, I can get myself a cup of tea."
- At an afternoon safety huddle we observed staff reviewing the needs of a young person who was physically disabled. Staff were informed that a nurse from another ward was covering the night shift to ensure there was sufficient staffing numbers to ensure the young person's needs were met. Staff agreed the young person's needs would be reviewed again in the following morning's safety huddle to see if further staffing was required.
- The practice educator had developed a cultural awareness programme to improve staff communication with people from minority ethnic communities.

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- Where a child, young person or parent did not understand or speak English translation services were available. Staff we spoke with were aware of the process to access a telephone translation service or face-to-face translator. We saw posters displayed on all the wards with the same information in 15 different languages providing information on how to access a translator. We also saw a 'Patient Advocate' service being publicised on the wards that could be booked by PALS.
- Children and young people had access to other departments in the Trust for supportive services. In Sutton this was radiotherapy, imaging, theatre, 'step up' for young people over 16 years old. Young people over the age of 16 would also access the Chelsea critical care unit (CCU). If the TCTU were unable to accommodate young people between the ages of 16-24 years, they may have been treated on an appropriate adult ward until a bed became available.
- A registered mental health nurse worked on the TCTU during the day Monday to Friday. Staff told us they worked closely with child and adolescent mental health service (CAMHS). Staff provided us with an example of how they had worked with staff from CAMHS in supporting a young person who had experienced steroid induced psychosis as a side-effect of their treatment for leukaemia.
- RMH in Sutton had a multi faith chapel. A prayer mat was available to parents and there was access to a quiet room for religious observance.
- Each ward and department catered for the needs of individual children. This included ensuring there was enough space next to each bed for families and carers to visit and for a family member to stay overnight. There were sufficient play areas on the wards. Staff we spoke with told us the service could meet the needs of all children admitted to the wards, regardless of the complexity of their physical needs. The needs of children with disabilities had been considered in the design and layout of the Oak Centre.
- Play rooms equipped with books and toys were available for children in the radiotherapy department and the outpatients department. The surgery recovery room had a children's bay that had a Donald Duck poster on the wall which made the bay more child friendly. However, the main theatres anaesthetic rooms were not child friendly and had nothing in place to make the rooms more child-friendly.
- There were two social areas on the TCTU: The 'chill-out zone', where young people could meet to play pool, watch TV, make a snack or play games. The 'chill out zone' had a pool table, two televisions, a variety of gaming consoles, DVDs including some in other languages, and a digital jukebox. The 'hub' was an area used for schoolwork and group activities such as music, art, pizza nights, film nights, animation activities and filmmaking. Young people also had access to four computers in the room for either study or leisure purposes. The Teenage Cancer Trust youth support coordinator ran the 'chill out zone' and 'hub' areas from Monday to Friday to help with activities. Staff and young people told us the unit had access to Wifi but mobile network coverage was limited. Laptops and iPad could be borrowed from the youth support coordinator.
- The Oak Centre had a roof terrace with artificial grass, deck chairs and sun loungers to enable young people on the TCTU to get outside in the fresh air when weather permitted. Plans were also in place for an outside space to be developed outside the playroom on McElwain Ward.
- The Day Care unit and McElwain Ward had a 'pod' for children aged between eight and 11 years old. Children could take their treatment into the room. We saw children receiving intravenous (IV) chemotherapy playing video games with other children who were receiving treatment using the room during our inspection. The room was equipped with large television screens, gaming consoles and a wide selection of video games. Staff told us children playing with other children helped to normalise their experience of treatment.
- McElwain Ward was equipped with a sensory room for young children or children with learning disabilities.
- The Oak Centre had a school room with qualified teaching staff. The school room provided specialist tuition in core curriculum subjects for older pupils. The schoolroom was open from 10.00am to 12.00pm and 1.00pm to 3.00pm every weekday during term times. The school room was also an examination centre and could support children or young people who needed to take GCSE and 'A level' examinations during their time in hospital. Staff told us they could facilitate a child in isolation who needed to sit a GCSE or 'A level' exam.
- McElwain Ward and the TCTU had their own chef from 8.00am to 7.00pm. Children could choose food from a varied menu. Staff told us the chef would also make

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children alternative meals if they didn't want food on the menu. Snacks and drinks were available from ward staff 24 hours of the day, seven days a week. There was a kitchen on the TCTU for parents and partners to store food as well as make simple meals. The fridge in the kitchen had individual sections that could be locked for young people and families to store their own food.

Learning from complaints and concerns

- Staff told us patients were actively encouraged to raise concerns with the patient advice and liaison service (PALS). The matron told us this was one of the ways the service identified where service improvements were needed and how the service avoided having to deal with formal complaints. The matron told us where people had not received the care the service would expect to provide they would always be offered an apology.
- We saw 'viewpoint' boxes on all the wards we visited. These were boxes where children, young people and families could post comments, concerns and suggestions. These were collected by the PALS service, who addressed these with the children and young people's service.
- We viewed the PALS 'viewpoint action plan' dated April to September 2015. This recorded all issues and concerns children, young people and families had raised with PALS during this period and an action plan from the RMH ward staff addressing the concerns. The main issues raised with PALS between April to September 2015 were waiting times in the Day Care Unit. For example, the PALS 'viewpoint action plan' recorded a parent had raised an issue in June 2015 due to the length of their wait in the Day Care Unit. We saw that the service had responded to the parent's concerns. The service had said they were "sorry" for the inconvenience and had offered the parent an explanation. Furthermore, the service had redesigned the assessment system for children receiving chemotherapy in the Day Care Unit to reduce waiting times. We did not see evidence of whether this had improved waiting times. However, we spoke with two families in the Day Care Unit who were waiting for their children to receive chemotherapy. One family told us waiting times in the unit had improved with the new system and another family told us they preferred the previous system as the new system involved families moving to different areas of the unit.

Are services for children and young people well-led?

Good



We rated the service as good for well led. This was because:

- Children and young people's services were well-led. This was because there was a clear vision and set of values that were shared by staff and demonstrated in their work. There was a clear articulation of the strategic direction for the service and staff felt engaged with the strategy. Consideration was given to ensure developments were sustainable. We found evidence of extensive research including partnership working with academic organisations.
- There were systems to ensure appropriate governance and monitoring of standards and performance. There was an effective escalation and cascading of information from the board to front-line workers, and vice-versa.
- We found there was a positive culture, with staff and managers feeling proud of their work and achievements and speaking well of their colleagues and the organisation. Front-line staff felt supported by their managers to deliver high quality care, and empowered to implement and participate in quality improvement projects. Managers, including those at executive level, were described as being visible, open and accessible.

Vision and strategy for this service

- The RMH NHS trust had a set of 16 values that were developed by staff from all grades and disciplines. We found staff could clearly articulate the vision and values of the trust and their service. Staff told us that each month a trust value was highlighted on the website and evidence of how this could be demonstrated in practice was described. We had discussions with staff who explained, with examples, of how they found consideration of the trust values had helped them to approach their daily work and to address specific problems. The matron told us, "our vision is to have a model of survivorship and life after cancer."
- Staff told us about the trust's 'always events'. These were behaviours that promoted quality care. For example, some staff told us one of the 'always events' was to

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always introduce themselves to patients. We observed the value in practice as medical, nursing, and play specialist staff introduced themselves to patients in the Day Care Unit.

- The children and young people's strategy was based on the London Cancer Alliance 'children's cancer multidisciplinary team policy operational policy', October 2014. The policy outlined how the clinical teams at the PTC provided services for children with a diagnosis of cancer. The operational policy provided clinical management protocols for a wide range of disease types. The policy contained a concise, but clear vision for children and young people's services and a description of the operational arrangements to enable the vision to be realised. This meant children and young people's services were engaged with partner organisations in furthering the strategic objectives of the local health economy.
- Staff told us there had been recent discussions with senior managers in regards to a localised children and young people's strategy for staffing and the employment of a consultant for solid tumours. This was being taken forward to a governance meeting in June 2016.

Governance, risk management and quality measurement

- We found there was a system of governance meetings which enabled the escalation of information upwards and the cascading of information from the management team to front-line staff. We spoke with a wide range of staff who were familiar with the service's governance structures. We reviewed the minutes of various governance meetings and found they contained information on incidents, complaints and other critical incidents, the outcome of audit activity and progress against action plans and the review of the risk register.
- The risk register contained two items in relation to children and young people's services. These were: On the 30 July 2015 McElwain Ward had a risk of being 40% under establishment with nurse staffing due to a combination of maternity leave, retirements and vacant posts was added to the risk register. The register entry also recorded that Day Care and Outpatients had a risk of being 18% under staffed due to maternity leave. TCTU had a risk of being 17% under due to maternity leave. The risk register recorded the service as addressing the risk via attending a graduate career fayre, a recruitment campaign in nursing journals, fast tracking temporary

staff on the Oak Centre skills algorithm, contacting paediatric oncology shared care units (POSCU) colleagues in regards to upcoming vacancies, management and consultant meetings to discuss medical and nursing recruitment plans. On the 1 March 2016 the register had been updated and recorded a "good response to recruitment drives however new staff either still undergoing local induction or yet to start."

- On the 8 April 2013 the register recorded paediatric oncology cover at SGH was provided by: two advanced nurse practitioners (ANP) employed by SGH and one specialty doctor employed by the trust, who provided in hours cover. Out of hours (OOH) cover was provided seven days a week by the two SGH ANP posts and one trust fellow and one bank research fellow. The risk had been reviewed on 1 March 2016 recording that the trust and SGH were discussing a sustainable staffing model and the level of investment required. SGH were organising the rota with "bank cover for any unforeseen circumstances but a more sustainable solution is required." Children's services were in the process of drafting a paediatric strategy.
- There were systems for formally signing off action plans or removing risks from the register which ensured matters were managed appropriately to their conclusion. For example, the monthly clinical business unit meeting reviewed the children and young people's scorecard at every meeting to monitor the service's performance against NHS activity requirements. There was also a quarterly quality forum and a review panel where incidents, staffing and complaints were standard agenda items.
- All transfers to PICU at SGH were undertaken by STRS. A record of patients requiring transfer to PICU was collected via a logging system in the minor procedure suite. This information was also part of a formal weekly trust audit of transfers to PICU. Transfers and retrieval were discussed at weekly management and monthly joint operational meetings with SGH. Transfers and retrieval were also discussed at the SGH annual PICU review meeting with staff from Royal Marsden Hospital, Kings College Hospital, SGH, and STRS.
- The joint paediatric oncology chemotherapy group (JPOC) for the PTC had a primary role in ensuring consistency of practice in relation to the joint RMH and SGH chemotherapy service for children with cancer at the PTC.

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- Staff were clear about their roles and lines of accountability. Staff and ward managers we spoke with told us there was an “open door” policy to enable staff to speak to managers and senior clinical staff at any time.
- Staff told us they regularly engaged with POSCU’s however, governance was not integrated, with the exception of SGH and Kingston NHS Foundation Trust. POSCU consultants assumed responsibility for children and young people in their care; formal arrangements existed for care to be shared by way of service level agreements. At the time of the inspection, The Royal Marsden Children's service linked with sixteen paediatric oncology shared care units across London, Surrey, Sussex and Kent. The team acknowledged that formal governance arrangements did not exist in relation to the sharing of learning from incidents associated with the provision of children's cancer treatments. However, following concerns raised by a Coroner in 2013, the trust had embarked on enhancing the governance and operational arrangements between Kingston NHS Foundation Trust, St Georges NHS Foundation Trust and the Royal Marsden. A 20 point action plan had been devised which had seen the introduction of formal clinical pathways across the three services including the management of children who are assessed or suspected of having hydrocephalus as an example. Audits existed to ensure that improvements to a range of standard operating procedures were sustained and embedded so as to reduce the risk of similar incidents occurring in the future. The trust and leadership team reported that a reduction in POSCU numbers would greatly enhance the ability of the network to operate more seamlessly with greater sharing of learning, standardised operating procedures and consistent and reliable communication afforded to all involved in the provision of children's cancer care. Following our inspection the trust highlighted this was not a trust specific issue, but a network issue as specialist commissioners made the decision about POSCU providers not the trust. The trust said it did provide formal and informal support to the POSCUs in the network; for example, nurse training, shared-care study days, teaching and joint MDT meetings, as well as telephone contact via a 24 hour advice line. The trust said the issue was with no control over the size of the 16 POSCU network they were unable to provide the same level of support and joint governance arrangements that they had with their PTC partner.
- Staff told us that following a coroners report in 2013, procedures were put in place to ensure that children and young people should refer to their local POSCU service in the first instance if their child's condition deteriorated whilst at home. Where queries were received in to the Royal Marsden, a 24 hour advice line had been created which was supported by formal escalation pathways. This included the referral of high priority queries to a senior medical registrar or clinical nurse specialist in the first instance, with subsequent consultant to consultant referral for new diagnosis cases or complex concerns. The process was monitored with an annual audit conducted to ensure that appropriate and timely escalation had taken place as well as ensuring that SBAR tools had been completed and logged on the trust IT system. In addition, a review of the calls received by the RMH were considered and an analysis of clinical themes identified the need for further POSCU education as being "advantageous". Findings of the most recent audit were scheduled to be shared with POSCU leads at the next clinical quality forum in September 2016.
- There was a general belief amongst staff and the leadership team that they thought the Royal Marsden CYP cancer network needed to be reviewed, due to the demands of acting as a PTC for Surrey, Sussex and Kent; but also due to it's commitments to the London cancer network. The leadership team and wider children's cancer network recognised the need to review the existing arrangements for the provision of children's cancer treatment across London and surrounding counties. Formal plans had been developed which would have seen services consolidated across the network with greater level of skill mix and capabilities within fewer numbers of shared care centres. The trust reported that they had had little in the way of engagement with specialist commissioners in driving the quality improvement agenda forward. The leadership team, as part of the wider Vanguard Cancer Alliance, were considering treatment pathways across the whole of a place. The leadership team had entered

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into discussions with the national clinical director for cancer to request a review of children's cancer provision on a national scale as a means of enhancing the overall quality and governance of the pathway.

- As part of the RMH, Kingston NHS FT and St Georges NHS FT action plan, the trust acknowledged the need for a robust long term pathway for patients requiring tertiary paediatric specialist care. Work was undertaken by the London Paediatric Tertiary Review and Specialist Commissioners to devise such a strategy. The RMH had conducted an internal review in January 2013 to consider the long-term feasibility options for services which was reported to the executive team on 18th July 2013. A further internal review was commenced in January 2014 however this was placed on hold pending an external review commissioned by NHS England (London) into the London Paediatric Oncology network. Whilst the Commission was made aware of the existence of this report, the report had not been made publicly available at the time of the inspection and so there remained a hiatus amongst commissioners, NHS England and the relevant providers in addressing the need for a long term strategy for children requiring tertiary specialist care. The continuation of children's services at the Royal Marsden appeared as a strategic risk on the Board Assurance Framework.

Leadership of service

- We found leadership in children and young people's services to be good. Service level leadership was effective. Senior ward staff we spoke with said they felt supported by senior management, and if they raised any concerns about the service, they would be listened to.
- Staff told us the trust's board were visible and accessible. Staff said they had been invited to attend a board meeting. They told us the trust's chief executive had recently attended an event the children and young people's service had arranged in partnership with the Natural History Museum.
- The CYP service was represented by two directors at trust board level: The Chief Nurse was an Executive Director and the lead for safeguarding; and a Non-Executive Director (NED) who was the NED for quality and safety and chaired the board's 'Quality Assurance and Risk committee'.
- The lead paediatric oncology consultant was the lead for the PTC. Their role and responsibilities were clearly

set out in the London Cancer Alliance 'children's cancer multidisciplinary team operational policy', October 2014. For example, they were responsible for ensuring that the objectives of MDT working, as laid out in the Manual of Cancer Services, were met across the RMH and SGH joint PTC. The lead oncology consultant job planning process included time allocated to work each week on both RMH and SGH sites.

- Staff across the service were unanimous in telling us how the matron provided outstanding ward level leadership.
- We saw that local clinical leaders and managers encouraged co-operative, supportive relationships among staff and teams, and compassion towards patients. Staff told us local leaders were very visible and approachable. We observed the matron advising staff on the wards on several occasions.
- Staff told us they were actively looking at how they could support POSCU's.
- The consultant nurse was a reviewer for a European and a British journal for oncology nursing. Their leadership roles included involvement on national strategy and policy ensuring the health and social care needs of young adults with cancer were being met. They had also lectured on oncology nursing and been published on the subject.

Culture within the service

- There was a strong emphasis on promoting the wellbeing of staff. A staff member told us, "RMH are an excellent employer. The trust provides appropriate support to help staff deal with the emotional stress of working on a cancer ward." Another member of staff told us, "This is a learning organisation. We realise the learning from incidents and complaints in improving services."
- We spoke with staff at the data management team. Staff told us there had been a change in the culture across RMH whereby attitudes had shifted, "From a hospital that did research to a research hospital." Staff at the data management team told us they were well supported when conducting trials by the children and young people's clinical team.
- Staff told us the staff team was friendly and supportive with a team work ethic.

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Public engagement

- Children and young people who had been treated at The Royal Marsden Hospital contributed to the layout, design and colour schemes for the interior of the Oak Centre.
- The TCTU ran informal groups every week for parents and partners to get together for a chat. There was also a TCTU breakfast once a month for young people and their carers.
- We saw numerous examples of children, young people and their families being engaged with services. For example, a young person on the TCTU told us they had been involved in developing a smartphone application to set up a “Chemo Club” to enable young people receiving chemotherapy to support one another.
- RMH had active volunteer support from the ‘Friends of Royal Marsden Hospital’. We saw numerous examples of equipment the ‘Friends’ had provided. For example, ‘Friends’ fundraising enabled the Oak Centre to purchase an ‘echo ultrasound system’. A staff member told us, “We have a lot of charitable support. We are lucky here.”
- The Trust had introduced the FFT and promoted the participation of children by providing child friendly FFT feedback forms.

Staff engagement

- Staff we spoke with told us they had access to regular Schwartz Rounds. These were evidence-based forums for staff from all backgrounds to come together to talk about the emotional and social challenges of their role. The aim was to offer staff a safe environment in which to share their stories and offer support to one another.
- In the 2015 NHS staff survey the trust was in the top 20% of trusts or similar to other trusts for well led questions. For example, the percentage of staff that would recommend RMH as a place to work, 4.2 compared to the England average of 4.1: the trust scored 3.6 for recognition and value of staff by managers and the organisation compared to the England average of 3.5; and the trust scored 3.9 for effective team working compared to the England average of 3.8.
- The trust had an annual staff awards ceremony to reward staff that had demonstrated dedication and commitment, going above and beyond the Trust’s expectations in their work. For example, a children and young people’s CNS had been awarded the trust’s

‘clinical excellence’ award, and been presented with their award at a ceremony in London. Some of their colleagues had also been invited to attend the ceremony to see their colleagues receiving their awards.







Innovation, improvement and sustainability

- Staff told us they thought the service model needed to be reviewed and POSCU reconfigured, due to the Royal Marsden being PTC for not only London, but also Surrey, Sussex and Kent. Staff told us they were PTC to 16 POSCU and this sometimes proved a struggle. Staff said they thought eight would be the optimum number.
- RMH staff worked with a variety of academic partners in research. For example, a paediatric oncology consultant was a member of the National Cancer Research Institute Children’s Cancer and Leukaemia Clinical Studies Group.
- RMH had the largest paediatric inpatient drug development programme in the UK. The programme was set up with the objective of improving survival rates for children and young people with cancer. Its central theme was a bench-to-bedside approach which aimed to quickly bring new targeted therapies from the laboratory into the clinical setting. The ultimate goal was to develop personalized treatment options for children and young people in partnership with The Institute of Cancer Research and other key organizations meant the RMH offered access to leading-edge clinical trials and clinical trials of novel anti-cancer agents. For example, the ‘Hot Lab’ were a paediatric drug development team. At the time of our inspection staff were involved in a molecular profile study looking at targeted drugs for tumors in children. The RMH drug development unit was rated as “outstanding” by Cancer Research UK in 2015.
- The lead consultant paediatric oncologist was a principle investigator for a number of phase I and II research studies in sarcoma and melanoma as well as being a member of the Novel Agents Group for Childhood Cancer and a member of the Innovative Therapies for Children with Cancer (ITCC). One of the leukaemia consultants was the United Kingdom (UK) lead for early phase trials in paediatric leukaemia and also a member of the Novel Agents Group and ITCC. The drug development lead consultant was a member of the Novel Agents Group, ITCC and was a member of the clinical trials committee of the ITCC.

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- Staff across children and young people were involved in a wide range of research projects. For example, the lead clinical consultant for paediatric psychological medicine was the principal investigator of several research projects, including social functioning and social competence in survivors of paediatric brain tumours, and the development of a new paediatric psychosocial screening tool.

End of life care

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

Information about the service

End of life care (EoLC) relates to patients who have been identified as having entered the last 12 months of their life or less. It refers to care of patients in the final hours or days of their lives, and to the care of all those with a terminal illness that has become advanced, progressive and incurable.

Palliative care is a multidisciplinary approach to specialised medical care for people with serious illnesses, both cancer and other illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress and mental stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

Palliative care at the Royal Marsden is provided at by a specialist trained team of doctors, nurses and others who work together with other health service staff to support people at the end of their lives.

The specialist palliative care team at the Sutton site is made up of two clinical nurse specialists, **2.4 whole time equivalent (WTE) palliative medicine consultants** shared across sites, junior doctors and other allied health professionals to provide care for patients in the final phase of life.

There were 138 adult deaths on wards at the Sutton site in the year April 2014 to April 2015.

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

The Sutton site does not have any dedicated hospital beds for patients who are dying. Patients in the last days or hours of life were cared for in a side room on the main wards when possible. The specialist team works closely with the patient and those close to them, the hospital doctors, ward nurses and other allied health professionals in supporting the patient's needs. They also liaise with hospices and other community support agencies to facilitate rapid discharge to patients' preferred place of death. The hospital had set up a Hospital2Home service in order to improve effective handover and transfer of care to community providers.

The Royal Marsden does not have full 'mortuary' facilities as such and post mortems are not conducted on the Royal Marsden premises. The Royal Marsden has contractual arrangements with other NHS hospitals for post mortems. Therefore, the Royal Marsden's facilities are essentially refrigerated body stores which provide temporary storage for bodies and accommodate viewings by bereaved relatives.

During this inspection, we spoke with 34 members of staff which included members of the specialist team, ward nurses, health care assistants, trainee doctors, consultants, allied health professionals, porters, the chaplain and staff from the patient advice and liaison service (PALS). We spoke with eight patients. We reviewed nine care records and nine do not attempt cardio pulmonary resuscitation (DNACPR) records. We observed staff interactions with patients and those close to them. During and prior to the inspection we requested a large amount of data in relation to the service which we also reviewed and considered when making our judgements.

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We visited most of the medical and surgical wards, the body store, the PALS office, the chapel and multi-faith rooms and the room for relatives.

Summary of findings

We rated this service as 'good' because:

- We found the specialist palliative care team were highly skilled and knowledgeable. They worked effectively with ward staff 365 days a year to provide good quality, safe care to patients at the end of life. There was an education programme to support staff in delivering this care in line with appropriate national standards and best practice guidance.
- 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 that patients and their relatives were fully informed and involved in their treatment decisions. Consent and capacity were considered appropriately.
- Regular 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 these 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. A 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 regards to these outcomes. Symptom control was considered and well managed, using both traditional medical methods and complementary therapies. The needs of individuals were considered and largely met by the service.
- The trust had a clearly defined vision and strategy to improve palliative care provision, which staff in the specialist team were aware of. 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;

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- There were some minor issues that were found in the course of the inspection process. It was felt by some of the staff we spoke with that referral to palliative care could be made earlier in the patient pathway. The trust provided us with evidence that for lung cancer patients, the timeframe of referral before death was comparable with other patterns in Europe and the United States. However, their own audit data demonstrated that the vast majority of referrals across other cancer types were made within one month of death. This affected patients' 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 some of the wards for grieving relatives, where they now went for return visits and to collect the death certificate.
- Porters were broadly unaware of the procedures to follow in terms of infection prevention and control (IPC) and escalation of potential problems in relation to the body store. This suggested that training was not sufficient in this area and that further work could be done.
- There was little knowledge of items relating to EoLC on the trust risk register amongst staff.

Are end of life care services safe?

Good



We rated safe 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.
- Infection prevention and control (IPC) measures ensured that the environment was clean and suitable for purpose.
- 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.

However;

- Staff were unaware of an incident relating to the body store nor any learning arising from this.
- Porters were broadly unaware of the procedures to follow in terms of IPC and escalation of potential problems in relation to the body store.
- Do not attempt cardio pulmonary resuscitation (DNACPR) forms did not specify review dates as routine.

Incidents

- Staff in the both the specialist team and on the wards were aware of trust wide systems to report and record safety incidents and near misses. All staff we spoke with were familiar with the electronic reporting system and how to navigate this. Feedback and learning points from incidents of 'moderate harm' and above were shared with staff across the trust via monthly emails. Incidents were also routinely discussed in local ward and team meetings, as well as at monthly senior management meetings and quarterly unit meetings.
- The specialist nurses were unaware of any incidents relating to End of Life Care (EoLC) that had happened in last 12 months, the majority of which were reported and recorded by ward staff due to their nature. Between

End of life care

February 2015 and February 2016, 58 incidents graded between 'no harm' and 'moderate harm' classified under palliative medicine were recorded across both inpatient sites. The majority of incidents related to pressure ulcers detected on admission to inpatient wards (24) or accidental falls (14).

- One incident related to difficulty with the identification of a deceased patient as two identification tags had been added to the body when last offices (the preparation of a body for burial) were performed. Staff were able to positively identify the deceased person and release them to the undertaker. This was raised in the next ward team meeting to ensure that clear identification processes were followed in future.
- In the same period, 14 incidents were recorded across sites in relation to medicine errors, all rated 'low' or 'no harm'. The doctors that we spoke to confirmed that there was a good reporting culture of such incidents and these were flagged to the service leads. The consultant would then meet with the junior doctor involved to discuss what had happened and what could be learned. Any lessons were then used as teaching opportunities in quarterly complex case meetings.

Duty of Candour

- Staff at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan. They were aware of their responsibilities with regards to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were able to provide examples of situations when an incident had occurred, how they had informed the patient and their relatives of the incident, made an apology and explained what investigation and actions had resulted from this. There were clear examples of apologies made to patients and carers in the electronic records that we reviewed.

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 IPC link nurse. Link nurses act as a link between the ward and the infection control team. Their role is to increase awareness of infection control issues and motivate staff to improve practice.

- We found the body store and associated areas to be visibly clean and tidy during our inspection. There was a separate operational policy in place to ensure infection control processes were followed in the body store. The store was cleaned on a daily basis and we saw records indicating that fridges were deep cleaned every three months. Facilities were responsible for completing regular audits to check compliance with the infection protection and control processes.
- Appropriate procedures, forms and checklists were used in the event of death to identify and protect staff from infectious disease or radioactive materials. Clear procedures were followed and paperwork was completed by a doctor to evidence this, before a body could be removed from the place of death. Copies of these forms would be added to the patient notes and given to the Patient Advice and Liaison Service (PALS).
- Handwashing facilities and personal protective equipment were both available in the body store if required. There was a list of senior nurses who could be called in the event of infection control issues in the body store. This list was kept in a file in the body store and also in the resource file of each ward.
- Of the 21 porters at the Sutton site, 100% had completed IPC training in an annual mandatory update. However, porters we spoke with were unaware of appropriate infection control measures to take in relation to deceased patients. They were not able to locate the list of senior nurses to assist with IPC issues in the body store. They told us they would ring domestic staff to deal with this as they had the appropriate spillage kits, although this was not the case according to other staff we spoke with.
- The trust had recently recruited a mortuary technician who would work across both sites to ensure that these issues were dealt with in a timely manner. We were unable to interview him as he was on training during the course of our inspection.

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 subcutaneous infusions of analgesia (pain relief medication delivered via a needle or soft cannula under the skin). The syringe drivers had in-date annual maintenance checks and/or corrective maintenance in line with the manufacturer's recommendations.

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- Ward staff obtained syringe drivers from the equipment library. There were no problems in accessing syringe drivers whenever they were needed for patients. 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 that the syringe drivers were returned.
- The body store had capacity for 16 deceased patients from the hospital. The fridges consisted of a number of labelled compartment bays, each containing racks for holding the body trays upon which deceased patients 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, and a record of fridge temperatures was kept daily by facilities. 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. Facilities across sites had contacted an external engineer twice in the three months prior to inspection. In the event of problems occurring out of hours, escalation plans were stored in a file kept within the body store.

Medicines

- The Sutton site shared one specialist palliative pharmacist with the community, giving them access to 0.5 whole time equivalent (WTE) pharmacist for advice and guidance in EoLC medications.
- There were separate sections of the inpatient chart for controlled drugs, including opiates. There was also a separate controlled drug 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 was 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 utilised 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. Nursing staff had to undergo a syringe pump competency assessment prior to utilising these devices in practice. All qualified nurses new to the organisation

were educated at induction on medical devices including the McKinley T34 syringe pump. Further training then happened on the ward. A recent audit showed 79% of nurses had been trained across the trust.

- There was a guide for medical staff to follow on the prescription of anticipatory medicine. 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 that guidelines on this checklist were considered in appropriate circumstances. The specialist team were usually involved when these medicines were prescribed, as indicated by two junior doctors that we spoke with.

Records

- Hospital staff used electronic patient records to record patients' needs and care plans, medical decision making and reviews, and risk assessments. 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 action on the electronic system. This formed part of the inpatient case notes section of the record. The specialist team commented that 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 last few months and ward staff awareness and utilisation varied, according to the specialist team. Most of the ward staff that we spoke with were aware of the document, apart from one clinician.
- We looked at nine sets of patients' records. Information was concise and clear. Difficult conversations with both the patient and family were well documented and detailed. All handwritten notes were dated, signed and followed the trust's note writing protocol.
- Do not attempt coronary pulmonary resuscitation (DNACPR) forms were located at the front of the paper patient records for easy access. They were also scanned onto the electronic system but one junior doctor commented that these could be quite hard to locate if they had been in place for a while, due to the volume of scanned documents.

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- We reviewed nine DNACPR forms and all detailed full discussion with patients and their relatives. All forms but one had been signed by a consultant and all but one had appropriate reasons for the decision detailed on the form – when cross checked with the notes, there was a plan for this form to be signed by a consultant and full discussion of the reason for the decision was detailed therein. Doctors did not routinely fill out the section for a review date of the decision – this was only found in place on one form.

Safeguarding

- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Staff had access to the trust safeguarding policy on the intranet. Safeguarding was part of the trust annual mandatory training. Staff at all levels knew who to contact if they wanted further advice.

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. Anecdotal feedback from doctors and link nurses on each ward suggested these sessions were useful. The link nurses would then feedback any training or updates to other nursing staff on the wards.
- 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. She won an award for 'Excellence in Education' in the staff awards in 2015. Junior doctors were very positive about the training and support they received from the specialist team.

- Porters were also given annual mandatory training, covering topics such as safeguarding, patient handling, basic life support, information governance, infection prevention and EoLC. Of the 21 porters at the Sutton site, 100% had completed this training.

Assessing and responding to patient risk

- Staff had completed skin integrity assessments to evaluate patients' likelihood of developing pressure ulcers, which are more likely to occur at the end of life due to changes in the body. Patients were regularly repositioned and pressure relieving aids were used where appropriate to mitigate this risk.
- Falls risk assessments were undertaken in patients with impaired mobility. Management plans involving 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.
- Nursing and health care assistant staff monitored all inpatients regularly and used an Early Warning Score (EWS) to identify patients who were deteriorating. Staff on the wards were aware they could access advice and request support from the specialist team if their patient had been identified as requiring palliative support. However, some staff reported that it was sometimes not recognised early enough that a patient required palliative support as there was a focus on curing the patient due to the specialist nature of the service.
- Health care assistants and nurses monitored the comfort of patients who were in the final phase of dying and recorded symptoms on the 'Principles of Care' document, or in individual nursing notes. Nursing staff reported changes in condition, such as signs of discomfort or agitation, or change in breathing to medical staff.

Nursing staffing

- The specialist team had at the Sutton site had two whole time equivalent (WTE) clinical nurse specialists covering the inpatient wards. The nursing staff worked 8am -6pm on weekdays. There was another WTE clinical nurse specialist covering the Hospital2Home service at the Sutton site, alongside another 0.6 WTE, who shared

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their time between both sites. The Hospital2Home team worked 9am – 7pm on weekdays. There was also a nurse consultant and a matron who worked across both sites.

- Across both sites, there was one reported vacant 0.6 WTE post for clinical nurse specialists in palliative care, covering maternity leave. The nursing staff felt that 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 Sutton. Nursing and medical staff generally 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.
- There was consultant cover on the Sutton site for four days per week, but staff confirmed that the consultant would always come on site if there were any issues that the StR could not resolve independently. The StRs covered both sites and would split their weekends across sites, spending one day at the Sutton site and one day at Chelsea. Medical staff reported that 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. 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. Locum use in the period April 2015 – March 2016 varied between 2.4% and 58%, with the highest use being in November 2015 with 58%, and March 2016 with 56.8%. The service lead explained that 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.

Major incident awareness and training

- The specialist team were a floating team, who worked across different wards and departments of the hospital. As such, they were not specifically involved in major incident planning and were instructed to follow the lead of senior staff in the area in which they were working at the time of any event occurring.
- The body store had capacity for 16 deceased patients. There were appropriate arrangements with neighbouring mortuaries for the transportation and storage of additional deceased patients in case of emergencies.

Are end of life care services effective?

Requires improvement



We rated effective as 'requires improvement' because:

- Although there were many good things about the service, there was a feeling amongst many staff that we spoke to that referral to the team could be made earlier in the patient pathway, and that the 'Principles of Care' document could be implemented sooner. The trust provided us with evidence that for lung cancer patients, the timeframe of referral before death was comparable with other patterns in Europe and the United States. However, their own audit data demonstrated that the vast majority of referrals across other cancer types were made within one month of death. Delayed referrals to the specialist team meant that patients at the end of life were not always receiving consistent care.

However, once patients had been referred to the EoLC service, we found that;

- Care and treatment was provided in line with appropriate national professional guidance.
- Regular clinical audits were carried out. Improvements had been made across the service as a result of their findings.
- Care was delivered by a range of skilled staff who participated in annual appraisals and had access to further training as and when required.
- Pain relief, symptom control and nutrition and hydration were well managed.
- A multidisciplinary team approach was in effect both across the specialist team and with the wards and services they worked with.

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- Specialist palliative nurses worked Monday to Friday, 8am – 6pm. Out-of-hours cover was provided by palliative care Specialist training Registrars (StRs) and medical consultants.
- Consent and capacity were considered when patients were making decisions about their preferences at the end of life.

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' 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 that an education and training programme had taken place but admitted that its use varied from ward to ward. Staff from the specialist team commented that the pathway was sometimes implemented too late due to the fact that you had to get approval from the patient's oncology consultant and ward team. This was evident in some of the notes we looked at, especially in patients of the Clinical Trials Unit. The trust was in the process of auditing the use of the tool on the electronic records system.

Pain relief

- The hospital used a variety of tools to assess pain, depending on the needs of the patient. Medical notes showed that the numeric rating scale (NRS) and verbal

rating scale (VRS) were most commonly used.

Appropriate actions were taken in relation to pain triggers. Instructions on managing pain were also included in the hospital documentation on the 'Principles of Care' tool. The guide encouraged staff to contact members of the specialist team for advice in complex cases.

- The Royal Marsden had a dedicated acute pain service, who offered advice and support to patients who were experiencing pain as a result of their treatment or illness. The specialist team had close links with this service and a weekly joint MDT took place to discuss mutual patients and present new research in pain management.
- We saw examples in the records of pain control managed with PRN (pro re nata or as required) analgesia. Patients received adequate information on the use of analgesics, especially strong opioids (in accordance with National Institute for Health and Care Excellence (NICE) guidance on Opioids in Palliative Care). Some patients had syringe drivers, which delivered measured doses of drugs over the course of 24 hours. We saw examples of appropriately prescribed syringe drivers, which nurses checked to make sure they were functioning correctly and that the patient was receiving the correct doses of drugs.
- Patients that we spoke with were generally happy that their pain was well controlled. However, we spoke with one patient that had been in acute pain several times. When his prescription chart was checked, his overall syringe driver dose has not been increased, despite a marked increase in his need for PRN medication. There were also two incidents recorded in August and September 2015 in which scheduled doses of pain medication were missed.
- We saw evidence that 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 and regular medication in view of changing symptoms. For example, staff adjusted one patient's anti-sickness medication when this proved ineffective, and an appropriate laxative was later commenced due to constipation.
- Complementary therapies were also available to patients to help manage symptoms and side effects. For example, aromatherapy massage was used in two cases to help manage nausea. However, the results of the

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FAMCARE survey in 2014 showed the highest frequency of dissatisfaction or very dissatisfied responses (16.7%) in relation to speed with which symptoms were treated. This may reflect the complex nature of the symptoms experienced by patient at this specialist trust, being a tertiary oncology hospital.

Nutrition and hydration

- Patient's nutritional and hydration needs during the dying phase were identified as a concern from the results of the previous National Care of the Dying Audit in Hospitals (NCDAH) 2014. The trust scored lower than the England average in this measure. They had addressed this through multidisciplinary (MDT) documentation and discussion of nutrition and hydration and ensuring assessment of nutrition/hydration requirements were highlighted on 'Principles of Care' tool. In the 'End of Life Care Audit: Dying in Hospital' in 2016, this was no longer a concern.
- Dietitians attended the weekly specialist team MDT and contributed to discussions regarding appropriate nutrition and hydration at the end of life. Assessments and advice from dietitians were seen in the notes we examined. For example, a dehydration risk assessment was carried out for a patient who had been vomiting excessively prior to their admission. Referrals to the speech and language therapist were also made for patients who found it difficult to eat solid food.
- Patients gave positive feedback about the range and choice of food available. One patient described how staff were considerate in the variance of her appetite due to her symptom fluctuation. They ensured that she had access to food when she needed it even when she did not order a meal through the normal process.

Patient outcomes

- The trust carried out routine audits of the palliative care service, providing meaningful data to improve patient outcomes. Staff were actively engaged in a range of ongoing audits on topics including patient experience, the effectiveness of the electronic version of 'Principles of Care' document and opioid prescribing. A three monthly audit meeting was held to present results and to report on audits in progress. For example, changes were made as a result of a DNACPR audit in April 2015 to improve the inclusion of the original red form in the patient notes. The resuscitation service completed a large print run and delivered these forms to the wards/departments and streamlined the process of ordering

these. Compliance rose from 40% to 100% by December 2015. Changes had also been made in doctors' training to increase the quality of the discussions with patients and their families described on these forms.

- The trust participated in the National Care of the Dying Audit – Hospitals (NCDAH). The audit was made up of an organisational assessment and a clinical audit. In 2014, the trust collated their data with the Royal Brompton Hospital (RBH) and scored higher than the national average on eight out of ten clinical key performance indicators (KPIs). The audit revealed shortcomings in review of patients' nutritional and hydration needs, access to EoLC information and specialist support, EoLC education and audit and gathering the views of bereaved relatives.
- The trust had analysed the main findings of this audit and proposed a number of recommendations and action plans to improve the provision of EoLC. They also looked at KPIs in which they 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, 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' in 2016, the trust reported their data separately to RBH and had achieved all five new clinical KPIs.
- Patients receiving palliative and end of life care were cared for on the wards, with advice and support from members of the specialist team. There were 1,293 referrals to the specialist team between April 2014 and April 2015, although this covered both the Chelsea and Sutton sites.
- 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

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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 described having strong links with each ward in this sense, especially with the nominated palliative care link nurse on each ward. The specialist team rarely refused referrals but we were told it did happen in some cases, perhaps when it was considered too early in the patient pathway for palliative care input. The specialist team had a list of patients to be aware of that had not yet reached the threshold for referral.
- 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.
- In an audit conducted between October and December 2015, the trust found 43 of the 51 (84%) patients who died were referred to and seen by the specialist team before their death. However, of these 43, only 8 (16%) patients were referred to the specialist team more than one month before death. There was a feeling amongst many staff that we spoke to that referral to the team could be made earlier in the patient pathway in some cases. Staff were of the opinion that this was due to the specialist nature of the hospital and the type of treatments offered, which often were the last line of treatment available. Patient expectations were focused on cure and conversations about dying could be difficult to instigate. One doctor went as far to say that they believed palliative care was an 'afterthought', especially in the outpatient department, where there were no clinics relating to EoLC as it was not seen as necessary to consider this as an option early in the treatment pathway. It was felt that patient care could be impacted by late referral, as symptoms at end of life could be readily controlled but psychological care and preparation for death could be lacking. Prompt referral was especially important in cases of neuro-oncology, as cognitive impairment tended to prevent advance care planning discussions in later stages of the disease. Most patients we spoke with were aware of palliative care options, although some were reluctant to consider their long term prognosis.
- Some members of the specialist team were of the impression that some of the reluctance to refer to the service was because some staff and patients thought of them as 'the death people'. In actual fact, symptom

control made up a lot of their work and the specialist nurses introduced themselves to patients as 'symptom control and palliative care nurses'. The specialist nurses felt that earlier referrals would be more likely if their official titles and name badges reflected this part of their role. Another member of staff thought that issues around referral were 'generational' and actually improving.

