The ROYAL MARSDEN
NHS Foundation Trust

Board of Directors Public Meeting

Chelsea Boardroom

26 March 2025, 12.30pm – 2.30pm

Clinical Presentation: ***Micro Robot by Dr Aadil Khan***

1. Welcome, Apologies for Absence and Declarations of Interest

2. Minutes of the Public Board Meeting held on 27 November 2024 Enclosed
Chairman

3. Matters Arising

- **HRH visit and the Royal Patronage** Verbal

Chairman

- **NHS England Leadership Changes** Verbal

Chief Executive

4. <u>Strategic</u>

4.1 Financial Plan 2025/26 Enclosed
Chief Finance Officer

4.2 ICR/RM Research Strategy Enclosed
Director of Clinical Research

4.3 Digital, Data and Technology Strategy 2025/26 – 2028/29 Enclosed
Chief Information Officer

4.4 RM Partners Cancer Strategy 2025-2030 Enclosed
Managing Director of RM Partners

4.5 People Strategy 2025-2030 Enclosed
Chief People Officer

5. <u>Quality & Performance</u>

5.1 Staff Survey Results Enclosed
Chief People Officer

5.2 Financial Performance Report – February 2025 Enclosed
Chief Finance Officer

5.3 Performance Report Q3 Enclosed
Chief Operating Officer

5.4 Monthly Quality Account – February 2025 Enclosed
Chief Nurse

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6. Regulatory

6.1 Mortality Review Q3 Enclosed
Chief Medical Officer

6.2 Board Evaluation Report Enclosed
Company Secretary

6.3 Risk Appetite Statement 2025/26 Enclosed
Company Secretary

6.4 Board Assurance Framework Enclosed
Company Secretary

7. For information

7.1 Communications Briefing Enclosed
7.2 Medical Appointment Enclosed
7.3 Board Standing Orders Annual Review Enclosed
7.4 Board Sub-Committee Terms of Reference (AFC & QAR) Enclosed

The ROYAL MARSDEN
NHS Foundation Trust

Minutes of The Royal Marsden Board of Directors Public Meeting

27 November 2024, Chelsea Boardroom

Present	
Sir Douglas Flint	Chairman
Dame Cally Palmer	Chief Executive (CE)
Liz Adekunle	Non-Executive Director
Professor Ted Baker	Non-Executive Director
Jane Bentall	Non-Executive Director
Katie Bickerstaffe	Non-Executive Director
Alison Dickinson	Non-Executive Director
Baroness Rona Fairhead	Non-Executive Director
Sofia Colas	Chief Operating Officer (COO)
Mairead Griffin	Chief Nurse
Karl Munslow-Ong	Deputy Chief Executive
Professor Nick Van As	Medical Director
Karry Tymieniecka	Interim Chief Financial Officer

Attendance	
Brinda Sittapah	Company Secretary
Martin Burke	Governor
Louann Heale	Governor
Jane Hewlett	Governor
Philippa Leslie	Governor
Penka Nikolova	Governor
Sophie Uren	Governor
Ian Frankcom	Public member
Robin Harmer	Public member

Clinical Presentation by Dr Irene Chong, Head of Clinical Oncology

Dr. Irene Chong, Head of Clinical Oncology at The Royal Marsden, provided a presentation to the Board on advancements in radiation oncology, focusing on technological innovations and strategies to improve treatment precision and patient outcomes.

Key highlights include:

- **Technological Advancements**:
  - Integration of RADNET and AI to enhance radiotherapy, such as the automated contouring of normal tissues for accuracy and efficiency.
  - Introduction of adaptive radiotherapy platforms like the Elekta MR Linac and Radixact machines, focusing on precision and reduced exposure to normal tissues.

- **Treatment Innovations:**
  - Hypofractionation studies (e.g., the CCHIP trial) aim to optimise dose delivery and improve patient convenience.
  - The Patriot Study explores ATR inhibitors combined with radiotherapy, showcasing progress in tailored therapies.

NHS

- **Tumour Biology Understanding:**
  - Emphasis on personalised vaccines and research targeting the immunogenicity of cancers to improve prevention and treatment strategies.

- **Data Integration:**
  - Leveraging clinical and imaging data to personalise treatment pathways and maximise patient outcomes.

- **Future Directions:**
  - Expanding adaptive platforms and MR simulators.
  - Implementing Surface Guided Radiotherapy to improve patient comfort and safety.

Dr. Chong emphasised the importance of leveraging integrated datasets, advancing training, and recruiting skilled professionals to propel radiation oncology into a future of highly personalised and effective cancer care.