- The trust had recognised more work needed to be done in the outpatient department in terms of referral to the specialist team. The trust was in phase two of a pilot research study to evaluate the impact that proactive screening had on advance care planning (ACP) and referral to the specialist palliative care team within the lung oncology outpatient department. Phase one, a retrospective audit, had been completed at the end of 2015. This found that referral to the specialist team was generally occurring 79 days before the death of a patient. Data presented at the European Society for Medical Oncology (ESMO) congress in Copenhagen, in October 2016, showed that referral to palliative care services currently happened at a median of 90 days before death. Further analysis of the audit findings showed that ACP was happening, but relatively late in the disease trajectory. The second phase of the study plans to introduce an "Advance Care Planning Framework" and evaluate the effect its implementation has on earlier referral to the service.
- 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 an electronic system to help ensure more timely ACP and referral to specialist palliative care where appropriate. The service were planning to recruit two more specialist nurses to support the implementation of these projects.

Competent staff

- The specialist team was made up of competent and highly trained individuals. They had opportunities to undertake personal development opportunities to enhance their skills. The two specialist nurses gave several examples of study days, courses and conferences they had attended over the course of the last 12 months in topics such as psychological support

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and conflict resolution. The team were also encouraged to research and present on recent developments relating to EoLC and pain management in joint MDT teaching sessions with the acute pain team.

- The doctors and nurses we spoke with in the specialist team all reported receiving annual appraisals which looked at their development needs and set achievable and realistic targets to measure progress against. The specialist nurses confirmed that they attended monthly clinical supervision sessions and could request more ad hoc support as and when required. Junior doctors felt they had sufficient consultant contact and support when considering more complex cases.
- Ward nurses, health care assistants and therapists indicated that they felt knowledgeable in terms of supporting patients at the end of their lives. Staff confirmed they had received training and support from the specialist team and were able to confidently discuss their role in terms of symptom control and family support, for example. Monthly staff support sessions facilitated by a psychologist were held on each ward to enable staff to talk about difficult events and issues, including the death of patients. These were well attended by ward staff of all levels and identified actions that could be taken forward to improve support around such difficult situations.
- 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. Staff knew where to access information held on the ward, such as leaflets for patients and their relatives about dying.

Multidisciplinary working

- There was good attendance at the weekly MDT specialist palliative care meetings. One or more specialist nurses attended every meeting along with one of the palliative care consultants and registrars. The chaplaincy team also attended every week, with professionals such as physiotherapists, dietitians, pharmacists and occupational therapists contributing where appropriate. We observed one such meeting and discussion of each of the 11 patients was holistic and sensitive. A structured and detailed proforma ensured

that specific areas of care were covered for each patient and that each professional had a chance to offer their input, with appropriate challenge and request for further information from other team members.

- A member of the specialist team aimed to attend other MDT ward and speciality meetings, especially on wards where patients were likely to be identified as requiring palliative care. Some of these were covered via video link if staff were not able to attend in person. However, some staff reported that these video links could be technically unreliable.
- All members of the MDT reported feeling valued and respected. The doctors appreciated the specialist nurses, describing them as 'phenomenal' and 'medically minded'. Their level of expertise enabled them to manage referrals from the outpatient department independently, which freed the medical team up to concentrate on inpatient referrals to the specialist team.
- We accompanied a specialist nurse to the wards and saw her supporting the work of nursing staff in a constructive and practical way to enhance the care of dying patients. All the staff we spoke with knew the team and said they were readily accessible to give advice and support on EoLC. Senior nurses and doctors were aware of the referral process to the specialist team.
- The care records that we examined confirmed active involvement from health professionals of all disciplines where appropriate, including referrals to complementary therapists in areas such as aromatherapy and massage, for symptom control.
- The specialist team worked closely with the Critical Care Unit (CCU) outreach team. They described times in which they would end up at the same patient's bedside after a major event and where difficult decisions had to be taken in regards to which team would be appropriate to continue supporting the patient effectively.
- 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 from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. Staff that we spoke to, including porters, 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.

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- There were service line agreements held by the by the Principal Biomedical Scientist/ Pathology Services Manager to transfer bodies from the Sutton site to another local trust if they required post mortem. This arrangement worked well and we saw evidence of one such transfer that took place shortly before our inspection.

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. Both nursing staff and consultants felt that nursing cover at weekends was not necessary. Ward nurses confirmed that they were able to flag up issues directly to doctors at weekends and had no problem accessing support or advice. Doctors routinely attended the wards out-of-hours where required to provide care to dying patients. Care for patients dying at home was covered by other community providers.
- 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. Ward staff were aware of these files and found them to be helpful.
- Trust information advertised that staff had access to an electronic system developed to give patients an opportunity to create a personalised urgent care plan to express their wishes and preferences in relation to how and where they are treated and cared for.

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. We saw

evidence of a capacity assessment in one of the patient records and a junior doctor was able to describe how best interest decisions were reached. The MCA form was described as being 'easy to use' for this purpose. There was a section relating to mental capacity on each do not attempt cardio pulmonary resuscitation (DNACPR) form, which was filled out by the doctor completing it.

- Some staff felt that conversations around EoLC and DNACPR could happen earlier and that the orders were put into place much later than in other district general hospitals they had worked in. Staff told us they attributed this to the specialist nature of the service and the difference in the expectations of the patients. However, nursing staff felt that they were able to instigate this conversations with doctors where necessary and get a DNACPR order in place, particularly before weekends and bank holidays, where they might be more difficult to instate. No staff had witnessed any cardiac arrests where inappropriate resuscitation had occurred as the result of a DNACPR form not being in place.
- An audit of 162 DNACPR forms completed in December 2015 showed some significant improvements since the last audit in April 2015. The inclusion of a valid clinical reason being recorded on the form had risen from 93% to 100%. The inclusion of a discussion with the patient had improved from 66% to 85%, and discussion with the family from 40% to 78%. Consultant verification had also improved from 53% to 78%.

Are end of life care services caring?

Good



We rated caring as 'good' because:

- Patients were cared for in a caring and compassionate manner by all staff.
- Patients' privacy and dignity was maintained throughout their hospital stay.
- Staff ensured that patients and their families were informed about their care and were fully involved in any treatment decisions.
- The chaplaincy team offered comprehensive spiritual support to those at the end of their lives.

However;

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- Psychological support to patients at the end of life was often not timely.

Compassionate care

- Staff consistently treated patients with dignity and respect. Nurses and doctors from the specialist team introduced themselves to patients and sought permission to enter their bed space. Ward staff drew curtains around bed bays when privacy was needed. Patients who remained on the ward in their final stages of life were moved to side rooms where possible.
- Interactions between staff and patients were positive across the service. Staff were warm and caring, with a compassionate and sensitive manner. Patients described how the nursing staff answered call bells very promptly and made sure they were comfortable and cared for. There were examples of health professionals who went that extra mile. Nursing staff on Smithers ward gave a patient flowers and a card for their birthday as this occurred whilst they were in hospital. Another patient on Kennaway ward who was not able to have a church wedding was supported in organising a blessing as close as possible to this in the hospital chapel.
- A patient reported that the specialist team were “very good at both pain and the bigger picture”. We accompanied nurses from the specialist team when they visited patients on the wards and observed how they spoke to each patient empathetically about their worries and fears. Symptoms were discussed and treatment options were explained to each patient, before a final decision was reached. Agreed changes were then made to patient care plans and these were shared with the wider team.
- Patients reported that the medical staff were “fantastic” and “incredibly caring” and had a “real skill” in anticipating individual patient needs. Another patient felt that they had finally been given the right diagnosis and corresponding treatment since being admitted to the hospital as an inpatient.
- Staff at all levels contributed to patient care. Porters were described as “excellent” and “kind” in the way that they spoke with patients. Nursing staff described how the porters really got to know the patients as it was a small hospital. Patients reported that the domestic and catering staff were “polite” and “always working hard”. Staff in the Patient Advice and Liaison Service (PALS)

office demonstrated a great deal of knowledge and empathy when speaking about helping grieving relatives to manage the practical aspects of bereavement.

- A small survey of 15 patients who had received care from the specialist team was completed in October 2015. The results were largely positive, with 100% of respondents agreeing that they had been treated with privacy and dignity. All rated the care received from the team as either ‘excellent’ (80%) or ‘very good’ (20%). These findings were supported by the FAMCARE survey from August 2014, where a further 18 bereaved relatives were surveyed. Overall satisfaction was high at 79.7%, compared to a mean of 77.2% from service evaluation data from the Association of Palliative Medicine report. Specialist palliative care input had been positive and effective, especially with regards to patient comfort, explanation of patient’s progress and condition and respect of patient dignity. Although both of these surveys used small sample sizes, they were reflected by the findings of our inspection process.

Understanding and involvement of patients and those close to them

- Involvement of, and communication with, patients at the end of life and those close to them was central to the ‘Principles of Care’ document adopted by the hospital. In records where this was used, we saw detailed and thoughtful consideration of the patient and family wishes and circumstances, especially in regards to preferred place of death and information provision. One patient expressed a preference that their family be told their prognosis and they only be told as much as was necessary. Another patient wanted his wife to be given less detailed information about his condition as he felt she was too vulnerable to cope with every detail at that time. These choices were understood and respected by staff at all levels. Members of the specialist team often led these conversations or attended the wards on request to assist and support doctors in communicating with patients and their families.
- Results from the local survey of 15 patients in October 2015 indicated that 73% of patients had received written or printed information about their condition and that 86.6% believed this to be the right amount of information. In regards to their families, 73.3% were involved in discussions about their care and 66.6% reported that they received sufficient information. If

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patients needed to clarify anything, 73.3% reported that they always received explanations they understood from the specialist team. Results from the FAMCARE survey of 18 bereaved relatives in 2014 reflected this, rating 'the inclusion of the family in treatment and care decisions' highly.

- Facilities were available for relatives to stay overnight, either on fold-out cots by the patient's bed or in specific accommodation. The canteen was not open overnight but there were kitchen facilities in the accommodation or vending machines within the hospital. Staff also informed us that relatives were welcome to ring and order takeaway if they wished. Patients we spoke with confirmed that their relatives had been comfortable staying overnight.

Emotional support

- Emotional support for patients was provided by two psychiatric nurses and a consultant psychiatrist, who also gave other doctors advice regarding psychiatric medicines. Although we saw referrals to psychology in the care records we looked at, these were often only made a few weeks before the death of a patient. Meaningful involvement was therefore limited as patients were only seen once before the end of life. However, following the inspection, the trust informed us that psychological support was provided to inpatients at the end of life on the day of request, or the next working day.
- Staff we spoke to told us that it could take up to six weeks to get an appointment with specialist psychology. This was recognised by the trust and had been added to the clinical risk register in January 2014. Action plans had been put into place and regularly reviewed in this time, reducing the wait time from ten weeks to six.
- The trust had developed adult psychological support referral criteria and an additional agency/bank post focusing on assessments for two days a week had been instated. They also recruited a further 0.6 WTE staff grade psychiatrist. A priority list for patients had been instated but the increasing number of referrals meant that capacity was still not meeting demand.
- There was access to multi-faith chaplaincy, seven days a week through a rota and on-call system. Church of England, Free Church, Roman Catholic, Jewish and Muslim chaplains were available to offer spiritual care for patients nearing the end of life and their families.

Chaplains of other faiths could be contacted if required. From October to December 2015, the Sutton chaplaincy team saw 44 people receiving palliative care. The team were clearly intuitive, caring and open to anyone who wished to speak with them, whether they had a religious belief or not. They routinely offered informal support to patients receiving palliative care and lent a listening ear. The service had also helped to recently help to facilitate a marriage blessing in the chapel and the chaplains often acted as a bridge to people's local faith communities to enable them to make funeral arrangements.

- Staff were aware of the importance of finding out about the spiritual needs of patients and their families and knew how to refer people to the chaplaincy service. There was a section in the 'Principles of Care' document to document this and any further actions relating to spirituality. The chaplain attended the weekly specialist palliative care multidisciplinary (MDT) meeting. The discussion of each patient included a check that staff had asked the patient and/or family about their spiritual needs. The chaplaincy team reported a great working relationship with the specialist team.
- The chaplaincy service held an annual 'Time to Remember' service each June. All families of those patients who died in hospital were invited and encouraged to bring along anyone they wished. In December, they also led the annual 'Celebration of Life' which was for all patients of the hospital to attend, as well as the bereaved.

Are end of life care services responsive?

Good



We rated responsive as 'good' because:

- Services were designed appropriately to meet the needs of local people and the wider population and take into account their preferred place of death.
- The needs of individuals were considered and largely met by the service.
- Complaints were dealt with well and learning points were developed into actions to develop and improve the service.

However;

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- There was a lack of quiet or private space in some of the wards for grieving relatives.
- 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 local providers and Sutton and Surrey Downs Clinical Commissioning Groups.
- 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 outpatient department, wards were also able to refer more complex patients. One ward sister commented that it had helped many patients with the discharge process and achieving their preferred place of death (PPD).
- There were no designated EoLC beds at the Sutton site. 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.

Meeting people's individual needs

- The chaplaincy team provided spiritual support for different faiths. The across site team of two Anglican chaplains (1.8 WTE); one catholic chaplain (0.4 WTE); two other Christian denomination (0.4 WTE) and a Muslim Iman (0.2 WTE) was proportionally representative of the faiths and denominations of the patients attending the hospital. This 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. From October to December 2015, the Sutton chaplaincy team saw 211 patients who identified as Church of England, Roman Catholic or Christian Other, and only five Muslims, two Hindus and zero people who identified as Jewish, Buddhist or other faiths.

- The hospital chapel did have Christian symbolism but the chaplain explained that this was taken down on the East facing wall and the room was used for Friday prayers for male patients from the Muslim faith. There was a separate small Muslim prayer room, separated by a curtain so men and women could use it at same time. There was also an ablutions room. The chapel and separate Muslim prayer room were open day and night for prayer or quiet reflection. Although the viewing room attached to the body store was neutral in decoration, holy books and prayer books of different faiths were available for families to use on request.
- There were few NHS patients at the end of life who did not speak English but staff were aware of how to access both telephone interpreting and face-to-face interpreting services. We were told that they try not use families as interpreters as a rule. Arabic advocates within the trust provide 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, but we were told that these could be requested.
- The hospital saw relatively few patients with complex needs such as people living with dementia or patients with learning difficulties. We were told that this was due to issues around consent and the fact that patients were only transferred from their general hospital if it was thought to be beneficial in terms of further treatment. Such moves could be very distressing for these patients and therefore not recommended in many cases. However, staff were aware of the existence of hospital passports and who to contact if they needed advice on a patient who presented with complex needs. There were pain assessment tools available for ward staff to use for those who had difficulty communicating verbally.
- There was emergency psychological support available through two registered mental health nurses and a consultant psychiatrist. The trust had developed adult psychological support referral criteria and an additional agency/bank post focusing on assessments for two days a week had been instated. They also recruited a further 0.6 WTE staff grade psychiatrist. For example, a lady who

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had been diagnosed with a mental health condition who was assessed by the psychological team as to whether she had capacity to consent to treatment. The safeguarding team was also involved in this process.

- Visits for relatives returning to the hospital were now held on the ward in which the patient had died. Relatives could return to view the body in the dedicated viewing room before it was moved to the funeral director and collect the death certificate directly from the ward. Some relatives who found this distressing could opt to collect the certificate from PALS office. Nursing staff told us that there could be a lack of space in terms of quiet or private rooms on some of the wards, which affected these visits in terms of there being little space for grieving relatives to gather.
- 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 that needed additional advice or signposting in the event of bereavement.
- The 'Principles of Care' document contained a section that was 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 PALS office indicated that it worked closely with funeral directors to link families in with local support agencies. However, staff that we spoke with felt that there was a lack of bereavement support for families as community agencies often had long waiting lists. Given the dispersed geography of the trust's patients, it was often more appropriate for relatives to access bereavement support closer to home in the long term. However, staff often did not have enough time to offer adequate emotional support to families informally whilst at the hospital. Historically, there had been formal bereavement support but this no longer existed. Staff we spoke to were keen for this post to be reinstated to address this gap in service provision.
- There was a lack of information relating to palliative care in the outpatient department, despite this being

recognised as an area where earlier referral to the service could be necessary. The only mention of palliative care was a brief one page summary of the community provision in the booklet entitled 'Support at Home'. The trust told us that this was an isolated situation where palliative care leaflets were in stock but had been exhausted in the department, due to their popularity.

Access and flow

- In the case of existing comorbidities unrelated to their cancer treatment, patients were referred back to their local district general hospital for treatment. The Royal Marsden had links with local hospitals such as St Helier Hospital, St George's Hospital and Croydon University Hospital. The trust worked closely with St George's University Hospitals NHS Foundation Trust to support patients with both parenteral nutrition and palliative care needs who were discharged into the community.
- Across both sites, between October and December 2015, 51 patients died in hospital. Of these patients, 29% (15) had chosen the Royal Marsden as their preferred place of death (PPD), 6% (3) died in critical care, 23% had not discussed their PPD and 41% (21) patients had selected a PPD elsewhere. Of these last two categories, patients had usually rapidly deteriorated and no discussion of PPD or transfer was possible. Two patients had declined to discuss their PPD and a further two patients died whilst discharge preparation was in process. No patients died at the Royal Marsden whilst fit for transfer and waiting for a hospice or continuing care bed.
- Staff we spoke to were aware of processes relating to rapid discharge to enable patients to die at home or in a hospice. In an audit of the 51 deaths taking place in hospital between October and December 2015, 41% of patients had chosen to die somewhere else but were not well enough to be transferred. The audit recommended that these findings be fed back to clinicians to encourage timely discharge planning when it is known that the patients preferred place of death is not the Royal Marsden. This had been a recommendation of the last two quarters in this audit and compliance had risen from 99% to 100%.
- Link nurses on each ward had ensured that the resource file relating to EoLC contained a rapid discharge checklist to ensure that all necessary arrangements had been put in place prior to the patient being sent home or to a hospice. Staff were reminded to consider family

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issues, communication with district nurses or the community palliative care team, appropriate transport, medication, equipment and written information and documentation. A form was given to ambulance crews that provided them with information regarding a patient's cardiopulmonary resuscitation status and the preferences of the patient or family should the patient die on route. On Oak Ward, the link nurse had also put together file of hospice referral forms from across the country, divided by county.

- 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. The DNACPR form was sent with the patient on discharge to their home or preferred hospice and could be used until a new form was put in place by their GP or doctor taking over their care.
- The specialist team maintained contact with the Community Palliative Care Team (CPCT) mostly through telephone calls. Apart from the scanned referral form, there was no additional indication on the electronic record that a patient coming into hospital was cared for under the CPCT. However, this question was usually included in the admission screening process to each ward and nurses from the CPCT would often alert one of the specialist nurses via telephone call.
- 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 that the impact of not being offered further active treatment could leave patients feeling isolated. After discharge, the team would 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.
- The administrative arrangements relating to death, including liaising with funeral directors, was undertaken by PALS. PALS liaised with bereaved families to facilitate the removal of bodies from the body stores within a timely period. We were told that this usually occurred within five days.

- Relatives and friends were able to view a body in a room attached to the body store. The public entrance to this area opened onto a small, but comfortable seating area, which led to the viewing room. Senior nursing staff took care in preparing the body for viewing. They were able to describe this process and any issues that may make viewing the body at the funeral parlour more appropriate.

Learning from complaints and concerns

- There were leaflets throughout each ward and department detailing how to access PALS and make a formal complaint, although none of the patients we spoke to had cause to do so.
- There had been two complaints relating to palliative care between February 2015 and February 2016. One of these complaints took place at Kingston hospital and the specialist team had not been involved as the incident was incorrectly classified. 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. A thorough incident investigation had taken place. This identified learning points such as ensuring that families understood the reasons behind treatment decisions, and limiting the number of professionals at the patient bedside at any one time. Clear out-of-hours escalation plans had been put into place in the event of future complex cases. Teaching sessions and supervision for junior doctors and nursing staff in escalation and communication around deteriorating patients had been enhanced as a result.

Are end of life care services well-led?

Good



We rated well-led as 'good' because:

- 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.
- Senior staff were described as supportive and approachable.
- Meaningful audits, data collection and research projects took place that drove innovation and quality improvement.

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However;

- There was a disconnect between trust wide and local service recognition of risk. Staff were not aware of items on the risk register that related to EoLC.

Vision and strategy for this service

- The trust had developed an EoLC strategy which aimed to ensure 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 that needed improvement, such as advance care planning and earlier referral to palliative care services to improve the patient experience in the last 12 months of life. These were included as aims within the strategy. Current ongoing research was underway aiming to improve advance care planning and referral to the specialist team.

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.

- We were told by staff that 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 lack of consultant cover as an ongoing risk, which had not been added to the clinical risk register. Staff were not aware that issues in regards to the electronic advance care planning (ACP) system had been added to the trust risk register, in terms of IT procurement and delays to ensuring a new system was in place. This demonstrated a lack of oversight in relation to risk management within the service at a trust level.
- 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 put into place.
- The specialist team collected data which fed into the quarterly governance reports. This included number of referrals, research projects, training, leadership and strategic developments.

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. This restructuring aimed 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 were now 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 2014 National Care of the Dying Audit – Hospitals (NCDAH) recommended that all trusts should have a named member on the board responsible for EoLC. For the Royal Marsden, this was the Chief Nurse. The

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modified 'End of Life Care Audit: Dying in Hospital' in 2016 also recommended that all trusts have a lay member with responsibility for EoLC on their board. The Royal Marsden did not have this, in common with only 49% of the 137 trusts who submitted data for the most recent audit.

- In the modified 'End of Life Care Audit: Dying in Hospital' in 2016 the trust also failed to meet a second organisational key performance indicator (KPI) as there were no dedicated EoLC facilitators (a new KPI as on May 2015). The specialist team felt that EoLC facilitators were not necessary due to the relatively small size of the service. The specialist nurses felt that they had enough time and resources to be actively and meaningfully involved in each patient's case where required.
- Staff within the specialist team were familiar with the senior team, both locally and at board level. 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 and Chief Executive visited the Sutton site regularly and could always be contacted via telephone. Some of the nurses with spoke with told us that members of the board knew them by name, which made them feel more valued.

Culture within the service

- The hospital had a good atmosphere. Many staff had worked there for a number of years and many patients had used the hospital for a long time. People commented on the small size of the hospital and what a difference this made as staff from different departments knew each other. The specialist team felt they had good working relationships with the ward teams, strengthened by the link nurses who acted as a bridge to each ward. No issues were raised by the doctors or senior staff in relation to cross site working with Chelsea.
- One of the service leads was mentioned as they had won an award for 'Excellence in Education' in the 2015 staff awards. These took place every year to recognise and celebrate achievements by individuals and teams within the hospital. Staff in the specialist team felt able to raise and discuss any concerns with their colleagues and managers, as appropriate. 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. Staff support sessions were facilitated on each ward every month to allow staff to talk about difficult events and patient 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. The trust attended patient forums and met with carer representatives to discuss elements of good palliative care. They took informal feedback from patients and improved small aspects of the service, as well as taking results from larger surveys or audits such as the most recent FAMCARE audit. This recommended that issues about speed of symptom control and information about symptom management needed to be addressed and explored in more detail within the specialist team. The specialist palliative care patient information leaflet was updated and any delays in getting a prescription from the parent oncology team were raised with the palliative care consultant.
- The trust published the Royal Marsden magazine four times a year to update patients on happenings around the trust and research developments. This often included items relevant to palliative care.

Staff engagement



- 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 to 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. Staff were involved in peer review documentation audits on a rolling basis to improve the quality of records, as well as being consulted on the development of the EoLC strategy.

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Innovation, improvement and sustainability

- There was trust representation at a national and European level to ensure that the service remained aware of developments and research. The hospital is part of the London Cancer Alliance (LCA) Vanguard and has been reaccruited as a recognised centre within the European Society of Medical Oncology (ESMO). There is also 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 will 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 that staff within the palliative care unit 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 one, a retrospective audit, had been completed at the end of 2015. Analysis showed that both ACP and referral to specialist palliative care were happening but relatively late in the disease trajectory. The second phase of the study planned to introduce an "Advance Care Planning Framework" and evaluate the effect its implementation has on earlier referral to the service.
- 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 the electronic ACP system to help ensure more timely ACP and referral to specialist palliative care where appropriate.

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

Information about the service

The outpatients department (OPD) at Sutton Hospital is located on the ground floor of the East wing close to the main entrance of the hospital. A high street pharmacy is located next to the outpatient clinic where patients collected their medicines prescribed in clinic.

There are 24 clinic rooms for consultations. There were 148 clinics per week held at Sutton Hospital. Outpatient clinics were held at Sutton Hospital in the main outpatient department for all cancer specialties except paediatrics. There were 189,000 outpatient attendances at the Sutton site between July 2014 and June 2015. These figures included a proportion of attendances for radiotherapy which had a high number of follow up visits. 91% of consultations were follow up appointments and 7% were new referrals and patients. Outpatient clinics were provided for consultations and treatments including chemotherapy planning.

The majority of patients seen at the Sutton site live locally although some travelled some distance to access services. Patients requiring chemotherapy at Sutton Hospital reported to the outpatient reception desk before their treatment but chemotherapy treatment was not provided in the outpatient department.

The hospital diagnostic imaging service was provided for outpatient, inpatient and research referrals. The service has two X-ray rooms used for general radiography examinations, one ultrasound room in the main department, two computed tomography (CT) scanners,

three magnetic resonance imaging (MRI) scanners. There are three general X-ray rooms and two ultrasound rooms in the Rapid Diagnostic Assessment Centre (RDAC) for breast examinations.

During the inspection of the radiology services we spoke with five patients along with some of their relatives. We also spoke with six members of staff including reception staff, radiographers, consultants and managerial staff. We reviewed the systems and management of the department including quality and performance information.

We spoke to 12 patients attending the outpatient department and staff including managers, consultants and junior medical staff and four 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.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated outpatients and diagnostic imaging as requires improvement because:

- There were limited areas to care for patients who became unwell while attending the OPD. The hospital did not have an acute oncology service.
- Surgical procedures were carried out in the outpatient department. The service was not using the five steps to safer surgery including the World Health Organisation (WHO) surgical checklist for recording information about these procedures. This did not meet with best practice guidance.
- The trust recognised the environment in the outpatient department was no longer suitable because of the increased number of outpatients attending. An outpatient transformation project was underway to improve how outpatient clinics were organised and delivered. However, the project was still in the early stages and improvements had yet to be realised.
- The trust acknowledged that a complete re-development of the outpatient department was required. Plans for re-providing the outpatient department had been developed to build a new outpatient department within the Centre for Clinical Care and Research.

However;

- The diagnostic imaging department had a local five year strategy in place to improve services and the facilities to remain at the forefront of research and service delivery.
- There were six nursing staff vacancies when we inspected but the trust had used temporary staff to fill the vacancies until permanent staff were recruited.
- Diagnostic imaging staff vacancies had improved following a recent recruitment drive. The issue with recruiting appropriately skilled radiologists was highlighted on the trust wide corporate risk register.
- Patients, visitors and staff were kept safe because staff were monitoring and responding to risk. Staff were encouraged to report incidents and we saw evidence of learning being shared with staff to

improve services. There was a process in place to report ionising radiation medical exposure (IR (ME) R) incidents and we saw the correct procedures were followed.

- Staff had good access to evidence based guidance and standard operating procedures
- Staff were aware of their responsibilities in relation to adult and children safeguarding practices and staff had good to the safeguarding lead in the trust.
- The rapid access and diagnosis clinic (RDAC) provided a one stop shop for the early diagnosis of cancer and patients told us they were impressed by the speed and efficiency of the service.
- There was evidence of service planning to meet patient need such as the proposals to extend the working hours in diagnostic imaging and the availability of scans to improve the patient pathway.
- Staff in outpatients and diagnostic services followed consent procedures and had a good understanding of the Mental Capacity Act 2005 following recent staff presentations at their departmental meetings.
- We observed and were told that the staff were caring and involved patients, their carers and family members in decisions about their care. There was good support for patients with a learning disability and other special needs. Staff demonstrated a passion for good patient care
- Staff spoke positively about the local leadership and there was a positive culture of support, teamwork and innovation in diagnostic imaging.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated safety as requires improvement because:

- The hospital did not have an acute oncology service. Although there were areas including a dedicated room off the main patients area and the clinical assessment unit where unwell patients could be cared for on some occasions staff found it difficult to find a room to care for unwell patients.
- Invasive surgical procedures were carried out in the outpatient department. The service was not using the five steps to safer surgery including the World Health Organisation (WHO) surgical checklist for recording information about these procedures. This did not meet with the best practice guidance.
- We found systems for managing access to controlled medicines were not robust in the outpatient department. We made the trust aware of our concerns and they have taken action to improve security.

However, we also found:

- Specialist pharmacists provided advice to medical staff in outpatient clinics to facilitate accurate and effective prescribing and the correct manufacturing of chemotherapy doses which reduced errors.
- Staff in the outpatient department had good access to essential training. 90% of staff had attended the trust's mandatory training. Figures provided by the trust showed 90% of outpatient nursing staff had completed the required training for 12 out of 15 topics.
- The diagnostic imaging department had robust policies and procedures in place based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The IR(ME)R regulations are to protect patients, staff and the public. The department had good support networks for expert advice from their Radiation Protection Advisory service.

Incidents

- No serious incidents were reported for the outpatient department in the 12 months prior to the inspection.
- Staff told us incidents were discussed at the morning staff meetings which were held daily before clinics

started. We saw an example of an incident which had been discussed at a staff meeting. A specimen had gone missing and had not been tested in the laboratory. Following the incident staff in the outpatient department recorded the date and time all specimens were sent to the laboratory so that they could be traced.

- Monthly incident summary reports were sent to matrons and sisters in the outpatient department and discussed at monthly sisters and matrons meetings. They were also discussed at monthly outpatient operational meetings. Incidents were reported using the trust's incident reporting system.
- We saw a leaflet in the outpatient department which described the trust's commitment to being open about mistakes. The leaflet reassured patients that in the unlikely event of something going wrong the trust would inform patients openly. The leaflet described the legal duty of candour to ensure appropriate processes were followed in the event of any incident resulting in harm.
- Incidents in diagnostic imaging were reported and managed appropriately, with actions and learning disseminated to staff. Staff we spoke with demonstrated a good understanding of the incident management process and were happy to report any incidents or near misses. Staff felt confident to discuss any issues regarding safety with their line manager.
- Outpatient services reported 57 incidents in 2015. The majority of incidents reported resulted in no harm to patients. Four incidents were graded as moderate but did not result in any lasting harm. These related to disruptions to patient's treatment following a breakdown in communication and problems with test results. One incident was investigated by the chief pharmacist and changes were made to the process for pharmacists checking prescriptions.
- Diagnostic imaging services reported 229 incidents in 2015. The majority of incidents reported were of minimal or no harm.
- One radiation incident was reported to the Care Quality Commission (CQC) in 2015. The incident involved a patient receiving an unnecessary radiation dose. It was investigated and a full report submitted. The incident was closed by the IR(ME)R inspector at the CQC. The incident was shared with the staff and learning points identified. 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.

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- Senior managers in diagnostic imaging 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. For example, a form for requesting radionuclide tests was changed to include a specific area to write the hospital number and staff were reminded about the importance of checking documentation when requesting tests at the department's meeting. The wrong patient identification information had been attached to the test request form.
- Staff we spoke to in diagnostic imaging and the outpatient department described their understanding of the duty of candour and their obligations. They were confident the systems ensured patients were fully informed of the circumstances which led to any incident resulting in moderate harm.
- There was bacterial hand gel available outside the outpatient clinic rooms. We observed that not all staff entering or leaving clinic rooms used the hand gel. When we spoke to nurse managers they told us they were monitoring hand hygiene closely to improve compliance. Staff used personal protective equipment (PPE) including gloves and aprons.
- Staff in the diagnostic imaging department understood their responsibilities in relation to infection control and hygiene. Hand hygiene audits for the department demonstrated 98% compliance for Allied Health Professionals in March 2016 and 100% compliance in April 2016.
- The Methicillin Resistant Staphylococcus Aureus (MRSA) status was checked for all patients attending the outpatient department and all new patients were screened for MRSA.

Cleanliness, infection control and hygiene

- We spoke with a manager responsible for the domestic staff who cleaned the outpatient department. and they told us they assessed the outpatient area as 'high risk' for infection control because of the large number of people who attended. As a result they cleaned the toilets three times a day, dusted daily and mopped the floors every day. Clinical and domestic waste was stored separately. The manager told us supervisors checked the cleanliness of the department several times a day.
- The clinical areas of the outpatient department were visibly clean and we saw the toilets had been cleaned and checked that day.
- Equipment in the outpatient department and diagnostic imaging was labelled with 'I am clean' stickers which recorded the date they were cleaned.
- Information on the results of infection prevention and control (IPC) audits was on display on the outpatient department notice board for the month of April 2016. This showed 85% compliance with the trust's hand washing policy and 90% compliance with the bare below the elbow policy. Figures provided by the trust showed that for the four months from October 2015 to January 2016 the highest level of compliance achieved was 80%. Managers told us the figures had improved in recent months because they frequently reminded staff about the importance of hand hygiene. Information about compliance with infection control policies in the outpatient department was monitored by the trust's infection control department.
- On visual inspection all areas we visited in the diagnostic imaging department were clean and tidy, including the toilets and changing cubicles. Records of cleaning were complete in all the areas of the department we visited.
- There were clear notices around the hospital detailing hand hygiene and infection prevention and control measures for patients and visitors.
- We saw that all staff in imaging diagnostic services were bare below the elbow' in clinical areas. This reduced the risk of infection to staff and patients and was in line with the trust's policy. All sinks were hand wash stations and fully compliant with HBN 0009 Infection Control in the Built Environment (March 2013), which meets national guidance. All soft furnishings were wipeable and in good condition. The vinyl floor was in good condition and complied with good practice.
- There were adequate supplies of personal protective equipment (PPE) including glove and apron dispensers in diagnostic imaging.
- The diagnostic imaging department reported that 95% of staff had attended infection prevention and control (IPC) training against a target of 90% over the last 12 months. Infection control policies were available on the intranet and staff were able to show how easy it was to access these.
- 90% of nursing staff in the outpatient department had received infection prevention and control training.
- We observed good waste streaming with the use of hazardous waste bins and recycling bins in diagnostic

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imaging. Good practice was followed in the nuclear medicine department for disposal of radioactive waste materials. The amounts of waste were monitored and the environmental agency standards were adhered to.

Environment and equipment

- The phlebotomy room in the outpatient department, where patients had blood tests carried out, was located in a narrow corridor. The room itself was an open plan space and segregated using curtains. There was a risk that the door was not wide enough if a patient was unwell and required a stretcher. Access was restricted due to the narrow doorway and corridor. We saw records of an incident where a patient had collapsed. The incident report described the difficulty staff experienced resulting in 10 staff becoming involved in providing treatment in the room because they were unable to relocate the patient. Managers were aware of the risks related to this and mitigated these by using reclining chairs which could be used to transfer a patient out of the room. Slide boards were also available which could be used if a patient collapsed. A formal risk assessment had been undertaken and the risk was added to the risk register. The area was assessed as safe for continued clinical use because of the measures that had been put in place.
- We checked the resuscitation equipment trolley in the outpatient department and found there were records of daily checks. Resuscitation equipment was available within the diagnostic imaging department. All the relevant safety checks had been completed.
- The trust performed better than the national average in eight out of 10 measures on the UK radiotherapy equipment survey 2013.
- Staff in diagnostic imaging were seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation. There was a wide range of protective equipment available.
- Patient waiting areas in diagnostic imaging were comfortable and well equipped.
- The reception and waiting areas in the outpatient department were frequently busy and over-crowded. The layout of the waiting area had been changed in response to comments received from patients. The waiting area had been organised into zones to make the area less impersonal.
- 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. The diagnostic radiology team were responsible for the detailed checks of the CT scanner attached to the PET system.

- We saw the Society of Radiographers 'pause and check' policy was implemented to comply with the IR(ME)R operator checks
- We saw the bariatric patient policy which clearly outlined the equipment available and the capacity of each machine. Walk in bariatric scales were available within nuclear medicine

Medicines

- There was a patient group direction for nurses in the outpatient department to prescribe antibiotics for patients with sepsis. This authorised nurses to write prescriptions according to a protocol defined by the trust. Neutropenic sepsis packs were prepared in advance for staff to use if a patient attended who was unwell. The matron was a trained prescriber who could write prescriptions for patient's treatment or if they became unwell.
- Systems for managing access to controlled medicines were not secure in the outpatient department. Access to the clinical room where the medicines were stored was controlled by a keypad. There was no system for changing the keypad access code and the number was widely known by staff throughout the department who accessed the room for a range of clinical equipment and supplies. The keys to medicines cupboards including controlled medicines cupboards were kept in an area widely accessible to a range of staff. This meant access to the clinic room where medicines were stored and access to the cupboards where the medicines were stored were both not secure. We brought this to the attention of managers during the inspection who took immediate action to improve the security. When we visited the department again in the week after the inspection we found managers had improved the security of medicines
- We checked the controlled drugs register in the outpatient department and found this had been correctly completed and the medicines reconciled with the records.
- The bespoke electronic chemotherapy prescribing system used by the trust had in built safety systems and

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version controls that ensured all the relevant information relating to the patient journey and treatment pathway was held centrally. Although the outpatient pharmacy dispensary services were provided by an external pharmacy, the computer systems were provided by the Trust which increased patient safety especially when dispensing supportive chemotherapy medicines.

- Specialist pharmacists provided advice to medical staff in outpatient clinics to facilitate accurate and effective prescribing and the correct manufacturing of chemotherapy doses which reduced errors.
- There was a system for ensuring prescribed medicines were available for patients to take home. Patients could collect their prescriptions from the pharmacy located next to the outpatient department.
- There were arrangements to ensure medicines were stored at the correct temperature in the outpatient department. An electronic temperature monitor alerted pharmacy staff if the temperature exceeded recommended levels.
- The arrangements in the diagnostic and imaging service for ordering, storing and prescribing medicines were appropriate and complied with relevant legislation.
- The medicines cupboards we inspected in diagnostic services were locked and secure, all stock was within expiry date and there was evidence of stock rotation.

Records

- Patients' clinical records were held on an electronic patient record (EPR) information system. Referrals and other correspondence were scanned on to the system and clinicians recorded information on the system following outpatient consultations.
- The records for four clinics were not on the electronic system. There were plans to move these to electronic records later in the year as part of implementation of the trust's new electronic records system.
- Information about clinical trials, radiotherapy and photographs were not held on EPR. Some clinics requested a summary of the last consultation to be printed in advance.
- The EPR was sometimes unavailable. Staff in the outpatient department told us this happened approximately once a month. If it was known the EPR would be unavailable for a period of time then

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 reviewed six outpatient care records saved on the trust's EPR and found these included referral information, assessments and care plans. Alerts were in place for patients who had allergies. Records included evidence of multidisciplinary team (MDT) discussions and the patient's consent.
- The diagnostic imaging department also had a central electronic patient record system to record comprehensive details of each patient's imaging history.
- Staff in the diagnostic imaging department were able to show us how the radiation doses were recorded on the system for each procedure. Radiation doses were sent to the physics department to be checked and monitored for safety.
- Images were available to view via the Picture Archiving and Communications Systems (PACS) and could be shared across sites.

Safeguarding

- Staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They told us they had good support from the hospital lead and felt they could ask for advice.
- Out of 39 staff, 37 in the outpatient department had completed level one child safeguarding training at the end of January 2016. 33 staff had completed level one adult safeguarding training at the end of January 2016. Only two healthcare assistants had completed the adult safeguarding training. Other groups including admin staff and registered nurses had all completed the training.
- All staff in 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%.

Mandatory training

- The trust's standards required 90% of staff to participate in mandatory training. Figures provided by the trust showed 90% of outpatient nursing staff had completed the majority of the required training for 12 out of 15

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topics, Mandatory training included for example adult basic life support, blood transfusion, conflict resolution, equality and diversity, health and safety and moving and handling.

- Staff in diagnostic imaging told us they were encouraged to achieve their mandatory training targets. There was a mandatory training radiography lead within the department.
- Mandatory training included e-learning and face to face meetings. Staff in outpatients told us the quality of the training was good.

Assessing and responding to patient risk

- The outpatient records we reviewed all contained a range of risk assessments for example a patient's risk of acquiring an infection.
- Eighty per cent of staff in the outpatient department had completed training in risk awareness.
- There was a dedicated room off the main patients area and the clinical assessment unit near the main OPD where unwell patients could be cared for. However, on some occasions staff found it difficult to find a room to care for unwell patients. This was because the room had other uses including clinical procedures which meant staff sometimes had to care for patients in clinic rooms until an inpatient bed could be found or the patient was transferred to another hospital.
- Surgical procedures, such as skin biopsies and skin excisions 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. However, the service was not using the five steps to safer surgery including the World Health Organisation (WHO) surgical checklist for recording information about these procedures. This was contrary to national best practice guidance. Staff were not aware of any formal assessment of the risk of not undertaking the WHO checklist. Following the inspection the trust told us it was introducing the National Safety Standards for Invasive Procedures (NatSSIPs) in September 2016.
- There was a standard operating procedure (SOP) for surgical procedures carried out in the outpatient department which contained checklists and other information for the teams who carried out the surgical procedures. The documents included the standard operating procedures for each minor operation pathway and a checklist for the stock on the minor operations trolley. We saw the folders of documents stored electronically and in a folder for reference for staff.
- Staff in the outpatient department were regularly reminded of the pathway for caring for patients who became acutely unwell whilst attending clinic. The national early warning score (NEWS) was used for monitoring patient's whose condition deteriorated. This process included contacting the critical care outreach team or an advanced nurse practitioner, based on the site, to assess patients they were concerned about. Facilities for caring for patients who became unwell were limited. Patients were cared for in a consultation room whilst they waited for a bed at Sutton hospital or to be transferred to another hospital.
- Patients who were unwell after receiving chemotherapy were able to contact the department for advice and treatment. If the patient lived a long way from the hospital staff would assess their symptoms over the telephone and direct them to attend their nearest accident and emergency department. Patients who lived closer to the hospital were instructed to attend the outpatient department during the day. This was to ensure the patient received antibiotics within the national standard of an hour if they had developed sepsis, a serious condition. Medical staff had to write the prescription which staff used to ensure the patient receive their medication.
- The trust discharged patients following completion of their treatment in outpatients and encouraged them to return to their GP if they felt unwell. Managers told us there were occasions when patients returned to the hospital after a lengthy absence. When this happened clinical staff did not necessarily have information about their condition in the intervening period which made it difficult to treat the patient appropriately particularly if they were very unwell. The service contacted the patient's GP to request they made an appropriate referral.
- The hospital's medical physics department were contactable for any support required and to give 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) to give advice

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when needed to ensure patient safety and minimise radiation risk. They were adequately trained within national recommended requirements. One RPS told us they had three days training at the start of their RPS role and continued to have regular updates.

- A radiation safety policy was in place which included the Ionising Radiation Medical Exposure Regulations (IRMER) procedures. There was also a protocol for the management of contamination, 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.
- Senior staff told us checklists had been improved to include information about the pregnancy status of female patients in CT to minimise the risk of scanning a pregnant patient.

Nursing staffing

- There were 18.8 registered nurse posts in outpatients and the rapid diagnostic and assessment centre (RDAC). There were 11.6 whole time equivalent health care assistants.
- The outpatient department had six staff vacancies when we inspected. Three vacancies were for registered nurses and three were for care assistants. Senior nursing staff told us it had been difficult to recruit to junior nurses' roles. They had appointed three registered nurses who were due to start shortly. The department used agency phlebotomists to take patients bloods which enabled health care assistants to be re-deployed to cover nurse staffing vacancies.
- We discussed the number of vacancies in the outpatient department with nursing staff and managers who told us the staff who had left did so to pursue their career elsewhere or for personal reasons. Information supplied by the trust showed the turnover rates over the last 12 months were high, 30% for trained nursing staff and 26% for healthcare assistants. Temporary staff who had worked in the department before and agency staff were used to fill the vacant shifts until the permanent staff could be recruited.

Radiology staffing

- There were adequate levels of radiography staff with a recent recruitment drive being successful in recruiting further staff.
- There was limited use of agency staff.

Medical staffing

- Medical staff was provided by the specialty running the clinic 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 being present for example if the consultant was teaching.
- A policy was in place which stated medical staff must provide six weeks notice of leave or other absences to allow clinics to be re-organised. Clinic administration staff told they sometimes reduced the number of patients attending if the clinic was not fully staffed.. The outpatient department monitored the number of clinics which were cancelled or reduced as a result of medical staff not being available.
- Three GP trainee posts were being de-commissioned following adverse feedback on training by the General Medical Council. The trust was planning to recruit trust grade doctors, develop physician assistant roles or appoint more advanced nurse practitioner roles by June 2016 to cover the gaps.
- Two locum consultant posts had recently been recruited to for radiology to address the current shortage.
- We spoke with a junior doctor who told us the training and education they received was excellent.
- We saw three incidents reported during 2015 of outpatient clinics running late because of medical staff shortages. One clinic required four doctors but only two were available, another had more patients booked than the clinic booking rules allowed. There were two doctors available to see 43 patients. As a result the administration staff had been instructed not to agree to requests to overbook clinics. On another occasion a clinic had overrun by more than two hours because there were only three doctors to see 53 patients.

Major incident awareness and training

- The risk and reliance manager prepared staff to respond to a major incident and worked with the site management team to assess current risks. At the time of our inspection, there was building work on site and the team received weekly reports from the contractors so they could plan for the following week, for example if it was necessary to close a corridor because of the works.
- We looked at the major incident policy on the intranet, which included easy-to-follow action cards for the members of staff with specific responsibilities. There

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were tested back-up arrangements for possible failures of electronic and telecommunications systems. Each department had their own business continuity plan in case of a major incident

- The electronic patient record system was on occasions not available. Staff told us this happened several times a month. They said they had developed contingency arrangements for recording the information manually and updating the system when it was available.

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;

- The needs of patients seen in the outpatient and diagnostic imaging were assessed and their care and treatment was delivered following local and national guidance for best practice.
- Patient's diagnosis and treatment was planned by a multi-disciplinary team. This included patients with a recurrent condition as well as patients who were newly diagnosed.
- Staff in outpatients and diagnostic imaging obtained written and verbal consent to care and treatment which was in line with legislation and guidance.
- Staff were qualified and skilled to carry out their roles effectively and in line with best practice.
- We saw that 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

- Staff in outpatients had access to evidence based protocols and pathways based on the National Institute of Health and Care Excellence (NICE) and Royal College guidelines. These were available on the trust's intranet.
- Relevant clinical guidelines, technology appraisals, interventional procedures, quality standards and diagnostic guidelines were available to staff to support the services delivered.

- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice in diagnostic and imaging services. Patients involved in research studies attended the department. There were research nurses and radiographers to support patients participating in clinical trials
- Medicine policies were available on the trust intranet and were easily assessable to all staff. Nursing and medical staff could access the trust's formulary which listed pharmacy stocked medicines. This was used to promote evidence based cost effective prescribing. The drug and therapeutics committee (DTC) oversaw and approved any amendments to the formulary and implementation of relevant NICE and other national guidance.
- We looked at a range of radiation protection audit reports. Compliance with IR(ME)R 2000 standards had been met and no recommendations were required.
- Quality assurance tests on the x-ray equipment were routinely carried out and any trends or increases in exposure were reported to the RPS for further investigation.
- 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 which meant the patient would routinely receive a lower dose.
- Local rules were in place and available for all staff to follow in the imaging areas we visited. There were also clearly visible on the mobile imaging equipment.
- 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. We looked at radiological protection advisory service (RPA) reports which showed compliance with the radiation regulations.
- Representative doses for all nuclear medicine and positron emissions tomography (PET) procedures were provided by the Administration of Radioactive Substances Advisory Committee (ARSAC) for an average

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sized adult. The nuclear medicine 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 nuclear medicines and PET department.

- We looked at the radiology audit schedule for 2015/16. We saw the agenda for a recent half day audit meeting which included results from recent audits such as imaging referral guidelines and magnetic resonance imaging (MRI) breast biopsy.
- The nuclear medicine team had recently completed an audit on radioisotope injections. Actions had been agreed to assess injections based on patients' body mass index.

Pain Relief

- Patients returning to an outpatient clinic usually brought their own pain relief medicines. Pain was discussed as part of the consultation with the patient and medical staff would make any changes required so that the patient received a prescription which they could collect to take home before they left.
- Clinical teams in outpatients could also refer patients to the specialist pain team if required and patients were often seen on the same day by the pain clinical nurse specialist or doctor.
- Patient's pain was assessed on initial referral to the outpatient department as part of the London cancer alliance holistic needs assessment.

Patient outcomes

- The trust treated a smaller proportion of urological and head and neck cancers with IMRT than the England average and a greater number of gastrointestinal, lung, and musculoskeletal cancers.
- The proportion of radical IMRT episodes was slightly higher than the England average for most of the period April 2014 to July 2015.
- The trust participated in a large number of national audits for example the lung and bowel cancer audits. The lung audit results for 2014 showed 65% of patients were discussed at a lung multi disciplinary team meeting at The Royal Marsden NHS Foundation Trust. The national audit recommends that 95% of cases submitted to the audit should be discussed at a

multidisciplinary team (MDT) meeting. 94% of cases submitted nationally were recorded to have been discussed in an MDT meeting. 92.3% of patients were seen by a specialist nurse at the Royal Marsden. The national audit recommends at least 80% of patients should be seen by a specialist nurse. 78% of the cases submitted nationally to the audit had been seen by a specialist nurse.

Competent staff

- We saw an example of a performance assessment tool used by managers to assess the competency of outpatient nurses. New staff joining the outpatient department were required to undertake the trust's induction training programme and were supernumerary for two weeks. As part of the induction process managers identified staff training needs. A competency framework was available and this was supported via a mentor.
- The appraisal rates for staff in the outpatient department had improved for trained nursing staff and health care assistants in the last 12 months from 80% to 83% for nurses and from 75% to 100% for healthcare assistants. Appraisal rates for other staff groups including admin staff had also improved from 78% to 82%.
- All staff in the diagnostic and imaging department had received an appraisal. New staff were also given an introductory appraisal within three months of starting in post.
- A local induction plan was in place for all new staff starting within the diagnostic imaging department. We looked at the induction checklist for a new member of staff and saw they had completed all necessary sections of the induction process. A six week induction pack was also in place for computed tomogram (CT) with a clinical competency workbook.
- Continual professional development was encouraged throughout the diagnostic imaging department and staff were currently undertaking post-graduate training. Staff told us they were able to access in-house courses.
- Specialist nurses working in outpatients told us they had completed the specialist nurse training programme provided by the trust.

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- We spoke with a research nurse who told us they had completed a relevant masters degree and nursing staff were supported to study for master qualifications. Research nurses supported patients to access clinical trials of new medicines. They were employed by the trust but worked closely with the trials unit. Research nurses provided information and training for other staff working in the outpatient department about clinical trials.
- We spoke with a junior doctor who told us the trust provided excellent training opportunities. They said they would like more experience of caring for people whose condition had deteriorated to help them recognise the signs and provide appropriate care.
- Diagnostic imaging staff told us they were able to identify specific learning through the appraisal process and were encouraged to develop their professional practice.
- We saw that all radiography staff were registered with the Health Care Professions Council (HCPC). Managers checked the registration of their staff regularly.
- Nurses in the outpatient department told us preparation for re-validation had gone well. They said it had been incorporated into their appraisals and staff had access to professional education to help them prepare. Staff had access to drop in sessions to discuss re-validation and information was available on the trust's internet site.

Multidisciplinary working

- Patient's care and treatment in the outpatient department was planned by multi-disciplinary teams of medical and nursing staff. Specialist oncology and diagnostic imaging staff also attended to contribute to discussions about patient's diagnosis and treatment plans.
- Medical and nursing staff met at the beginning of outpatient clinics to discuss the patients they were seeing, review reports and test results and plan the care the patient received. This included agreeing the role of individual members of the team, the follow up actions required.

Seven-day services

- An outpatient transformation team was looking at extended working to assess the potential for reducing waiting times. Currently, the service ran from Monday to Friday with clinic sessions extended to 7pm in the evening.
- The diagnostic imaging services were available seven days a week with a combination of regular opening times and on-call services.
- The MRI and CT services were moving towards extended hours. Plans had been developed for the service to be open from 8am-8pm Monday to Friday with regular sessions on a Saturday.

Access to information

- The trust used information prescriptions. Information prescriptions have been developed by the NHS to improve the information given to people with cancer. They provide high quality, tailored information appropriate to the patient's condition and stage rather than provide general information some of which might not be appropriate. We spoke with a specialist nurse who described the process for compiling the patient's information prescription using sources which were approved by the Department of Health. We spoke to a patient who had been provided with an information prescription and they said it was really helpful and meant they did not have to search on line to find the information.
- Staff in the outpatient department showed us how they accessed trust policies and procedures on the intranet.
- Diagnostic imaging results were available electronically which made them promptly and readily accessible to staff at both Royal Marsden sites
- Electronic access to radiology results were available across the hospital.
- A patient told us they were able to see their records. They said their consultant shared the information documented in their records. Patients received copies of letters sent to their GPs following their outpatient consultation which contained information about their condition and treatment. They said this was helpful and they could use this to ask further questions when they saw their GP.

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- We saw the results of a recent patient satisfaction audit undertaken in CT. The results showed that 97% of patients were satisfied with the information they received prior to their scan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients and diagnostic imaging were aware of their duties and responsibilities in relation to patients who lacked mental capacity. Staff demonstrated a knowledge and understanding of Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS). Staff reported they had received update training at a recent staff meeting and we looked at the presentation content.
- Staff in outpatients and diagnostic imaging knew the procedures to follow to gain consent and understanding from patients, including involving other professionals. Carers were encouraged to escort their relative to appointments in diagnostic imaging where needed to offer support.
- There were clear protocols about how clinical trials should be conducted and the information to be provided for patients to enable them to decide if they wished to participate. This included information about the trial which they could take to their local hospital if the patient became unwell. The contact details of staff involved with the trial meant patients or staff in another hospital could ring to ask for clinical advice if the patient was unwell.
- We observed a patient being informed about a chemotherapy regimen they were about to start. The consultant explained how the cycles of chemotherapy would be given, the possible risks and side effects. The consultant alerted them to the symptoms they should be looking out for which might be a result of the new chemotherapy regimen they were starting. The patient asked a number of questions which were answered in full, before the consultant asked them if they were happy to sign the regimen specific consent form.

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good. This was because:

- Throughout the inspection we witnessed good care being given in the outpatient and diagnostic imaging departments. Patients were kept informed and staff provided emotional support when appropriate.
- There was a patient-centred approach across the diagnostic imaging team and this came across clearly from all the staff we spoke with.
- Patients told us that the staff in the outpatient department were friendly, kind and approachable. All the patients we spoke with gave examples of good care. Several patients described the care as 'excellent.'
- Staff in the outpatient department demonstrated a good understanding of the privacy and dignity needs of their patients.
- We observed staff being respectful at all times.

Compassionate care

- Radiographers, medical staff, healthcare assistants, administration staff worked as an effective team to ensure patients in diagnostic imaging received a service which was sensitive to their needs..
- Nurses, medical staff and other members of the outpatient department team demonstrated a shared commitment to providing patients with a service which was compassionate. A patient in the outpatient department told us staff were exceptionally kind and compassionate.
- 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 4.76 (90.9%) in February 2016, the lowest score was 4.73 (84%) This meant 90.9% of patients would recommend the service to friends and family.
- We saw examples of staff treating patients as individuals asking about their family, their journey to hospital and making sure they had somewhere private and quiet to sit if they had received bad news.

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- Curtains could be drawn around patients in the outpatient consultation rooms for example when they were dressing or undressing for examinations. Staff told us they ensured patients were covered during examinations to maintain their privacy and dignity.
- We spoke with five patients and carers across the diagnostic imaging department. We were told the staff were very kind and friendly. One patient told us they always had a good experience whenever they needed to attend x-ray.
- We observed nursing staff in the outpatient department comfort one patient who was upset. They took them to an empty consultation room and stayed with them.
- Chaperones were available for all patients if required. Staff in the outpatient and diagnostic imaging departments followed the trust's chaperone policy but told us patients usually attended with a friend or relative.
- We observed patients in the outpatient department being greeted in a friendly manner by the reception staff when they arrived and by all the staff they came in contact with.
- We saw positive patient feedback in a recent survey carried out for diagnostic imaging. One patient said, "All the staff were lovely as usual," and another, "The courtesy and performance of the staff were of the highest standard throughout."
- One patient in the outpatient department who had been attending appointments for a year said reception staff knew them and greeted them by their first name. They said staff always made them feel very welcome and supported.

Understanding and involvement of patients and those close to them

- One patient in the outpatient department told us everyone treated them with respect. They said reception staff spoke quietly to patients so no one else could overhear. Another patient said staff are very open about things even when the news isn't good. They stated, "I get to see my care plan I don't think anything is hidden."
- With a patient's permission, we observed their consultation with their consultant in the outpatient

department. The consultant answered their questions fully providing more information when they required it, encouraging the patient to do the things they enjoyed in life.

- One patient we spoke with had attended their outpatient appointment with a friend. They told us their friend made notes which helped clarify anything they might have missed during the consultation. Their friend told us they had always been made welcome by staff in the department.
- Patients and their relatives were involved in discussions about their care
- Another person told us staff could answer anything they asked and were always prepared to listen and answer.
- Patients told us staff in the diagnostic imaging department were caring and professional. We observed staff acting in a professional way.

Emotional support

- Patients' levels of distress was discussed and recorded in the outpatient department. There were pathways for referring patients to psychology services if their distress level was high or increased during their treatment.
- The trust used a distress thermometer as part of patient's holistic needs assessment in outpatients and we saw examples of these which had been completed on the EPR
- One patient attending an outpatient clinic told us, "It's made clear to me that staff will give me all the time I need to ask questions and discuss how I feel about what they tell me."
- Assessment of psychological and emotional needs were carried out by CNSs in outpatients. Audits were carried out to check this process was being completed effectively. The audits found that referrals to psychological support services were not always made and nursing staff were encouraged to make appropriate referrals.
- There were two counselling rooms in the rapid diagnosis and assessment centre (RDAC) where specialist nurses were able to talk to patients.
- Three nurses in the outpatient department told us they completed an advanced course in communications skills every three years. They had received training in

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breaking bad news as part of the programme. They said the course had helped them develop their skills and deliver important information professionally, recognising and responding to the patient's need for emotional support.

- There were support groups available for example for patients with breast cancer. Nursing staff in outpatients provided patients with information about the support groups which could be accessed in the patient's local area.
- Staff told us they had good support networks within their teams if they needed emotional support. Following a patient's death during a scan, all the staff involved were offered emotional support.

Are outpatient and diagnostic imaging services responsive?

Good



We rated responsive as good. This was because:

- From Feb 2015 to Jan 2016 referral to treatment times were consistently better than the England average for patients being seen in the outpatient department.
- National 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 trust including Sutton and Chelsea for the final three months of 2015-2016 showed 98.1% of all patients started treatment within 18 weeks exceeding the operational standard.
- The number of patients seen by a specialist in outpatients within two weeks of an urgent GP referral was higher than England average from January 2014 to December 2015 for all cancers at the Sutton hospital site.
- A rapid access diagnostic assessment centre (RDAC) had been developed to provide a rapid diagnostic service for breast, skin and urology cancers. Patients we spoke with were very impressed by the one stop breast clinics. It enabled them to access examinations, diagnostic tests and a variety of health professionals at one appointment.

- The diagnostic imaging department was providing access to tests and results in a timely manner, including one stop clinics for several specialities. This reduced the number of appointments a patient needed.
- There was a passport and buddy system to support patients with a learning disability when they attended the outpatient department.
- Staff in the outpatient department were aware of the needs of patients with dementia and disabilities.
- There was access to interpreters for patients whose first language might not be English.
- The service closely monitored any complaints and tried to reach a local resolution where possible.

However;

- One of the main challenges of providing a good service in the outpatient department was the accommodation. The number of patients being seen and treated in clinic was increasing and it was difficult to find suitable space for consultations and treatment.
- Some patients told us they waited a long time in the outpatient department to be seen sometimes up to two hours and staff told us clinics often overran.

Service planning and delivery to meet the needs of local people

- Clinics were organised so that patients could access services together for example breast and plastic surgery clinics were organised on the same day. Testicular cancer and urology clinics were run as joint clinics.
- Patients collected their prescribed medicines from a branch of an external chemist which was located in the main entrance area close to the outpatient clinic department. Pharmacy outpatient waiting times had reduced since the dispensary was set up.
- Four surgical operating lists took place each week for minor operations in plastics and dermatology. The consultant or a specialist doctor in training carried out the procedures assisted by a nurse in an outpatient clinic room or in the Rapid Diagnostic and Assessment Centre (RDAC). Plastic surgery and dermatology staff worked together once every other week so that patients with large incisions could be seen jointly by plastic surgery and dermatology staff.
- The rapid diagnostic assessment centre (RDAC) provided a rapid diagnostic service for breast, skin and urology cancers. Some patients received a diagnosis on

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the day, other patients who required more tests or investigations would be contacted with their results quickly once the results were available. We spoke with a patient attending the rapid diagnosis and assessment centre (RDAC) who told us they had received an appointment three days after they had seen their GP. They were prepared to be at the hospital for up to four hours so they could have all the tests required. They said everything was explained really well in an information leaflet including a number to ring if they were unclear about anything. They said the speed with which they were seen and would receive the results was impressive.

- Patients we spoke with liked the efficiency of the one stop breast clinics. It enabled them to access examinations, diagnostic tests and a variety of health professionals at one appointment. A senior member of nursing staff had received training for carrying out breast biopsies to respond to increases in demand.
- An outpatient clinic utilisation model was being developed to match the level of clinical activity with staffing and clinic spaces. Staff in the department were aware of the plans to review clinic utilisation and told us they hoped this would result in reducing clinic overruns and the length of time patients waited before being seen.
- 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.

Access and flow

- One patient said they had previously had to wait for a week for test results but this had improved and they now got the results the same day. They said they could ring their specialist nurse to discuss anything they were unsure about following their appointment or before they attended their next appointment.
- A patient also told us they had been referred by their local hospital and were attending for their first appointment within two weeks. They said they were very impressed by how quickly they had received their appointment.
- One patient told us they had been referred by their local hospital and were attending for their first appointment within two weeks. They said they were very impressed

by how quickly they had received their appointment. Another patient told us their condition had recurred last week and they rang the hospital. They said they were offered an appointment within two days but it was difficult for them to attend. They said they were worried they may have to wait but had received an appointment for the following week and said they thought this was excellent.

- Referrals were received from GPs and through the central referral office. Managers told us that the trust achieved the waiting time standards for local patients referred by their GPs. A large number of patients were referred by other hospitals and there were sometimes a delay in forwarding the referral which meant the standards were not always achieved.
- Information in the following paragraphs relates to data for the whole trust and in some cases more than the OPD.
- National 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 trust including for the final three months of 2015-2016 showed 98.1% non-admitted patients started treatment within 18 weeks.
- Breaches of the 31 and 62 day and 18 weeks targets were analysed and discussed by each of the business units. Two week wait referrals were monitored daily to organise appointments as quickly as possible for any patients who had waited longer than two weeks to be seen. Patient navigators told us they tried not to overbook clinics but with the consultants permissions they could add patients to the clinic list if they had waited longer than the two week target to be seen. Similar processes were applied to patients referred for initial treatment and patients referred by other trusts for specialist treatment. An inter trust referral had been introduced to try and reduce the length of time it took to arrange an appointment for a patient newly referred..
- [Ninety eight point three per cent of patients with suspected breast cancer were seen in two weeks by a specialist following referral by their GP during the three months between September 2015 –December 2015. The figures were similar for the preceding six months prior to September 2015. The figures for blood malignancies

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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, 97.9 % for lower gastrointestinal and 100% for lung.
- The percentage of patient who commenced their treatment within 62 days following urgent 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), 100% for skin. There was wide variation in the figures for the preceding six months from March 2015 to September 2015. For example the percentage of patients who completed treatment for breast cancer improved from 83% to 100% and from 50% to 100% for patients with a skin condition whilst the figure for lung cancer improved from 28% to 80% reducing to 50% in the three months between September and December 2015. The treatment within 62 day figures were adjusted to a degree to take account of the increased length of time it takes for patients to be referred from their GP to their local hospital and then on to the Marsden
- From Feb 2015 to Jan 2016 referral to treatment times were consistently better than the England average for patients being seen in the outpatient department
- The number of patients seen by a specialist in the outpatient department within two weeks of an urgent GP referral was higher than England average from January 2014 to December 2015 for all cancers at the Sutton hospital site.
- The number of patients waiting less than 31 days from diagnosis to first definitive treatment was also consistently higher than the England average for the same period.
- Treatment within 62 days was similar to the England average between January 2014 and December 2015.
- The trust received a high number of referrals from other hospital as well as local GPs. The overall split between referrals from other hospitals and referrals from GP was approximately 50:50, although for referrals that proceed to treatment the ratio changes to 84:16.
- Staff told us one of the main challenges of providing a good service in outpatients was the accommodation. The number of patients being seen and treated in clinic was increasing and it was more difficult to find suitable space for consultations and treatment.
- We saw the CT scanner had recently been relocated to the ground floor to be co-located with the second scanner. This improved service efficiency and patient flow.
- A patient told us they sometimes waited up to six hours for test results but they were pleased they had received them on the day. Another patient told us the clinics were usually overbooked. They told us clinic staff fitted patients in if they have any concerns. They said, "I can't complain because they fitted me in and usually they manage it all very well".
- Delays in appointment times were audited. We saw the results of audits which were sent to each of the business units for review. Staff told us any clinics running 60 minutes late were reported on the trust's incident reporting system. We saw examples of clinic overruns being reported as incidents. The outpatient transformation team had identified which clinics had the longest waits and were working on improvements to the organisation and management of these clinics. Changes to the urology and gynaecology clinics were being made as a result of the audits.
- Some consultants held outpatient clinics for new referrals but most combined new and follow up patients. 91% of consultations were follow up appointments, 7% were new referrals.
- Clinic staff told us they would always fit a patient in for an appointment if they were worried about their condition. Some patients also arrived in clinic without an appointment.
- One patient told us they had been referred in August 2015. They said they attended their outpatient appointment at the end of November but did not understand why it had taken so long. They said from that point on they had attended four times and the longest they had waited in clinic to be seen was 20 minutes which they thought was pretty good. Other patients told us they had been waiting between three and four hours.

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- We observed managers check to see how clinics were running to see if there was anything they could do to improve patient flow and keep patients in the waiting area informed about any delays.
 - The trust had set a standard that 90% of patients should be seen within 30 minutes of their outpatient appointment time. A performance report produced by the trust showed they had achieved 83.3% during the three months September to December 2015 across both hospital sites. The proportion of patients seen within 30 minutes at Sutton Hospital ranged from 75% in August the lowest level to 81.2%, the highest in December 2015.
 - The trust also monitored the number of outpatient appointments cancelled by the patient and cancelled by the hospital. The figures showed the percentage of appointments cancelled by the hospital ranged from 8.1% to 8.8% during the period April 2015 to December 2015. The proportion of appointments cancelled by patients ranged from 3.0% to 3.7% over the same period. The reasons for cancelling appointments was monitored by the trust. These included changes to the days in which clinics were held and consultant's annual leave or other commitments. Do not attend rates were consistently lower than the England average from 2011 to 2015 at 2%.
 - Clinic staff told patients if their outpatient clinic was running late and there was a screen above the reception desk which provided a range of information including waiting times for clinics. We saw from the notes of outpatient department meetings that clerical staff were reminded to inform patients if their clinic was running late when they arrived at the reception desk.
 - We found that patients received x-rays and scans in a timely manner and these were reported promptly.
 - On average 58% of all diagnostic imaging examinations were reported on the same day during the period Jan 2015-Dec 2015.
 - At the time of inspection the waiting time for a CT scan was under four weeks. Waiting times for patients accessing diagnostic imaging was monitored. Across all modalities 88.39% of patients waited less than 30 minutes, 5.3% waited for up to one hour and 6.31% waited over an hour.
 - The CT department had installed a portable blood analyser machine that 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.
 - Referral to treatment times were reviewed weekly. Additional operating sessions and clinics were organised on occasions to reduce waiting times.
- ## Meeting people's individual needs
- We spoke with a consultant in the rapid access diagnostic centre who told us depending on the patient's condition it was sometimes possible to give them their results the same day.
 - We saw posters clearly displaying information about accessing translation services if required.
 - The staff we spoke with in outpatients demonstrated a good understanding of the needs of patients with dementia and learning disabilities. One member of staff told us they prioritised patients who had a learning disability because they understood how anxious they might be having tests and investigations. They said they had received training to help them care for people with dementia.
 - There was a passport and buddy system to support patients with a learning disability. 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 and any particular anxieties or fears they might need support with whilst attending clinic. The trust's safeguarding lead was responsible for ensuring vulnerable patients were supported.
 - We spoke with a nurse who told us about some research she was involved with about older people accessing follow up care and access to clinical trials. They described how they kept in touch with the patient and their GP if they lived some distance away.
 - Staff told us one of the reasons clinics over ran sometimes was because staff had spent longer than planned discussing a patient's needs. They said staff wanted to ensure the patient needs were recognised and met whilst attending clinic.

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- Explanatory leaflets were available to assist staff 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 outpatient department providing information to patients and staff such as referral to treatment targets. There was a comprehensive photographic board detailing all staff members and their roles.
- Some multidisciplinary team meetings were also held on the same day which meant a decision was made about the patient's treatment on the same day they were seen in clinic.
- Multidisciplinary team 'navigators' were employed by the trust to co-ordinate patient's treatment organising follow up appointments.
- We found there were arrangements to meet the needs of children and young people in the diagnostic imaging department. Staff told us the hospital play specialist supported children and young people attending the diagnostic and imaging service. DVDs were available for children and young people having a CT or MRI scan. These were watched using a specialist mirror attached to the machine.

Learning from complaints and concerns

- 20% of the complaints received by the trust related to appointment delays and cancellations in outpatients. Managers told us they were aware of patients' concerns and were working to address them. Delays were monitored and reported to the relevant business unit so they could address issues such as lack of medical cover. The outpatient transformation project had identified those clinics with the greatest scope for improvement and changes had been made to the gynaecology and urology outpatient pathway.
- A patient told us if they had a complaint about their medical care they would contact the patient advice and liaison service (PALs).
- Leaflets informing patients how to make complaints were available in waiting areas. Staff felt able to handle complaints and preferred to do so at a local level to diffuse the situation.
- Staff in outpatients told us they received feedback about complaints in the staff meetings and we saw

records of these discussions in the staff meeting minutes. In response to complaints, staff had created zoned waiting areas to improve the environment, an electronic noticeboard was installed which provided patients who were waiting with information about any delays and reception staff had been reminded to inform patients as they arrived about any delays.

- Managers had reviewed outpatient reception processes following the receipt of complaints from patients. For example, reception staff were asked to ensure that the correct information was inputted accurately onto the system at the point of registration and that any discrepancies identified during a consultation were immediately communicated to the relevant administrative staff for amendment.

Are outpatient and diagnostic imaging services well-led?

Requires improvement



We rated well led as requires improvement because:

- More services were being delivered in the outpatient department and the environment was no longer suitable because of the increased number of outpatients attending. Space was limited and the highest risks on the department's risk register related to the environment.
- The problems in the OPD had persisted for several years and the trust had only recently started to address them through plans for a new OPD in the Centre for Clinical Care and Research and the Outpatients Transformation Project.
- Nursing staff told us they had been consulted about possible improvements to the service and in the past but staff shortages meant there had been fewer meetings in 2016.
- 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.

However:

- The diagnostic imaging service had developed a strategy to deliver a flexible service able to respond to capacity challenges.

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- The diagnostic imaging department was well-led. Staff and managers had a vision for the future of the department and were aware of the risks and challenges they faced.
- Staff in both departments spoke positively about their managers and senior team. They felt they were visible and supportive and they had confidence in them.
- There was good staff engagement and patient's views had been sought about the proposed new outpatient building.

Vision and strategy for this service

- The trust recognised that changes in cancer pathways were resulting in more patients being treated in outpatient settings. However, the problems with the environment in the OPD had persisted for several years and the trust had only recently started to address them. The trust was also working as part of a collaborative with other hospitals to develop seven-day services.
- The trust had set up the 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. Plans to build a new OPD in the Centre for Clinical Research and Care had been approved in March 2016.
- Staff in the outpatient department were unable to tell us how new models of care would operate in the future in a new department.
- 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. However, the diagnostic imaging service had developed a strategy to deliver a flexible service able to respond to capacity challenges. We looked at the five year development plan for radiology which address issues of capacity and demand. We spoke with senior staff who told us the business case had been submitted for the extended day in CT and MRI for the Sutton site and also to recruit a further breast radiologist.
- All the staff spoke with pride about their services and how diagnostic imaging made an impact on the patient pathway.

Governance, risk management and quality measurement

- The trust's risk management team met with staff in the outpatient department each year to review the risk register. One of the risks identified was the safe

decontamination of naso endoscopes. There was a risk decontamination equipment could break down. This risk was reviewed annually. The department had developed a standard operating procedure for cleaning the equipment which meant patients' appointments were not cancelled. This remained as a risk on the register but managers were confident the procedures in place were effective.

- 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.
- Another risk was the loss of the department's IT system. Managers told us this happened on average once a month. To enable clinics to go ahead a hard copy of clinic lists was routinely printed off which staff used to check patients in to the clinics. The trust had business continuity plans to allow for eventualities such as IT system failures
- The outpatient and diagnostic services departments were managed as part of the Clinical Service Division. An Outpatient Operational group met monthly to review the performance of the outpatient department and any governance issues which were fed into divisional meetings through the Head of Patient Support Services. 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. A performance scorecard had been developed to monitor the performance of the outpatient service. Senior staff told us there were clear lines of communication into the division and beyond to the Board.
- We noted the performance dashboards for the diagnostic imaging service and discussed these with senior staff. There were no issues identified on the dashboards that would raise any concern.
- We saw the diagnostic imaging departments had updated risk registers in place and the risks identified in our discussions were reflected on these registers. We looked at the recent risk assessment for moving the CT

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scanner. Risks such as infection control, manual handling and medicines management had been outlined and relevant actions and preventative measures put in place.

- 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. We spoke with one member of staff who had presented their audit on patient experience at the last study day. The audit was to be rolled out further across the department.
- Good governance processes were in place for radiation safety monitoring and all staff reported that the Radiation Protection Advisory Service gave excellent input and support.
- There were clear lines of accountability across the department and we found the diagnostic imaging staff worked well as a team.

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. professional support was provided by the Divisional Nurse Director and Clinical Business Unit Lead (Consultant). 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.
- We attended the daily staff meeting held before clinics started. The meetings were used by the outpatient sister to provide staff with information and highlight any issues or concerns about the clinics that day. Staff were updated about recruitment to vacant posts and about a patient experience survey which would be carried out shortly
- Nursing and administrative staff who worked in the outpatient department told us their managers were approachable and supportive.

- Staff in diagnostic imaging told us they had confidence in their leadership. Modality leads were visible and approachable and we observed good interactions between managers and their staff.
- The radiology service was led by a team of specialist, radiologists and radiographers. Staff told us their managers provided effective leadership for example in planning the department's response to increasing demand.

Culture within the service

- We spoke with six members of staff working in diagnostic services who were all positive about working for the trust. One staff member said they came to work there because of the reputation of the trust. They said there was a sense that everyone was working towards the same goals of giving patients the best possible experience.
- The outpatient transformation team had identified that clinician's time in their outpatient clinics was not protected and they were interrupted for example by phone calls, contributing to clinics running late and the length of time patients waited to be seen. The transformation project team had proposed a charter, a set of cultural expectations to be communicated to staff describing how clinics should run and defining unacceptable practice. Staff told us they supported the principles but, in reality it would take a long time for behaviours to change.
- Staff in the outpatient department said they enjoyed working for the trust because of access to training and education which was good. They told us there was a nurse forum held four times a year where they could discuss clinical practice and training.
- Staff in the outpatient and diagnostic imaging departments told us they felt well informed by managers and contributions from staff were acknowledged for example at the annual staff awards event. They said all staff had development plans including care assistants.
- Some staff told us the outpatient department felt less of a priority than the wards but as more treatment were provided in outpatient settings managers were taking more of an interest.

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- We were told the culture within the diagnostic imaging department was open and friendly. It was evident that quality and patient experience was seen as a priority for the services and was everyone's responsibility. There was a good level of morale across the diagnostic imaging team although staff were working to capacity and looked forward to extending the working day with increased staffing levels.
- Good working relationships and support networks had been built with other diagnostic imaging services in local hospitals and the research institutions.
- All diagnostic imaging staff we spoke with described a positive working environment. Many of the staff had worked at the hospital for many years and there was a relatively low turnover of staff.

Public engagement

- Patients were involved in mapping pathways of care and providing feedback on ways of improving pathways.
- Patients had chosen new chairs for the outpatient department. Patient experience was discussed bi-monthly. Feedback from this was used to improve communication and resulted in "zoning" in the waiting area.
- Staff and patients were involved in plans for the new outpatient department. Staff from the transformation team had interviewed patients about their experience of using the service to identify aspects of the service they thought should be improved. Patient representatives were involved in identifying issues and problems with the current outpatient clinics.
- Leaflets were available in clinic explaining how patients could provide feedback on their care. Patients could record their views at the time of the visit and hand the feedback form to staff or place it in the feedback post box. Alternatively, patients could also provide feedback on line. The survey asked patients if they felt treated with dignity and respect, were adequately involved in decisions about their care, received timely information and felt well cared for by staff.
- In response to concerns raised by patients about delays in clinics car park charges were reduced if a patient was delayed.
- A survey of patient experience had been piloted in the CT department and was to be further rolled out across

all modalities. 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.

Staff engagement

- Staff we spoke with in the outpatient department who told us there was good teamwork between nurses, medical staff and managers. Staff said managers listened to their ideas for improvement and implement their suggestions. The examples they gave were for re-designing some clinics and improvements to the waiting areas. They told us nurses now called for patients from the waiting area and showed them to the clinic room. They said they felt they were offering a more personal service to patients and it enabled them to get to know patients.
- Nursing staff said they were consulted about possible improvements to the service and in the past there had been regular meetings to discuss improvements.. However, there had been staff shortages in 2015, including a shortage of senior staff notices and there had been fewer meetings and staff had felt under pressure. With new appointments, there were plans to reinstate these meetings
- Senior staff told us they sent out regular emails to the staff and staff confirmed this was a good method of communication.

Innovation, improvement and sustainability

- The outpatient transformation project had developed an action plan to make improvements to outpatient services. The outpatient transformation project work streams focused in particular on areas where there were recognised problems with waiting times.
- Nursing staff and managers told us the volume of work was increasing and the approach to providing outpatient services required re-designing strategically. The transformation project was looking at different ways of providing consultations remotely using technology but the timescales and scale of the work was not clear. This work was in the early stages and was not yet having a major impact on patient experience.
- Advanced practice was evident in the radiology department with breast radiographers undertaking ultrasound scans and interventional breast procedures.

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This meant the trust had invested in the on-going quality of the service and maintained a sustainable way forward in the light of consultant vacancies and increasing workload.

- 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
- We spoke with the lead research radiographer who outlined her role and told us how imaging led studies were being used to innovative and improve patient care. For example, endocervical MRI scans were undertaken with a coil inserted in the cervix to assist with fertility sparing surgery.

Chemotherapy

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

Information about the service

The Royal Marsden NHS Foundation Trust in Sutton provides a specialist tertiary service for patients diagnosed with cancer. The trust has a strong reputation nationally and internationally for treatment and research as well as being a major contributor to clinical trials.

The following wards provide chemotherapy for patients diagnosed with different forms of cancer: the medical day unit (MDU), the private patient medical day unit (PPMDU), Kennaway ward, Robert Tiffany ward (private in-patient) and Smithers ward. Chemotherapy also takes place on Bud Flanagan West for patients requiring high dose chemotherapy.

The MDU provides, the administration of all systemic anti-cancer therapies including chemotherapy, monoclonal antibodies (laboratory-produced antibody that mimics the antibodies in the body to attach to specific defects in cancer cells), supportive therapies and blood transfusion. There were 13,817 attendances in the year from January 2015 to December 2015. The MDU is open Monday to Friday from 8.30am to 8pm and has 26 dedicated chairs in three separate treatment areas.

The private patient medical day unit (PPMDU) provides ambulatory care for private patients undergoing systemic anti-cancer therapy or supportive care for a range of solid tumours/haematological cancers as day cases. Haematological cancers are cancers that begin in the blood forming tissues e.g. bone marrow. There were 10,134

attendances in the year from January 2015 to December 2015. The unit is open Monday to Friday from 8.30am to 8pm and has 10 dedicated chairs in three separate treatment areas.

Each medical day unit has its own pharmacist and there is a trust wide cannulation service available. Intravenous (IV) cannulation is where a cannula is placed inside the vein to provide venous access, in this case, for chemotherapy treatment.

Kennaway ward is an 11 bed inpatient ward that cares for patients who are newly diagnosed and those who have metastatic disease. Metastatic disease is where cancer has spread from the place it first started to another place in the body. The ward administers chemotherapy and supportive therapies.

Smithers ward is a 23 bed mixed general oncology ward. Oncology is the treatment of solid tumours. There are four day case beds used for patients requiring day surgery, day chemotherapy and blood transfusions. The ward cares for patients who are newly diagnosed as well as patients who have metastatic disease.

Robert Tiffany ward provides inpatient care for private patients undergoing diagnostic investigations, systemic anti-cancer therapy and supportive therapies for a range of solid tumour and haematology malignancies.

During our inspection we spoke with 10 patients and seven family members and friends. We spoke with 15 members of staff including three matrons, three doctors, two consultants and nine nurses and clinical nurse specialists. We spoke with pharmacists, physiotherapists and

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members of the trust admin team as well as two health care assistants. We observed interactions between patients and staff, considered the environment and looked at 14 patient care records.

Summary of findings

We rated the chemotherapy services at The Royal Marsden in Sutton as 'outstanding' overall.