The Board thanked Dr. Irene Chong for her exceptional work, enthusiasm, and passion, recognising her significant contributions to advancing cancer research. They also commended Dr. Chong and her team for their dedication to enhancing the patient pathway through innovative advancements that make treatments more tailored, precise, and effective. Reaffirming that patients remain at the heart of The Royal Marsden's mission, the Board emphasised its continued commitment to improving outcomes and experiences through pioneering research and care.

1. Welcome, Apologies for absence & Declarations of Interest

Sir Douglas Flint, Chairman, opened the public Board meeting by welcoming attendees and introducing Katie Bickerstaffe and Baroness Rona Fairhead, the newly appointed Non-Executive Directors, attending their first public Board meeting.

Apologies were noted from Professor Kristian Helin, Non-Executive Director & Chief Executive of the ICR and William Jackson, Non-Executive Director & Senior Independent Director.

No additional interests were declared beyond those already on record.

2. Minutes of the Board Meeting held on 28 March 2024

The minutes of the Public Board meeting of 28 March 2024 were approved as an accurate record of that meeting.

3. Matters Arising

Board appointments

The Chairman highlighted the recent appointments of two Non-Executive Directors, Katie Bickerstaffe and Baroness Rona Fairhead, to the Board.

Specialist Emergency Care Hospital (SECH)

The Deputy Chief Executive provided an update on the Specialist Emergency Care Hospital (SECH) programme, noting that a decision from the government, as part of the new hospital programme, is awaited. Progress continues on the London Cancer Hub project in Sutton, with Studio Egret West commissioned by the Royal Marsden (RM) and the Institute of Cancer Research (ICR) to develop the site masterplan. RM and ICR are actively exploring joint opportunities, with further efforts underway to strengthen relationships with Aviva and Socius in support of creating a Health and Life Sciences campus.

4. Strategic

4.1 Outline Business Case for Children's Services

The Medical Director provided an update to the Board on the Outline Business Case (OBC) for the transition of Principal Treatment Centre (PTC) services for children with cancer from The Royal Marsden (RM) to Guy's and St Thomas' (GSTT)/Evelina Children's Hospital.

The Board was reminded that this service transfer, initiated by NHSE (London) in March 2024, is scheduled for October 2026. GSTT is leading the development of a fully funded delivery plan, with RM providing input to ensure the future service configuration meets requirements. The OBC, shared on 13 November 2024, was reviewed by RM, and feedback was gathered from key individuals. Based on the comments received, RM recommended changes to address significant concerns.

The OBC outlines that the revised PTC will be delivered across multiple sites, with radiotherapy services relocated to University College London Hospitals (UCLH). This change may increase the logistical burden on families, particularly those requiring daily radiotherapy, as they will need to travel between GSTT and UCLH.

Concerns were raised regarding significant capital and revenue costs, with GSTT estimating a £45.6 million capital requirement for the infrastructure. There is also uncertainty around the agreed revenue model with NHSE.

Parents and staff concerns were noted, particularly regarding the accessibility of the new central London location and the impact on staff who live near Sutton. It was noted that there are now 48,000 signatures from parents on the petition to maintain the PTC at RM. There is also concern about the potential risk to research, as RM and the ICR are major contributors to paediatric oncology research, and maintaining this at the same level may be challenging under the new model.

The Board discussed the risks associated with the tight timeline, the financial model, the impact on research, and concerns from both staff and families. The Medical Director added that RM remains committed to working collaboratively with GSTT to ensure that the transition meets the needs of children, families, and staff while safeguarding the quality of care. The Board will receive further updates on the impact on other services, including Teenage and Young Adult (TYA) care.

The Chairman reiterated that the Trust would support any change that benefits children and their families, emphasising that the key objective is to improve the experience and service delivery for patients and staff.

The Board noted the progress made and the concerns raised with GSTT.

4.2 Response to Consultation on the 10 Year Health Plan – The Royal Marsden & RM Partners (RMP) Response

The Chief Executive (CE) advised that, following the publication of the Darzi Report on the state of the NHS and the 10-Year Health Plan consultation, significant changes are needed to ensure the sustainability and improvement of healthcare services.

The Darzi Report provides a comprehensive assessment of the current healthcare system, highlighting areas that require urgent attention and reform. This is complemented by the ongoing consultation on the 10-Year Health Plan, which seeks to outline a roadmap for addressing both the immediate and long-term challenges facing the NHS.

At the heart of the Darzi Report are three key shifts that will shape the future of healthcare:

1. Moving care from hospitals to communities – Increasing the provision of care in community settings to reduce the reliance on hospital-based services.