- Patients were provided with individual care in a timely and appropriate manner. Staff provided patients with both internal and external opportunities to emotionally cope with both their condition and treatment. Staff often went out of their way to ensure patient care went beyond their remit as healthcare professionals.
- Staff knew about the vision and strategy for the chemotherapy service and senior staff knew about the strategy of the chemotherapy service as it related to the trust as a whole. The vision for the service was embedded in the culture and every day workings of the staff.
- There were processes in place for reporting of incidents and staff could clearly outline the reporting system used by the trust. Staff reported incidents and the trust ensured there was a system in place to learn from incidents and improve practice including regular meetings for staff.
- The trust's pharmacy team were leading a national project on dose banding of chemotherapy medicines. Once achieved, the effect of this project would be the standardisation of chemotherapy doses, which would mean most chemotherapy medicines could be batch produced, improving efficiency and reduction in wastage.
- There was an open culture of incident reporting and learning from these incidents was disseminated to all staff through regular meetings. We found that staff felt confident about being candid with patients.
- We found that the measures used by the chemotherapy service for preventing and controlling infection met national guidance. Hand hygiene was important to staff and audits were maintained to ensure on-going quality.
- Staff were aware of the escalation policies around safeguarding concerns, mental capacity act and deprivation of liberties. Deteriorating patients received a speedy response.

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- Patient treatment plans were decided in effective multidisciplinary meetings. Patients told us that they had their pain managed and this followed national guidelines.
- The service supported staff with access to training and supervision for competencies. There was a programme of staff led audits regarding clinical practice.
- Dietitians were on hand to provide regular support to patients. Nurses and housekeepers offered patients food and fluids regularly.
- The Friends and family test (FFT) is a quick and anonymous way for patients to give their views after receiving care or treatment across the NHS. The trust's performance in the FFT was consistently higher than the England average. Patients told us that they felt very involved in the decisions regarding their care and treatment. Patients were assessed holistically and psychological support was available on request.
- The service was responsive to the needs of people using it. The trust understood their limitations regarding not having a critical care unit on site. To lessen the risk there were processes in place to ensure that patients requiring emergency care had access as soon as possible. The service proactively managed discharges.
- Patients were provided with written up information concerning their treatment plans and had access to a key worker. There was a minimal amount of complaints. The Patient Advice and Liaison Service (PALS) investigated and fed-back learning to the staff dealt with formal complaints effectively.
- Staff were aware of the vision and strategy for the chemotherapy service. Quarterly governance reports were published and available to staff on the ward. Staff could name members of the executive team and felt there was a friendly and approachable governance structure. The culture of the service was one of openness and staff felt supported by their teams and team leaders.
- Generally staff were very proud to work at the trust and within the chemotherapy division.

Are chemotherapy services safe?

Good



We have rated safe as good because:

- There were processes in place for reporting of incidents and staff could clearly outline the reporting system used by the trust. Staff understood their responsibility to raise concerns and received feedback from incidents via email. Staff discussed learning in monthly ward meetings. Patient facing dashboards displayed rates of harm free care above the trust target of 93%.
- The prescribing, dispensing, storage, delivery and administration of chemotherapy was all done safely and in line with national and local policies.
- On inspection, we found the standard of cleanliness and hygiene of all clinical areas were good. The service protected patients, staff and visitors from the risk of infection and met national and trust guidelines.
- Staff understood the importance of escalating safeguarding concerns and all staff could identify the trust safeguarding lead. Mandatory training rates were 87% for staff in the chemotherapy division. This is just below the trust target of 90%.
- There were sufficient nurses and doctors on duty. Nurse staff levels were tracked twice a day in multidisciplinary huddles. Nurses were happy to work bank shifts to make up any shortages.
- There was a bespoke electronic chemotherapy prescription service that reduced opportunities for prescription errors.
- There were processes in place for responding to patients who presented at the hospital with potential neutropenic sepsis. These processes were also in place for patients who became ill with suspected sepsis on the wards.

Incidents

- Staff told us that the hospital's incident reporting system was easy to follow and they received feedback on all incidents reported.
- Staff we spoke with across both medical units told us that most incidents related to allergic reactions. To lessen the risk against allergic reaction patients were provided with information sheets on what to do if they were concerned or developed a temperature.

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- From February 2015 – January 2016 the chemotherapy service reported 333 incidents to the National reporting and Learning System (NRLS). Of these incidents, 327 were reported as low/no harm.
- Many of the incidents reported were due to allergic reactions or hypersensitive reactions to chemotherapy.
- Staff received feedback on incidents through email. Discussions were held at ward meetings to discuss learning from incidents. There were patient facing dashboards throughout clinical areas with information regarding incidents.
- Chemotherapy Mortality and Morbidity (M&M) meetings took place every other month. We reviewed minutes of the latest M&M, which identified lessons learnt from deaths within 30 days of systemic anti-cancer therapy. A register of attendance was not attached to the minutes.

Duty of candour

- The duty of candour is a legal duty on staff within a trust to inform and apologise to patients if there has been a mistake in care that has led to significant harm.
- All staff we spoke to understood their responsibility to be open and candid with patients. All staff knew who to speak to if something went wrong in clinical practice.
- When asked what they would do if something went wrong a staff member told us that they would “inform the patient and the patient’s family right away”.
- To ensure staff understood the importance of being candid in clinical practice, sessions on the duty of candour were held by ward managers and practice educators.
- Duty of candour training was included in the health and safety training in the mandatory training programme.

Safety thermometer

- The NHS Safety thermometer is an improvement tool to measure patient ‘harms’ and harm free care. It provides a monthly look at the prevalence of avoidable harms including; pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter-acquired urinary tract infections. Safety thermometer stats were broken down and placed on patient facing dashboards in relevant clinical areas at the trust.
- The safety thermometer tool was not relevant to either the medical day unit for NHS patients or the private patient medical day unit.
- All wards displayed patient facing dashboards that patients could see and staff had access to. The trust target for harm free care was 93%.

- Two harm free champions on Kennaway ward were responsible for monitoring ongoing safety thermometer issues. At the time of the inspection the ward boasted 100% compliance with harm free care
- Smithers ward reported 95% harm free care on the safety thermometer in March 2016.
- Robert Tiffany ward reported 90% harm free care on the safety thermometer at the time of the inspection.

Cleanliness, infection control and hygiene

- All patients admitted to the inpatient wards were screened for meticillin-resistant staphylococcus aureus (MRSA) carriage. MRSA is a bacteria that can be present on the skin without causing infection but can be a common cause of infection. Between October 2015 and December 2015 there were zero cases of MRSA throughout the chemotherapy led wards and units.
- All clinical areas were visibly clean. At the Sutton site the overall hand hygiene score was 99%. There were infection prevention and control link nurses.
- We saw good practice by staff with regards to hand hygiene. Hand hygiene was monitored monthly and results were displayed in patient facing dashboards located in all clinical areas. As well as weekly hygiene checks by senior staff in clinical areas and monthly hand hygiene audits by the infection control team there were also random hygiene checks by members of the infection control team and housekeeping staff.
- Patients receiving chemotherapy are more prone to infection. All wards possessed side rooms that could be used in the event of a patient requiring isolation due to their weakened immune systems.
- In all clinical areas there were bins for the disposal of cytotoxic contaminated materials and equipment. There was a bin labelled ‘cytotoxic waste’ that appeared to be used correctly and closed after use. Cytotoxic drugs are medicines used in the treatment of cancer that contain chemicals that are toxic to cells and prevent their replication or growth.
- There was another larger bin labelled infection control where soiled linen was disposed of and this was locked.
- We observed the cytotoxic spillage kits in all clinical areas and found them to be in date and regularly checked and signed for. All staff we spoke with were aware of the process to follow if a cytotoxic drug was spilled.
- The domestic staff room on the medical day unit displayed protocols for spillage management.

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- Adequate supplies of personal protective equipment (PPE), for example, gloves and aprons, were available on the wards and we observed staff adhered to the trusts “bare below the elbows” policy.
- Infection and Prevention control training formed part of the mandatory training programme that was updated yearly. The trust’s target was 90% of staff having completed the training, within the chemotherapy unit between 75% and 95% of staff had completed the training.

Environment and equipment

- The trust score was above the England average from 2013 to 2015 for Patient Led Assessments of the Care Environment (PLACE) with regards to cleanliness and facilities.
- We observed all clinical areas to be clean and equipment properly maintained. Staff called the biomedical engineering team in the event of any concern regarding equipment in clinical areas.
- We saw that all Electrical Medical Equipment (EME) was serviced in accordance with recommendations and had a registration sticker. The Portable Appliance Testing (PAT) labels were attached to non-clinical electrical systems showing that they had been inspected and were safe to use.
- We checked the resuscitation trolley on each ward and unit and found they were all stocked with equipment that was in date and the trolleys were stored in a central position. We saw that there was a logbook on the top of each resuscitation trolley which indicated that they had all been regularly checked in accordance with the trust policy. The trolley drawer was tagged to ensure that no items were removed and a different tag was placed on the trolley with each daily check. We observed a sufficient amount of medical equipment, for example intravenous pumps and subcutaneous drivers. All equipment was tested and calibrated in accordance with trust policies.
- The extravasation kit policy stated that equipment should be checked daily. Extravasation is the escape of medicine from the vein causing damage to surrounding tissue, which can cause death of the tissue and ulceration. Prompt action from staff is required to minimise damage
- Extravasation kits were being checked on all wards and units with the exception of the private patient medical day unit. Although staff told us they checked the kit the

daily records did not support this as they were never checked and signed for. As the kit was present and all equipment was in date there would be minimal risk to a patient requiring extravasation, however, the lack of formal checks went against the trust policy.

- Although staff felt the clinical areas and NHS wards to be slightly cramped, there was no evidence to suggest that this affected patient safety. We observed a general lack of space, especially in the medical day unit where patients received visits from friends and family. The staff tried to lessen the risk by asking the patients to arrive at the exact time of their chemotherapy appointment and limit the number of visitors on the unit.
- There were no beds in the MDU for patients to lie on if they became unwell.
- Health and safety was part of the statutory training programme which staff were required to attend. The trust’s target was for 90% of staff to have completed the training. Within the chemotherapy service between 73% and 96% of staff had completed the training.

Medicines

- Medicines were stored safely and in accordance with trust policy with systemic-anti cancer therapies (SACT) being prepared in a germ free (aseptic) setting by specialist pharmacists.
- The bespoke electronic chemotherapy prescribing system had inbuilt safety systems and version controls that ensured that all relevant information relating to the patient journey and treatment pathways were centrally held. This had helped to significantly reduce errors in prescription. Staff told us that medication errors were low since adopting this system. Staff told us that they were confident using the electronic system.
- The chemotherapy prescriptions were released onto the ward by authorised prescribers who were usually a suitably trained oncology pharmacist. The trust used a London Cancer Alliance training programme.
- Controlled drugs (CDs) were securely stored and managed appropriately on wards and units across the service. CD stocks were checked daily. Pharmacists conducted quarterly CD audits on wards and the results of these audits were escalated to ward managers. IV fluids were stored in a locked room but not in separate locked cabinets.
- The medicines cupboard in the MDU was unlocked. When asked about this the ward sister told us that because the unit was extremely busy, the trust carried

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out a risk assessment and authorised that the cupboard to be left unlocked as the room that contained the drugs was always occupied by staff. On our inspection, we saw that staff continuously manned this room and the room was locked.

- The trust had policies on the safe administration of chemotherapy and the safe administration of intrathecal chemotherapy. Intrathecal chemotherapy is the chemotherapy administered to treat cancers that have entered into the cerebral spinal fluid. We observed good practices with regards to intrathecal chemotherapy.
- For intrathecal chemotherapy, pharmacists, nurses and medical staff received specific training to administer it to patients. Only those trained could handle intrathecal chemotherapy. An annual date-expiring certificate was issued to staff on satisfactory completion of training. Staff involved with intrathecal chemotherapy had to use the trust policy in conjunction with the national guidance HSC 2008/001 and the rapid Response Report NPSA/2008/RRR004 related to intravenous Vinca alkaloid administration.
- Some nurses could prescribe drugs such as antibiotics and fluids under Patient Group Directions (a written instruction for the supply and administration of a specified medicine) before a doctor arrived.
- Nurses had to complete specific training and be assessed as competent before they were allowed to administer chemotherapy. Their competency was tested again after a year and thereafter they completed annual assessments.
- Fridge temperatures throughout the chemotherapy led wards and units were checked and maintained within safe limits.
- Except in certain emergencies, staff administered chemotherapy during normal working hours. We looked at 14 patient care notes and found that all patients had received chemotherapy during normal working hours.
- The pharmacy team in the trust were leading a national project across England on dose banding of chemotherapy medicines. The aim of the project is for chemotherapy to be prescribed in standard doses. This would mean most chemotherapy medicines could be batch produced, improving efficiency and reduction in wastage. The pharmacists were trained in the preparation of systemic anti-cancer medicines.

- Specialist pharmacists provided clinical support to doctors in the MDU and PPMDU to facilitate accurate and effective prescribing of chemotherapy doses.
- There was a contracted out pharmacy on the ground floor of the Sutton site, which acted as an outpatient pharmacy dispensary for take home drugs. The dispensary had access to the trust's IT system, which helped reduce risks to patients when dispensing supportive chemotherapy medicines.

Records

- The hospital staff used electronic patient records (EPR) to record patients' care and treatment with some additional paper nursing records, such as observation charts and fluid balances. Ward managers regularly audited patient records to ensure completeness. We were unaware of any ongoing issues.
- Staff could access patient medical records with a unique login in order to increase accountability of information being accessed.
- We reviewed 14 sets of care notes for patients undergoing chemotherapy and found that patient notes were fully completed. On admission, risk assessments were completed and reviewed daily and this included pressure assessment within six hours of admission, Venous Thromboembolism (VTE), nutritional and falls risk assessment.
- Patients and their GPs received written copies of their end of treatment record after a chemotherapy cycle.
- Information Governance was part of the mandatory training programme which all staff were required to attend. The trust's target was 95% of staff having completed the training, within the chemotherapy service between 83% and 100% of staff attended training.

Safeguarding

- Staff understood the escalation processes and their responsibilities if they had a safeguarding concern. All staff we spoke to could name the safeguarding lead and knew who to contact if they ever had a safeguarding concern and there were systems in place to make safeguarding referrals if staff had concerns about a particular patient.
- Staff told us that safeguarding concerns rarely posed an issue on the unit but staff could identify the potential signs of abuse and gave us an example of when a concern was identified and managed.

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- Staff in the day units told us that safeguarding concerns were added to the patient's individual care plan.
- Safeguarding was part of the mandatory training programme and different levels of training were provided for different roles. The trust's training target was 90% of staff having completed their training. Within the chemotherapy service between 91% and 100% of staff had attended level one safeguarding training.

Mandatory training

- All staff we spoke with knew about the mandatory training they were required to complete.
- The mandatory and statutory training programme covered basic life support, equality, diversity and human rights, prevention of blood clots, blood transfusion, conflict resolution, health and safety and the duty of candour.
- An electronic system was used to inform senior staff when training for nurses was due to be completed. Medical staff had training on a three-year cycle.
- Mandatory training in chemotherapy was required for all staff involved in prescribing, reconstituting, dispensing, and administering chemotherapy.
- Compliance with mandatory training overall for the chemotherapy service was 87%. This was just below the trust target of 90%.

Assessing and responding to patient risk

- Before administering chemotherapy, staff discussed the potential side effects with patients and gave them time to decide on the treatment option. Once the patient had provided consent, the staff assessed the patient before administering the chemotherapy by checking weight change, blood tests and platelet count. This was to reduce the risk to the patient as for example, if the patient's weight had changed the chemotherapy dose would have to reflect that change.
- During treatment, nurses monitored patients for signs of swelling, inflammation or high temperature to assess whether the patient showed any adverse reactions to the chemotherapy.
- All patients on the wards had a National Early Warning Score (NEWS) completed as least four hourly or more frequently if required. The NEWS score measured respiratory rate, oxygen saturation, temperature, blood pressure, pulse rate and level of consciousness to identify if a patient was deteriorating.

- The duty consultant carried out a full review of the patient within 12 hours of admission in line with the Guidelines for Provision of Intensive Care Services.
- There was a 24-hour nurse-led critical care outreach team (CCOT) in the hospital. The on call anaesthetist supported the CCOT 24 hours a day.
- There was a two bedded 'Step-Up' unit on the Bud Flanagan ward which provided Level 1-3 care for critically ill patients (this included the care of patients requiring advanced respiratory support). Patients were transferred from the 'step-up' unit to the Chelsea critical care unit (CCU) at the earliest opportunity unless they were too unstable for transfer.
- A research fellow undertaking Gastrointestinal Clinical Fellowship training held a clinic from 9am to 5pm on the MDU and was available for medical emergencies.
- Staff provided patients leaving the medical day units with an information pack with helpful hints and tips for keeping well during chemotherapy treatment.
- We saw the information packs and noted that there was specific information on: recognising the signs of blood clots, a chemotherapy alert card and reducing the risk of infection. Patients were given the number of who to call during the day and out of hours if they had any concerns. Patients who fell ill outside the Marsden were told to call 999 for their local A&E.
- The chemotherapy service used a combination of the National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines to treat patients. For example, the trust had their own Management of Neutropenic Sepsis policy, which was based on the NICE guidelines on prevention and management of neutropenic sepsis in cancer patients (2013) and guidelines from the Infectious Diseases Society of America (IDSA). Staff understood these guidelines and told us that they were all readily available on the trust intranet along with various other standard operating procedures.
- The trust had a safety improvement plan in place from 2015-2018. The plan focused on three key safety priorities: sepsis – increasing awareness, identification and treatment of sepsis and reducing death from it; reducing harm from medication errors and reducing harm from pressure ulcers. 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.

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- 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.
- Telephone triage at RMH followed a flow chart dependent on the symptoms the patient reported. Staff recorded the patient's details and symptoms on a triage template. If the patient presented unwell, 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.
- If a patient fell ill outside of the hospital, priority for admission would be given to patients who presented with severe complications e.g. suspected spinal cord compression or patients with suspected sepsis.
- The trust joined the Sign Up to Safety campaign in 2014. One of the aims was to reduce the number of avoidable deaths from sepsis by 100%. One area of improvement was to deliver antibiotics to sepsis patients within one hour – only 41% of patients met this target.
- Adult basic life support was part of the mandatory training programme for nursing staff to attend. The trust's target was 90% of nursing staff having completed the training; within the chemotherapy service between 75% and 96% of nursing had attended the training.

Nursing staffing

- All staff we spoke with said that agency staff were rarely used and staff seemed happy to work additional shifts via the hospital bank. One member of staff said "it's easier for us to do bank ourselves as the competencies needed are very specialist". If agency staff were used they were provided with a full induction into the trust and the clinical unit.
- Senior nursing staff on the MDU produced a schedule three months in advance in order to ascertain how many staff they needed for the number of patients receiving chemotherapy on the unit. They used this, alongside an acuity tool, to confirm they needed between 11-13 members of staff at any given time on

the unit each day. The skill mix was also taken into consideration to cover the three shift times. The first shift was an early shift from 8.30am until 5pm the second shift was from 8.30am until 6.30pm and the last shift was a long day from 8.30 until closure of the unit at 8pm.

- Handover on the MDU happened every morning at 8.30am. At handover, the designated co-ordinator of the day told staff what area they would be working in and discussed the patients who were being admitted that day. We observed a morning handover on the day unit and noted that equipment checks were discussed as well as the number of patients attending the unit and staff vacancies. The staff were also asked to share ideas for innovation.
- Staffing levels on Kennaway ward had been at full establishment (establishment is the term used to describe the numbers of staff and skill mix needed to meet patient needs) since February 2016.
- On Smithers ward staff turnover was around 7% compared to the trust target of no more than 10%. Short-term sickness was less than 3% throughout the last year and long term sickness sat at around 4% as recorded in February 2016. The ward was at an establishment level of 20.88 with a target of 23.32.
- Staffing levels on Robert Tiffany ward were at full establishment. Staff turnover on the ward was at zero and short term sickness sat at 1.2% over the last year.
- Senior staff would ensure that skill mix on the wards and units were extremely varied. Advanced nurse practitioners, clinical nurse specialists, nurses trained in phlebotomy were all involved in the care of patients receiving chemotherapy.
- Nurse staff levels, skill mix and caseloads were tracked twice a day in staff huddles.
- All staff we spoke with had received a trust induction when they commenced employment.

Medical staffing

- There were consultants for each tumour group at the hospital who were supported by department based speciality doctors and junior doctors.
- Junior doctors that we spoke with said the workload was varied and interesting but sometimes difficult to manage. They told us that although there were varied and effective training days, their capacity to attend was sometimes affected by the workload.

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- There was a speciality gastrointestinal doctor located on the medical day unit. We were told that there was rarely need for a consultant to be on the day unit and if a doctor was needed they were always on call.
- Medical staffing differed between private and NHS patient and between wards and units. Patients on the private patient medical day unit and the private inpatient ward told us they frequently saw their consultant and had a visit from a doctor every day.
- All staff knew about the processes for contacting doctor both in and out of hours. The rota for the doctors was available on the trust intranet.

Major incident awareness and training

- The risk and reliance manager prepared staff to respond to a major incident and worked with the site management team to assess current risks.
- Clinical site practitioners (CSPs) received annual practical training in responding to various scenarios e.g. IT problems, snow or the junior doctors strikes
- The matron on each ward attended major incident training along with the ward sister and junior sister.
- Fire training was part of the trust mandatory training programme. The trust target for staff having completed this training was 90%. Between 73% and 95% of staff within the chemotherapy service had completed the fire training. There were fire wardens in each clinical unit.
- On Kennaway ward, 100% of nursing staff had completed emergency planning training.

Are chemotherapy services effective?

Good



We rated the effectiveness of the chemotherapy service as good because:

- Patients had their needs assessed and care plans individualised on admission, in line with best practice, and evidence-based standards and guidelines. Patient treatment plans were developed in effective multidisciplinary meetings.
- Patients told us that they had their pain managed and we saw this was done in accordance with national guidelines.
- Staff were supported with access to training and supervision for competencies. Staff told us that there was good access to training opportunities.

- There was a programme of staff led audits regarding clinical practice.
- Dietitians were on hand to provide regular support to patients and patients were regularly offered food and fluids. Patients nutritional needs were assessed with risks identified.
- Patients were asked for consent before being treated. Staff understood the principles behind legislation governing mental capacity and the Deprivation of Liberty Safeguards (DoLS).

Evidence-based care and treatment

- The trust ensured that its care and treatment was delivered in line with international research and evidence based guidance. Treatment plans were not exclusively chemotherapy based but could contain surgery, radiotherapy or indeed palliative care depending on the patients' needs.
- Patients had their needs assessed and care plans individualised on admission.
- The weekly MDT meetings discussed complex patients and brought together doctors from different specialities to discuss patient treatment options. The results of these meetings were shared with patients.
- The chemotherapy service held an ISO9001:2008 quality accreditation and was assessed by an external auditor from the British Standards Institute (BSI) twice a year. The ISO chemotherapy committee had monitored and discussed waiting times.
- Throughout the chemotherapy service, staff encouraged patients to choose the two-stop method in order to decrease their overall waiting time. However, patients opting for one stop could be given a pager therefore allowing them to leave the site whilst preparation takes place, which could take between three to five hours.
- Many policies were based on the Royal Marsden Hospital Manual of Clinical Nursing Procedures, 2015.
- The trust scored well in the National Lung Cancer Audit for Small Cell Lung Cancer patients having chemotherapy.
- Staff involved with intrathecal chemotherapy had to use the trust policy in conjunction with the national guidance HSC 2008/001 and the rapid Response Report NPSA/2008/RRR004 relating to intravenous Vinca alkaloid administration.

Pain relief

- We observed staff using a pain scale to assess patients' pain. Pain was also discussed during the handover.

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There were various methods for dealing with patient pain including the prescription of analgesia (pain-relieving medicine) but where patients had more complex needs the pain team were involved.

- Patient pain was assessed in routine observations. The 'intentional rounding' process (where staff attend patients at set intervals to check a range of patient-centred issues) ensured patients were comfortable and free from pain. Patients we spoke with told us that they had received appropriate pain relief.
- If analgesia was given more than 30 minutes late staff reported the delay to the site practitioners with omissions being reported as an incident.
- Staff knew how to contact the acute pain team which was available trust wide for both NHS and private patients.

Nutrition and hydration

- From 2013 to 2015 the Patient Led Assessment of a Care Environment (PLACE) scores for the trust were 98% for food and hydration. This was above the England average, which is 90%.
- On admission patient's nutrition and hydration needs were assessed, using the Royal Marsden nutrition scoring tool, and then re-assessed on a weekly basis.
- Food and drinks were provided on the medical day unit. On the private patient medical day unit there was an everyday menu along with a hot food menu that changed every day.
- We observed housekeepers asking patients if they would like water, tea or coffee. There was water widely available to all patients in clinical areas.
- We were told that there was a dietician team available at the trust. The dietitian saw patients who were at risk of malnutrition or suffering nausea caused by chemotherapy treatment. Patients on the day units were weighed each time they attended and patients on the ward were also weighed frequently.

Patient outcomes

- The trust contributed to the Systemic Anti-Cancer Therapy (SACT) dataset that covers patients receiving chemotherapy in England.
- The trust took part in the National Confidential Enquiries into Patient Outcomes and Deaths (NCEPOD) pilot and study.
- The trust continued to collect data on chemotherapy in order to track trends in the number of deaths within 30 days of receiving SACT. Between January 2016 and

March 2016, 2.2% of patients receiving chemotherapy died within 30 days of chemotherapy administration. This includes patients who were receiving chemotherapy for palliative reasons.

- Trust wide, rates of unexpected death were below 1%.

Competent staff

- All staff, including agency staff, received an induction. Junior doctors had a two day corporate induction. Staff told us that their induction was useful and the governance team welcomed them.
- Nurses told us there were "fantastic opportunities for further education and continued professional development". Much training took place in programmes, modules and study days in the Royal Marsden school but external training was also available, for example through the London Cancer Alliance. A number of staff boasted the completion of the oncology course at diploma or degree level.
- Practice educators spoke of regular away days and training days where staff could boost their knowledge of essential competencies.
- Some staff on the wards were qualified mentors. There were some staff on the wards who did not have a mentorship qualification but still act as a mentor to new members of staff.
- Practical work was assessed by practice educators who covered areas such as: controlled drugs, blood administration, IV drugs, oral medication, phlebotomy and cannulation. Staff would have to ensure their competencies were kept up to date, and that they recorded their medical device training
- Junior doctors told us that although the training programme was adequate, it was difficult to attend all the training required as the workload was frequently heavy.
- Between 91%-93% of staff in the service had completed their appraisals. Staff told us that they found the appraisal useful to discuss any concerns and their career aspirations.
- Each member of staff was responsible for ensuring they were up to date with their revalidation. Nurses told us that they could receive support on how to comply with Nursing and Midwifery Council (NMC) revalidation requirements.

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Multidisciplinary working

- We observed a strong culture of multidisciplinary working. Multidisciplinary teams (MDTs) were based on tumour type and the meetings were held according to tumour groups e.g. myeloma/leukaemia was held at a different time to the lymphoma MDT.
- Clinical pharmacists were well integrated into the multidisciplinary team, which facilitated effective and efficient delivery of care and design of treatment pathways.
- In cross site MDTs, videoconferencing was used to link with the Fulham site but a consultant told us that the IT equipment was often lacking and at times did not work at all.
- On the wards and units there was a daily handover attended by all nurses on shift. On wards physiotherapists, occupational therapists and dietitians would visit after handover to ask if there were any updates and if their services were required.
- There was a twice-daily multidisciplinary bed meeting to ensure all admissions were admitted to the right place and that discharges were planned accordingly. The discharge coordinator would also attend the wards twice a week.
- Specialist pharmacists provided clinical support to doctors in the MDU and PPMDU to facilitate accurate and effective prescribing and manufacturing of chemotherapy doses, which reduced error, patient waiting time and overall improved patient experience.
- Counselling services, psychiatric support and a clinical nurse specialist were available to patients who needed these.
- The skill mix of staff was taken into consideration when making up rotas and staff worked effectively in multidisciplinary settings. Staff spoke very highly of MDT working throughout the trust.
- For patients who needed to transfer between Sutton and Chelsea there was collaboration from pertinent staff across the sites, for example, the anaesthetists, consultants and nurses as well as the critical care outreach team.
- We attended some chemotherapy MDT's and noted that attendance was monitored. Decision-making was collaborative and all new patients were discussed.
- The attendance rates at the MDT's were usually above the target of 66%.

Seven-day services

- The wards were open 7 days a week and patients were reviewed daily.
- The medical day units were open Monday to Friday 8.30am to 8pm.
- There was 24/7 medical cover as well as a 24/7 critical care outreach team.
- There were no clinical pharmacy services on Sundays but on call pharmacists were available.

Access to information

- Staff knew about trust wide protocols and told us how they obtained key trust policies and standard operating procedures on the intranet.
- Results of tests were readily available but staff in the private patients medical day unit told us that lab results could sometimes take 'too long' to reach them and this can cause the one stop patients to wait for a long time.
- All patients care notes were kept on the trust wide electronic patient record (EPR) system. For example, if a patient was transferred from a ward to the 'step-up' unit and then to the Chelsea site, all of this information was maintained on the EPR.
- Protocols and treatments were the same trust wide.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at 14 patient care records and found that all of them contained signed consent forms. All the patients we spoke with told us that their consent had been obtained prior to commencing treatment.
- Staff told us that Mental Capacity Act 2005 and Deprivation of Liberties Safeguards training was part of their mandatory training.
- Staff were familiar with the trust's up to date consent policy and all staff we spoke to were clear about their responsibilities for gaining appropriate consent.
- For patients undergoing chemotherapy, the risks and side effects were outlined to them before providing their consent. Three patients that we spoke with about their treatment verified this. Side effects were recorded in writing.
- All policies relating to mental capacity and safeguarding were available on the trust intranet and staff knew how to access these.
- To ensure they had capacity to make decisions appropriate to their care all patients over 70 were screened for dementia.

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Are chemotherapy services caring?

Outstanding



We rated the caring aspects of the chemotherapy service as outstanding:

- We spoke with 17 patients and their family members and the feedback was overwhelmingly positive from everyone.
- It was clear that staff understood that the impact of the patient's care and treatment affected the patient's wellbeing and the wellbeing of the patients friends and family. All patients we spoke with talked very positively about the way staff treated them.
- Patients received compassionate care and were treated with dignity and respect. The trusts performance in the Friends and Family test (FFT) was consistently higher than the England average. There was a strong sense of person-centred care and the relationships between staff and patients was highly valued by staff.
- Patients told us that they felt very involved in the decisions regarding their care and treatment and were given appropriate information in a timely manner.
- Despite the fact that some patients we spoke with were unaware of patient forums, there were support groups available both within the trust and externally.

Compassionate care

- The trust used the Friends and Family Test (FFT) to obtain patients' views on whether they would recommend the service to a friend or loved one. The results for the majority of 2015 showed between 90% and 100% of patients on the unit would recommend the hospital to their friends and relatives.
- We observed caring and compassionate interactions between all staff and patients.
- The patients we spoke told us positive things about the kindness they received from all staff that interacted with them. One patient said that the care in the unit surpassed any care they received elsewhere. All patients we spoke to on the unit echoed this.
- Patients told us the "care is very good" and "nurses are very kind" and we observed staff taking the time to

consider individual patient needs. For example, we observed a nurse asking a patient if they were warm and comfortable enough and providing them with additional blankets and a pillow.

- Patients that we spoke to told us of the kindness and consideration they had received whilst being treated at the Marsden. Relatives also spoke with the same intent and were pleased with how their loved ones were being treated. One patient said it was a 'privilege' to be treated at the Marsden.
- We looked at the results of the patient led assessments of the care environment (PLACE). The trust scored an average of 85% for privacy, dignity and wellbeing from 2013 to 2015. This was just below the England average which was 87%.

Understanding and involvement of patients and those close to them

- Patients we spoke with said they felt involved in medical decisions the clinical staff made. One patient reported being 'a part of the team' when it came to their treatment options and care plans.
- All patients were offered their treatment plan in writing which included information specific to the patients type of cancer and the potential risks and benefits of treatment. This was in accordance with NICE QS15 statement 5 as the healthcare team supported the patients to understand their treatment plan. The patients were also provided written information on the services offering psychological, social and spiritual support.
- All patients were allocated a key worker who was the main point of contact. The key worker met all new patients assigned to them and played a key role in assisting the patient through their pathway of care. Patients had the details of their key worker and had opportunities to discuss their care plan and any concerns they may have had. This is in accordance with NICE QS15 statement 4.

Emotional support

- Staff had a profound understanding of the psychological and emotional impact that the conditions the patients suffered had on them and their families. To this end, staff were always on hand to provide emotional support and this was supported by all the patients we spoke with, even the patients in the day units.

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- We observed staff taking the time to interact with patients and their relatives and nurses seemed skilled in dealing with patient anxieties.
- Although the patients emotional needs were not discussed in the MDT, the key workers assessed the patients psychological and emotional needs and was able to refer them to both internal and external counsellors.
- The trust had a Key Worker Operational Policy (1678) that stated that the key worker acted as the point of call between the patient and the MDT team. The key worker could direct the patient to support groups both within the trust and externally and several patients confirmed this. However, the patients we spoke with did not know there were any patient forum groups available.
- The trust provided a confidential psychological support service to help individuals and those close to them to adjust to the emotional impact living with cancer.

Are chemotherapy services responsive?

Good



We rated the responsiveness of chemotherapy services to be good:

- Care plans were highly individualised with the needs of the patient being taken into consideration.
- Assessments where the patient would come in for bloods and laboratory tests on one day and come back to receive chemotherapy – known as ‘two-stop’ patients – greatly reduced patient waiting times.
- ‘One-stop’ treatments were available for patients who came from further afield and could not come to the trust on two separate occasions.
- Out of hours assistance was available and patients were provided with the details of the clinical unit if they had concerns.
- Patients were provided with written information concerning their treatment plans and had access to a key worker.
- There were a minimal number of complaints. The Patient Advice and Liaison Service (PALS) who investigated and fed-back learning to the staff dealt with formal complaints effectively.

- The trust understood their limitations regarding not having a critical care unit on site. To lessen the risk there were processes in place to ensure that patients requiring emergency care had access as soon as possible.
- Key workers and nursing staff assessed patients holistically and psychological support was available on request. Patients were provided with a key worker to ensure complex needs were supported appropriately.

However;

- One-stop patients felt they often had to wait too long for lab results and medication. This would range from between three to five hours.

Service planning and delivery to meet the needs of local people

- Outpatients who lived local to the hospital were encouraged to take up the two-stop treatment plan. This enabled patients to prepare for their chemotherapy.
- A range of booklets and pamphlets were available to patients receiving chemotherapy. The information could be tailored to meet special needs.
- There were huddles that met twice a day to discuss discharge. Patients were encouraged to be discharged before midday so that the bed was free for other patients.
- Some patients who drove to the trust spoke of the difficulties with parking. Three patients told us that there was a steep walk from the car park to the hospital. A local bus service was available outside the main foyer of the hospital.

Access and flow

- The trust target for patients waiting more than four hours for treatment was 5%. At the time of our inspection, 7% of patients were waiting more than four hours for chemotherapy.
- Waiting times throughout the chemotherapy service were largely dependent on whether a patient chose to have their bloods taken, consultation with a doctor and chemotherapy prepared by pharmacy all on the same day (one stop). Alternatively, a patient could decide to have chemotherapy on a separate day to preparation (two stop). Throughout the chemotherapy service, staff encouraged patients to choose the two-stop method in

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order to decrease their overall waiting time. However, patients opting for one stop were given a pager, which allowed them to leave the site whilst preparation took place. This could take between three to five hours.

- Patients receiving two-stop care (where bloods and preparation were taken on one day and chemotherapy treatment was received on a different day) had shorter waiting times than patients receiving one stop care (where bloods, preparation and treatment all took place on one day).
- On the medical day unit (MDU) 87% of one-stop patients were seen within one hour of attendance. Within one hour of attendance, 84% of two-stop patients were seen on the MDU.
- Patients who lived locally were encouraged to become two stop patients in order to minimise their waiting time.
- Nurses in the MDU spoke of the pressures that one-stop patients created and would tell patients that the 'two stop' treatment system would reduce their waits; they recognised, the 'one stop' treatment was an easier option for patients who lived far away.
- Bed occupancy on Smithers ward ranged from between 82% - 88% and there were four chairs used for day care chemotherapy/blood transfusions. Between April 2015 and December 2015, the bed occupancy rate was around 73% on Robert Tiffany.
- In line with the southwest London reallocation policy, the trust reallocated breaches to referring trusts when referrals were received very late in the 62-day pathway. The trust referral to treatment for patients requiring admission was around 95%. The trust target was 90%.

Meeting people's individual needs

- In the medical day unit (MDU) there were various leaflets on evidence based complementary therapies to aid relaxation and salon services available to patients who were undergoing chemotherapy. These leaflets were located on a wall in the foyer before entering any of the treatment areas.
- The MDU staff told us that care plans were altered to support individual needs. For patients who had a fear of needles, staff ensured the same staff for each appointment was on duty to foster familiarity with the patient. The staff also used the assistance of the counselling service to help reduce the patient's anxiety prior to chemotherapy.
- In the private patient day unit, there were two cold cap machines that could seat four people at a time. A cold cap machine can be used by patients undergoing chemotherapy to lessen the risk of hair loss by keeping the scalp cool when receiving chemotherapy.
- A high proportion of patients using the private patient medical day unit were from Arabic speaking countries. To reflect this, the unit had all leaflets in Arabic. The daily menus were written in both English and Arabic. A translator could be made available for these patients.
- In both day units, refreshments were provided to patients and water was always readily available. There was wi-fi throughout and a television located in each area.
- Staff told us they made adjustments for patients who presented with learning disabilities. We were given the example of an autistic patient who was only comfortable with a few nurses on the unit. Those same nurses would ensure they were on shift whenever that patient was having chemotherapy.
- Although the use of agency staff was low throughout the trust, the wards and units usually used agency mental health nurses for relevant patients needing 1:1 care.
- Private overseas patients would be assisted by the international patients team and the private patients accounts team coordinated all embassy sponsored and insured admissions. There was also an advocacy service for international patients.
- Telephone translation services were available trust wide.
- From 2013 to 2015, the site Patient Led Assessments of a Care Environment (PLACE) scores with regards to being handled with privacy, dignity and wellbeing were 85%. This is slightly below the England average of 87%.
- The Royal Marsden Help Centre assisted in producing pamphlets for patients whose first language was not English or needed an alternative format. We spoke with patients and their relatives for whom, English is their second language and they said that the care staff went out of their way to ensure the patients understood their care plans.
- A trust wide chaplaincy team provided spiritual and religious guidance to patients. A chaplain held a weekly service in the chapel and separate prayer rooms open for anyone that needed them, which were mainly inpatients. Between October and December 2015 the chaplaincy team made 519 visits on the Sutton site.

Chemotherapy

Learning from complaints and concerns

- Staff told us that in the first instance they would deal with any concerns themselves before escalating to the Patient Advice and Liaison Service (PALS). They saw this proactive approach as the reason formal complaints were so low.
- The number of compliments far outweighed complaints.
- All formal complaints were recorded and learning shared throughout the particular ward or unit. From October 2015 to December 2015, one formal complaint was received and this was regarding waiting times.
- The majority of informal complaints were about long patient waiting times. To lessen the risk of this, staff encouraged patients to come in on one day for their pre-assessment bloods and to come in on another day for their chemotherapy. This style of treatment was referred to as two-stop.
- Throughout the wards and units we saw patient facing 'comment cards' that patients could use if they had an informal complaint.
- Private patient complaints were considered by the matron at weekly complaints meetings and learning was discussed at ward meeting and circulated by email to staff. Any complaints were posted on the patient facing dashboards.
- Concerns and complaints were highlighted on the ward metrics that were available to staff.

Are chemotherapy services well-led?

Outstanding



We rated the well-led aspects of the chemotherapy services to be outstanding because:

- Staff knew about the vision and strategy for the chemotherapy service and senior staff knew about the strategy of the chemotherapy service as it related to the trust as a whole. The vision for the service was embedded in the culture and every day workings of the staff.
- Quarterly governance reports were published and available to staff on the ward. Staff could name members of the board and felt there was a friendly and

approachable governance structure. Risks were identified and managed in line with best practice and staff on the units were aware of the risks that faced their service.

- The culture of the service was one of openness and staff felt supported by their teams and team leaders. Senior and executive managers were visible on the wards and staff saw them as approachable.
- All staff could recognise members of the executive team and board and knew about the vision for the trust as a whole. There was strong support across the department and staff informed us that the service felt like a family.
- Staff and patients were engaged with the development of the trust and of the cancer division.

Vision and strategy for this service

- All staff were aware of the trust vision to provide safe, effective and high-quality care to all patients accessing services and this vision was embedded by all members of staff.
- Staff on the day units were aware of the projected growth by 2018/19 and understood the trust's vision to continue to recruit and appraise. Staff spoke excitedly about the new builds planned for the service.
- The majority of staff knew about the overall published strategy for the trust to provide the best possible person-centred care.
- Staff told us they were kept up to date with key trust strategies through the trust intranet and emails.