2. Analogue to Digital – Accelerating the adoption of digital technologies to enhance efficiency, access, and outcomes.
3. Sickness to Prevention – Transitioning the healthcare focus from treating illness to proactive prevention and health promotion.

Both the Royal Marsden (RM) and RM Partners (RMP) are providing responses to the consultation. RM's approach focuses on the challenges and enablers surrounding the three shifts, with an emphasis on how service innovations within a tertiary organisation can support these changes. RM has identified opportunities such as better integration of care, enhanced public health measures, and digital transformation initiatives to drive improvements. RMP's focus is on the role of Cancer Alliances in early diagnosis, with key areas including cancer screening, primary care engagement, and improving patient experience. RMP also emphasises removing barriers to access, such as addressing geographical and logistical challenges, and advocates for public awareness campaigns to promote early detection. Equity of access is a critical theme, particularly in underserved communities, alongside efforts to close the deprivation gap by addressing social determinants of health.

The consultation closes on December 2, 2024, and the government is expected to publish the 10-Year Health Plan in the spring of 2025. RM and RMP are committed to submitting robust responses that address emergent themes and contribute to shaping the future of healthcare.

The Board endorsed the approach The Royal Marsden and RM Partners are taking to contribute to the consultation, including their response to the emergent themes and how these align with organisational priorities.

4.3 Chelsea Development Programme

The CE briefed the Board on the Royal Marsden Chelsea Development programme, focusing on the progress of the design development phase and the public consultation process.

The project, in development since late 2022, has now reached a critical milestone with the commencement of the formal public consultation as part of the Town Planning process. The design development phase is progressing as planned and remains aligned with the project timeline. The aim is to submit a detailed Planning Application during the summer of 2025, subject to ongoing discussions with Royal Borough of Kensington and Chelsea (RBKC) officers and the readiness of the design. To support this submission, a structured Pre-Application process is underway with RBKC.

The formal public consultation, which began in early November, is a key component of the Town Planning process. Stakeholder engagements have already taken place with local residents' associations, heritage societies, and councillors. Early feedback has been generally supportive, particularly regarding The Royal Marsden's continued presence in Chelsea and the clinical need for expansion. However, concerns have been raised around building massing and aesthetics, traffic and parking management, and construction activities.

The consultation process will continue to gather feedback, which will inform tailored next steps for engaging specific stakeholder groups. These include addressing traffic management issues on Dovehouse Street and refining design details to align with community expectations.

The Board noted that the design development phase is progressing on schedule and acknowledged the start of the formal consultation process.

4.4 Green Plan

The Chief Operating Officer (COO) briefed the Board on the Trust's performance against the nine key themes of the 2021–2024 Green Plan, providing insights that will shape the development of the next plan.

Governance developments and key activities were highlighted as part of the Trust's commitment to environmental improvement. While the Trust compares favourably with others in sustainability efforts, areas for further focus were identified.
The COO outlined key metrics to demonstrate the impact of changes in headcount and estate on the Trust's sustainability efforts. She acknowledged challenges in year-on-year trend analysis, stemming from updates to carbon emissions measurement methodologies and the return to standard operations post-COVID. Improved carbon footprint reporting, nearing completion, is expected to enhance the setting of clear objectives and targets.

The supply chain remains the largest contributor to the Trust's carbon footprint. Ongoing efforts to engage sustainable suppliers, tackle waste reduction, and improve procurement practices were noted, alongside initiatives to enhance staff awareness of environmental impacts.

The COO outlined the focus for the Trust's Green Plan for 2025–2027, which will prioritise several sustainability initiatives. A key aspect will be the introduction of a smart carbon calculator to improve carbon reporting. The plan will also aim to integrate sustainability more closely with the Trust's overall efficiency strategy and enhance staff education on environmental issues. Key priorities will include optimising estate efficiency, implementing sustainable building management practices, and reducing food and general waste. Further initiatives will involve exploring plant-based menus, partnering with climate-conscious utility providers, and re-evaluating the Combined Heat and Power (CHP) system at Sutton. These initiatives are designed to reinforce the Trust's commitment to sustainability and align with emerging best practices in environmental management.

The Board noted the progress made in implementing the 2021–2024 Green Plan and the steps taken to finalise the updated plan. The updated Green Plan will be presented for Board approval in early 2025.

5. Quality & Performance

5.2 Monthly Quality Account October 2024 (September data)

The Chief Nurse presented the Quality Account for October 2024 (September data) highlighting areas of good performance and areas for improvement.

An improvement in SACT performance was noted, now at 81.2%, which is only 0.2% lower than the pre-EPIC figure of 81.4%. The Division is aiming to reach the internal target of 85% by March 31st of 2025, a revised date following recent service challenges.

The Trust reported 13 Healthcare-Associated Gram Negative Bloodstream Infections (BSI) and six hospital-associated cases of C. difficile. Despite considerable efforts to address the issue, the Trust has breached its national target for C. difficile for this year. Nationally, C. difficile cases have increased across the UK. The Chief Nurse explained that while the Trust adheres to NICE guidelines for antimicrobial prescribing, other Trusts may follow European guidelines. The Trust is undertaking a deep dive into its cases to ensure all necessary steps are being taken to prevent C. difficile. Discussions are ongoing with Christie's and Clatterbridge to review case mix, clinical management, and antibiotic usage to determine if their practices differ from RMH's. The Board discussed and agreed that a paper on C. difficile and other BSIs deep dive should be presented at the next Quality Assurance and Risk (QAR) Committee in February 2025.

Three moderate-harm medication incidents were reported this month, and the mention of four incidents in the report is an error. All three incidents have been thoroughly investigated. Of these, one incident that caused harm to a patient was attributed to human error involving a miscalculated dose. The affected patient is now stable.

The Trust has experienced an increase in hospital acquired pressure ulcers, with 17 attributed to the Trust this month. In one clinical area, seven hospital cases were recorded. While some cases were due to delays in assessing pressure areas on admission, this does not account for all incidents. Under patient safety incident framework (PSIRF), a thematic review is being

undertaken on pressure ulcers management across the Trust. The findings will be available by the end of December. The Board discussed and agreed that a paper on pressure ulcer management should be presented to the next QAR, focusing on the increase in cases observed in August and September. While staffing issues and the role of practice educators have been discussed, the Board requested a deeper dive into pressure ulcer management and a clear action plan to reverse the trend. It was also suggested that certificates be implemented in each area for days without hospital-acquired pressure ulcers.

The EPIC Sepsis dashboard and workflow are in development, aligned with NICE Sepsis guidelines. The Lead Nurse for Sepsis and the deteriorating patient will commence in post in January 2025. The Board discussed and agreed that a paper on Sepsis management should be presented to the QAR, addressing the Trust's red rating for the last two quarters (Q1 and Q2) and focusing on antimicrobial administration within one hour, changes in national policy, and NEWS scores.

The Chief Nurse noted that patient experience feedback remains highly positive, with 99% of inpatient respondents and 98% of outpatient respondents to the Friends and Family survey stating they would recommend The Royal Marsden. This reflects an improvement from July's results.

The nursing vacancy rate has slightly increased to 3.0%, and voluntary nursing turnover has also risen to 9.4%, though this still represents a reduction compared to the previous month.

The Board noted the Monthly Quality Account for October.

5.2 Q2 2024/25 Performance Report

The COO presented the Key Performance Indicators (KPIs) for Quarter 2 (Q2) of 2024/25, highlighting several key improvements.

Performance against the 31-day standard reached 96.5% in Q2, surpassing the national target, while the 62-day standard improved to 71.9%, moving from red to amber. The Trust also exceeded its 28-day Faster Diagnosis Standard (FDS) target, achieving 88.3% and maintaining a green rating. Progress was noted in staging KPIs for the first time this year and in SACT/MDU same-day infusion waits.

Despite these achievements, some challenges remain. While the overall percentage of red-rated metrics decreased slightly, three metrics moved to red: the number of 52-week waiters, private patient activity income, and the number of patients added to PIFU pathways. Improvement in these areas is expected in Quarter 3.

The COO reiterated concerns regarding infection control, previously discussed earlier in the meeting. The Trust, currently amber-rated for infection control metrics, is projected to breach the NHS England trajectory for 2024/25 by year-end. To address this, the Infection Prevention and Control (IPC) team is undertaking comprehensive reviews of all gram-negative infections and introducing high-impact interaction audits to strengthen line care practices.

The Board received the Q2 Performance Report.

5.3 Financial Performance Report

The Interim Chief Financial Officer presented a report on the Trust's financial position as of 30 September 2024.

The Trust reported a year-to-date (YTD) deficit of £4.5m, which is £1.8m adverse to plan. At the control total level, excluding the impact of donated asset income and depreciation, the deficit stood at £3.2m YTD, reflecting a £1.4m adverse variance to plan. The adverse position was primarily attributed to NHS paediatric income, which remains unresolved with NHS England and continues to pose a risk to the Trust's financial stability. The Interim Chief Financial Officer

reported that pay costs remained on budget, and the Trust's Cost Improvement Programme (CIP) target of 5.5% (£25m) was reported to be on plan.

The capital programme was under plan due to timing variances within Trust-funded Capital Departmental Expenditure Limit (CDEL), though overall targets remained achievable.