Governance, risk management and quality measurement

- The divisions risk register was up to date. There were no high level risks but there were risks recorded about SHO cover and the environment in the day units. Consultants had raised the issue of low SHO staffing with us and in order to lessen the risk were recruiting more advanced nurse practitioners for their clinics.
- Throughout the service we saw posters on each of these priorities and the wards and units had taken steps to ensure that awareness of these issues was shared amongst staff.
- We were informed by nursing staff that trust wide strategies were mentioned at monthly ward meetings and on Schwartz rounds.

Chemotherapy

- We observed that quarterly governance reports were published and available to staff in the medical day unit. Staff throughout the division were aware of how to gain access to quarterly governance reports.
- The trust continued to collect data on chemotherapy in order to track trends in the number of deaths within 30 days of receiving SACT. Between January 2016 and March 2016, 2.2% of patients receiving chemotherapy died within 30 days of chemotherapy administration. This includes patients who were receiving chemotherapy for palliative reasons.

Leadership of service

- The leadership structure was well understood by staff and staff described senior managers as 'visible' and 'approachable'.
- Regular focus groups were held for staff and were chaired by the chief nurse, deputy chief nurse and divisional nurse director. Staff felt very comfortable in attending a focus group or open door session as they were encouraged to be honest and open.
- Staff were aware of the trust 'whistleblowing' policy and could raise concerns with senior staff.
- Staff we spoke with were able to name members of the executive board and felt that there was a friendly and approachable leadership. Both senior and junior nurses felt as though they had ample opportunities to grow and develop within the unit.

Culture within the service

- Staff reported they were proud to work at the trust and especially proud to work on their particular service. Several nurses mentioned that having the Royal Marsden school on site meant they had wider opportunities to increase their knowledge and study which added to their continued professional development.
- Staff reported the working atmosphere to be a kind and supportive one. When asked about training and career growth opportunities, one staff member said 'they take care of you here at the Marsden'. Staff said that there was a strong culture of development within the trust.
- There was a culture of openness and staff reported that they felt comfortable reporting incidents and raising concerns. All staff we spoke with reported that they were encouraged to learn from incidents.
- Staff mentioned that in their appraisals the importance of openness was mentioned as a pillar of the work they do.

- Throughout our inspection we observed and spoke with staff who were happy to work at the hospital and were proud to work in their unit. Staff especially liked the opportunities for development and further study and felt supported by management to take on new opportunities.

Public engagement

- Patients and relatives that we spoke to felt very engaged in the service and there were opportunities to offer feedback. There were comment cards in all clinical areas that patients could fill in. The matron or the ward sister reviewed the cards and shared learning from negative comments amongst staff.
- There were thank you cards in all wards and units and patients were encouraged to share their opinion of the care they had received.
- There were a minimal number of complaints but staff informed us that constructive challenge was taken on board and changes were made as a result of these challenges. An example of this would be the strides towards ensuring that patients were not waiting too long for medicines and procedures. The advances in reducing waiting time came primarily from patient initiatives.

Staff engagement

- All staff we spoke with said there were various opportunities throughout the year to engage with governance teams and members of the board.
- Staff could identify the CEO and the Chief Nurse who both made unannounced visits to the clinical areas throughout the year. One staff member told us that the CEO understood the needs of working directly with patients and this understanding filters down to staff members.
- Staff told us about Schwartz rounds, which were forums to discuss the emotional and social aspects of working at the trust. The trust held these every quarter. They sought to bring together staff from various backgrounds. Staff found these helpful and would attend when they had time.
- The Chief Nurse and Divisional Nurse Director had regular contact with staff in clinical areas, staff referred to senior staff as 'approachable' and 'kind'. One staff member noted 'I never feel like there is a stupid question'.







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- On the private patient medical day unit, there were comment boxes for staff on the unit to put in comments relating to their views on the provision of care.

Innovation, improvement and sustainability

- The trust's pharmacy team were leading a national project on dose banding of chemotherapy medicines. Once achieved, the effect of this project would be the standardisation of chemotherapy doses, which would mean most chemotherapy medicines could be batch produced, improving efficiency and reduction in wastage. We received no information on when this was due to be complete.
- The private patient medical day unit was in the process of introducing an advanced nurse practitioner to assist with shortfall. They were also rolling out the two-stop service.
- The NHS medical day unit was in the process of rolling out a vascular access team – this would assist patients with vascular conditions.
- Both the private inpatients and outpatients units were excited about their upcoming symbiotix audits – which would mark a new way of collecting and sharing audit information.

Radiotherapy

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

Information about the service

The radiotherapy service at The Royal Marsden NHS Foundation Trust operates on both the Chelsea and Sutton sites and forms part of the London Cancer Alliance with three other NHS trusts. Radiotherapy is a specialised service that is commissioned centrally by NHS England.

The South West London host population for The Royal Marsden NHS Foundation Trust is approximately 1.5 million people. However, as radiotherapy is a specialised service it provides for a larger population of 2.4 million people.

Between April 2015 and April 2016 The Royal Marsden NHS Foundation Trust provided 6699 courses of radiotherapy to 4979 people (as some patients would have had multiple treatments) with a total of 73,283 attendances to the department.

The radiotherapy department at Sutton has a total of eight linear accelerators (Linac's), a superficial treatment machine (SXR), and a computed tomography (CT) scanner. The funding for a magnetic resonance (MR) Linac was announced by the government in May 2014 and building work for this was underway during the inspection.

During this inspection a CQC inspector, a specialist advisor and an expert by experience reviewed records, observed practice, and spoke with 33 staff including doctors, managers, radiographers (including bank and agency radiographers), administration staff, engineers,

physicists and radiotherapy planners. We spoke with six students from different years in their training. We also spoke with six patients and relatives and looked at four sets of treatment records.

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Summary of findings

We rated the radiotherapy service to be outstanding because:

- There was a clear embedded focus on safety and reporting throughout the department and learning from incidents was identified and shared with all staff. Staff were able to describe incidents to inspectors and the learning taken from these incidents from the department itself, the wider Royal Marsden Trust, and from other hospitals outside of the trust.
- The management of risks and incidents were done through a management system and systems were in place to review regularly any concerns within the department. The management team had oversight of this and the quality team held the department to account when issues arose.
- The centre was involved in and led multiple projects for the development of best practice processes in radiotherapy. This had led to many centres in England adopting their techniques and learning from them. There was a comprehensive system to review internal techniques and how they had been implemented elsewhere to drive improvement.
- Many staff had been involved with research, projects, and papers. A third of the staff at the centre had masters level credits or PhD's resulting in a plethora of research and development. Staff felt that they were fully supported when new techniques were introduced.
- Strong relationships had been built between the patients and people close to them and the radiographers resulting in subtle changes in a patient's wellbeing being noticed and acted upon. Patients we spoke with could give multiple examples of how staff had gone the extra mile for their patient.
- We observed that the management of paediatric patients was tailored to their specific needs and showed creativity in how care was delivered. Play sessions on the treatment machines, the making of thermoplastic masks and staff interactions with the children resulted in a better experience for the patient.

- There was access to a range of clinical specialist nurses when required and radiographers managed care on a daily basis well. There was consideration for dementia awareness and learning difficulties.
- Access to the service was better than the national average and was exceeding the 28 days from referral to treatment target. When patients arrived in the department they were never left waiting and were seen earlier if they could be.
- The department embedded governance at every level and ensured that the management systems proactively reviewed best practice. The department had achieved ISO 9001:2008 accreditation and all staff were enthusiastic about governance and risk management.

However, we found that;

- Some staff had incomplete mandatory training including paediatric basic life support, conflict resolution and moving and handling.
- Some high areas were not free from dust even though a cleaning rota was in use.

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Are radiotherapy services safe?

Good



We rated safe to be good because:

- There was clear evidence of an open safety culture where learning from incidents was fully embedded and a part of working in the department. Staff could demonstrate understanding of learning from incidents in their department, the wider trust, and from hospitals in the wider London Cancer Alliance.
- There was a clear culture of reporting and review when an incident occurred to ensure that as much learning as possible was achieved based on thorough analysis and investigation of the incident. Staff were fully engaged and involved in the process of review and investigating incidents.
- There was a comprehensive safety management system which was bespoke for the radiotherapy department and a team of quality managers engaged in reviewing and improving safety systems.
- Although some of the radiotherapy machines were older, there were no performance issues or problems in getting replacement parts when necessary. All equipment was clean and checked appropriately.
- Staff were aware of their responsibilities under safeguarding both adults and children and could give inspectors situations where they had reported concerns.
- Patients were adequately risk assessed and where necessary individual risk assessments were completed. Patients were discussed daily to ensure that safety and risk were embedded.
- There were adequate levels of radiographer, physics, engineering and medical staff to provide the service in a safe way for patients.

However;

- High dusting was an issue in some of the areas we inspected in the radiotherapy department.
- The levels of some mandatory training for some staff, including paediatric basic life support training was not complete.

Incidents

- No serious incidents, never events, or safety thermometer incidents attributable to the radiotherapy department were reported between January 2015 and January 2016.
- All staff we spoke with were aware of the incident reporting process and had access to the computer reporting system. Staff also had a good understanding of what was considered an incident. When asked, staff could describe how they would report an incident. However, none of them said they would report an incident without the support from a senior member of staff.
- Staff could describe how practice had changed as a result of reporting incidents and sharing of learning. One example was when an incident occurred involving the use of automatic couch movements on the computer system. Different staff could describe the incident and what changed as a result. Staff told us that when this scenario happened again they were able to look back at the email and rectify the issue.
- Staff were also able to provide detailed information of learning from incidents which occurred on the Chelsea radiotherapy site, the wider trust (outside of the radiotherapy department) and with other hospitals in the London Cancer Alliance.
- Prior to the start of each day all staff working on a machine were involved in a team talk. During this session any incidents or learning from other machines were described and reflected upon. Although this was not recorded staff were able to describe learning from incidents shared at this forum and how it had changed practice.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. The aim of this regulation is to ensure that providers are open and transparent with people who use services in relation to care and treatment. It sets out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. Staff understood the duty of candour regulation and were able to give examples of when they had been open and honest about mistakes, not necessarily mistakes exceeding the regulatory threshold, with patients and their relatives. We were told that radiographers who were involved in

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incidents were included in the investigation process and all patients were invited to a meeting with either the radiographers or the consultant oncologist responsible for their care.

- There were leaflets in the radiotherapy department about duty of candour and the investigation process called 'Being Open'. This detailed what the duty of candour meant for the patient, how a patient would be informed of progress during the investigation, support that was available and information for the patient advice and liaison service (PALS) and an external advocacy service.
- Case reviews were held for all patients who had died during a course of treatment or immediately after radiotherapy. This was a discussion between the oncologists who shared learning to improve future care. This forum was not minuted but staff could describe the processes involved and the outcomes from this meeting. These patients would have been discussed in formal mortality and morbidity meetings with other services in the hospital.
- The department could clearly demonstrate a change in the incident reporting culture over the last few years. Although the numbers of incidents resulting in harm had remained consistent the number of no harm incidents and non-conformances reported has increased dramatically. This shows that there was a positive incident reporting culture. All incidents were categorised to determine the nature of the incident and to allow the department to identify themes and disseminate learning.
- Incidents were reported on a computer system which alerted senior staff when submitted. Monthly reports were sent from the trust's quality team to allow the department to identify trends. One example was with the consistency of a mattress used when planning a particular technique. This theme and learning was disseminated through staff meetings and staff in all areas could describe to inspectors the learning from this.
- Staff could describe learning from national trends in incidents. One example of this was with the use of wax build up material on a treatment. Although no incidents had occurred at this department concerning this processes had been changed to improve safety.

- A 'Pause and Check' system was being developed to encourage staff to perform additional checks when delivering radiotherapy. However, some staff were concerned as to how effective this technique would be.
- The document Towards Safer Radiotherapy was used as a benchmark for quality standards and reporting. The purpose of this document was to look at ways of reducing errors in radiotherapy which are caused by individual human error or failure of systems of work, with a view to finding practical and cultural solutions which will result in patient safety being optimised.
- All incidents were discussed bi-monthly at a 'multi professional quality assurance in radiotherapy' meeting which included consultants as well as staff from radiotherapy and physics. Action plans were discussed in this forum. Where there was learning to be shared information was disseminated through 'Comms' meetings with the service leads as well as through emails to all staff.
- Radiotherapy managers from other local departments were invited to attend the quality assurance in radiotherapy meetings to share their knowledge and experiences in their departments. This allowed sharing of incidents between departments. We saw that managers from other services were regularly attending the meetings.

Cleanliness, infection control and hygiene

- Equipment used on a regular basis had an 'I am clean' sticker with current dates on them. There were also weekly cleaning rotas for radiographers (for the clinical equipment and machines) and cleaners (for the rooms) to follow.
- The children's waiting area had a weekly cleaning schedule for toys and games. Toys were also regularly replaced to ensure that they were in a good condition without any breakages to reduce the risk of infections and harm to patients.
- There were weekly infection prevention and control (IPC) audits conducted in radiotherapy which covered 17 different points. Some of these included having appropriate amounts of hand gel available, the appropriateness of hand washing facilities, water outlets flushed, and ensuring staff were following the trusts uniform policy. These were completed by the lead superintendent for the department.

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- We saw evidence of monthly hand hygiene audits which showed the department consistently achieved 100% compliance. Where there was a rare situation that they were not fully compliant an action plan was created, followed up, and subsequent re-audits completed.
- There was a high dusting rota in place for cleaners to follow. In the superficial treatment room and the simulation room we found there were dusty areas in high places on the top of security cameras and cupboards. This was raised with the superintendent radiographer who informed us that the cleaner was new and was still to have their induction. Subsequent to this a meeting had been arranged the week after the inspection between the head of estates and the superintendent radiographer to discuss how the processes could be improved to ensure cleaning was done appropriately.
- In the simulation area we were told about the technique used to put tattoo ink under the patients skin to aid in the identification of the treatment position. Although the pot of tattooing ink was used for more than one patient the process of distributing the ink ensured aseptic techniques were used.
- Non disposable tourniquets were in use increasing the risk of spreading infection.
- The lead for IPC attended a link practitioner meeting once a month to discuss concerns around infection control and to gain knowledge and understanding best practice and developments.
- Patients who had communicable diseases were treated at the end of the day to ensure that appropriate cleaning could be done afterwards. The department had access to an ultraviolet bulb which was able to perform a clean which was more effective than a deep clean.
- Staff could show me where to find infection prevention and control policies on the intranet and there were clear processes to gain access to cleaning staff and additional equipment.
- There were some clinic rooms where staff could be working on their own which did not have immediate access to a nurses call bell. We also found that the call bell in the simulation area was not checked routinely and that not all staff knew where it raised the alarm too.
- Some of the radiotherapy Linacs were aged compared to other machines. One linear accelerator was 11 years old, and several others were 8/9 years old. There was a clear strategy for a replacement programme and there were no concerns about reliability or functionality of the machines.
- Downtime of the Linacs was low (at around 2%) which included time allocated for servicing, physics work, and upgrades. If an issue was picked up by a radiographer it was logged in a book by the machine. The engineers would then look at this log at the end of the day and either perform repairs then or schedule it during a specific time. All staff we spoke with said they would look at this book prior to starting a shift so they were aware of any changes to the machine.
- We saw detailed risk assessments for the equipment used in the radiotherapy department. These defined the risk with and without control measures, contingency situations and summaries. Where risks involved the use of radiation; assessments needed to be validated by the radiation protection advisor.
- There was a fully equipped recovery room in the radiotherapy department with trolleys with children and young people's specific sides to make them less intimidating for the patient.

Medicines

- Although no staff in the radiotherapy department had prescribing training there was access to clinical nurse specialists and doctors to prescribe medicines when required. If it was identified that a patient required medicine a radiographer would get the prescription from the pharmacy and store them securely in the department.
- Contrast media used in the simulation suite was stored securely and at the appropriate temperature. There was no use of controlled drugs in the radiotherapy department.

Environment and equipment

- Oxygen and suction in the treatment rooms were checked daily as part of the daily machine quality assurance processes.

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Records

- Treatment records were stored in lockable cupboards which were secure overnight. There were also records transcribed onto computer systems to allow treatment to commence. When information was transcribed they were checked by a second radiographer.
- Computers were locked when left unattended to prevent access to these records unless authorised.
- We looked in several records and found them all to be legible. However, in one set of notes we reviewed we found that allergy information had not been filled in. This was raised with a radiographer who spoke to the patient straight away and updated the details.
- All treatment records were inputted from the prescription and the treatment plan onto the treating computer system. This was then checked by a second radiographer. All treatment plans were checked weekly to ensure that ongoing treatment records were complete.

Safeguarding

- Staff were able to give examples of where they had raised safeguarding concerns. Staff were clear about the forms of abuse and could describe the processes which would be followed to raise a concern.
- Of the 66 radiography staff, seven were overdue either safeguarding level one or safeguarding level two training.
- Local rules (the responsibilities of each member of staff, depending on grade, when working with and around the use of radiation) were stored on the computer systems and were available to all full time staff, bank staff, agency staff, and students. All members of staff had to re-read and sign a form every time they were updated. Managers told us that they would readily chase up staff who had not read the updates if necessary. However, they had not been in the position to do this yet.

Mandatory training

- There was clear oversight by the education team of both trust wide mandatory training and radiotherapy specific training. Specific training included local rules training and radiation protection training. Radiotherapy physics staff were mostly fully compliant in their mandatory training. However, not all radiotherapy radiographers were fully compliant in their mandatory training. Out of 66 radiotherapy radiographers; 15 were overdue paediatric basic life support training; 11 were overdue conflict resolution training; 10 were overdue moving and

handling training. A small number were overdue either equality and resolution training, infection control training, adult basic life support training or fire safety training.

- We were told that processes had recently changed which meant that booking for training was done centrally and that training days had been reduced. This meant they had little control as to when staff could be sent.
- We were told that mandatory training records were not observed when creating rotas to ensure the correct skill mix. This could have been a risk particularly when treating children as this was a gap in training. However, this was minimised due to the competence of the anaesthetic team.

Assessing and responding to patient risk

- Every patient who was deemed to not fall into standard protocols for treatment had a comprehensive risk assessment completed to ensure that staff were aware of risks before a patient attended. We were given examples which included aggressive patients. All patients had their risk assessments regularly reviewed.
- When a new technique was implemented all patients were risk assessed regardless of their risk level. These patients included those having breath hold treatments, ultraviolet tattoos, specific machine upgrades. All patients had their risk assessments regularly reviewed.
- Every treatment machine and the simulator room had a team talk before each day to discuss each patient individually and their care needs for the day. This also involved a reflection on how the patient was the day before, if any medication needed dispensing, the imaging requirements for the day, and different setup techniques used.
- On the treatment machines there were reference sheets to ensure that imaging was conducted appropriately to the modality and treatment regime. Staff we spoke with found these sheets useful when they were unsure if imaging needed to be conducted and the tolerance of the setup.
- Some children were required to have a general anaesthetic (GA) in order to have their radiotherapy. We saw examples of completed World Health Organisation (WHO) safer surgery checklists which were completed

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before each patient had a GA.. We observed a WHO safer surgery checklist being done in line with best practice. We saw that the students were included in the checklist as well.

- In order to minimise risk there was a red chair in each treatment area. This chair indicated they were in control of the radiotherapy machine during treatment and that they were not to be interrupted. We observed that this rule was being followed and that the radiographer in the red chair had complete concentration on the patient in the room.

Therapeutic Radiographer staffing

- There were adequate staff on duty to provide safe care. The department had total of five vacancies due to recent promotions. All of these positions had been appointed too and agency and bank staff were being used in the interim.
- The staffing establishment was created using a live staffing analysis tool which was managed by the management team. This used live data based on activity to calculate the length of the days required and the number of staff required. This meant that staff were always deployed when necessary to meet the demand of the service.
- Additional extended roles had been filled at the Sutton site. There was one band 7 radiographer funded for the insertion of gold grains for image guided radiotherapy (IGRT) prostate radiotherapy. There were two band 7 radiographers appointed to partake in urology treatment review. There was also a magnetic resonance (MR) radiographer who was starting after the inspection to assist in the MR Linac project.

Radiotherapy Physics and Radiotherapy Engineering staffing

- The physics and radiotherapy engineering teams were both staffed to their established levels with no use of bank or agency staff. However, their workload was being monitored as it was recognised in the annual report 2015/2016 that as planning techniques became more complicated they would become more time consuming.
- Four of the physics staff were employed as part of joint research and clinical posts through funding from external organisations. Two of the physics staff were also employed through funding of PHD grants.

Medical staffing

- There were sufficient consultant and registrar grade doctors to provide the level of care needed in the radiotherapy department.
- Many of the oncologists worked across both the Sutton and the Chelsea sites. However, there was always sufficient medical cover at Sutton.
- Consultants commented that the department was moving in a positive way by having advanced practitioner radiographers perform clinics for urology patients. This freed up consultants time. There was also scope for this to be extended to breast treatments also.

Major incident awareness and training

- The radiotherapy department had a business continuity plan which was stored behind the reception desk. This was a detailed, clear and concise document which described the processes involved in an emergency situation, when the document was activated, and activities and expectations of each staff group.
- Staff we spoke with from all levels (including agency staff) could all describe the location of the business continuity plan as well as its purpose and when it was activated. Staff were able to describe hypothetical situation of when it would need to be activated and the importance of having the plan. Examples were given of no senior cover during a bank holiday working pattern, and if no senior staff were able to attend the department.

Are radiotherapy services effective?

Outstanding



We rated the effectiveness of the radiotherapy department to be outstanding because:

- Care and treatment was planned in line with current best practice, guidelines and legislation. The centre led nationally for the development and implementation of best practice for radiotherapy departments and as a result of this was improving patient outcomes. Techniques and protocols developed by the radiotherapy department were regularly audited and assessed at a local and national level to ensure improvement in outcomes was achieved.
- Staff received appropriate training to carry out their roles effectively and in line with best practice. All staff

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had their appraisals and a third of staff had undertaken masters level qualifications through study leave with the department. Some staff were undertaking PHD level work within the department. Training for new techniques and trials was delivered effectively and safely to ensure competence.

- Multi professional working was embedded into the department. Clinical nurse specialists, dieticians and doctors were available through clinics or through ad hoc requests to manage pain relief, nutrition and hydration. Radiographers had a system to follow up patients who raised concerns throughout their treatment. Also clinical decisions were made using an MDT approach to effectively and quickly ensure timely treatment.

Evidence-based care and treatment

- At the time of the inspection the radiotherapy department were leading 33 clinical trials to develop best practice in radiotherapy. Many trials which the department had led on had become recognised best practice for other departments to follow.
- When a new technique was rolled out from the department to other centres feedback was always collected to allow them to learn from other departments about how their techniques were implemented. Continual audit programmes were developed for any new technique to assess ongoing compliance and effectiveness.
- The department was involved in the creation of the good practice guide for paediatric radiotherapy which is now used nationally. This document set out ten key themes which department should aspire too to achieve good paediatric radiotherapy processes. The unit was compliant with the recommendations.
- Where National Institute of Clinical Excellence (NICE) guidelines existed for radiotherapy these were written into the standard operating procedures for treatments. These included for breast cancer, lung cancer and more recently for the management of patients with dementia.
- It was clear that change was 'normal' in the radiotherapy department and that protocols and best practice were constantly being developed by the service. Staff we spoke with said that this constant change was well organised and that they felt they were suitably prepared to give the treatments due to adequate supervision, competency management, and workbooks.

- There were clear processes in place to ensure that standard operating procedures and documentation was updated in accordance with review dates as a result of good oversight from the departments quality team. Documents were allocated to individuals when they required updating and were held to account by the quality team if they were not completed.
- Trajectory planning was conducted monthly for documentation review which highlighted to radiographers how many documents required updating into the future to encourage timely review of standard operating procedures.

Pain relief

- The radiotherapy department had access to a pain clinical nurse specialist (CNS). Patients had access to this nurse either through a booked radiotherapy pain clinic or through ad hoc requests. Radiographers were able to advise patient to take non-prescription pain relief based on clinical judgement and experience and could refer to the CNS if necessary. Doctors were also available through clinics or by ad hoc requests if necessary.
- If a patient reported pain the radiographer would request a review by the pain CNS and then follow up with the patient the following day to ask about progress or any changes.

Equipment

- The radiotherapy department was one of 17 nationally who were commissioned to perform stereotactic ablative radiotherapy (SABR). SABR, also known as stereotactic body radiation therapy (SBRT), is highly focused radiation treatment that gives an intense dose of radiation concentrated on a tumour, while limiting the dose to the surrounding organs.
- Through complex techniques patients who would historically have been untreatable had radiotherapy as an option. One example given was of an 80 year old patient with poor lung function and was unsuitable for surgery was able to have radiotherapy as a treatment and therefore a better prognosis.
- Audit records showed that for patients who had SABR as a treatment option the department had local control rates greater than 90% over two years and that toxicity to normal tissues was as low as 5%. This meant that patients had a better quality of life after radiotherapy.

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- Patients with multiple lesions were able to have SABR as a treatment option which improved patient outcomes. This was done with specialist commissioning from NHS England.
- The department was going to be one of seven centres worldwide to have a magnetic resonance (MR) linear accelerator which had been proven to provide better outcomes for patients.
- Electronic Portal Imaging Dosimetry (EPID) was standard for quality assurance for treatment plans. This minimised disruption to patient's treatments in order to quality assure treatments.
- We found that not all patients were having the most up to date treatment techniques and were using step and shoot intensity modulated radiotherapy (IMRT) where the treatment is delivered over a 20 minute timeframe rather than a two minute timeframe. Although this did not have an impact on the effectiveness or safety of the treatment, it did mean that some patients were spending longer on the treatment couch than others. Staff we spoke to said that this was due to a lack of computer systems to allow complex IMRT planning for all patients. Funding had been agreed for a new planning system which was being set up for clinical use during the inspection. This system would mean that the processes for planning an IMRT treatment would be more readily available, be quickened and the length of the patient pathway reduced. This would also increase access for patients to more complex techniques.
- The National Cancer Action Team identified that at least 24% of patients receiving curative radiotherapy should be offered radiotherapy using IMRT. The National Clinical Analysis & Specialised Applications Team (NATCANSAT) monitored levels of IMRT in England on behalf of NHS England. The national percentage of IMRT conducted was 37% of treatments 15 fractions and over between April 2014 and June 2015. The percentage of IMRT conducted by The Royal Marsden was 44.2% of treatments over 15 fractions which was significantly higher than other radiotherapy departments.
- This excluded an additional 107 inverse planned IMRT treatments which were less than 15 fractions. These patients would have been treated with stereotactic radiotherapy or would have had a treatment less than 15 fractions and is not recorded nationally.
- Local evaluations of techniques were performed to monitor their own effectiveness compared to previous and current practice. This took into account current evidence based research to draw conclusions on their practice. Examples included a 27 patient review of IMRT in Anal Cancer, the use of image guided radiotherapy for bladder cancer, and the use of CT to improve outcomes for breast cancer.
- The radiotherapy quality management system had been accredited by the British Standards Institute since 1997 and was re-accredited for a further three years in March 2015. As part of the radiotherapy ISO 9001:2008 certification a programme of internal audits needed to be completed, along with audit reports. . These were then reported to the information governance reference model (IGRM) committee.
- The department took part in various external quality control audits as defined by an institute of physics and engineering in medicine (IPEM) sub-committee with clear definitions, scopes and treatment modalities to be audited. In total 16 external audits were completed between April 2014 and February 2016.
- Outcomes of toxicity were recorded using radiation therapy oncology group (RTOG) scores to monitor the effect of radiotherapy to the skin. Action (such as ongoing monitoring, review with the clinical nurse specialist, or review with a doctor) was triggered with certain thresholds being met. All patients were assessed

Nutrition and hydration

- The radiotherapy department had access to dieticians and clinical nurse specialists. Patients had access to this team either through booked clinics or through ad hoc requests. Radiographers were able to advise patients on how to improve nutrition and hydration and information leaflets provided instructions on how to improve on nutritional and hydration needs.
- If any concerns were raised to a radiographer it would be logged in a diary to be followed up the next day and at regular intervals after that.

Patient outcomes

- Intensity modulated radiotherapy (IMRT) provides better outcomes than that for conventional treatments. The NHS commissioning clinical reference group stated that Intensity Modulated Radiotherapy (IMRT) was the gold standard of care.

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using RTOG during pre-treatment (as a baseline assessment) and subsequently at weekly intervals during treatment. This score was then used to assess ongoing care needs and recovery during follow up.

- All patients attending the hospital for treatment had a holistic needs assessment conducted by their key worker, clinical nurse specialist, or research nurse to monitor their ongoing care needs. This was assessed by radiographers before, during, and after treatment to assess deterioration of a patient or the change in their needs.
- Patients who were part of trials had patient reported outcome measures (PROMS) data collected. Staff we spoke with said that it was important to collect this data as it allowed them to work out what was important to the patients as well as what was clinically wrong with them. An example of this given was that patients receiving prostate radiotherapy are more concerned about bladder function than erectile dysfunction. This allowed radiographers to tailor the information given to the patient based on their needs improving quality of life.
- Clinical trial teams at the hospital had focused on reducing the clinical toxicity of patients and improving their quality of life and survivorship.
- The department led The Conventional or hypofractionated high dose intensity modulated radiotherapy for prostate cancer (CHHIP) trial assessed hypofractionation (a method of delivering radiotherapy in less visits to the department) and toxicity of prostate radiotherapy reducing a treatment to 20 fractions. This is now used as standard practice for this radiotherapy technique at the hospital.
- The department led The Apply and Ideal trials showed the effectiveness of adaptive planning reducing treatment toxicity. This is now used as standard practice for this radiotherapy technique at the hospital.
- One member of staff was particularly proud that the centre was the first to develop a protocol for four dimensional paediatric radiotherapy planning (planning which takes into account the movement of the patient due to breathing). This was currently being audited so no outcomes were available but previous research had shown to reduce toxicity to patients.

Competent staff

- There was a programme of workbooks which radiographers had to complete before being deemed

competent in a certain technique or process. These workbooks were for treatment, planning and simulation processes and required a signature from an assessor when complete. They were made up of a personal reflection, the achievement of objectives, discussion as to best practice with an assessor, and a record of clinical competences and reflection on practice.

- Fifty per cent of the radiographers in the department either held credits towards an MSc and post graduate credentials or had full MSc certification with a majority of this being supported through trust study leave. There were two radiographers which held PHD certification in the management team with a third with funding from the charity Prostate Cancer UK.
- The centre also partook in various continual professional development activities including cross site (video link) lectures, journal clubs, email activities or smaller tutorial sessions.
- When a new trial was set up workshops, journal clubs, and workbooks were used to ensure the competence of staff when treating patients using new techniques. Staff said that they felt that “change was a normal part of working here” and that they were not rushed or pushed outside of their comfort zones. They said that the workbooks were good and that they allowed them to treat trial patients safely.
- We spoke with an agency radiographer who said that the trust induction was the best she had undertaken and that they were able to improve and take on responsibilities at their own pace. They also liked that the induction was adapted to suit their own abilities and skills.
- The radiotherapy physics team maintained the training of specialist trainee physicists (four positions), and the training of post graduate diploma physics practitioners (two positions). The physics team also regularly receive students and teach for BSc and MSc courses.
- Registrar’s had access to training in the radiotherapy department which included treatment planning and tumour voluming (the defining of the area to be treated on a computer system).
- There were three staff members dedicated to education and development both for full time staff and visiting students.
- Students were well supported in the department and regularly had supervision and support from either the educational team or radiographers they were working with. All students were offered counselling every three

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months to discuss difficult and traumatic situations. Students were also offered additional training for imaging, and mock interviews and feedback during their third year.

- Some students were part of a four year radiotherapy student programme developed by the Royal Marsden in conjunction with a local university. These students worked and were paid a wage at the Royal Marsden while they trained to become a radiotherapy radiographer. Out of these students many of them had gone on to work at the department with a clear and experienced understanding of processes and protocols.
- Students said they were well supported by radiographers and got quality time in other areas such as consultant clinics, mould room and with the palliative care team. They also said they felt privileged to be involved as a team member with clinical trials and complex treatments.
- Staff commented that their appraisals were well constructed and completed in a timely way. Managers had oversight documentation of appraisal rates. The documentation showed that all staff had either had their appraisal completed or had their appraisal booked.
- Doctors had sufficient speciality knowledge to prescribe treatment to all radiotherapy sites using a range of complex techniques.

Multidisciplinary working

- We saw a well organised and efficient technical multi-disciplinary meeting (MDT) meeting where oncologists and radiographers discussed the appropriateness of stereotactic ablative radiotherapy for specific patients. Patients discussed in this forum were first discussed at a site specific MDT and we saw examples decisions leading to further intervention the same week. This was done using a cross site video link where both the other staff and their computer screens could be viewed. This allowed the use of imaging storage systems and medical records including tumour marker's to be viewed on both sites. One example of strong MDT working was when a patient who was referred by a specialist to an oncologist was discussed a day later at the SABR MDT and had a treatment plan agreed.
- We observed a multi professional audit meeting where we saw effective communication, challenge, and applied expert knowledge to provide the best outcome

for the patient's treatment. We saw examples, through this forum, where patients had their treatment regimens changed based on progress through treatment. We also saw discussions about where patients were to be treated off protocol to ensure that all safety mechanisms were in place.

- There were clear MDT processes between radiographers, doctors and clinical nurse specialists to ensure that patients were seen at the right time by the right specialist. Radiographers said that clinical nurse specialists were easily accessible and there was always someone available to see a patient if any concerns arose. There were weekly clinics for radiotherapy patients to see a clinical nurse specialist which were operated using an MDT approach. For example the head and neck treatment clinic was made up of a head and neck CNS, a speech and language therapist, and a dietician. There were also CNSs available for pain and consultants for specific concerns.

Seven-day services

- There was an on-call system over the weekend for emergency radiotherapy patients. This involved several radiographers to scan, simulate, and treat patients with the supervision of a consultant or registrar.

Access to information

- Although paper records were in use to deliver the radiotherapy all supporting systems were readily available on the computer. This included access to medical records and diagnostic image storage systems.
- Documents specifically for radiotherapy services (for example on-call rotas and staff competencies) were held on a shared drive so all staff could access them.
- Staff in all areas had access to the radiotherapy management system. This managed work flow, patients' appointments and other key clinical information. We saw that there were sufficient terminals in appropriate places to ensure that all staff had access.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient consent to treatment was obtained at the clinical consultation phase. Patients confirmed their consent at scanning and prior to treatment.
- Staff understood the Mental Capacity Act 2005 and were able to describe the appropriate steps to take if they thought a patient lacked capacity. A system was in place to support mental capacity assessments.

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Are radiotherapy services caring?

Outstanding



We rated caring to be outstanding because:

- Feedback from service users and those close to them was consistently positive about the way they were treated by staff. We were given multiple examples of where staff had gone the 'extra mile' to ensure the care provided exceeded expectations.
- Staff we spoke with were highly motivated and inspired to offer high quality care. We observed interactions where strong relationships had been built with service users and those close to them. These relationships were highly valued by staff and patients. We observed occasions where staff recognised subtle differences in a patient's character which may have indicated they needed additional support.
- Particularly when managing the treatment of children staff showed creativity in how to ensure that high quality care was delivered. This was through interactions with the staff and the use of play sessions.

Compassionate care

- The service did not partake in the friends and family test. However, it did contribute to the London Cancer Alliance (LCA) patient experience feedback which analysed feedback and benchmarked it against the other three centres in the network. Of the 162 questionnaires returned the findings were that 86% of patients said that the overall care was excellent (highest of any department in the LCA) and 95% said they were treated as a whole person all of the time (highest of any department in the LCA).
- Patients we spoke with said that staff were compassionate towards them. One patient said that they "could not fault the staff. They have all been brilliant, even the car park attendant".
- We saw a plethora of thank you cards on the treatment machine with staff thanking radiographers for their care and support. One card read "a big thank you! To the professional and highly efficient teams that administered my daily treatment. I will always remember the way you all made me feel special every day".

- One patient we spoke with had an appointment at a different hospital when they could have had it at the Royal Marsden. The radiographer rang the hospital and cancelled the appointment which had a positive impact on the patient. The patient described the staff as "fantastic" for doing this.
- Patients described how staff went the 'extra mile' for them. One patient said "my wife was going to go for a cup of tea but the radiographer went out of their way to go and get one for her instead". Another said "they all seem to go the extra mile".
- One patient said "staff are very pleasant; they treat me with respect and dignity". We observed treatment being delivered in a dignified and respectful way. Where possible patients were being covered up with gowns and patients who made staff gender requests were accommodated for.
- One patient said they look after my wellbeing and they treat me like a human being". Radiographers we spoke with talked about the caring attitude needed to treat patients and that they could "get to know the patients really well during the course of treatment". One member of staff told us that they liked the "banter and the jokes" they could have with the patient to put them at ease during their weeks of treatment.
- One child had their birthday while they were having treatment. The radiographers went the extra mile by making balloon models to have in the treatment room to make them feel special and to feel like their birthday was a celebration.

Understanding and involvement of patients and those close to them

- It was clear that all staff valued the patients as individuals and ensured that relationships were built with them through the course of their treatment. We were given multiple examples of patients who had been distressed about not coming to the department again to see the staff. Staff commented that a patient who was leaving the department "had tears in [patient]'s eyes because he couldn't believe he would not see us again".
- All patients we spoke with said they were fully informed of the risks and the side effects of having radiotherapy and that their schedules and treatments were fully explained to them. One patient said "when I first came

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here I was a bit worried but the staff are fantastic and the treatment is very good. I was worried about having radiotherapy, not knowing what it was but the staff explained everything to me”.

- We were given an example of where a patient’s husband was living with dementia. The patient was struggling to manage his care and they arranged for the dementia team to provide training and psychological support to the patient to aid them in coping better.
- One patient said “the radiographers understood that all decisions about my health were made jointly with my wife”.
- In order to ease children into the processes involved for radiotherapy they were offered several play sessions before they had their treatment to allow them to become accustomed to the environment. This would involve playing with the play specialists, parents or carers, and radiographers in the treatment control area, in the radiotherapy room (allowing the child to move the machine) and allowing them to sit on the bed.
- This would extend to having the parents wait outside of the treatment room to read stories to their child using a tannoy system. We observed this happening during a child’s treatment and could see they were at ease and comfortable with this interaction.
- Prior to having radiotherapy some children needed to have a thermoplastic mask made. This also involved having a play session to allow for the child and their parents get used to the mask. In one session the child’s teddy bear would have a mask made to help them get used to the process.

Emotional support

- Patients were offered specialist cancer counselling as part of their radiotherapy. One patient said that it was “very helpful” and that they were glad it was available in the hospital.
- We observed discussion between two radiographers which demonstrated the subtle details which they picked up on about a patient. One radiographer said to another “how was [patient] today, he didn’t have a smile on his face yesterday”.

Are radiotherapy services responsive?

Outstanding



We rated responsive to be outstanding because:

- People’s individual needs and preferences were met through the planning and delivery of services. We were given multiple examples of where the service had been flexible to meet specific needs of treatment and tailored care accordingly. Staff had specialist knowledge about the management of patients living with dementia and for children..
- There were innovative approaches for providing integrated centred care pathways for children.. This included the use of transfers on thermoplastic masks, the use of play sessions for every step of the process and visual aids for progress during treatment.
- Targets for access to treatment were always met and patients had access to techniques and treatment regimens which reduced the number of attendances required for radiotherapy. Access to complex techniques such as Intensity Modulated Radiotherapy was significantly higher than the national average.
- Although few were received there was an active review of complaints, concerns and compliments which were quickly responded too and improvements made. Learning from complaints was shared both with the staff in the department and nationally with other radiotherapy departments.

Service planning and delivery to meet the needs of local people

- The trust’s radiotherapy departments were one of 17 nationally who were commissioned by NHS England to provide commissioning through evaluation stereotactic programme. This programme was developed to evaluate the use of stereotactic ablative radiotherapy (SABR). The centre had treated 63 individual patients to 66 sites since June 2015 and included complex treatment to various sites such as the spine, lymph nodes, and re-irradiation of the pelvis.

Meeting people’s individual needs

- Radiotherapy review radiographer clinics had been set up for urology patients to relieve some of the pressure on the urology CNS and This acted as a triage system

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where patients were either treated by the review radiographers or had their care escalated to the CNS. This improved access to this support service and provided prompter access to advice and intervention, making the experience better for the patient.