Capital expenditure for September was £5.2m behind plan, with Trust-funded spending £5.3m below target and Charity-funded spending £0.1m ahead, reflecting timing variances in the planned budget.
The cash balance as of 30 September 2024 was £101.9m, a decrease of £7.1m since year-end. This lower-than-expected position was driven by delays in private care cash recovery, reduced payables, and lagging NHS income payments relative to activity.

Jane Bentall, Chair of the Audit and Finance Committee assured the Board that the Managing Director of Private Care, Mark Hawken, had attended the November AFC meeting to outline recovery plans for private care billing. The Committee also received a report providing assurance on private care contracts, previously requested by Non-Executive Directors (NEDs), with confirmation from the Managing Director that financial and clinical metrics are being met across all cohorts.

It was noted that this meeting marked the final Board session for the Interim CFO, Karry Tymieniecka, who was commended for her excellent leadership over the past 11 months. The new CFO is set to commence on 29 November.

The Board received the Financial Performance Report for September 2024.

6. Regulatory

6.1 Mortality Review Q1

The Medical Director presented the Q1 Mortality Report to the Board, noting that it had been thoroughly reviewed at the Quality Assurance and Risk Committee meeting.

There were 53 inpatient deaths between 1 April 2024 and 30 June 2024, of which 52 were reasonably expected. All deaths were reviewed by Medical Examiners, independent of the clinical team, and were determined to be not avoidable. Four deaths were referred to the coroner. A total of 12 inpatient deaths underwent a 'Structured Judgement Review' (SJR), and no issues in care were identified. None of the 53 deaths in the quarter were investigated as serious incidents.

Regarding patients with learning disabilities, no deaths were reported. Additionally, one internal child death was reported, although it occurred in Q4 of 2023/24. There were also seven external paediatric deaths. No hospital-acquired COVID-related deaths were reported between 1 April 2024 and 30 June 2024.

The Board received the Quarterly Mortality Report and noted that The Trust received a Green rating for the period from 1st April 2024 and 30th June 2024.

6.2 Board Assurance Framework

The Company Secretary presented the Board Assurance Framework (BAF) to the Board.

The Board had approved the Risk Appetite Statement for 2024/25 in May. Since then, the BAF has been reviewed in alignment with the newly launched Clinical Strategy and the Risk Appetite and was presented at the July and September Board meetings.

There are currently 13 risks on the BAF, 5 of which exceed the risk tolerance threshold. Mitigations are in place for all of these risks, which exceed the threshold due to the Board's low-risk tolerance and external factors beyond the Trust's control.

The Board approved the Board Assurance Framework.

7. <u>For information</u>

<u>7.1 Senior Medical Appointments</u>
The Board noted the Senior Medical Appointments.

<u>7.2 Communications Briefing</u>
The Board noted the Communication briefing.

The next date for the public Board meeting was confirmed as 26 March 2025.

Signed as a true and accurate record.

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

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 4.1
Title of Document: Business Planning 2025/26	**To be presented by:** Chief Finance Officer

1. Status **For noting**

2. Purpose:

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

3. Summary

NHS England published planning guidance at the end of January 2025. For 2025/26, the NHS mandate has reduced the number of essential objectives for the NHS with an emphasis on maximising delivery within the given financial envelope.

The plan has been developed in consultation with Divisions and stakeholders across the organisation and the ICB through an iterative process.

The resulting financial plan is to deliver a £0.5m surplus, reflecting national planning assumptions, approved business cases and cost pressures, supported by an efficiency programme.

The Trust's capital plan was developed in a similarly iterative process and is set at a value of £33.9m including charitably funded expenditure.

The operational plan has been developed in line with the finance plan, to deliver the national priorities and meet the expected demand on services through 2025/26.

The outcome of workforce planning is for a flat workforce in comparison with 2024/25. The Trust is planning on an increase of 3% in non-NHS workforce and 1% reduction in NHS workforce to reflect the service developments and efficiency programmes planned for 2025/26.

4. Recommendations / Actions

The Board is asked to note the position set out in the report.

2025/26 Business Plan

1. Introduction

This paper provides an outline of the business planning process for 2025/26 and the financial plan proposed.

2. Planning guidance national priorities

NHS England published its planning guidance at the end of January 2025. The key national priorities have been set out below.

The government mandate has reduced the number of essential objectives for the NHS. Consistent with these objectives, NHS England has reduced the number of national priorities for 2025/26:

- Reduce the time people wait for elective care (18 weeks RTT target 65%; cancer 62 day target 75%; 28 day faster diagnosis standard 80%);
- Improve A&E waiting times and ambulance response times;
- Improve patient access to general practice;
- Improve patient flow through mental health crisis and acute pathways including children and young people's mental health services.

To deliver the goals set out above and live within budget:

- Providers will need to reduce their cost base by at least 1% and achieve 4% overall improvement in productivity before taking account of any new local pressures or dealing with non-recurrent savings from 2024/25.
- Providers are expected to reduce agency expenditure by a minimum of 30% on current spending across the system.
- Close the activity/WTE gap against pre-Covid levels.

3. Revenue and capital planning guidance assumptions

Revenue finance and contracting

NHS England will set a 2025/26 plan limit for each System, reflecting the improvement required from 2024/25. Systems are required to prepare 2025/26 financial plans that achieve the plan limit position (or better where achievable) set for the system.

Baseline growth of commissioner contracts are set at 4.4% to reflect:

- the cost uplift factor (CUF) for 2025/26 of 4.15%, including a 2.8% headline pay assumption and the impact of other pay-related cost pressures on NHS services
- the general efficiency requirement of 2.0%
- the Clinical Negligence Scheme for Trusts (CNST) increasing by 4.6%
- affordable activity growth

The convergence policy continues to apply across systems, with ICBs converging to their population based "fair share target income allocation" through a convergence adjustment to a maximum of -/+ 0.5%. For SWL ICB this is expected to be the max -0.5%.

Additionally, systems due to repay prior year overspends will also be subject to a repayment plan set to an annual cap of 0.5%. For SWL ICB this is also expected to be the max -0.5%.

The 2025/26 NHS payment scheme is now published for consultation. The proposals below are planned but not finalised until the conclusion of that consultation.

The Aligned Payment and Incentive contract and Low Volume Activity (LVA) contract schemes will continue into 2025/26 with some small amendments to definition of LVAs and in scope Aligned Payment and Incentive (API) contract payment limits for elective services.

Capital Finance

The 2024 Autumn Spending Review provided the NHS with a 1-year capital settlement covering 2025/26. The government has not yet awarded a capital settlement beyond 2025/26. However, a multi-year settlement is expected as part of the 2025 Spending Review (Phase 2), which will conclude and be published in June 2025.

For 2025/26 there is an indicative business as usual capital allocation of £4.9bn. Additional PDC funding is available from national programmes covering: estates safety (£750m); constitutional standards (£1.65 bn); and digital transformation (£596m).

NHS England is also considering introducing capital freedoms for high-performing trusts that deliver a surplus in 2024/25 that would allow these trusts to invest in capital equivalent to their 2024/25 surplus in 2025/26 and 2026/27.

4. Revenue financial plan

Process

Divisions have drafted initial budgets using the following key elements:

- Budgets costed based on Q3 forecasts.
- Normalised to take account of changes in second half of the year.
- Pay updated based on Month 10 pay establishment.
- Non-pay based on Q3 forecasts.
- Approved business cases included.
- Unavoidable cost pressures included.
- Development of efficiency plans.

Plans have been developed and iterated through Performance Review Group governance process.

The Finance team have worked with the Divisions to develop an efficiency programme. Each scheme will be subject to the quality and equality impact assessment (QEIA) process which will be reviewed by the Medical Director and the Chief Nurse before implementation sign-off.

The Operations Senior Management Team have reviewed activity plans for 2025/26. The activity plans are based on expected demand, and the requirement to meet operational objectives set out in the planning guidance.

Due to the ongoing consultation regarding the NHS payment scheme no additional NHS income has been factored in above income levels achieved in 2024/25. The initial proposals suggests that variable activity will be capped at least at 2024/25 levels, therefore additional income assumptions would be at risk.

Workforce plans have been produced based on current establishment levels, adding in additional posts relating to the approved business cases or supporting non-NHS activities with a corresponding reduction in NHS WTEs reflecting efficiency plans.

At the beginning of the financial planning process the senior management team for operations, finance, workforce and informatics review and agreed the key principles that would be applied to the respective plans for activity, workforce and finance. Following the completion of the draft plans and ahead of the March submissions, senior management came together to review the plans and ensure consistency. The conclusion drawn from this meeting was that the key plans had been produced using the same principles, and confident that the plans are triangulated.

Revenue plan

The Trust plan to deliver £0.5m surplus in 2025/26. In order for the Trust to fund the resources needed to develop its services and infrastructure, the Trust will require an efficiency programme.

5. Capital Plan

Process

The Trust's capital needs were arrived at following consultation with all of the relevant business units. The various capital needs were prioritised using a risk-based approach and presented to the Trust's Capital Programme Board.