- Patients requiring prostate radiotherapy need to empty their bowel and fill their bladder a set amount daily before having their treatment. They were invited to attend the department before their radiotherapy started to have an education session on bladder filling, bowel preparation and to have a tour of the department. This also acted as a forum for radiographers to assess if they required additional care to manage the filling protocol.
- If a patient saw a CNS or doctor a record was kept in a diary for the radiographer to follow up the next day to collect any medicines or to ask the patient or staff involved about progress or further actions. We saw that this system was very effective.
- There were six dementia champions in the radiotherapy department at Sutton, some of which had focused their MSc work on dementia awareness. Changes made to the department included the use of two handled cups for patients and a photobook for patients who would be attending for radiotherapy.
- The London Cancer Alliance patient experience feedback report (for both Sutton and Chelsea radiotherapy departments) said that of the 162 questionnaire returned 98% said the environment was very good and 99% said their appointment was on time or within 20 minutes (both were the highest of any department in the LCA)
- There was on-site accommodation available for children and their parents and relatives. A team of play specialists from the children's unit met with radiotherapy patients before and during their treatment was due to commence to ensure that both patients and parents or carers were fully informed and supported through the treatment.
- The department were putting transfers on the paediatric thermoplastic masks so that they looked like butterflies or superheroes making them look more appealing and less threatening to the child.
- If it was appropriate children were offered 'beads of courage' during their radiotherapy as a visual representation of their journey. Each aspect of their care involved getting a different coloured bead to attach to a string. The radiotherapy department had a glow in the dark bead. Some staff said that sometimes, for children who attended for multiple treatments, their string was several metres long. However, for some patients with a poor prognosis it was recognised that this was not appropriate.
- All children were offered a sticker chart which was attached to the wall of the children's waiting area as a visual aid for when they would finish their treatment.
- Staff told us that although it was rarely used the department had a long plastic rope which the child and the parent could hold onto to allow the child to remain having contact during the treatment.
- There was a separate waiting area for children which was close to their treatment machine. It had a range of toys and books for the children to play with. There were also toilets specifically for children and young people which were lower and more easily accessible by this age group.
- It was recognised by the department that there was not sufficient waiting facilities for young adults as they may not wish to sit either in the children's waiting room or the adults waiting room. Funding had been secured to make a young adults waiting area which would include game consoles and age appropriate furniture.
- We observed one child who required a general anaesthetic to keep still. We observed the anaesthetist playing with the child prior to administering the drug and allowing them to press the button on the machine. We observed that this put both the child and the attending parent at ease.
- Feedback from patients was displayed at the entrance to the department. Comments included; "my son loves the toys. Were very satisfied with his radiotherapy"; "roomy light atmosphere with loads of magazines"; "Staff are great. Everyone is helpful. No problems at all".
- There was a quiet area for patients and relatives to sit away from other patients. There were vending machines and a television in this area.
- There was a large waiting area for adult patients in the main department area. This area was visible by reception staff and patients had access to reading material, drinks and food machines.
- The pathway for patients coming for radiotherapy included a trigger mechanism for patients with dementia to be picked up and alerted to the department prior to attending for their simulation session.
- The department was directly involved in the development of the trust's dementia strategy and the

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trusts dementia board and had used the Kings Fund assessment tool to audit the suitability of the radiotherapy department. Findings from this led to changes such as; having more clocks put into the department to allow patients to orientate themselves; painting contrasting colours on the back of toilets; appropriate signage on doors to allow patients to understand where to go.

- Staff told us about the plans to raise dementia awareness during the national dementia week which included a journal club for staff to attend, and stalls for staff, patients and carers to gain more information and awareness about dementia care.
- A radiographer completed a green form with all patients during their simulation appointment. This gathered information such as preferred name, and contact details.
- Patients were monitored daily by the radiographers and were referred to a dietician, physiotherapist doctor, clinical nurse specialist or for psychological support. Staff we spoke with said that these support services were always readily available and that there was always space on a clinic for a patient to be seen.
- There were many post boxes around the radiotherapy department to allow for feedback along with leaflets detailing explanations on how to fill them in.

Access and flow

- The number of patients attending both the Chelsea and Sutton radiotherapy departments for a course of radiotherapy had increased slightly from 6625 patients in 2014/2015 to 6699 patients in 2015/2016. Of the patients who attended in 2015/2016; 29.3% were breast treatments; 18.7% were urology treatments. All other treatment sites ranged between 11% and 0.5% of activity. This data was unavailable for individual sites.
- In terms of the number of attendances during a course of treatment the number had dropped from 76459 in 2014/2015 to 73774 (3.5% decrease) in 2015/2016. This was due to increased use of stereotactic (more precise treatment) and hypofractionated (less attendances during treatment) radiotherapy and more time consuming complex techniques. One example of this was with the hypofractionation of prostate treatments (as a result from the CHHIP trial) from 37 to 20 treatments decreasing the amount of time a patient needed to attend for treatment.

- NHS England monitored the proportion of patients receiving radiotherapy as the first treatment of choice and as a subsequent treatment. There was a national target which stated that 96% of patients who need radiotherapy should receive it within 31 days. The department was achieving 100% compliance with this target and almost all patients started their radiotherapy within 28 days of referral. Every week there was a capacity and demand meeting where patients who were close to the target could be discussed and ensure that there was adequate space to treat all of the patients.
- Patients we spoke with were satisfied with the timeliness of the hospital transport. One patient said “they are always on time and so friendly too”.
- The department did not record individual waiting times for treatment once they had arrived. We were told that this was due to the fact that this was not considered to be an issue although had been considered. Patients commented that appointments always ran on time. One patient said “The appointments run on time and if I come in early I’ve been seen up to an hour before and even when I have come late they have been able to treat me straight away”.
- We observed that a treatment machine broke down for an hour on a morning of the inspection. Patients were easily moved to other machines and there were minimal delays for patients during this time. Once the machine was returned to the radiographers they quickly recovered and patients did not spend long amounts of time waiting.

Learning from complaints and concerns

- Information available for patients concerning the radiotherapy department including the process, the use of students, appointments, the cancellation of treatments, and how to make a complaint or raise a concern. There were also phone numbers available on the leaflet for a patient or member of the public to gain more information.
- Concerns and compliments were tracked and feedback shared with radiographers. A vast majority of these were positive. One example was having hand rails put into a corridor. Staff we asked were able to describe the concern and what was being done about it.
- The department has only had one complaint, which was several years ago, which had gone to the Parliamentary

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Health Service Ombudsman. We were told how learning from this complaint was shared with all radiotherapy departments nationally to ensure that other departments learnt from this incident.

Are radiotherapy services well-led?

Outstanding



We rated well led to be outstanding because:

- The strategy was challenging and innovation was at the forefront. It was aligned with the trusts values and national objectives for radiotherapy.
- Leaders worked together to ensure that governance and performance management systems were proactively reviewed and reflected best practice. This had led to the achievement of the ISO 9001:2008 accreditation. It was clear that all staff, including bank and agency staff were enthusiastic about governance and its role in the radiotherapy department.
- Patients and carers were involved in the development of clinical trials and acted as expert contacts for new patients who were going through a trial to share their experiences.
- There was a strong common focus and collaboration across radiotherapy, physics, and the medical staffing to ensure robust governance systems and an MDT approach to leadership and quality improvement.
- There was a plethora of articles, presentations, posters, and abstracts which had been published by the radiotherapy department from the research team, radiographers, and physics.

Vision and strategy for this service

- The radiotherapy strategy group (for both the Chelsea and Sutton sites) met four times a year to discuss advances in treatment planning systems, radiotherapy imaging simulation options, radiotherapy IT infrastructure and the radiotherapy workforce. This forum fed into the Department Development Strategy and was discussed and agreed at divisional level at the Clinical Services Divisional Quarterly Review.
- The radiotherapy development strategy 2016/17 detailed progress in the last quarter in terms of

workforce, capital equipment, information technology, and research infrastructure. The strategy also detailed future developments and was aligned with the trusts strategic priorities.

- Staff were clear about the values of the trust and could describe what it meant to them. On every machine and in the corridors there were posters displaying the trusts values.

Governance, risk management and quality measurement

- There was a clear governance structure that linked multi professionals across both sites which fed into divisional governance meetings. The arrangements around this governance were driven by innovation and proactively developed best practice.
- The MPTQART Multi Professional Quality Assurance in Radiotherapy Team (MPTQART) met every two weeks to discuss compliance with the ISO 9001/ 2008 quality system and ensured that all new trials, techniques, and work streams were managed safely. This MDT meeting included all professional groups in the radiotherapy department and fed into the trusts integrated and risk management committee.
- The Cross Site Radiotherapy Departmental Audit Meeting was held twice a year and provided a forum for all professionals in the department to present clinical audits and service developments. This aimed to present to the whole department, where possible and was video linked to the other site.
- The Radiotherapy Liaison and Quality Circle Meetings were held monthly on each site by all operational superintendents and leads for physics and dosimetry, quality assurance and research. This was used to provide a forum to improve communication between the MDT and to discuss all current work streams, technical development, and action plans around them. This forum reported to the MPTQART.
- Medical Exposure Committee Meetings were held quarterly and attended by the managers from radiotherapy, radiology and nuclear medicine, head of physics, consultant physicist in radiology and the radiation protection advisor. This meeting discussed all governance issues around IR(ME)R including incidents, and risks. This meeting reported to the trust's integrated and risk management committee.

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- The nursing, radiography, rehabilitation advisory committee met monthly and was a forum for policies to be discussed and approved. Incidents and learning were also discussed and shared at this forum across the whole trust.
- We observed a COMMS meeting which was held on a weekly basis. These meetings were a forum for learning from incidents to be shared and discussed as well as a forum for concerns to be raised. This was an MDT meeting between radiographers and physicist's and had a rolling agenda. Staff we spoke with could give examples of learning from incidents which were disseminated through the COMMS meetings.
- There was a risk register for radiotherapy which was regularly discussed at all governance meetings. At the time of the inspection only one item was on the risk register. The age of the CT scanner and we were shown the actions in place to mitigate this risk. Staff could describe the scanner as the main risk in the department and had good knowledge of the mitigating actions.
- The governance arrangements clearly demonstrated and evaluated the audit requirements to meet the ISO 9001:2008 standard. Audits were stored and evaluated collectively with reports produced on a monthly basis to evaluate current practice, with requirements, and best practice. Governance structures ensured a process of audit, review, action, audit to ensure that progress was made with compliance and that there was an accurate log of progress that had already been made. We were able to see historical audit trails and were given examples of where learning had been shared.
- If an audit was deemed not to be 100% compliant there was a strict process of classification (depending on the seriousness of the non-compliance) and actions which were followed up on a monthly basis and escalated if appropriate.
- There was clear oversight of actions from audits, risks, and incidents through the use of a spreadsheet. Where actions were not completed in a timely way the individuals responsible for these were held to account.

Leadership of service

- Staff felt that there was a strong leadership presence in the radiotherapy department and there was always someone to ask if they needed assistance. Staff said that managers empower radiographers to raise concerns and issues to them. Staff we spoke with said that the

local leadership was very supportive. Several members of staff felt there was a flat hierarchy and that there were opportunities and channels to raise concerns with leaders.

- Weekly emails were disseminated to all staff to ensure that high level information and news was shared appropriately. However, some staff said that these emails could long and found them difficult to read.
- Radiographers described the superintendents as very good and that staff could approach them about anything. Where changes could not be implemented staff felt they were given good reasons as to why and were given explanations of the challenges the department was facing.
- The senior staffing structure ensured that there were always suitable skills in both leadership and specialist knowledge in radiotherapy treatment sites. Senior staff rotated on a yearly basis as part of a 'bubble' of responsibilities. This ensured that staff did not have only one specialist field of knowledge and could manage the department as a whole. However, one senior staff member said that the team rotated too quickly and felt that a rotation every two years would be more appropriate.
- Staff said that local leaders were always visible and available to talk. However, they could not recall the last time someone from the executive team went to radiotherapy and was available to talk to staff.

Culture within the service

- There was a clear culture of quality and safety which everyone was involved in. The quality manager said that the radiographers "take quality very seriously" and were fully involved and committed to the quality processes.
- Staff (including bank and agency) said that they felt part of the team and that the team extended to all administration staff and consultants. They felt that the doctors were all approachable and included them in conversations and as part of the wider team.
- One member of staff commented that "considering it is a big department, people look out for each other" and that "they felt like they had found their extended family here".

Public engagement

- The use of expert patients to provide advice to new patients was being operated as part of the support mechanism for patients undergoing clinical trials. Where a patient required additional information on the

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practicalities of being in a trial they would receive a phone call from an ex-patient who would answer any questions. We were told consideration was being given to see if the service could be expanded for all radiotherapy treatments.

- The radiotherapy physics team took part in a Health Education England (HEE) Reach-out for Healthcare Sciences initiative delivering talks about medical sciences to school children. The physics department also had several STEM ambassadors to work with schools to encourage student to consider a career in medical physics. The department was also recognised in the Healthcare Science Ambassador of the Year awards for its contribution to the annual schools science conference.
- The radiotherapy radiographers took part in running career events in local schools, career conferences and host “schools days” to encourage prospective students into the career of radiotherapy. Members of staff from the radiotherapy department had been nominated as part of the Queens Award for Charitable Service as a result of this work.

Staff engagement

- Superintendent work streams were set up to develop the service based on the views, opinions and visions of the staff working in the department. This led to project groups looking at patient information, imaging competency and the development of learning management systems to make workbooks available on the intranet.
- Staff used comms meetings as a forum for engagement with other areas in the department and this was clearly demonstrated in these meetings.

Innovation, improvement and sustainability

- The radiotherapy department had 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.
- DEESCALATE: a trial looking at the side effects of treatment for throat cancer.

- ART DECO: a study looking at increasing the dose of radiotherapy to treat cancer of the voice box or lower part of the throat.
- HYBRID: a study comparing hypofractionated bladder radiotherapy with or without image guided adaptive planning.
- RAIDER: a trial comparing adaptive image guided standard radiotherapy or dose escalated tumour boost radiotherapy in cancers of the bladder.
- POPS: a study looking at reducing side effects of prostate cancer radiotherapy.
- The radiotherapy department had presented research at both national and international conferences and had many articles and abstracts published. Some staff at the radiotherapy department also sat on European and American education and training committees.
- The radiotherapy department had run three national training days for the voluntary inspiration breath hold techniques. As a result of the technique development and the training provided by the department 25 centres nationally now use the technique. To ensure that competence remained a video was developed by The Royal Marsden for other radiotherapy centres to use.
- The radiotherapy physics group host and run various annual courses for both national and international delegates. These include IMRT/ IGRT training; radiotherapy physics courses, diagnostic imaging courses, and radiation protection courses.
- The radiotherapy physics groups (across both the Sutton and the Chelsea site) were accredited by HEE, IPEM, and Academy of Healthcare Sciences for training physicists and dosimetrists. This provided better care for patients by having processes and practices in place to ensure that a high standard of care was achieved.
- The department had recently developed the use of ultraviolet treatment tattoos (setup tattoos which could only be seen when a ultraviolet light was shone on them) based on patient feedback. Breast patients attending the post treatment radiotherapy clinic commented that the tattoos to align the radiotherapy in cosmetically sensitive areas were having a negative effect on their confidence. The department engaged with an advocacy group to hold a forum of 14 patients to discuss this issue and found that for a third of patients the tattoos were an issue. The development of ultraviolet tattoos led to work with other radiotherapy departments about their experiences of tattoos.

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

Information about the service

The Royal Marsden NHS Foundation Trust (the trust) is a specialist service for patients diagnosed with cancer. There are two sites, at Chelsea and at Sutton. The Sutton hospital (the hospital) treats local patients and those from neighbouring areas; patients referred from other parts of England for treatment; patients participating in clinical trials, and private patients.

The trust has a national and international reputation for cancer treatment and research.

The most common types of surgery carried out at the Sutton hospital are breast, plastics and sarcoma. Patients receive surgery for gastrointestinal, neurological, lung, gynaecological, head & neck and other cancers at a hospital in their local area and receive other forms of treatment at the Royal Marsden. The hospital assesses local patients pre-operatively, who have surgery at either of the trust hospitals. High-risk surgical patients have procedures at the Royal Marsden at Chelsea, where there is an intensive care unit. Patients who deteriorate while they are at the hospital are transferred to other London hospitals or to the Royal Marsden at Chelsea for emergency or intensive care.

There is close working between the hospital and other hospital trusts in South London providing surgery for cancer patients, and there are some joint consultant posts.

There is a pre-assessment service for patients booked for surgery at the hospital. There were 853 face to face assessments and 276 telephone assessments in 2015.

The two theatres are open Monday to Friday, with on call cover in case of returns to theatre. There were 1537 operations in 2015.

There are two wards for solid tumour patients, one female and one male. Smithers Ward is a 23-bedded ward for female surgical and medical oncology patients, which includes a four-bedded area for day surgery patients. Kennaway ward is an 11-bedded inpatient ward for male surgical and medical oncology patients. Robert Tiffany ward provides inpatient care for private patients for all forms of cancer treatment.

There is a shielded unit on Smithers Ward, for patients receiving radioisotope therapy (RIT). This uses radiopharmaceuticals such as radioactive iodine to target cells, in the treatment of thyroid and other cancers. There are three radionuclide rooms with their own bathroom facilities, used by both female and male patients.

The therapy service of dietetics, physiotherapy, occupational therapy, and speech and language therapy (SALT) specialise in providing therapy to cancer patients. There is a lymphoedema service.

Consultants, senior managers, and senior nursing and therapy staff work across the trust at both the Chelsea and Sutton hospitals.

During our inspection at the hospital in April 2016 we:

- Inspected the pre-assessment area, wards, the therapy unit, and the theatres and recovery room. Spoke with 37 members of staff individually: administrators, domestic

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staff, healthcare assistants, all grades of nurses, theatre staff, clinical nurse specialists, junior doctors, medical, surgical and anaesthetic consultants and managers.. We also spoke with 16 therapy staff in group interviews.

- Talked with two patients and two relatives of patients on the ward. The expert by experience who came with us on the inspection spoke with patients in the outpatient department, the drug trials unit and wards.
- Looked at the electronic patient record system, paper records, theatre logs and the electronic theatre management system.

We also:

- Reviewed national data about cancer services in England.
- Reviewed information provided by the trust, such as self-assessments for each clinical area, policies, audits, risk registers, incident data, and plans for developments. Most audit and data was trust-wide, combining data from the Chelsea and Sutton hospitals' data.
- Held focus groups to hear the views of staff.
- Spent time at a stall in the reception area of the hospital to talk to patients and their relatives.

Summary of findings

We rated solid tumours as good overall because:

- The drive to deliver the best care and treatment was present in all areas and among all staff groups at the hospital. The leadership was visible and staff felt supported in pursuing innovative and effective care and treatment for patients.
- Surgeons, anaesthetists, medical staff, therapy staff and specialist nursing staff contributed to evidence-based practice through participating in research and evaluating their work. Patients received care and treatment that reflected the most recent evidence.
- There were exceptional opportunities for staff development, which contributed to a highly skilled, competent and motivated workforce. Nursing and theatre staffing levels and skill mix were reviewed to make sure there were enough staff to provide safe, responsive care on the wards and in theatres. Frontline staff felt valued by their managers and teams worked well together.
- Staff were caring and compassionate. Patients told us, and we observed, that staff at all levels shared the ethos of patient-centred care.
- Staff reduced risks by assessing patients at all stages of the surgical patient's pathway. There was a strong focus on surgical safety in theatres, and staff had awareness and knowledge of the best ways to keep patients safe.
- Theatres and wards were clean and there were safe practices to minimise the risk of infection. The hospital had improved the timeliness of its response to patients at risk of developing a serious infection.
- Patients had access to physical therapies, complementary therapies and psychological support tailored to their needs. They were given information about their treatment and how to manage after discharge from the hospital. The trust was developing services to support patients living with cancer or beyond cancer when they returned to their home.
- Training and support for junior doctors had improved

However;

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- There was limited involvement of non-consultant staff in discussion and review of patients' treatment and needs at multidisciplinary meetings.

Are adult solid tumours services safe?

Good



We rated solid tumours good for safe because:

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents that affected the safety of patients or were 'near misses'. There was an appropriate review or investigation of incidents and lessons learned were communicated to staff to support improvement. When something went wrong, people received an apology and were told about any actions taken to prevent the same thing happening again.
- Staff were trained, and processes were in place, to assess risks to patients and to take the required action.
- The hospital had improved their response to inpatients who deteriorated by extending the hours of the outreach team. The timeliness of the response to patients at risk of developing a serious infection had improved. Anaesthetic, surgical and theatre staff worked together to keep surgical patients safe by following checks and being aware of safety. There was continual auditing of the use of the five steps to safer surgery with a particular focus on improving compliance with briefings and de-briefings.
- Nursing and theatre staffing levels and skill mix were planned, implemented and reviewed to keep patients safe. Senior nursing staff reviewed information about staffing and addressed staff shortages promptly.
- There were policies and processes in place, and staff were trained to safeguard vulnerable adults, children and young people.
- Plans were in place to respond to emergencies and major situations. Staff with key roles took part in scenarios to test preparedness.

Incidents

- The hospital encouraged openness about safety, and teams discussed incidents to promote learning. Permanent staff, including consultants and health care assistants completed incident reports and senior staff thanked them when they did this. The trust 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 errors, near misses and incidents. It was ranked third in the NHS England

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Learning from Mistakes League, which lists trusts for openness and transparency. The trust had a better rate of reporting incidents than the England average, but reported fewer incidents that caused harm to patients. The trust had only two serious incidents relating to surgery in 2015, both at the Chelsea hospital.

- Theatre staff told us they reported any error, failure in process or near miss. One of them said 'it doesn't occur to me to think about blame'. They reported hitches affecting the smooth running of theatre lists, which were also discussed at the post list de-brief of theatre staff.
- Nominated staff reviewed incidents reported in their clinical area and decided what action was needed, supported by the risk management team. They sent an email to the person who reported the incident and discussed trends and the findings of investigations at team meetings.
- Theatre staff gave examples of reports, such as a patient not informed about a change in the list order, and the steps taken to prevent this happening again. The cross-site theatre quality and safety group discussed incidents and identified learning to be shared with staff. The therapy teams discussed incident reports that were valuable for learning, whether this resulted in harm or not. For example, a patient misheard the information a therapist gave on the telephone so staff now asked patients to repeat the information back to them.
- There was a process for escalating and investigating serious incidents, when there was medium or severe harm to the patient. A panel reviewed these, and other incidents with potential to cause significant harm, and decided on the investigation process. Consultants participated in the investigations when appropriate. Each investigation included a detailed chronology of events, root cause analysis, contributory factors and recommended actions.
- There were a variety of forums that discussed incidents, including theatre and anaesthetic audit days, and regular therapy meetings, which were cross-site. Learning from incidents at one hospital was shared across both sites.
- The trust-wide multidisciplinary executive medicines safety group, which included a patients' representative, reviewed medication incidents monthly. There were also groups to review falls and pressure ulcers.

- Anaesthetics had a lead for patient safety, who raised awareness of safety in theatres and promoted systems to keep patients safe. A patient safety fellow was in post, who was developing a programme to raise safety awareness.
- Mortality and Morbidity meetings reviewed all 30-day mortality cases across both sites. We saw from the minutes of these meetings that when the deaths took place in other hospitals and the reason for death was not evident, trust staff followed these up for more information. The meetings identified learning points. However, we noted that one point was raised at two successive meetings, which highlighted the potential value of considering serum albumin levels (a protein found in blood plasma) when assessing patients for chemotherapy. There was no record of who would be responsible for implementing this recommendation.
- The Surgical Audit Group of surgeons and anaesthetists from both hospital sites reviewed all surgical deaths and complications. The group identified deficiencies in management and discussed whether the decision to operate was appropriate. The group had approved refinements to the selection criteria for high-risk patients and interventions.
- The hospital took steps to comply with the duty of candour, and the trust's incident and root cause analysis tool included checks that the duty of candour was met, including the dates for notifying the patient or next of kin, making an apology, and sending a letter. We saw examples of when the trust had used this tool. The professional staff we spoke with were aware of the duty, and senior staff understood the steps they needed to take to comply with requirements. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and to provide reasonable support to that person.

Safety thermometer

- Nursing staff on the wards assessed each patient to check they had received 'harm-free care', using the specific measures of the NHS Safety Thermometer, such as pressure sores and falls. These were recorded as part of the hospital ward metrics which were sent to the risk team weekly. Each clinical area received a graphical

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display of their performance against the targets, which were displayed in the staff room. The wards also displayed patient facing information about harm free care.

- The trust target for harm free care was 93%. Smithers ward reported 95% harm free care in March 2016. Kennaway ward reported 100% harm free care at the time of our inspection. Robert Tiffany ward reported 90% harm free care on the safety thermometer at the time of the inspection.

Cleanliness, infection control and hygiene

- There were arrangements to minimise risks of infection to patients and staff in theatres, the pre-assessment unit and the wards. An infection prevention and control (IPC) nurse was frequently present on the wards and the IPC team responded to staff's requests for advice. They provided training and passed information to infection prevention and control link nurses in theatres and wards.
- The pre-assessment unit, theatre area and wards were visibly clean and uncluttered, and there were protocols for infection protection and control. The equipment in the areas was labelled to indicate it had been cleaned. The sharps bins (for the disposal of syringes and other sharps) were labelled and dated.
- Staff on the wards followed the processes for the disposal of domestic, clinical and radioactive waste. There were bins for the disposal of cytotoxic contaminated materials and equipment on the wards. Cytotoxic drugs are medicines used in the treatment of cancer that contain chemicals that are toxic to cells and prevent their replication or growth. There was another, larger bin labelled infection control where soiled linen was disposed of and this was locked.
- We checked the cytotoxic spillage kits and found them to be in date and regularly checked and signed for. All staff we spoke with were aware of the process to follow if a cytotoxic drug was spilled.
- Infection prevention and control was part of mandatory training for all staff. The overall trust compliance rate for October to December 2015 was 85% against the trusts target of 90%. We observed ward staff complying with the infection prevention and control policy by being 'bare below the elbow' and following hand hygiene practices. They wore personal protective equipment (PPE) when they needed to and took additional precautions when entering an isolation room. However,

we observed a volunteer entering a room that had a sign denoting high infection risk without wearing PPE. There were side rooms that could be used in the event of a patient requiring isolation due to their weakened immune systems following chemotherapy treatment.

- There were weekly hygiene checks in clinical areas, which staff recorded on the intranet. There were monthly hand hygiene checks in all areas and the results recorded 100% compliance with hygiene practices in the areas we visited.
- The wards had non-disposable cloth tourniquets for use when taking bloods, which staff used a universal wipe to clean after each use. Staff said these were preferred to the disposable tourniquets, but they did not tell us if they were checked to make sure they were not an infection control risk.
- Patient feedback indicated they were satisfied with the cleanliness of Smithers ward. All patients receive MRSA screening before admission. There were no cases of Methicillin-resistant *Staphylococcus Aureus* (MRSA) or *Clostridium difficile* in 2015.
- The housekeeper on Smithers ward carried out a monthly check of mattresses and arranged for porters to take away damaged ones. Infection control nurses also checked mattresses and marked those to be removed.
- Staff working in theatres followed NICE guidelines on the prevention of surgical site infection.
- Cleaners attended theatres when required in addition to cleaning each evening. There was a schedule for regular deep cleans. Theatre staff checked the area was clean when they came in the morning and cleaned equipment. There were weekly and monthly audits to check cleanliness. No-one was allowed in theatres unless they were wearing appropriate clothing and shoes. Recovery nurses cleaned beds between patient and cleaned the equipment.
- We observed good infection prevention and control practices during our inspection. This included porters and consultants gelling their hands on entering the recovery room.
- Sterile equipment was delivered three times a day to theatres and used kits returned to the sterilisation service. Trained staff received deliveries and dispatched used kits. We inspected three large sets of sterile instruments and three supplementary items, all of which were securely packaged. We observed a member of theatre staff using a universal wipe on the handle of a

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blade after disposing of the blade safely. Theatres had decided to re-use handles instead of using single disposable handles after consulting the IPC team. There was an audit to check the microbiology on the handles.

Environment and equipment

- There was efficient management of estates and equipment.
- We observed estates staff responding to requests for small maintenance and staff confirmed they provided a responsive service. Estates staff carried out the plant, ventilation and water safety checks in theatres in line with health and safety requirements.
- Staff in pre-assessment, theatres and on the wards said they had the equipment they needed to keep patients safe. Any problems with equipment were dealt with promptly. The equipment had labels with the date when maintenance. There was annual safety testing for electrical appliances.
- All equipment, including theatre equipment was logged on a database and there was an equipment manual on the intranet. There were service contracts with companies to maintain equipment and for sterilising instruments. Staff reported problems with equipment and these were discussed at regular meetings with contractors. The Clinical Product Review Committee and the procurement team took account of national recommendations before they approved any request for a new item of equipment.
- The three pre-assessment rooms where patients came before they were booked for surgery had all the equipment the nurses required, such as an ECG, bladder scanner, blood pressure machine and scales.
- The trust expected staff to check resuscitation equipment daily. We saw the log to record checks on the resuscitation trolley in the recovery unit of theatres was signed with no gaps.
- Staff kept an equipment 'passport' with a list of equipment signed to show they were competent in its use. Team leaders also kept a record of medical device competencies

Medicines

- Staff in the hospital managed medicines safely with support from hospital pharmacists.
- Medicine policies were available on the trusts intranet. Staff received medicines 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

- Controlled drugs (CDs) were stored in locked cupboards on the ward and in theatres. Two members of staff checked the administration of CDs. Pharmacists conducted quarterly CD audits and sent the results to unit managers to action if necessary. Staff monitored the temperatures of fridges used for storing drugs and chemotherapy drugs and recorded these in a log book.
- We spoke with the pharmacist on Smithers ward, who was checking biochemistries and drug charts. They showed us a prescription error they had identified, which they would report as a 'near miss'. Pharmacy technicians carried out medicines reconciliation for newly admitted patients, and reviewed patients own medicines before they were used on the ward.
- Patients' allergy status and venous thromboembolism (VTE) risk assessments were completed on all the drug charts we looked at. We saw that the patient had appropriate medication when they were at risk of VTE.
- We observed ward nurses following the medication management policy in the administration of drugs. The nurse wore a red tabard signifying she should not be disturbed.
- We observed the consultant anaesthetist drawing up drugs in the anaesthetic room before a procedure. He confirmed it was formalised practice for the clinician administering the drug to draw it up. 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.

Records

- Patient records were accurate and stored securely. However, some manual records were not scanned onto the electronic patient record system (EPR), as expected.
- We reviewed three sets of records on Smithers ward, which included the pre-assessment notes, risk assessments, care plans, nursing and medical reviews.

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These were all complete, legible and signed. We reviewed the paper observation charts, which were all completed. There were regular documentation audits. A recent audit of the EPR had identified that improvements were needed for the recording of holistic needs assessment for all patients.

- There was a separate electronic anaesthetic record system, which was not linked to the EPR system process and therefore not integrated with the pre-assessment information.
- The EPR system provided the patient data used for monitoring cancer waiting times, and patient outcomes. These were validated at the multi-disciplinary team meetings.
- Information governance was part of mandatory training. Staff were 91% compliant against the trust's target of 95% at December 2015.

Safeguarding

- Staff we spoke with understood their responsibilities in safeguarding vulnerable adults and knew how to get the trust policy and further information from the intranet or the safeguarding lead.
- Level one training in safeguarding vulnerable adults was mandatory and 89% of trust staff had completed the training at December 2015. Level two training for senior staff was group based to promote discussion, such as the vulnerability of cancer patients. The compliance rate was 73%. The compliance rates for children's safeguarding training were 87% for level one, 88% for level two and 89% for level three. The trust target was 90%.

Mandatory training

- The rate of attendance at mandatory training improved during 2015 and was over 80% overall at the trust in December 2015. On Smithers ward 86% of staff were up to date with mandatory training at March 2016. Compliance with mandatory training for anaesthetic staff was 80% for consultants and 95% for junior doctors at December 2015 (across both sites). Training was recorded and displayed on an electronic system, which managers and staff checked.
- Qualified staff new to the hospital had a week's trust induction followed by two weeks' orientation on the ward. A health care assistant on Smithers ward told us she received the training and support she needed for her first hospital job. She had two weeks' induction

training and three months on the ward working with another member of staff. The sister encouraged her to do tasks unsupervised after senior staff checked her competence. Theatre and recovery staff completed competency documents when they started working.

Assessing and responding to patient risk

- The hospital had taken steps in 2015 to improve the response to patients whose health deteriorated. The nurses running the out of hours triage service had additional training and used a revised triage tool that had been validated for hospital use. The Outreach team, trained in advanced life support, was now on duty 24 hours a day seven days a week and provided a responsive service to inpatients who deteriorated. The trust had improved their response to patients at risk from neutropenic sepsis (when cancer patients' white blood cells are low).
- An audit at the end of 2015 found only 41% of patients with sepsis received antibiotics within the one hour target. There was a programme to raise awareness and to train nursing staff in administering intravenous antibiotics to address the shortage of appropriately trained staff identified in the audit. The pharmacy department kept a log of the nurses who had these competencies. This had resulted in a marked improvement: the audit for the first three months of 2016 found 94% of patients received antibiotics within an hour.
- Tackling sepsis effectively was one of the three safety priorities of the trust as part of the NHS 'Sign up to Safety' campaign, which promoted harm-free care for patients. The priorities were, reducing harm in medical errors and reducing harm from pressure ulcers. We saw evidence of the steps the hospital was taking to meet the target of harm-free care by 2018.
- Assessment staff highlighted surgical patients at risk of pressure sores, and sacral pressure dressings were used during operations for these patients. Theatre staff minimised the risk for patients having long procedures by repositioning the patient during the operation. They checked the patients' skin and passed on information to ward staff. Ward staff observed good pressure care by assessing risk and taking action when needed. This included the use of pressure relieving mattresses and turning charts.

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- There was no specialist tissue viability nurse at the hospital. The patient group was younger, and therefore lower risk, than patients in non-specialist hospitals. There had been four pressure ulcers recorded on Smithers Ward in the three months to January 2016; none of these were grade four (the most serious).
- All in-patients had a basic falls risk assessment and physiotherapists and occupational therapists jointly reviewed patients at high risk on the day of referral. Patients at risk had a red square above their bed, and were offered red non-slip slippers.
- Surgical patients received the level of assessment appropriate to their needs before they were booked for surgery. The hospital had introduced a telephone assessment process because some patients were low risk, following a pilot that was popular with patients. The pre-assessment nurses used a set list of questions to decide whether a patient needed a face-to-face assessment. The nurses saw these patients at the hospital and identified any health problems that might require further tests before surgery. An anaesthetist attended the pre-assessment unit one day a week to see patients identified as high risk. When the patient received a date for surgery the nurse contacted the anaesthetist allocated to the list to discuss any specific patient concerns. Patients at high risk were referred for surgery to the hospital at the Chelsea site, which had an intensive care unit.
- Patients' vital signs were monitored electronically in theatre and recovery. Patients did not return to the ward until their observations were below a minimum level. There were two high dependency beds for patients who needed enhanced care post-operatively.
- There were emergency bells in recovery and the anaesthetic rooms, which were regularly checked, in case assistance for a patient was needed urgently. There were staff in theatres with advanced life support training. Ward staff used the National Early Warning Score (NEWS) to monitor patients and staff knew when to raise concerns about possible deterioration. The Outreach team regularly audited compliance with the use of NEWS.
- Theatre, anaesthetic and surgical staff followed best practice to keep surgical patients safe. The trust had reinforced the importance of completing all five steps to safer surgery: pre-list briefing, the three stages of the World Health Organisation Surgical Safety Checklist (sign-in, time-out, sign-out) and post-list debriefing. An

audit of the level of completion of the checklist from two weeks' procedures in September/October 2015 at the Chelsea and Sutton sites found improvement in the completion of the three steps and in the pre-list brief and post-list debrief since the previous year. The audit team found no documentation in four of the 275 cases audited; sign-in and time-out were completed in nearly all the remaining 271 cases (270 and 269 cases). The percentage of sign-outs completed had risen to 86 from 73 percent of these cases, but was not the 100% compliance expected by the trust. Staff confirmed that there had been a transformation in attitudes towards the use of the checklist in recent years, with surgeons now leading its use. They also told us the brief and debrief was becoming routine, with staff instructed not to proceed with the list unless the surgeon was present for the briefing. Theatre staff told us they were encouraged to report to the matron when briefs did not take place and to record it on the incident reporting system. We saw an example of an incident report and the decision to escalate this to the management team for action. However, an audit of February 2016 did not find good compliance with the debrief. The auditors suggested that this was because the records were not being collected at the end of the day. Theatre staff said the briefing made the list run more smoothly because it started on time and everyone knew what was happening with each patient. The debrief was an opportunity to note what had gone well and what could improve and for the surgeon to thank the team. A theatre nurse said the five steps 'levelled out the hierarchy' and made it easier to speak out. For example, she had pointed out in the debrief that the surgeon had not giving all the relevant information about a patient at the brief.

- We observed staff completing checks, including the WHO Surgical Safety Checklist, before, during and following an operation, with the patient's permission. The anaesthetist led the sign in in the anaesthetic room with the ward nurse present; the surgeon led the time out with all members of the team present in theatre and the scrub nurse led the time out. All staff present were attentive and engaged with the checks. We observed a minor procedure during our inspection when there was no count of swabs recorded on the theatre board; the theatre matron assured us this was not usual practice. Audits indicated that staff used the WHO check list for all

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procedures in theatres, including minor procedures such as the insertion of a 'Hickman line' (a central venous catheter inserted for the administration of drugs).

Nursing and theatre staffing

- There were enough staff to provide safe care on the wards and in theatres. There was now senior cover six days a week on Smithers ward following the addition of a junior sister post. There was always an experienced nurse to act as co-ordinator. There was usually one nurse to five patients on the ward, working with two health care assistants. The majority of nurses were experienced and many had worked at the hospital for some time. There were three vacancies at the time of our inspection; one had been advertised, the other two were to cover for maternity leave, which were more difficult to recruit
- Staff raised concerns, for example by completing an incident report, when they thought staffing levels were not safe. Senior staff responded to these concerns in 2015 by extending the hours of the Outreach team, who provided prompt support when patients deteriorated. There was a recent increase in the number of nursing staff on Smithers ward at night and an additional health care assistant was on duty during the day.
- Ward nurses measured each patient's level of need and dependency using a recognised tool, which they recorded on an electronic system. Ward co-ordinators had an easily accessible overview of staffing and patients' level of need and reported any staff shortages to the matron, who looked at whether there were staff on other wards who could be moved temporarily. The morning meeting with bed managers and ward co-ordinates now included the manager of the temporary staffing team, and this made it easier to get bank staff to cover if this was necessary. The ward clerk sent staffing reports monthly for senior nursing review.
- There were two full theatre teams at the hospital and one nurse to two patients in recovery. If a patient had to return to theatre, there was a full team on call. There were four vacancies of theatre staff, which the trust had advertised. When there were staff shortages, staff worked bank and the manager occasionally used agency staff. There were sometimes overruns and staff

stayed to finish the list. Managers told us they informed staff in advance when this was likely to happen, but staff told us they were sometimes not given notice, even when it was clear an overrun was likely.

- The clinical site practitioners (CSPs), who had a dual role, provided cover for the pre-assessment nurses. There was only one CSP on duty outside daytime hours to triage phone calls from patients and to address any incident affecting the running of the hospital.

Medical and surgical staffing

- There was a lower percentage of junior doctors working at the trust than the average for England. The hospital did not deploy junior doctors in their first or second foundation year because of the type of tasks and responsibilities required. A junior doctor was allocated to each ward during the day, with one junior doctor covering the two solid tumour wards out of hours. Specialist registrars were on site during the day seven days a week and one of them was on call out-of-hours.
- Consultant surgeons and anaesthetists on call came to the Sutton site as required. We did not meet many consultants during our inspection, except in theatres. Following the inspection the trust has told us there are 38 oncologists and surgeons practising out of Sutton each week covering 34 NHS inpatient beds and 51 clinics (this excludes paediatric and haematology). They can be contacted at any time by their registrar or ward team for their patients. All speciality teams provide at least a weekly consultant led ward round and this is built into the consultant job plans (14 consultants have weekly ward rounds included in their job plans).

Major incident awareness and training

- The risk and reliance manager prepared staff to respond to a major incident and worked with the site management team to assess current risks. At the time of our inspection, there was building work on site and the team received weekly reports from the contractors so they could plan for the following week.
- Clinical site practitioners (CSPs), were 'bronze commanders', and received annual practical training in responding to a scenario. A CSP explained that this included setting up a command room and addressing problems such as how they would evacuate a patient who was radioactive. 'Silver commanders' (nominated senior staff) and 'gold commanders' (members of the executive team) also had annual meetings. Staff were

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encouraged to attend major incident training, which reinforced everyone's role in being prepared for a major incident. Each clinical area had a plan to follow in case of major incidents.

- We looked at the major incident policy on the intranet, which 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. There were also stocks of paper and pens in case these were needed. There was a printout of outpatient department patient appointments as a back-up for the electronic record.
- Following a major incident at the Sutton site when IT systems failed because of a flood, the trust had prioritised projects to limit the impact of any further incident. There had been a simulation of a failure of the main electronic patient record systems so they could test how to isolate the failure. The projects would include all key IT systems.

Are adult solid tumours services effective?

Good



We rated the effectiveness of solid tumour services as good because;

- Trust staff contributed to national and international research and provided treatment and care based on the most up-to-date evidence.
- The workforce was , competent and had excellent opportunities for development .There was an extensive audit programme of local and national audits. Actions were identified and improvements monitored.
- Therapists, anaesthetists and Clinical Nurse Specialists gathered local data to inform improvements in treatment and care.
- There were regular, well-attended meetings to discuss patients' treatment attended by consultants of different specialities.
- There had been an improvement in the support and training for junior doctors.

However;

- Here was limited contribution on non-consultant staff to multidisciplinary review of patients' needs in some specialties.

Evidence-based care and treatment

- Hospital staff from all professional background used evidence-based practice to assess, diagnose and treat patients.
- The trust contributed to the evidence-base for cancer care and treatment by participating in local and national research. Examples included the study that demonstrated improved survival for patients with operable gastric cancer who were given chemotherapy before and after their surgery. The trust was the largest contributor to a national trial in endometrial cancer, assessing the role of both radiotherapy and extended surgery, with lymphadenectomy, after a conventional hysterectomy. The trust was leading the cancer element of the 100,000 Genomes Project. This collaboration with other organisations aimed to improve understanding of how disease develops, Staff gave us other examples of how the trust reviewed evidence, undertook research and audit, and piloted new practices in order to deliver the most effective care and treatment.
- Anaesthetists at the trust used total intravenous anaesthesia (TIVA) for most patients, after undertaking a retrospective analysis of all surgical patients in a three-year period to investigate the association of anaesthetic technique with long-term survival in patients.
- The hospital used lower doses of iodine for some patients with thyroid cancer treated with radioisotope therapy (RIT), which was consistent with findings of international research studies.
- Physiotherapists changed the exercises for breast patients to reduce the risk of lymphoedema (swelling related to cancer treatment);
- Dietitians designed and validated an oncology adult nutritional screening tool.
- The speech and language therapy (SALT) team performed specific swallowing tests using latest technology (video fluoroscopy, which uses x-ray radiation to produce moving pictures of the mouth) so they were able to assess the effectiveness of treatment before and after the intervention.

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- The Royal Marsden Hospital Manual of Clinical Nursing Procedures was used nationally as an evidenced-based guide to cancer nursing.
- Staff showed us how they found the policies, guidelines and protocols they needed on the intranet. For example, we saw that the infection control policy and the pre-operative fasting policy were in date and appropriately ratified. The trust Integrated governance and risk management group reviewed new NICE guidelines. There was a clinical protocols review schedule.
- Theatre staff, anaesthetists and surgeons followed guidance produced by their professional bodies and other national organisations. For example, anaesthetists followed the Difficult Airway Society Guidelines (DAS), and the guidelines and a flow chart for staff to follow kept on the difficult airway trolley in theatres. The trolleys were redesigned to adhere to the latest DAS guidelines.
- Enhanced recovery care pathways were in place for breast patients, in line with national good practice. The Royal College of Surgeons had endorsed the enhanced recovery plan for upper gastrointestinal cancer, devised by staff at the trust. Enhanced recovery pathways for other patient groups were under development.
- During the inspection staff were unable to locate holistic needs assessments. Staff told us the key worker completed these manually with the patient and staff suggested to us that these had not been scanned onto the EPR system. Following the inspection he trust provided us with audit data showing high levels of holistic needs assessments completed.
- 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. These included a multi-centre audit of surgical site infections in gynaecology surgery (results not yet published) and contributions to the National Flap Registry of the British Association of Plastic Reconstructive and Aesthetic Surgeons and UK.
- 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.
- Local audits identified action points and there were re-audits to check improvements. Among the many local audits were acute pain management, documentation and Intravenous (IV) audits.
- The trust reviewed the recommendations of reports produced by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and identified the actions needed to meet the recommendations. For example, the trust reviewed the recommendations of the gastrointestinal haemorrhage report of 2015.
- The pain team followed British Pain Society guidelines for acute pain, chronic pain & cancer pain and regularly audited pain relief provided at the hospital, identifying action points and monitoring these.
- The trust was hosting the Global Conference on Perioperative Medicine - Care of the Cancer Patient later in the year. Staff from all professions attended conferences and presented papers or posters about their work.

Pain relief

- Staff in all areas responded promptly to prevent and relieve patients' pain.
- Nurses assessed patients' pain on admission as part of the holistic nursing assessment. The pharmacy team monitored the prescribing and administration of pain relief. Any omissions in administration were reported as incidents. Ward staff recorded patients' pain score regularly to assess the effectiveness of pain relief. A pain assessment chart designed for patients with dementia was used when required.
- There was a consultant-led acute and chronic pain service which responded promptly to referrals when staff found it difficult to manage patients' pain. The service also provided telephone advice.
- The anaesthetic team promoted effective peri-operative pain management, and audit results demonstrated good post-operative pain scores. The service had decreased epidural pain relief and increased intrathecal morphine for complex major surgery. This had been found to improve the patient experience and recovery time.

Nutrition and hydration

- Nursing staff assessed patients' nutritional requirements and dietitians responded promptly to referrals. There were regular audits of adherence to nutritional guidance.

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- The hospital audited whether staff followed the National Institute for Health and Care Excellence (NICE) guidance for Nutrition Support in Adults. Recent audits found nurses assessed patients on admission for their nutritional needs, but did not always record patients' height and weight on admission or reassess them within seven days. There was not always prompt referral to a dietitian for those screened as high risk. Wards were working to improve adherence to the guidance and re-audits were planned.
- The dietetics and speech and language team (SALT) responded promptly to referrals for patients' who had special dietary needs or had difficulties swallowing food. Staff recorded food intake when this was indicated. Food allergies were highlighted on admission and a copy given to the kitchen staff.
- The hospital was responsive to patients' needs and preferences. There was a special diet for neutropenic patients (those with a weakened immune system).
- We observed that staff who brought the meals to the ward were well known in the ward and interacted well with patients and staff. All patients who required assistance at meal times were given a red napkin on their tray. This was recorded on a white board in the kitchen.
- Ward staff gave patients food and drinks in-between meals and there was a ward fridge with food and drinks for use out of hours.
- The hospital carried out regular patient surveys on satisfaction levels with the food. The satisfaction rate was over 90%.
- Staff followed the trust policy, based on national guidelines, when advising patients about fasting before surgery. There were also pre-operative guidelines to address the risks of surgery for diabetic patients. Pre-assessment nurses gave surgical patients verbal and written information and admissions staff reinforced this when telephoning patients to remind them of when they should arrive at the hospital. Ward staff checked when patients had last eaten and drunk when they arrived on the day of surgery. Patients were allowed sips of clear fluids until two hours before they went to theatre.
- Intravenous fluids were provided when necessary intra-operatively and the patients' fluid balance was monitored. Recovery staff provided water for patients.

Patient outcomes

- The Royal Marsden is a tertiary cancer centre and many patients are referred from other hospitals after receiving their initial diagnosis and treatment. Because of this absence of a common denominator, it is not usually possible to compare outcomes for patients attending the Marsden with patients from non-tertiary centres. We asked the trust whether they had undertaken their own analysis, but they did not provide comparative outcome data.
- The trust information governance report for January to March 2016 showed the trust's 30 days death rate following surgery and anaesthesia was 0.9% which represented 29 deaths out of 2564 patients.

Competent staff

- One of the trust's main objectives was to recruit, retain and develop a high performing workforce to deliver high quality care. The clinical areas we inspected were meeting this objective.
- The trust had taken steps to improve staff appraisal and development. Experienced nursing staff on Smithers ward had taken on the supervision and appraisals of nursing staff following training and all appraisals were up to date. The appraisal rate on Smithers ward was 93%. The trust was meeting the target of 85% of staff having received appraisal.
- Therapy, nursing and theatre staff told us of the discussions they had about their professional development during appraisals. Staff of all roles and levels of seniority told us of the variety of opportunities to develop and to take additional training. For example, a nurse took a mentorship course and received good feedback from a student nurse was encouraged to take on more mentees. Therapy staff had taken post-graduate courses and used their learning to enhance the service.
- Staff told us about the courses run by the Royal Marsden school, such as the advanced nurse practitioner course, and shorter training such as a physical assessment course. A senior nurse was attending an independent prescribing course at a nearby university. The trust had introduced more opportunities for career development for registered nurses and Operation Department Practitioners to take on surgical practitioner or advanced nurse practitioner roles.
- All agency and new staff did a training programme and a practical assessment before they were allowed to

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administer intravenous drugs. Some new nurses felt they could not use their skills and training from their previous other organisation because the trust insisted on this..

- During our inspection, specialist and junior doctors-in training in some specialities told us they did not have time to go to their teaching sessions because of the demands of their role. Furthermore, they told us there was limited consultant presence on the wards, including at ward rounds and this restricted the opportunities for learning. Following the inspection the trust told us there were 38 oncologists and surgeons practising out of Sutton each week. covering. They could be contacted at any time by their registrar or ward team for their patients. All speciality teams provided at least a weekly consultant led ward round and this is built into the consultant job plans (14 consultants have weekly ward rounds included in their job plans).
- Junior doctors rated anaesthesia placements highly in the 2015 General Medical Council (GMC) survey. Junior doctors on surgical placements told us there had been improvements in the last two years, with consultants at the hospital taking time to teach surgical procedures and to support the doctors' training programme.
- Following the inspection the trust provided information showing improvements in the GMC survey between 2015 and 2016 in all the metrics described in the narrative (supportive environment, induction and feedback) between 2015 and 2016.
- The trust had taken action in response to the survey, increasing the number of Advanced Nurse Practitioners and developing nurses' roles and training, so that they took on some of the tasks previously allocated to junior doctors. There were formal meetings for junior doctors arranged by consultants to discuss any concerns, and these were acted on. No junior doctors in their first two years of training took on a placement at the trust. A junior doctor told us he was taking part in a quality improvement project looking at the development of nurses' roles to take on other tasks so there was less demand on junior doctors
- There was an MSc program for doctors beginning their specialist training which counted as training. Some consultants developed courses in-house for junior doctors. This included a training scheme for medical staff, based on serious incidents, 'minimising harm from chemotherapy'.

- All doctors, including junior doctors involved in recruiting to and carrying out clinical trials (clinical fellows), had training in Good Clinical Practice (GCP), the international ethical, scientific and practical standard to which all clinical research is conducted. All clinical fellows responsible for recruiting to and working on the trials were named on the trial log.
- 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.
- Over 80% of consultants at the trust had a current appraisal. However, the personal development plan rate for consultants was below the trust target at 75% in December 2015.
- The Hospital did not employ endocrinologists, who specialise in the effects of hormones. Many cancer treatments affected fertility and the hospital relied on the specialists at the patients' local hospitals to provide advice.

Multidisciplinary working

- Surgeons, medical oncologists, radiographers, pharmacists, therapists and clinical nurse specialists (CNS) provided multidisciplinary treatment and care for patients. A therapist said 'everyone's contactable'. All professions showed respect for other staff. CNSs and therapist said consultants were always available to discuss a patient. However, there were no multi-disciplinary ward rounds or handover and there was limited consultant presence on the wards at the hospital. A therapist said that consultants 'were not so present (at Sutton hospital) but were available'. There was close team working in theatres. Staff from all specialities showed that they understood the importance of good team working in theatres in keeping patients safe.
- There were regular MDT meetings for each solid tumour specialty, which were usually held cross-site with video links. We observed the breast meeting, attended by nine consultants including medical oncologists, surgeons, histopathologists and radiographers. Other attendees included specialist registrars, therapists and CNSs, but they did not contribute to discussions. The MDT lead presented each patient in turn, with contributions from the other consultants, and the team decided on a treatment plan. All core MDT members attended at least

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80% of meetings. We were told the meeting usually covered all patients, but there were occasions when there was not enough time to discuss all cases, which resulted in delays in decisions about treatment.

- The responsibility for ward rounds was unclear and this sometimes resulted in duplication. One surgical consultant had a fixed weekly time when they attended the ward, but nursing staff told us they did not always know in advance when consultants or the specialist registrar was coming to the ward. Junior doctors allocated to the ward sometimes saw each patient on the ward, and discussed the patients with the senior nurse, and then a more senior doctor or a consultant repeated this a short time later.
- There were meetings three times a week with ward staff and therapy staff. Other multidisciplinary discussions included the handover at Sutton between the SHOs and the hospital at night team each day at 8pm and in the morning at 8am. The handover was between the medical SHOs, site practitioner, outreach team and anaesthetic registrar
- The specialist registrars made decisions about patients' discharge in discussion with consultants. Staff gave us two examples when the patient's consultant agreed to delay the discharge when non-medical staff contacted them following a medical decision to discharge patients. Medical staff had not informed them of the decision. We also saw that a report of an incident when a complex discharge was cancelled by the consultant on the planned day of discharge because that was the first time they had spoken with the family of the patient, who did not want the discharge.
- There was a nurse handover by the patient bed on Smithers ward when there was a change of shift and nurses told us they valued this as it gave them a good understanding of the patients' physical and non-physical needs. There was strong team working on Smithers ward, with health care assistants, nurses of all grades, the ward clerk and housekeeper all valued as part of the team. Staff told us, and we observed, that the housekeeper and ward clerk were key to the smooth running of the ward.
- The therapy service of dietetics, physiotherapy, occupational therapy, and speech and language therapy (SALT), provided support and advice tailored to the individual's need. They received referrals from ward and outpatient nurses, consultants and CNSs. In some specialties such as neurology, therapists were involved in the patient's treatment from the time of referral and worked closely with consultants in enhancing the patient pathway.
- We observed a physiotherapy session with a patient, with his permission. The graded exercise programme was designed for the patient to prepare him for surgery. There were group sessions for some patients, which enabled patients to share experiences as well as have therapy. The service had initiated a joint dietetics and physiotherapy session for a group of patients and there were enhanced care pathways in place for breast patients. Therapy staff gave patients written information including their treatment plan, leaflets about nutrition and exercise and phone numbers to contact if they wanted advice. They gave a DVD to patients with advice and exercise following breast surgery.
- As part of service developments, therapy services were providing 'complex rehabilitation' to about 50 patients a year. Services were coordinated to cover all aspects of rehabilitation.
- There was a lymphoedema clinic for patients with swelling as a result of cancer treatment. Patients with lymphoedema attended one-to-one and group sessions with the nurse practitioner, and received written advice on how to manage the condition. There was a prosthetic service to provide wigs for patients who had lost their hair in chemotherapy treatment.
- Inpatients had access to complementary and other therapies, such as yoga, massage, art therapy and reflexology.

Seven-day services

- Theatres operated Monday to Friday. A theatre team was available out of hours and at weekends, but there were very few procedures at the hospital at these times.
- The Outreach service had been extended to 24 hours.
- There was a pharmacy service six days a week, with a pharmacist on-call out of hours and on Sunday.
- Radiologists and pathologists came in out of hours if patients needed an x-ray or CT scan or a blood test.
- Physiotherapy provided on-call cover across both hospital sites at weekends
- Specialist registrars conducted a full ward round on the two days of the weekend. Consultants sometimes came in at weekends to review specific patients.

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Access to information

- All clinical staff had access to the electronic patient record (EPR) and the picture archiving and communication (PAC) systems. Staff told us it was straightforward to find the information they needed on the EPR, but the system was slow and sometimes there were not enough computers available for staff.
- There was an electronic theatre management system, which provided easy access to scheduling and other information. However, this was not linked to the admissions booking system.
- There was regular communication between consultants at the hospital treating patients referred from consultants at other hospitals in England. There was detailed discharge information provided to local GP and specialists. The hospital was taking steps to improve the timeliness of this information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients we spoke with said consultants explained treatment very thoroughly before they signed the consent form. Staff from all professional backgrounds emphasised the importance of a patient understanding proposed treatment before they gave their consent. This included taking into account the Mental Capacity Act 2005 and patient's capacity to understand the particular discussions about treatment. When there was a decision to have a best decision meeting, the patient's family was involved in discussions. Medical staff had consent awareness training as part of their mandatory training and 79% had attended the training at December 2015.
- The trust had run a programme of information and training sessions to raise staff awareness about the deprivation of liberty Safeguards (DoLS).
- There were protocols in place to ensure patients understood the implications of joining a clinical trial. Patients we spoke with who were participating in trials said medical staff provided a full explanation and they received a lot of written information.

- Patients we spoke with and were overwhelmingly positive about the caring and compassionate staff.
- We observed that patients were at the centre of everything the hospital did, with all staff conscious of their responsibility in enhancing patient care and experience.
- Staff consistently demonstrated their focus on the patient's needs, with attention to the individual preferences and concerns.
- We found examples of staff going beyond the usual expectations in the steps they took to provide care that made a difference.

Compassionate care

- Patients told us of the lengths that staff went to in providing compassionate care. For example, in greeting them by name, spending time with them, checking that they were comfortable, and providing food they wanted.
- A patient said the kindness of the staff made the hospital 'a happy place'. A relative described the 'first class experience' at the hospital and said all ward staff were 'very kind'.
- Staff had time to provide individualised care. A new member of staff said she felt supported to provide the care patients needed and that the ethos at the hospital was that the patient was paramount.
- We observed kind and responsive interaction between staff and patients in the wards and in theatres. For example, a ward clerk greeted a patient by name when they arrived on the ward and showed them her bed. We saw the housekeeper responding to a call bell and passing information onto a nurse. Senior nursing staff told us of examples of kindness that went 'above and beyond' the expectations of good care. Staff had organised two weddings on Kenaway ward in the last six months.
- In theatres and recovery, we observed staff communicating with patients with kindness and treating them with dignity and respect.
- 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%).
- From January 2016 to March 2016, the trust scored 97% compared to the national average of 96% for the friends

Are adult solid tumours services caring?

Outstanding



We rated solid tumours as outstanding for caring because;

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and family test, which asks whether patients would recommend the trust to those close to them. However, the response rate was much lower than the national average.

Understanding and involvement of patients and those close to them

- Consultants, Clinical Nurse Specialists (CNSs) and therapists spent time with patients explaining the treatment and the likely side effects and recovery. They encouraged patients to ask questions and to contribute to the decision-making. A relative said consultants involved the patient in all decisions. Senior nurses went round the wards to check if patients were comfortable and to answer questions.
- In the cancer patient experience survey of 2014, ninety percent of patients said staff gave a complete explanation of what would be done, better than the England average.
- We observed a procedure in theatre, with the patient's permission. The anaesthetist and operation department practitioner explained what they were doing and checked the patient's understanding before anaesthesia.

Emotional support

- A key worker was allocated to each patient. The key worker encouraged patients them to contribute to a holistic needs assessment by talking about what was important to them and what worried them most. However, we did not find evidence from reviewing the records of a holistic needs assessment for every patient.
- Clinical Nurse Specialists (CNS) and ward nursing staff spoke about the importance of giving people time to talk about their concerns and not making assumptions about what was important to patients, as this was often very specific to the individual. CNSs remained in touch with allocated patients throughout their treatment at the hospital and beyond. We spoke with the CNS for head and neck and thyroid, who was passionate about supporting the patients through the difficult side-effects they often experienced. She visited inpatients and was available by phone to outpatients to provide advice and reassurance.
- Therapy services provided advice to patients on fatigue management and anxiety management when appropriate. They worked closely with the neurology team in supporting patients with brain tumours and

their families in understanding and managing cognitive impairment. The therapy service and clinical nurse specialist had set up a health and wellbeing clinic for neurology patients geared to patients' specific needs for rehabilitation, fatigue management and planning to return to work.

- Therapy staff had training in motivational interviewing of patients to support self-management of their disease, the side effects and the emotional impact of cancer.
- Nursing staff referred patients to the psychology service and to the chaplaincy service

Are adult solid tumours services responsive?

Good



We rated solid tumour services as good for responsiveness because:

- The hospital worked with commissioners and other hospitals to plan cancer services for local people. There were arrangements for providing transfers to other hospitals and to patients' home.
- Care, therapy and treatment focused on the individual patient. Patients were given information about their treatment and how to manage on discharge.
- The admissions service worked with outpatients and other staff to streamline appointments for surgical patients.
- The target for referral to treatment times was similar to or better than the England average.
- Discharge was planned so that patients had the ongoing support they needed.
- Services were developing to support patients living with cancer or beyond cancer when they returned to their home.
- The number of compliments far outnumbered complaints on the ward and in therapy services and both were used in staff discussion to improve services.
- The facilities in theatres, wards and the therapy unit were appropriate for the services being delivered.

Service planning and delivery

- The hospital worked within a network of acute NHS trusts in South London.

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- Local patients had some types of surgery, such as gastrointestinal and neurology, in other South London hospitals. There were well-established working relations, including some joint posts, with oncology consultants at these hospitals. Other hospitals also carried out endoscopy procedures, at the request of medical staff. Junior doctors had asked for information about the arrangements for organising these procedures, and the hospital provided a service level agreement, which clarified that medical staff should contact consultants at neighbouring hospitals directly. The hospital arranged urgent transfer of patients who required emergency or ICU care to other hospitals, and referred outpatients who became unwell to local hospitals. We asked for, but did not receive, service level agreements with these hospitals about these arrangements.
- The Royal Marsden Trust was part of the Vanguard New Care Models programme. The aim was to improve cancer survival, quality and patient experience, but there had been limited progress with this model at the time of our inspection.
- The two operating theatres were under-used, at about 50 per cent utilisation. Options to expand were limited because there was no ICU at the hospital.
- Therapy services had well-developed plans to provide improved support along the whole patient care pathway, involving patients in feedback about developments.
- The theatre and ward areas had the appropriate environment for the services delivered. Therapy services were provided in a spacious unit, with a large waiting area. The drug trials ward was crowded during our inspection and there was nowhere for people to wait so they used the therapy unit waiting area.
- The refurbishment of the shielded unit on Smithers ward was completed in December 2016 and included a heating and cooling system to provide a comfortable temperature in all seasons.

Meeting people's individual needs

- Care, therapy and treatment focused on the individual patient and was responsive to their particular need.
- There were several initiatives to raise awareness among staff about dementia. This included a group of 'dementia champions' who promoted understanding of the needs of people living with dementia and were

making suggestions for environmental changes to make wards more dementia friendly. Ward sisters deployed an additional member of staff if a patient living with dementia needed extra care and attention.

- The meeting about the theatre schedule discussed the needs of patients and whether an additional member of staff was needed to support them. A nurse on Smithers ward gave an example of the care provided to a patient with a learning disability. The patient was cared for in a side room and their carer came with them to support them. They had a 'passport', available to staff to explain what they liked and did not like, and the best way to care for them.
- The hospital had information from the referring clinician about patients who needed an interpreter. Staff of all grades and professions were clear that interpreters were used for clinic appointments and were booked for pre-assessment appointments for surgical patients. The interpreter returned on the day of surgery when the patient gave consent for the procedure.

Access and flow

- There were systems in place to book patients for surgery and to follow up on any patient-led cancellations. Admissions staff liaised with nursing staff to co-ordinate outpatient and pre-assessment appointments, but had limited access to each other's information.
- The target for referral to treatment times was similar to or better than the England average. Examples of these at December 2015 for 2015-2016 were: 87.6% of patients treated within 62 days of urgent GP referral (post reallocation); 94.6% of patients seen within two weeks for breast symptoms; 97.2% of patients receiving subsequent surgery treated within 31 days of decision to treat. The RTT was 95.8% for patients requiring admission who waited less than 18 weeks. Over 95% of breast patients were treated within the 62 day target.
- Admissions staff booked a ward bed for all medical and surgical patients, a theatre slot for surgical patients and a space for patients receiving blood transfusion. Staff acted to limit the number of times surgical patients came to the hospital by arranging a pre-assessment on the same day as their attendance at a clinic appointment. The pre-assessment nurses also saw some surgical patients attending OPD on the day without an appointment. These arrangements to limit

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appointments were not formal at the time of our inspection, but senior staff told us there were plans to systematise this process by sharing information electronically.

- The admissions team met weekly to review bookings to make sure all patients had a date for surgery. When admission staff received a phone call to cancel surgery, they emailed the consultant and their secretary and made sure another date was agreed. The pre-assessment nurses followed up any patients who did not attend an appointment to make another time, and emailed the surgeon and the specialist nurse to inform them.
- There was a weekly meeting to discuss the following two weeks' theatre list attended by theatre staff, admissions staff, and others. Admissions staff sent a letter to the patient with their allocated time and followed this up with a telephone call to confirm with the patient their time of arrival and to reinforce the information about food and drink before surgery.
- There were about 50 blood transfusions a month for outpatients at the hospital (58 in January 2016). Staff told us it was difficult to find an area to care for these patients. Admissions staff booked a bed or chair for them, but sometimes it was difficult to find a space. Day-surgery beds were used at weekends when there was no surgery, and bed managers helped to find a place when there was a shortage, such as on the drug trials ward. Staff told us it was particularly difficult to get a space for male patients.
- Smithers ward had occupancy levels of 79.3% and 83.4%. However, this included the four day-surgery beds which were generally not used at weekends except for blood transfusions. Staff were currently collecting data to establish the occupancy levels on weekdays, which they said was higher. There was no split between the nursing care provided to surgical and medical patients on the ward, although infection protection and control was taken into account when patients were allocated to beds. The hospital was considering dividing the two patients groups and to evaluate whether this improved patient care.
- Therapist gave examples of how they made their service more accessible by telephone so patients could contact them after they had gone home. We observed a patient

come to the therapy unit to make an appointment. A therapist took them to a private space to answer questions so that they would not have to return another time.

- The hospital had protocols for all intra-hospital and inter-hospital transfers. These included a flow chart listed the criteria for the appropriate transfer of patient to a ward from a theatre recovery bed after a general anaesthetic. Staff followed instructions for transfer of patients to another hospital, such as completing a risk assessment form, identifying appropriate escort and transport, and medical and nursing staff doing a telephone handover to the equivalent staff at the other hospital. Ward sisters assessed staffing levels if a nurse left the ward to accompany the patient. If a patient was transferred to the Chelsea site or another hospital because they needed critical care, a member of the Outreach team or an anaesthetist accompanied them in the ambulance.
- There was an agreement with the London Ambulance Service (LAS) that patients who were stable would be taken to the person's local hospital if it was within an hour's journey. However, there were two incidents recorded in October 2015 when the ambulance had taken the patient to the nearest hospital instead of the patient's hospital. The hospital reinforced the agreement by sending the transfers flowchart and instructions to unit managers and matrons and asking for them to be distributed to junior doctors. Staff were instructed to contact the medical directorate on-call at LAS who would then liaise with the ambulance crew.
- We observed patients waiting for transport and did not see any major delays. Staff said the transport services were responsive and timely.
- Ward staff recorded the expecting length of stay of patients from the day they were admitted and had meetings with therapy and discharge staff three times a week to discuss readiness for discharge and what arrangements were needed to facilitate discharge. There had been delays in sending discharge summaries to GPs and an additional member of the discharge team was given the task of chasing medical staff for the summaries, with the support of ward staff. The trust had approved funding to train nursing staff in discharge.

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- Medical, CNS and therapy staff gave information to patient to help them manage at home. Therapy nursing and discharge staff liaised with local services to have services in place when they arrived home.
- Therapy staff described, and we saw examples of, the advice, preparation and written information they gave to patients so they and those close to them could manage at home. Therapy services liaised with local services to make sure that support continued if patients and their families were unable to manage on their own. They made sure local therapy and nursing staff understood the often complex requirements of patients with dietetic and SALT needs.

Learning from complaints and concerns

- The number of compliments far outnumbered complaints on the ward and in therapy services and both were used in staff discussion to improve services. Theatres received very few complaints.
- The trust minimised the number of formal complaints by addressing patients' concerns before they chose to complain in writing. Hospital staff sometimes talked to patients or relatives to clarify misunderstandings, and there was no need for a formal complaint. We also heard an example of the hospital providing an additional service to satisfy the patient, which resulted in them receiving different provision from other patients. Staff sometimes reported a concern as an incident so that there was an investigation without a formal complaint. We saw an example of a relative's letter saying they had not been kept informed of an investigation. We were not clear whether the concern was investigated as an incident or as a complaint. The complaints policy stated that complainants should be kept informed of any investigation.

Are adult solid tumours services well-led?

Good



We rated solid tumours as good for well led because:

- The hospital aim to provide the highest quality standards for patients was shared by staff
- There was a strong emphasis on learning, with involvement of staff at all levels in improving the safety of patients and contributing to service improvements.

- Staff felt well-supported in their work.
- Staff reflected the trust values in their work and behaviour.

Vision and strategy for this service

- The trust aim was to achieve the highest possible quality standards for patients, exceeding their expectations, in terms of outcome, safety and experience. We found that staff at all levels and of all professions shared this aim
- Staff were involved in developing the trust values and reflected them in their work. This included treating patients with compassion, having a positive attitude to their work, being open and working collaboratively.
- The trust had a five-year surgical strategy, which included developing the Sutton site.
- 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

- There were risk registers for the cancer services division and the clinical services division, which were regularly reviewed and updated by the risk management team in consultation with senior clinical staff and managers. These identified a number of risks and the plans to address these. However, we noted that risk ratings remained at the same level, sometimes for over a year, and that action to address risks was sometimes slow. For example, the hospital had taken some action to address the risk that it relied on other hospitals for clinical support functions that it did not have on site. The trust did not collect feedback from neighbouring hospitals and therefore had limited understanding whether the flow of patients to and from local hospitals was well-managed
- Senior surgical staff attended cross-site monthly surgical strategy meetings. Topics covered, included theatre utilisation and key performance indicators (KPI's).
- Formal service level agreements were in place for some services e.g. cardiology and others were currently being reviewed at the time of the inspection.
- The surgical audit group (SAG) had monthly meetings, discussing the results of audits and the strategies to implement identified improvements.

Adult solid tumours

- There were cross-site forums in therapy services to collate and discuss information from audits and incidents. There was a trust committee structure for quality and safety.
- The hospital had signed up to the national safety initiatives to reduce sepsis and to reduce harm from medication errors and pressure ulcers.

Leadership of service

- Clinical staff worked with operational managers to respond to problems and to improve services. There were good working relationships between matrons and managers, for example in theatres. Theatre staff said they were encouraged to raise issues with the matron and that she took action to address these. Therapy staff felt they contributed to service developments and that their contribution was valued. Staff in Smithers wards said they were well-supported by the ward sister.
- The trust performed better than the England average on a number of measures in the national survey of NHS staff, including recognition of staff by managers and the organisation, and good communication between senior management and staff.
- Consultants told us they were in regular contact with operational managers to resolve issues that came up. They felt valued and supported by senior management. A consultant commented that the trust attitude was one of 'can do'.

Culture within the service

- We observed a friendly environment, with staff happy in their work, which influenced the care they provided. A junior doctor commented 'if nurses are happy, it's a happy place'.
- Staff were proud to work at the trust. The Staff Friends and Family survey results were that 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.
- Staff sickness was lower than the England average and staff retention was improving.
- Staff, including administrative staff and healthcare assistants, were encouraged to attend courses and to look for progression. If staff wanted to continue working at the same level, this was respected. Staff said they were treated equally, regardless of their gender or ethnic

background. The trust performed better than the England average in the survey of NHS staff in the percentage of staff experiencing discrimination in the last 12 months.

- Teamwork was strongly valued and staff said they could always ask their colleagues or manager for advice or help if they needed it. A student nurse on the ward said 'everyone wants you to improve. They have time to show you'.

Public engagement

- There was a trust Patient and Carer Advisory group of patients and carers. The group worked with the trust on projects.
- Volunteers from the local community supported the hospital and we saw them during our inspection in a number of roles, such as supporting the hospital radio station, running a book exchange and raising funds for additional non-medical services. Hospital staff involved patients in developing patient information leaflets.

Staff engagement

- Staff consistently told us the hospital was a good place to work and that they were valued and their work recognised. There was an annual ball and wards for people nominated by other staff. There had been awards for administrative, estates as well as clinical staff.
- The trust was above the national level on several responses for the 2015 NHS staff survey. For example, 77.5% of staff felt they were able to contribute towards improvements at work, compared to the national level of 73.2%. Although the percentage reporting good communication between senior managers and staff was better than the national average of 35.4%, less than half (41.2%) responded positively to the question.
- Staff could get counselling individually and in groups from the trust psychological support team. Smithers ward had a list of monthly meetings when a member of the team was on the ward for reflective practice sessions. There was a peer support group for sisters at the hospital which enabled discussions of challenges.
- There were regular Schwartz Rounds, when staff from all backgrounds met to talk about the emotional challenges of caring for patients.
- Staff were encouraged to make suggestions for improvements and managers acted on these.

Adult solid tumours

Innovation, improvement and sustainability

- The trust was constantly innovating with treatment and care found to effective in research studies or which they had piloted and found to be effective.
- 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.
- A nurse consultant was overseeing the implementation of a national initiative to meet the needs of people living with cancer and those living beyond cancer. The therapy service was playing a key role in promoting supported self-management. One example of this work was the use of motivational Interviewing to encourage patients to identify their needs and wants and work out ways to address them.

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

Information about the service

The Royal Marsden Hospital NHS Foundation Trust (RMH) in Sutton provides a comprehensive service for the diagnosis and management of all haematological cancers. Haematological cancer (cancer of the blood cells) can be divided into three main diseases: myeloid neoplasms, lymphoid malignancies and plasma cell disorders.

There is a bone and stem cell transplantation unit accredited by Joint Accreditation Committee of the International Society for Cellular Therapy for assessment and accreditation of stem cell transplantation (JACIE). The majority of transplants on the ward are for patients with haematological malignancies. In 2014, the service carried out 241 blood and marrow transplants.

The haematology-oncology and transplantation service at the Royal Marsden Hospital in Sutton are on the Bud Flanagan unit (East and West ward) and offer both outpatient and inpatient treatment.

Bud Flanagan East (BFE) is a JACIE accredited stem cell transplant unit, which cares for patients requiring intensive chemotherapy and bone marrow transplantation. BFE comprises 16 single, en-suite rooms with filtered air protected environments for patients. There is also a two-bedded apartment for patient use in the early part of transplantation.

Bud Flanagan West (BFW) combines an ambulatory inpatient service and outpatient ambulatory care and day-unit facilities. Chemotherapy and stem cell transplants are delivered using the persons own stem

cells on BFW. BFW has 12 beds including four single rooms. The Apheresis unit (for the withdrawal of blood from a donor's body, removal of some blood components and transfusion of the remaining blood into the body) is also on the ward. The Apheresis unit has three dedicated chairs for procedures.

There is also a two-bedded 'step-up' high dependency unit (HDU) for patients requiring a higher level of care.

The Bud Flanagan Ambulatory inpatient unit has three dedicated treatment chairs and one bed. The ambulatory inpatient service is designed to ensure that patients can spend as much time at home as possible during their treatment.

The Haemato-oncology unit received 724 referrals (private and NHS) during 2014/15. Of these, 185 were direct from GPs with an additional 539 from non-GP referrers.

During the inspection, we spoke with 10 patients and family members, four doctors and 10 nurses. We observed interactions between patients and staff, considered the environment, observed the care and treatment of patients and reviewed eleven care records.

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Summary of findings

We rated the haemato-oncology services at The Royal Marsden in Sutton as 'outstanding' overall.

- The vision and strategy of the haematology team working within the unit was one striving for excellence, this was demonstrated through the innovation of their treatment, and their affiliation with world-renowned transplant registers. A collaborative and enthusiastic team who worked in a culture of openness and mutual respect delivered the treatment provided on the unit.
- Ambulatory inpatient care had reduced the number of bed days for inpatients requiring transplants.
- The unit had robust systems in place for the transfer of unwell patients who required a critical care unit (CCU). Although there was no CCU on the Sutton site, we were assured that the discharge and step-up unit team were fully trained in the event that a patient would require emergency transfer. This was confirmed by training data we observed. We observed trust policies that outlined the effective methods used by the outreach team in the event of the emergency discharge of a patient.
- There was a strong culture of multidisciplinary (MDT) workings across the unit. All new patients were assessed in the MDT and there was a high attendance rate.
- Staff were encouraged to report incidents and did so with the understanding that learning would be fed-back to the wider team. Complaints often involved waiting times, and investigations into these complaints were robust and impartial.
- Measures for the prevention and control of infection met both national and trust guidelines. Staff and the infection control team regularly audited hand washing and cleanliness of the unit. The environment was visibly clean and scored highly in the Patient Led Assessments of a Care Environment (PLACE) scores.
- There were sufficient doctors and nurses on duty and nursing staff levels were monitored twice a day. Staff were qualified and had the skills and expertise to carry out their roles effectively.

- Staff were supported with access to training and nursing staff were provided with away days focussed on clinical practice and competencies.
- There were several programmes of national audits that the unit took part in regarding the clinical practice of transplantation and haematology.
- Patients we spoke with stated that they were asked for consent prior to receiving treatment and the consent forms we saw in the medical records we observed confirmed this.
- Patients were regularly weighed and dietitians were involved in the patients care plans. Staff recorded the patients nutritional needs.
- The interactions we witnessed between staff and patients were based on respect and compassion and staff treated patients with dignity. Feedback we received from patients was positive about the care received and one patient stated that he felt like "one of the team".
- The trust had a key worker operational policy and patients were provided with a key worker that they could direct queries to. One of the key worker duties was to help patients with gaining access to support groups.
- There was a culture of openness amongst staff and staff were enthusiastic about working within the division.
- The majority of staff we spoke to felt supported by their managers and there was an appropriate system of clinical governance.
- The unit had adequate processes in place to deal with patients who presented with neutropenic sepsis.
- The estate was well maintained but there were capacity issues. These issues were highlighted on the trust risk register. The unit had undergone refurbishment and staff were looking forward to expanding further in order to better accommodate patients.

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Are haematology services safe?

Good



We rated safe as good because:

- There were processes in place for the transfer of acutely unwell patients out of the hospital. Deteriorating patients had their needs assessed promptly in line with trust policies. The service has processes in place for ensuring that they knew where patients were transferred to.
- The service had a robust process for ensuring that clinical incidents were reported and investigated. All staff were aware of their responsibilities to report and lessons were learnt where incidents had taken place. Care records were completed and risk assessments took place for patients in order to lessen risk on the ward.
- The unit was visibly clean and well maintained. The standards of cleanliness and infection control met national and local guidance.
- All equipment was centrally located and in date. The staff were supported by an engineering team.
- Staff were aware of their role in relation to safeguarding adults and could identify the safeguarding lead.
- There were sufficient doctors and registered nurses on the unit.

However;

- Space was somewhat restrained and several staff members we spoke with told us that they would like more space in clinical areas for their patients.

Incidents

- There was a strong culture of reporting incidents on the unit and staff were aware of the systems to report and record safety incidents, and could explain the process.
- Staff reported incidents through an electronic reporting system. There was evidence that learning from incidents was fed back to staff at monthly ward meetings.
- There were harm free care champions on each ward who were tasked with ensuring patients safety came first.
- From February 2015 – January 2016 the haemato-oncology unit reported 161 incidents to the National reporting and Learning System (NRLS). All of

these incidents were reported as low/no harm and the majority were regarding waiting times and delays in treatment. Senior staff knew of these issues and they were identified on the trust risk register.

- The matron reviewed all incidents on a regular basis and shared learning from these at the monthly ward meetings. On both Bud Flanagan West and East there was an incident book that kept track of all incidents that were logged on the electronic incident reporting system.
- Staff could identify situations requiring completion of an incident form and told us there was a good reporting culture where they were encouraged to report 'near-miss' situations in addition to incidents that had occurred.
- There was evidence that practices on the ward had changed and been adapted as the result of an incident. An example of this was the case of patient who was being treated on the ambulatory care unit. The patient was eager to go home and told staff that he had family at home to care of him, which staff accepted. The patient did not in fact have anyone at home to look after him, developed neutropenic sepsis after discharge and died soon after. This incident was investigated as a Serious Incident (SI). The ward now has disclosure forms that patients have to sign prior to discharge to confirm that they have a carer or family member to take care of them post discharge.
- Multidisciplinary mortality and morbidity (M&M) meetings took place every other month. We observed minutes from these meetings that demonstrated learning had taken place. We received evidence that the trust continuously monitored and reviewed mortality and morbidity figures. These figures were regularly discussed and reviewed with external stakeholders.
- The 100-day mortality figures were presented and discussed at the Haematopoietic Stem Cell Transplant (HSCT) Committee meeting, the quality committee for the external JACIE accreditation and the European Group for Blood and Marrow Transplantation (EBMT) and were signed off as agreed by the JACIE Clinical Programme Director.

Duty of Candour

- Duty of candour is a legal duty on staff within a trust to inform and apologise to patients if there has been a mistake in care that has led to significant harm.

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- Staff showed awareness of the duty of candour. Staff described this as the duty to be open when things go wrong, to apologise and have “integrity in the work”.
- Some junior nurses weren’t aware of the term ‘duty of candour’ but could explain the principles of being open and honest when things go wrong with patients.
- Duty of candour training was included within the health and safety training programme that staff were required to attend every year. Within the haemato-oncology service, 95% of staff had attended this training as of January 2016. This was above the trust target of 90%.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter associated urinary tract infections (UTIs).
- Ward managers recorded safety thermometer results on a monthly basis.
- From February 2015 – January 2016 there were 13 new pressure ulcers, 10 falls with harm and seven catheter-acquired UTIs.
- Safety thermometer, staffing details and hand hygiene audits were displayed at the entrance to the ward on patient facing dashboards that were easy for patients and their relatives to understand.

Cleanliness, infection control and hygiene

- Throughout our inspection we found the Bud Flanagan unit was visibly clean and tidy with cleaning audits being undertaken monthly. The wards had daily cleaning schedules in place which staff ticked to show that the specific area had been cleaned. We observed support staff cleaning throughout the day.
- We observed “I am clean” labels being used on the unit to indicate that the equipment had been cleaned.
- All patients admitted to the unit were screened for Meticillin-resistant Staphylococcus aureus (MRSA) in pre-assessment and then again on admission to the unit. MRSA is a bacteria that can be present on the skin without causing infection but can be a common cause of infections. On the unit the test was done via a stool sample so as to limit errors. Patients found to be carrying MRSA were treated prior to high dose chemotherapy. Patients who were carrying MRSA were cared for in a single room to limit the spread of infection.