The available capital envelope was arrived at following discussions with SWL about the system's capital needs and how they should be prioritised. Notably, SWL decided that in the first instance national PDC funding should be used to fill funding gaps for ICB-funded schemes, leaving less additional capital for trust-funded schemes.

Capital plan

Set out below is an initial view of high-level capital financial plan to fit within the indicative funding allocation provided by SWL.

Trust funded capital expenditure	£30.1m
Donated capital expenditure	£3.8m
Total capital expenditure	**£33.9m**

6. Operational performance plan

Process

Activity plans have been set following an analysis of activity growth since 2022, and the figures were then adjusted to take into account organisational changes such as the opening of the Oak Cancer Centre. The time period for analysis was restricted due to the significant activity impacts of the pandemic in prior years. The trend data was reviewed in a meeting pre-Christmas by clinical, operational, informatics and finance teams to consider where past growth was a reasonable indicator for future activity, and local operational knowledge was used to adjust plans, for example based on available capacity. The plan also includes a full-year adjustment for Endoscopy Sutton which opened mid-year. Ultimately the activity plan delivers growth, which given continual year on year increased referral volumes into the Trust is to be expected.

Standards

This activity plan will allow the Trust to continue to meet the 28 Day Faster Diagnosis standard, RTT standard and will deliver the national ambition of hitting 75% for 62 Days by the March 2026. The cancer performance trajectories have been set in discussion with RM Partners and take into account seasonal trends.

7. Workforce Plan

The workforce has been developed alongside the finance and operational plans, based on the same planning principles as set out above. The plans have been built using current establishments and adding the workforce elements of the approved business cases.

The outcome of this process is the workforce will remain flat compared to 2024/25 overall with an expected increase of 3% in our non-NHS workforce supporting planned growth activities such as private care, research and commercial opportunities, and a reduction of 1% in our NHS workforce in line with the efficiency plan and productivity initiatives. This has reflected the service developments and efficiency programmes planned in 2025/26.

8. Conclusion

The planning guidance has been published with the key priorities for the NHS with a reduced number of national priorities to support delivering within the financial envelope.

The national focus requires increased productivity, and cost reduction rather than increased NHS income, with the NHS funding envelope under significant pressure. The translation of this into local budgets contains a number of as-yet unquantified elements which makes the planning process more challenging. As a result, the financial environment will be more challenging in 2025/26.

The Trust's plans to deliver a £0.5m surplus but for the Trust to fund the resources needed to develop its services and infrastructure, it plans to deliver a challenging efficiency programme. The outcome of the NHS Payment scheme consultation is likely to change the NHS financial framework. The ERF caps have been announced but with no detail as to how this will impact the overall financial envelope.

The Trust has produced a balanced, prioritised capital plan with a total planned capital expenditure of £33.9m.

9. Recommendation

The Board is asked to note the report.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 4.2
Title of Document: Institute of Cancer Research (ICR) and Royal Marsden (RM) Research Strategy	**To be presented by:** Professor Nicholas Turner, Director of Clinical Research

1. Status: For approval

2. Purpose:

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

3. Summary

Approach to development of the strategy: The ICR and Royal Marsden plan to develop a single Comprehensive Cancer Centre strategy to include 3 pillars – Clinical, Research and Education. In January 2024, the Research Strategy Board began discussions on the research pillar (strategy) and members were asked for feedback. The feedback and plans for the research strategy were further discussed at the Research Strategy Board in March 2024. The initial draft of the refreshed ICR and Royal Marsden research strategy was developed over the summer and circulated to Research Strategy Board members in October for feedback. The structure of the strategy was developed to align with the Five-Year Clinical Strategy, which was launched in April 2024. The strategy also contains content from the existing research strategy.

A finalised version of the research strategy document was approved by the Research Strategy Board in November 2024 and presented to the Board in February 2025. In this meeting, the Board noted the importance of moving discoveries from "bench to bedside" but questioned how insights from clinical care are fed back into the lab to drive further innovation and asked that this is more explicit in the strategy. This feedback has been addressed in the revised version which is presented to the Board for approval.

The research strategy will also be taken to the ICR Board for approval. Following these approvals, the strategy document will be developed into a standalone public facing document like the clinical strategy. The overall content and structure will remain consistent with the document but there will be rewriting of text to ensure it is understandable for a public audience. A short more digestible version of the strategy will also be developed.

Overview of the strategy: We have developed an ambitious strategy for world-class cancer research that will tackle the challenges of cancers across the globe. It builds on the foundations of our strong partnerships, our network of collaborators, patients, funders,

supporters and our track record in delivering impact and improvements for those affected by cancer.

Vision:
We will advance understanding of cancers and their ecosystems, improve diagnostics and treatment, overcome drug resistance, and minimise treatment side-effects to transform outcomes for patients – through world-class fundamental, translational, clinical, and applied research.