- As patients on the wards were particularly susceptible to infection the unit had 14 positive pressure rooms, two negative pressure rooms and four static rooms to accommodate patients with an infection. The rooms ensured that infectious/vulnerable patients were appropriately managed through either barrier or reverse barrier nursing. The service design met the trust’s IPC policy and procedures. When caring patients, nurses wore aprons and gloves and adhered to hand hygiene principles in order to protect patients from infection.
- The unit worked closely with the microbiology team. A consultant from the microbiology team attended the unit on a daily basis to discuss antibiotics for patients with junior doctors.
- The trust had an infection prevention and control (IPC) team who were known to staff. We observed good hand hygiene practice with staff adhering to the ‘bare below the elbows’ policy.
- There were ‘no-touch’ taps at the entrance to each area and prominent signs informing patients, staff and relatives of the importance of hand hygiene.
- Hand hygiene audit results from January 2015 - January 2016 found that the Bud Flanagan unit was between 85% and 100% compliant with effective handwashing. We observed staff using effective handwashing methods and anti-bacterial gel.
- Adequate supplies of personal protective equipment (PPE), for example, gloves and aprons, were available on the unit and we observed staff changing aprons between interactions with patients.
- The management of sharps complied with Health and Safety (Sharps instruments in Healthcare) Regulations 2013.
- A commode spot check audit on the unit carried out in January 2016 found that the commodes were clean and 100% compliant with the trust’s policy on cleanliness.
- Both BFE and BFW possessed a cytotoxic spillage kit with guidance on what to do in the case of a spillage. Cytotoxic drugs is the general term for medicines that contain chemicals that are toxic to cells. They are used in anti-cancer drugs and can be dangerous if spilled. All staff could identify that any spillages should be escalated to the ward sister.
- Noticeboards on the ward displayed trust policies on duty of candour and IPC.

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- Infection and Prevention Control training formed part of the mandatory training programme that was updated yearly. The trust's target was 90% of staff having completed the training, within the haemato-oncology service 93% of staff had completed the training.

Environment and equipment

- The trust score was above the England average from 2013 to 2015 for the Patient Led Assessment of a Care Environment (PLACE) scores for cleanliness and facilities.
- We observed that although space was restrained in clinical areas, the ward corridors were kept clear of obstructive equipment and there were no trip hazards.
- Each ward on the unit had a resuscitation trolley which was in a central location and readily accessible. We observed that daily, weekly and monthly checks were carried out and recorded in the logbook with no omissions.
- All clinical areas contained equipment relevant for the administration of chemotherapy: an extravasation kit and a cytotoxic spills kit. We checked both extravasation kits and spillage kits that all followed the trust's policy and were up to date.
- Equipment supplied by commercial companies were portable appliance tested (PAT) by the equipment library and had stickers showing the date this was performed. We observed the tests to be in date. An external sponsoring company carried out services on the equipment. In the event of equipment failure, the fault was reported directly to the sponsoring company who would then send out an engineer.
- All Electrical Medical Equipment (EME) had registration labels attached that were maintained in accordance with manufacturer recommendations.
- Health and safety was part of the statutory training programme which staff were required to attend. The trust's target was 90% of staff having completed the training. Within the haemato-oncology service 95% of staff had completed the training.

Medicines

- The trust's pharmacy team were leading a national project on dose banding of chemotherapy medicines. Once achieved, the effect of this project would be the standardisation of chemotherapy doses which would

mean most chemotherapy medicines could be batch produced, improving efficiency and reduction in wastage. We did not receive information about when the project was due to be completed.

- Medicines were stored safely and in accordance with trust policy. Systemic-anti cancer therapies (SACT) were prepared in a sterile (aseptic) environment by specialist pharmacists.
- The electronic chemotherapy prescribing system used by the trust had inbuilt safety systems and controls that ensured all relevant information relating to the patient journey and treatment pathways were recorded. Staff told us this helped to significantly reduce errors in prescription and staff told us that medication errors were low since adopting this system.
- Medicines were stored securely and appeared organised. This included controlled drugs (CDs) and cytotoxic medicines.
- Fridge temperatures were checked and recorded and were within the correct range to store medicines safely.
- CDs were stored in lockable wall units. Nursing staff checked them every 24 hours.
- Some medicines were stored in dedicated medicines fridges. The fridges were locked and the temperature was within the acceptable range.
- A specialist pharmacist checked and verified all prescriptions. The 11 patient care records we observed confirmed this.
- Staff told us there was a high level of specialist pharmacy support in both outpatients and inpatients.
- There was a dedicated outpatient pharmacist and an electronic prescribing system for chemotherapy medicines. We were told that this had optimised medicines management, reduced errors and improved patient experience by cutting down on delays.
- The pharmacy team had also been involved in the development of unit guidelines and the London Cancer Alliance (LCA) chemotherapy protocols and treatment pathways.

Records

- The hospital staff used electronic patient records (EPR) to record patients' care and treatment with some additional paper nursing records, such as observation charts.
- We looked at 11 sets of patients' records and found that patient notes were fully completed. Risk assessments

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had been completed on admission and reviewed daily and this included pressure assessment within 6 hours of admission, Venous Thromboembolism (VTE) checks, nutritional and falls risk assessment.

- Staff told us that the EPR recorded all updates to a patient's records and contained all relevant patient information from pre-assessment to discharge.
- We observed several computers on the wards with some on trolleys. Staff members had unique logins to access patient records on EPR to ensure accountability.
- Information Governance was part of the mandatory training programme, which all staff were required to attend. The trust's target was 95% of staff having completed the training. Within the haemato-oncology service an average of 93% of staff had attended this training.

Safeguarding

- Staff had access to and were aware of the trust's safeguarding policies.
- Staff understood the escalation processes and their responsibilities if they had a safeguarding concern. All staff we spoke to could give the name of the safeguarding lead and knew who to contact if they ever had a safeguarding concern.
- We were told that although safeguarding concerns rarely posed an issue on the unit staff could identify the potential signs of abuse and we were given an example of one concern that was identified and managed.
- Patients who suffered from delirium post treatment were often cared for on a 1:1 basis.
- Safeguarding was part of the mandatory training programme and different levels of training were provided for different roles. The trust's training target was 90% and within the haemato-oncology service 98% of staff had attended level one safeguarding training.

Mandatory training

- Staff we spoke with confirmed they were up to date with mandatory training.
- The mandatory and statutory training programme covered basic life support, equality, diversity and human rights, information governance, blood transfusion, adult basic life support, health and safety and the duty of candour.
- The ward managers we spoke to showed us the systems used by the trust to monitor staff attendance at

mandatory training and let them know when staff members mandatory training was due to lapse. Staff received advanced emails reminding them of scheduled mandatory training updates.

- The practice educator on the ward held monthly catch-up sessions to ensure that people were aware of the practical implications of the training they received.
- Due to the specialist nature of the unit, staff needed to have additional competencies e.g. delivering chemotherapy. Practice educators and ward managers monitored these competencies.

Assessing and responding to patient risk

- Patient's observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with National for Health and Care Excellence (NICE) guidance. A Royal Marsden scoring system based on the National Early Warning Score (NEWS) was used to identify patients who were at risk of deteriorating.
- The duty consultant reviewed all patients within 12 hours of admission in line with national guidance.
- There was a 24-hour nurse led critical care outreach team (CCOT) in Sutton. The CCOT was supported 24 hours a day by the on call anaesthetist. All patients on the wards had a NEWS completed at least four hourly, if not more frequently, based on clinical indication. We observed a NEWS score sheet and noted that it had the numbers of the team to call out of hours or if the patient was at risk of imminent cardiac arrest.
- Deteriorating patients were escalated to the CCOT via the NEWS escalation process. There were two 'step up' High Dependency Unit (HDU) beds located on Bud Flanagan West (BFW) which provided level 1-3 care for critically ill patients where they could be stabilised before transfer to the intensive care unit at the Chelsea hospital.
- The patient was always stabilised before transfer but in cases where transfer was not a suitable option and the patient was in fact approaching end of life then this was taken into consideration and the palliative care team were contacted. The CCU consultant in discussion with the on call anaesthetist will ultimately make the 'suitable for transfer' decision.
- Even after a patient was transferred out of Sutton, the team at Sutton ensured they were kept up to date on the patients care so that they could be brought back to

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Sutton if need be. We observed confirmation of this in the trust Transfer of Adult and Paediatric Patients between Wards, Departments and other hospitals policy.

- We saw patients that had been identified as a falls risk had a red square placed over their bed so they were easily identifiable to staff.
- We observed that patients had their individual needs assessed and were provided with written information about their treatment. The information contained guidance about possible side effects and all outpatients were provided with a card with contact details of who to call if they had a temperature or any general concerns.
- The trust had a safety improvement plan from 2015-2018. The plan focused on three key safety priorities: sepsis, increasing awareness, identification and treatment of sepsis and reducing death from it; reducing harm from medication errors, and reducing harm from pressure ulcers. The unit displayed clear guidance on what to do if you suspect neutropenic sepsis. The ward also had clear mandated policies for reducing the incidence of pressure ulcers.
- The trust joined the Sign Up to Safety campaign in 2014. One of the aims was to reduce the number of avoidable deaths from sepsis by 100%. One area of improvement was to deliver antibiotics to sepsis patients within one hour.
- As part of the safety improvement plan the hospital developed a suspected neutropenic sepsis pathway along with an audit of patients presenting with sepsis.
- The trust used the Multinational Association of Supportive Care in Cancer (MASCC) Risk Assessment for suspected neutropenic sepsis.
- Adult basic life support was part of the mandatory training programme for nursing staff to attend. The trust's target was 90% of nursing staff having completed the training; within the haemato-oncology service an average of 95% of nursing had attended the training.

Nursing staffing

- Staffing levels and skill mix were assessed using an acuity tool in line with the Royal College of Nursing standard.
- There was an Advanced Nurse Practitioner (ANP) who specialised in both inpatient and outpatient haemato-oncology. The role was developed to support the nursing and medical team in the day-to-day running of the unit.

- We observed there were sufficient registered nurses on duty to provide safe care and nursing numbers were reviewed twice a day at group huddles.
- Planned versus actual staffing numbers were displayed on the ward and in the ward staff room.
- Within the trust, two floater nurses could make up for staff sickness. Floater nurses were additional nurses with varied expertise who could be used to make up unexpected shift shortfalls. The floaters and the central bank office ensured that the unit rarely had to make use of agency staff.
- All agency staff were given a thorough induction. Senior nurses on the ward were hesitant to use agency staff as they were not trained to place intravenous lines, which were a main component of the work done on the ward.
- Staff were encouraged to pick up bank shifts where they could and staff told us that they were happy to do this.
- BFE had 34.39 whole time equivalent (WTE) nursing staff for 16 inpatient beds and BFW had 25.56 WTE nursing staff for 12 inpatient beds and 6 day case. Bud Flanagan day care had 15.36 WTE nursing staff.
- We observed a joint nurse handover for Bud Flanagan East and Bud Flanagan West, which took place daily at 8.30am. The handover took place jointly to ensure that all nurses were aware of the patients on the ward. Patients at risk of fall, patients being discharged and pain management were some of the issues discussed at the handover.

Medical staffing

- Consultants worked by tumour group. There were 2.5 WTE stem cell transplant consultants, 1.5 WTE myeloma consultants, one acute leukaemia consultant, two consultants for chronic leukaemia and lymphoproliferative disorders. One specialist fellow supported the consultants.
- There was a limited number of middle grade doctors throughout the trust. To lessen the risk and to support the consultants an Advanced Nurse Practitioner (ANP) role in haemato-oncology had been developed to support both the nursing and medical team in the day-to-day running of the unit. There was one ANP in post at the time of the inspection.
- Doctors had to follow a series of competencies in systemic chemotherapy before they could prescribe and administer chemotherapy.

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- Junior doctors that we spoke with said that although there was a varied and interesting workload, opportunities for training were at times limited due to the amount of work.
- Out of hours on-call junior doctors and clinical site practitioners could admit patients to the ward.
- We observed a medical handover and found this to be well structured and detailed.

Major incident awareness and training

- The risk and reliance manager prepared staff to respond to a major incident and worked with the site management team to assess current risks. The matron on the ward had attended major incident training.
- Clinical site practitioners (CSPs) received annual practical training in responding to a scenario such as a patient becoming radioactive.
- Fire training was incorporated into the trust mandatory training programme and there were fire wardens on the ward. As of January 2016, 95% of staff on average had completed fire safety training.

Are haematology services effective?

Good



We rated the effectiveness of the haemato-oncology unit as good because:

- There were weekly multidisciplinary team (MDTs) meetings that discussed all new patients. Staff worked collaboratively to ensure adequate care plans were in place for patients.
- Use of National Institute of Health and Care Excellence (NICE) and Royal College guidelines were in use for a range of conditions.
- Pain was assessed using a pain-scoring tool and there was a trust wide pain team in place. The palliative care team provided symptom control support.
- Patient outcomes were audited in line with national audits.
- Patients were asked for verbal consent before treatment and this was confirmed by the care records we looked at.
- Staff had awareness of Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLs) and knew how to escalate these issues.

However;

- Junior doctors we spoke with stated that they had limited capability to attend additional training sessions and increase competencies due to the workload.
- Not all patients had their holistic needs discussed at MDT's.

Evidence-based care and treatment

- The haematology unit used a combination of National Institute of Health and Care Excellence (NICE) and Royal Colleges' guidelines to treat patients.
- For example, the trust had their own Management of Neutropenic Sepsis policy, which was based on the NICE guidelines on prevention and management of neutropenic sepsis in cancer patients (2013) and guidelines from the Infectious Diseases Society of America (IDSA). Staff understood these guidelines and told us that they were all readily available on the trust intranet along with other standard operating procedures.
- Patients had their needs assessed at the morning handover that took place at 8.30am and at the bi-daily huddle where the nurses on shift discussed the needs of higher risk patients.
- In the ward staff room there was a list of all the roles and responsibilities held by staff. The staff themselves took responsibility of producing ward audits on anything from infection control to ensuring that intentional rounding took place. One of the ward managers told us "it's good for all staff to get involved in the audit process".
- The Stem Cell Transplant (SCT) facility at the Marsden was licensed by the Human Tissue Authority (HTA) for the use of stem cells in human application. There were regulatory requirements that the department were to adhere to regarding the procurement, storage and disposal of stem cells. The Marsden adhered to the quality assurance and improvement requirements of the HTA.
- The transplant unit received full JACIE accreditation in June 2009 with reaccreditation in April 2014. In 2014 the service carried out 241 transplants (100 allogeneic and 141 autologous). The unit has a dedicated quality management system to ensure that all procedures are carried out in line with agreed standards.

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Pain relief

- Patients told us that their pain was regularly assessed and they received appropriate pain relief. We observed staff assessing patients' pain levels and taking action with appropriate pain relief in a timely manner.
- The tools used by the ward for assessing patient pain were in line with the Faculty of Pain Medicine's core standards for pain management (2015).
- We observed the use of the pain scoring tool in handover.
- There was a Haemato-oncology cancer nurse specialist employed on the unit. One of the key roles was to ensure that adequate referrals to symptom/pain control teams were made. Joint meetings were held between the haemato-oncology clinical nurse specialist (CNS) and the palliative care team to ensure seamless collaboration occurred on the unit.
- There was a trust wide pain team. One patient told us that the "pain consultant once came to see me twice in one day to ensure I wasn't in too much pain".
- When a patient was in pain a variety of methods were used including analgesia, from oral to epidural, massage and coping mechanisms. Their key worker could also refer the patient for psychological support.
- The palliative care team also provided symptom control and palliative care support in a timely and appropriate manner.

Nutrition and hydration

- The Patient Led Assessments of a Care Environment (PLACE) scores for the trust from 2013-2015 for food and hydration demonstrated a 98% satisfaction rate. This was above the England average of 90%.
- Where patients were identified as at risk of malnutrition, food intake was monitored and recorded on the Royal Marsden Nutrition Screening Tool (RMNST). We saw copies of these in patient's notes, which were completed daily.
- Patients told us that the food was good and the menu offered a wide variety of choices. One patient stated that the food was "excellent". We observed patients regularly being offered drinks and snacks. The unit operated a protected meal time policy.
- The ward had its own dietitian who visited the ward daily.
- All neutropenic patients had a neutropenic diet to follow from the beginning of their treatment.

- We observed patients being weighed daily as part of the nutritional assessment. .
- Ward based hostesses provided patients with 24/7 access to snacks and fluids. The ward hostesses provided support to patients on the ward whenever help was needed to eat or drink.

Patient outcomes

- The unit had systems in place to track trends in death within the first 100 days of stem cell transplantation (SCT).
- From July 2015 to September 2015 there were 62 recorded transplants. Of this 62, two patients died within 100 days following the transplant. Both patients died from the effects of the SCT. Learning from these deaths was shared across the unit in monthly ward meetings.
- Since taking part in the National Confidential Enquiries into Patient Outcomes and Deaths (NCEPOD) pilot and study the trust continued to collect data on the number of deaths within 30 days of receiving systemic anti-cancer therapy (SACT).
- All cases were reviewed at the monthly Morbidity and Mortality meeting to ensure learning points were discussed and action points given to all staff

Competent staff

- All staff were inducted into the trust at the start of their employment.
- Staff competency was regularly monitored through clinical supervision and the staff appraisal process. A list of the dates when each staff member on the ward last received an appraisal was displayed in the staff room. It showed when the next appraisal was due for all nurses on the ward. Between 90% and 94% of staff across Bud Flanagan had received an appraisal in the last year. Junior staff received their appraisal from more senior members of staff on the ward and staff found this approach helpful in terms of learning.
- Several nurses noted that having the Royal Marsden school on site was a "fantastic resource". Some nurses mentioned that they could gain a Masters whilst working at the trust.
- All nurses were aware of their responsibility to ensure that they were up to date with the Nursing and Midwifery Council (NMC) revalidation and acted in accordance with the NMC code of conduct (2015).
- Staff across the ward spoke of the various ways information was shared with them. Whether it was

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through their intranet, discussions in monthly ward meetings or talks with their practice educator, staff were confident that they were up to date on training opportunities related to their job role.

- Staff were encouraged to take up new responsibilities such as performing local audits or training new staff members. Although staff were not provided formal training on how to do this, they had the support of the ward managers.
- The practice educator ensured that staff were frequently able demonstrate competencies concerning the use of equipment e.g. intravenous and subcutaneous pumps.
- One of the specialty doctors we spoke with said he had 10 days off a year for dedicated study and that he always tried to make good use of this.
- Junior doctors received two days corporate induction but some reported that they were not always able to attend follow up training opportunities because of workload. Junior doctors also said they had limited opportunities for laboratory work as the laboratories were constantly in use for clinical practice.
- As the patients' treatments were so specialised, nurses also had to be competent in: the use of oral chemotherapy drugs, IV drugs and chemotherapy administration amongst other things. Clinical supervision assessed these competencies.

Multidisciplinary working

- There was a strong culture of multidisciplinary team working. We observed several multidisciplinary team (MDT) meetings and noted that staff worked well together to produce individualised care plans for patients.
- The haemato-oncology service at Sutton was divided into four based on cancer type. The four cancer types formed two separate multidisciplinary teams (MDTs), one for Myeloma/acute Leukaemia and one for Lymphoma/Chronic lymphoproliferative disease (CLPD). There were two haemato-oncology MDTs in the week that we inspected and we observed both the haematology network MDT and lymphoma MDT.
- We observed that two consultants led the haematology network MDT with a clinical oncologist, a pathologist and a registrar all in attendance.

- During the MDT that we observed, 12 patients were discussed however, the holistic needs of only one of those patients was mentioned. Staff told us there was not always enough time to discuss the holistic needs of the patients.
- The management plan was documented on the electronic patient notes and was available to all clinicians. The plan involved further investigation and treatments that may be necessary. The patient's key worker was present at the MDT.
- There were also twice daily nurse's huddle attended by matrons, sisters and site practitioners. This was partly a bed management meeting to ensure all patients were admitted to the right ward and discharged on time.
- Patients also told us there were daily ward rounds with doctors, where discussions were held about patients' pain management, symptom control, treatment, investigations and well-being.
- Patient records showed input from a range of professionals including clinical nurse specialists, pharmacists and doctors.

Seven-day services

- The symptom control team were available Monday through to Saturday including out of hours on call. On Sundays, the palliative care team would assist with symptom control and pain management.
- Consultants were present on the ward frequently and held ward rounds twice a week.
- Ward sisters operated a weekend rota ensuring senior cover was available Monday through to Sunday.
- There were dedicated haematology pharmacy services that provided out of hours services. There was no specialist pharmacy service available on a Sunday.
- Physiotherapy services were available Monday through to Friday on the weekends for respiratory patients.

Access to information

- Handovers took place at 8am and 8pm each day. Nursing staff discussed general issues but highlighted concerns such as patient pain and patients at risk of falls.
- Nurses told us that trust policies were available on the intranet and that all standard operating procedures were available up to date on the trust intranet. Nurses showed us where to access these.
- Comment cards were available for patients to complete at the main entrance to the ward.

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- Staff told us that the electronic patient records (EPR) contained all patient information from pre-assessment to discharge. This meant that all patient information was accessible and in one place.
- Some staff members referred to the deficiencies in the IT systems and support with the maintenance of IT. One consultant mentioned that during cross-site MDT's the teleconferencing service would be quite slow and sometimes not work at all.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us staff explained treatment plans and sought consent before proceeding. All patients we spoke with said they had been given information about the benefits and risks of their treatment before they signed the consent form. This was confirmed by the records we observed.
- Patients undergoing chemotherapy were fully aware of the risks of the treatment and were visited by the symptom control team. A wide range of regimen specific consent forms listed the potential risks and their likelihood.
- Staff told us that Mental Capacity Act and Deprivation of Liberties Safeguards training was part of their mandatory training.
- All patients had a nursing assessment on arrival. If staff had any concerns about a patient's capacity they escalated that information to the safeguarding lead. The specialist safeguarding lead would be involved.
- For patients who developed psychosis under the influence of certain medications, staff knew the procedures to follow to obtain 24/7 one to one care or if the patient had to be restrained.

Are haematology services caring?

Outstanding



We rated the haemato-oncology unit as outstanding for caring because:

- Staff were able to offer an overwhelming amount of emotional support and patients were offered psychological support if need be. Patients holistic needs were important to staff of all levels.

- The vast majority of patients we spoke with said care was excellent and the minor concerns were dealt with swiftly by ward staff.
- Staff treated patients with kindness, compassion, dignity and respect. Most patients we spoke with told us that the care they received was excellent and shared other positive feedback.
- Treatment was provided in a respectful and dignified way. Staff pulled curtains around the patient before commencing treatment.
- Both patients and family members told us that they were involved in decisions about the care and were told of care plans and post-surgery care plans.
- Most patients were positive about their care and staff provided emotional support in their interactions with patients.
- The Friends and Family Test (FFT) showed that between 90% and 100% of patients would recommend the service to their friends and family.
- All patients were provided with key workers who acted as the patient's main point of call.

Compassionate care

- The trust used the Friends and Family Test to gather patient's views on whether they would recommend the service to family and friends. The scores for the haemato-oncology unit were between 90% and 100% for the most of 2015. For Bud Flanagan East the score was 100% for the entire year of 2015.
- We observed interactions between nursing staff and patients to be professional, compassionate and friendly. We observed a patient hold hands with a nurse and thanking them for being so kind. One patient said that it was a "privilege" to be treated by the staff and that they felt "at home" on the ward.
- There was a wall of thank you cards located in the main foyer at the entrance to the unit. Most of the cards we saw spoke positively about the care received.
- Most patients and relatives that we spoke with were very positive about the care they received. Patients told us that the care was "excellent" and highly individualised.
- Regarding ambulatory care, one of the patients we spoke to said "I've been here as an inpatient and now I'm on outpatient ambulatory care, the quality of care has been great on both".

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- We looked at the patient led assessments of the care environment (PLACE) and found that the trust scored 85% for privacy, dignity and wellbeing; this was just below the England average of 87%.

Understanding and involvement of patients and those close to them

- We observed staff involve patients in their care and treatment and tailor the care to meet individual needs. Patients felt as though they had opportunities to discuss their concerns and many patients told us that their treatment plan felt very “individual”. One patient said “I feel listened to and a part of the team”. The majority of patients we spoke to felt as though staff went the extra mile when it came to their care planning and ensured they understood the process.
- Patients were offered written information relating to their cancer and treatment and this included information specific to their multidisciplinary team meeting and the patient’s type of haematological malignancy along with potential risks and benefits. Patients received specific information sheets on individual chemotherapy regimens and related side effects.
- Several inpatients said they had a daily medical review and a consultant review twice a week. One patient said that the consultants were “very good at explaining what’s happening”.
- A holistic approach was taken in patient assessment to follow all patients on their first admission throughout their journey at the trust. This involved a discussion with the patient about their physical, emotional and social needs.

Emotional support

- Nursing staff demonstrated that they understood the importance of providing patients and their families with emotional support. At pre-assessment, all patients were assessed for anxiety and depression. If patients were found to be anxious or depressed, they were referred to the trust counselling service.
- One patient said, “Counselling services got in touch almost as soon as I got here. I’ve got a number to phone the psychologist if I need them”.
- The trust provided a confidential psychological support service to help individuals and those close to them to adjust to the emotional impact of a cancer diagnosis.
- We observed an MDT where a patients holistic needs were discussed. The patient was an inpatient who

wanted to attend a friend's stag party. the MDT meeting discussed the equipment the patient would need in order to attend. The patients emotional and social needs were a consideration to the care planning.

Are haematology services responsive?

Good



We rated the responsiveness of the haemato-oncology unit as good because:

- Services were planned and delivered to ensure that patient preference and individual needs were the centre of care planning.
- The ambulatory care unit had reduced the number of days patients had to be inpatients, which meant that patients could be at home for some of their care. We heard evidence of this improving the patients’ experience.
- There was a collaborative approach to treatment plans with regards to cancer care which was coordinated with care for patient’s non-cancer conditions at other hospitals.
- The trust key worker policy ensured that patients had a first point of call if they had any questions or queries.
- The nursing staff managed informal complaints in the first instance and escalated to the Patient Advice and Liaison Service (PALS) if they could not be resolved.
- There were very few formal complaints on the unit and the formal complaints that were received were dealt with appropriately and learnt from.
- There was an international team in place to assist patients coming from abroad for ease of treatment.

However;

- There was limited space on the wards and in the clinical areas which meant that there was no relative room on the unit. However this was on the risk register and was mitigated against by staff allowing patient's and relatives to use the staff room.

Service planning and delivery to meet the needs of local people

- There were processes in place for accessing services not provided at the Royal Marsden. For example, a patient with a non-cancer related condition would readily have access to doctors with specialities in that co-morbidity.

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- It was clear from talking with the site practitioner and other members of staff responsible for discharge that the arrangements with local hospitals aimed to deliver better outcomes and experiences for patients with cancer.
- The ambulatory inpatient care (AMBIN) service for transplant patients enabled patients who would otherwise be inpatients the opportunity to be cared for at home with frequent visits to the unit for review. The number of inpatient bed days saved had risen year on year since the inception of AMBIN in 2010.
- Several staff members felt as though the estate did not have enough space for the amount of patients the unit treats. Staff were proud of the services they offered but didn't feel as though there was enough space to accommodate patients and the needs of their relatives. One staff member stated that "if a patient's relative is unhappy we bring them into the staff room as there is no relative room for them". Another staff member stated that it would be good if there was more space so that patients felt more comfortable and could bring in more friends and family for visits.
- The lack of space was on the trust risk register and there are plans to expand the facilities offered.

Access and flow

- There was a meeting at 9am every weekday to discuss discharge, bed allocation and staffing on the wards with the clinical site practitioner, the discharge coordinator, the ward co-ordinators, the temporary staffing team, a pharmacists and a matron. Ward co-coordinators returned to their wards to discuss patients ready for discharge, in consultation with therapy staff if necessary. Discharge co-ordinators supported the complex discharges. There was another meeting 3.30 pm to discuss the picture for the following day.
- Ambulatory inpatient care had reduced the number of bed days for inpatients requiring transplants. Data provided by the trust stated that inpatient stay ranged between 11-42 days compared to ambulatory stay, which ranged from four-19 days.
- From April to December 2015, of the 1915 appointments on the Bud Flanagan Ambulatory care unit, 183 (10%) patients had to wait over four hours for their treatment.

Meeting people's individual needs

- The Patient Led Assessment of a care Environment (PLACE) scores for the trust between 2013 and 2015 were at 96% for facilities and 85% for privacy, dignity and wellbeing. The England average was 91% and 87% respectively.
- In 2014, the haemato-oncology unit appointed a dedicated transplant Clinical Nurse Specialist (CNS) to provide support and education to patients in the immediate post-transplant phase before they were discharged. The role supported the patient in transition from hospital to home and could assist with any initial complications such as nutritional concerns or fatigue. Patients we spoke with felt very 'in the know' about the complexities of their condition and the treatment they were receiving.
- The trust had a Key Worker Operational Policy (1678) that stated that the key worker acted as the point of call between the patient and the MDT team. The key worker could direct the patient to support groups both within the trust and externally.
- All patients were allocated a key worker who was the main point of contact. The key worker met all new patients assigned to them and played a key role in assisting the patient through their pathway of care. Patients had the details of their key worker and had opportunities to discuss their care plan and any concerns they may have had.
- Patients who were at risk of falls were discussed in handovers, provided with non-slip socks and also had red squares over their beds to ensure that they were immediately identifiable. Some patients even had low beds and were checked on hourly intentional rounds.
- We were told that patients with specific needs or a learning disability had tailored care plans and staff were made aware of their support needs when they were admitted to the unit.
- Call bells were within reach of patients and that staff generally answered call bells straight away. One patient told us that the "call bells are always answered in a timely manner".
- The trust used a telephone translation service. There was also access to face-to-face interpreting and translation.
- Patient information and advice leaflets were available in English and consideration was given to producing

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information in other languages. Information in other languages could be sourced through the Royal Marsden Help Centre. Information in alternative formats could also be sourced through the help centre.

- Patients that we spoke to were unaware of any patient forums or groups they could join for additional support but the trust did have forums available.
- There were various services available to rehabilitate and support patients with a cancer diagnosis. Most services were free and patients could refer themselves by contacting the Royal Marsden Help Centre. Services included massage therapy, rehabilitation outreach team and pastoral care.
- Staff photos and names were displayed at the entrance to the ward. Staff were eager to establish a friendly environment where patients could address them open and honestly.
- All inpatients over 70 were screened for dementia.
- A trust wide chaplaincy team provided spiritual and religious guidance to patients. There was a weekly chaplaincy service available at the trust with a chapel and separate prayer rooms open for anyone that required them, which were mainly inpatients. Between October and December 2015 the chaplaincy team made 519 visits on the Sutton site.

Learning from complaints and concerns

- Staff felt very capable of dealing with complaints and told us that in the first instance they would deal with things themselves before escalating to Patient Advice and Liaison Service (PALS). They saw this proactive approach as the reason formal complaints were so low.
- Throughout the ward, there were posters and leaflets available to patients on how to make a complaint. A leaflet was also given to patients directly on arrival at the ward.
- All staff we spoke with understood how to deal with complaints and the process of escalation. Senior staff on the ward preferred to use local resolution in the first instance to deal with complaints. If they could not resolve the complaint then Patient Advice and Liaison Service (PALS) would become involved. Staff told us that they received very few complaints that could not be dealt with by senior staff in the first instance.
- One patient stated that she knew how “to complain to PALS but have never had a reason to”. Information on how to raise a concern or make a complaint was displayed in patient facing areas on the unit.

- Over the course of 2015 there were only three formal complaints made. This is much lower than the national average for a service of this size. Two complaints related to the attitude of staff. The ward managers and the practice educator told us that they would deal with complaints of that nature. They would ensure the nurse in question wrote up a reflective piece and would be reviewed for a short time.
- The last of the complaints related to waiting times for lab results. The trust risk register takes note of this issue and it remains an ongoing issue.

Are haematology services well-led?

Good



We rated the haemato-oncology services to be good for well led because:

- Ambulatory care proved to be a valuable innovation both in terms of enabling patients to benefit from more time at home and reducing hospital costs.
- Staff were enthusiastic to work at the trust and within their division. There was a culture of openness and staff said their managers supported them. The vision of the service was embedded into practice on the unit.
- Both senior and junior nurses informed us that there were a vast array of opportunities for continued professional development and where they took in an interest in furthering their careers, they were actively encouraged by their managers.
- Risks were managed and mitigated against as far as possible, for example, the hiring of new staff to make up for the lack of SHO's.
- Staff told us that there were various opportunities throughout the year to interact with leaders of the service.
- There were regular quality and risk meetings held by senior ward staff and the learning was fed-back to staff on the wards.
- Staff were excited about the ongoing developments to the unit and refurbishment had already begun to take place.
- The innovative clinical nurse specialist's role supported patients for a year after stem cell transplant.
- Staff spoke very highly of the advanced nurse practitioner role.

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Vision and strategy for this service

- Senior staff had a clear vision of how the haematology services were going to develop moving forward. They were also clear as to how the haematology services sat within the trust vision as a whole.
- The junior staff we spoke with were unable to give examples of specific hospital strategies but were aware of where to find such strategies on the trust intranet or pamphlets available on the unit. Staff were aware of the unit's vision for providing excellent care and this was evident in the attitude of the staff on the unit and the care they provided.
- Senior staff were aware that the hiring and retention of specialist staff was the main focus going forward. They were looking to increase the numbers of consultants and doctors and hire another Advanced Nurse Practitioner (ANP).
- The service planned to improve service resilience by hiring a new full time consultant, additional bone marrow transplant consultants and extending outpatient hours.
- Staff were aware that the new-build haematology day unit is due to open in 2019.

Governance, risk management and quality measurement

- We saw Bud Flanagan's risk register was up to date. There were no high level risks but there were risks registered with regards to senior house officer (SHO) cover and the environment in the day units. Consultants had raised the issue of low SHO staffing with us and in order to lessen the risk they were planning on hiring more advanced nurse practitioners for their clinics.
- There were regular risk and audit meetings on the unit with quality management group meetings held bi-monthly for transplants.
- There was a wide availability of the trust quarterly Integrated Governance monitoring reports on the unit.

Leadership of service

- There was a strong leadership team on Bud Flanagan unit. All staff had a good awareness of the leadership team and could identify members of the board.
- Staff told us that senior staff members were both visible and approachable. There were routine unannounced visits from the members of the board.

- Junior staff mentioned that there were several opportunities throughout the year to engage with board members and divisional leaders. There were monthly meetings and an open door policy with some senior staff that helped to foster a listening culture.
- Ward managers and sisters reported they had a lot of support from their matron and divisional nurse leader.

Culture within the service

- Staff we spoke with were very proud to work for the haemato-oncology service and of the work the trust did. Staff we spoke with were enthusiastic and described the trust as a "good place to work".
- All staff that we spoke with had an understanding of what to do if they had concerns, including the whistleblowing process. They recognised the importance of the duty of candour with patients and their families. Staff described the trust as having an open culture.
- Nurses on the ward told us they valued the opportunities for development and growth. Several nurses mentioned that having the Royal Marsden school on site meant they had wider opportunities to increase their knowledge and study which added to their continued professional development.
- Patients we spoke with noticed a positive and caring environment and one patient described being on the unit as being 'part of a family'.

Public engagement

- We saw patient feedback information and thank you cards in the staff room.
- Staff who worked with patients in Bud Flanagan outpatients were working with NHS England on 'always events'. They were using patient input to co-design the services provided. The concept was to use the views of patients to develop services in line with service users' needs and wishes.
- Comment cards were available for the patients to use. When these were filled out, the matron and ward manager reviewed them. We also saw thank you cards at the main entrance to the unit that were very complimentary about the care patients had received.

Staff engagement

- Staff felt well informed about management decisions via their intranet and monthly unit meetings.
- The Royal Marsden's Staff Achievement Awards recognised both individual staff members and teams for

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outstanding efforts during the year. In 2015, a team from Bud Flanagan won an award for their multidisciplinary working. This was publicised in the quarterly Royal Marsden magazine.

- There were regular Schwartz rounds, which were forums to discuss the emotional and social aspects of working at the trust. These were held every quarter. There were also monthly ward meetings and quarterly meetings with the divisional lead and CEO that staff were encouraged to attend. The staff we spoke with said that although these were great opportunities to speak with senior staff.
- We were assured by staff on the ward that a small amount of refurbishment had already taken place and there were plans to relocate Bud Flanagan Ambulatory care to a new building by 2019. The matron on the ward felt very involved in the redesign of the new haematology day care unit.

Innovation, improvement and sustainability

- Ambulatory inpatient care has developed over the last five years to support patients remaining at home wherever possible.

- The Advanced Nurse Practitioner (ANP) role in haemato-oncology was developed to support both the nursing and medical team in the day-to-day running of the unit.
- The unit was out to tender for the refurbishment of some of the ward areas. On Bud Flanagan West, four side rooms were re-decorated before our inspection and there was a plan in place to redecorate the main bays on Bud Flanagan West and two side rooms on Bud Flanagan East by the end of 2016.
- Anthony Nolan is a register that matches stem cell and bone marrow transplant patients with donors. The haematology unit were very proud of their links with the Anthony Nolan register as it meant they had more access to UK based donors. The foundation provided the trust with funding to support a clinical nurse specialist (CNS) for post-transplant patients. The new role was a key development in 2014 and the CNS assists the patient's transition from hospital to home. The CNS could deal with any complications such as nutritional concerns, fatigue and graft versus host disease (GvHD).

Outstanding practice and areas for improvement

Outstanding practice

- Hospital staff of all professional backgrounds provided care, therapy and treatment that reflected the most recent evidence from international and national research findings, and from local audits and pilot studies.
- There were exceptional opportunities for staff development, which contributed to a highly skilled and competent workforce.
- Nursing and therapy staff had the commitment and time to provide person-centred care that often went the 'extra mile'
- The introduction of ambulatory care had managed to reduce patient bed stays and improve patient experience.
- In radiotherapy the development of best practice through constant innovation and change of practices and the way in which these were shared nationally with other departments.
- Management of the paediatric patient pathway with consideration to the needs of children through the traumatic radiotherapy pathway. This included the interactions with staff, the play sessions before radiotherapy and the way in which they were engaged throughout the process.
- The contribution made by the radiotherapy physics team to engage with school children to pursue a career in medical physics and the recognition of the department as a result of its contribution with the annual schools science conference.
- The children and young people's service sent families flowers on the first anniversary of a child's death and sent families cards for five years after a child's death.
- A youth support worker provided activities, games and other media to engage and occupy young people while in hospital.
- The process for both site specific and technique MDT meetings across both the Chelsea and Sutton sites linked through the use of technology and a shared understanding of the process by all parties.
- The accreditation the radiotherapy department has received from ISO 9001/ 2008, IPEM, HEE, and the academy of healthcare sciences for training.
- The plethora of research and publications released having an impact on both national and international practice Including the development of the Heartspare for breast radiotherapy (which has been rolled out nationally).
- The trust had the largest paediatric inpatient drug development programme in the UK. The programme was set up with the objective of improving survival rates for children and young people with cancer.
- The rapid access and diagnosis service provided a one stop shop for patients with suspected cancer .
- The use of patient information prescriptions which provided patients with information about their condition, using sources approved by the Department of Health.

Areas for improvement

Action the hospital **MUST** take to improve

- Implement and embed the World Health Organisation Safety Checklist in the outpatients department

Action the hospital **SHOULD** take to improve

- Continue with the redevelopment plans for the outpatient department.
- Provide an acute oncology service in line with best practice guidance.

Outstanding practice and areas for improvement

- Ensure that extravasation and cytotoxic spillage kits in all clinical areas are checked in accordance with trust policy.
- The hospital should improve the compliance with the high dusting audit and ensure that process are in place for all clinical areas to be cleaned appropriately.
- Ensure that staff always follow effective hand hygiene practice including the use of alcohol gel when caring for patients.
- Ensure systems for controlling access to medicines in the outpatient department are secure at all times.
- Take steps to ensure clinics are not overbooked and there is sufficient medical staff available to reduce the time patients wait to be seen in clinic.
- Reduce delays in referring patients, where appropriate, to the end of life care service
- Develop a consistent approach across the trust for recording and logging cadaver storage temperatures.

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

| Regulated activity | Regulation |
|---------------------|---|
| Surgical procedures | <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA (RA) Regulations 2014: Safe care and treatment.</p> <p>12 (1) (2) (a) (b)</p> <p>The world health organisation (WHO) five steps to safer surgery checklist was not being used in the outpatients department even though a range of procedures were being carried out for which it should have been used.</p> <p>The five steps to safer surgery checklist was not used in the outpatients departments.</p> <p>The hospital must take action to:</p> <ul style="list-style-type: none">• Ensure the safer surgery checklist is consistently implemented for all surgical procedures in the outpatients department including the five steps of team brief, sign in, time out, sign out, and debriefing. Reg 12 (1) (2) (a) (b)• Ensure adequate audit and monitoring systems are in place to monitor performance and compliance of the safer surgery checklist to guide improvement. Reg 12 (1) (2) (a) (b) |