To achieve this vision, the strategy has four Core Themes underpinned by four Enablers. The Core Themes are:

1. **Fundamental Science:** We will reveal how cancers develop, adapt, and evolve as part of a complex environment of signals, cells, tissues, and external stresses.
2. **Innovative Diagnostics**: We will diagnose cancer earlier, faster, and more precisely, and predict and identify initial signs of recurrence or resistance earlier by better understanding of cancer risk, using advanced diagnostic methods and digital approaches, and integrating data and data science methods to identify new biomarkers.
3. **Precision Therapies**: We will exploit our understanding of cancer's complexity, ecosystems, and evolution to create innovative, kinder and more precise ways to target and treat local and metastatic disease and test these therapies for the first time in patients.
4. **Changing Clinical Practice**: We will deliver benefits for cancer patients through generating the evidence for clinical adoption of precise diagnostics, treatments, and tailored supportive strategies and implementing them into care within the NHS and internationally.

These Core Themes are underpinned by four Enablers:

1. Ensuring financial and environmental sustainability of the research ecosystem
2. Attract, retain and grow our people
3. Maximising benefits from our partnerships
4. Enhancing our infrastructure.

4. Recommendations / Actions

The Board is asked to approve the ICR and Royal Marsden Research Strategy.

Foreword

We are delighted to introduce you to The Institute of Cancer Research (ICR) and The Royal Marsden's Research Strategy 2025-2030. We have a longstanding partnership, and a long history of performing research that impacts clinical care and practice in the NHS and internationally. Our partnership ensures that patient experiences directly inform our scientific research, leading to innovative treatments and improved patient outcomes.

In 2022, there were almost 20 million new cancer cases and 9.7 million cancer deaths worldwide. Living with a diagnosis of cancer can have short, medium and long-term effects that can reduce a person's quality of life and enjoyment of life. However, cancer does not affect everyone equally, some people and groups are more vulnerable, and often such groups are less likely to access timely or cutting-edge medical intervention and innovations and can be more likely to die from cancer.

This research strategy has been developed to tackle the challenges in cancer now and in the future. We are ambitious and will maximise the opportunities our partnership provides to improve outcomes for all those at risk of and affected by cancer through the identification of the causes of cancer, the development of faster, more accurate and earlier diagnosis, and tailored therapies which maximise cancer control and quality of life for patients underpinned by fundamental science insights and smart use of data and technology.

Our strategy has four core themes:

Fundamental Science – We will uncover how cancers develop, adapt, and evolve as part of a complex ecosystem of tissues, cells, signals and environmental stresses to inform the development of new diagnostics and treatments.

Innovative Diagnostics – We will diagnose cancer earlier, faster, and more precisely, and predict and identify initial signs of recurrence or resistance earlier by better understanding of cancer risk, using advanced risk stratification tools, diagnostic methods and digital approaches; and integrating data and data science methods to identify new biomarkers.

Precision Therapies – We will capitalise on our understanding of cancer's complexity, ecosystems, and evolution to create innovative and more precise ways to target and treat local and metastatic disease; and test these therapies for the first time in patients.

Transforming Clinical Care – We will deliver benefits for cancer patients through generating the evidence for clinical adoption of precise diagnostics, treatments, and tailored supportive care strategies; and implementing them into care within the NHS and internationally.

We would like to thank everyone who has contributed to this strategy and look forward to working with you to ensure The ICR and The Royal Marsden make the discoveries that transform survival and translate them into practice for all those affected by cancer worldwide.

Signed by Professor Kristian Helin, Dame Cally Palmer, Professor Dame Julia Buckingham and Sir Douglas Flint

Vision

We will advance understanding of cancers and their ecosystems, improve prevention, diagnostics and treatment, overcome drug resistance, and minimise treatment side-effects to transform outcomes for patients – through world-class fundamental, translational, clinical, epidemiological and applied research.

There has been considerable progress in the effectiveness of cancer treatments, with twice as many cancer patients surviving now compared to the 1970s. However, cancer incidence is rising, and it is predicted that one in two people will get cancer in their lifetime. Therefore, it is important to continue to identify the cancer-causing variants in genes, to understand the polygenic risk and how it interacts with environmental/lifestyle risk factors, and to improve the understanding of how cancer develops. Through these fundamental discoveries, researchers continuously propose, test and develop new ways to better identify those at risk, diagnose and treat patients. Moreover, while overall survival rates are improving, some cancers, such as pancreatic and brain cancer, remain extremely challenging to treat and some survival rates remain poor. We still have much to learn about cancer through research if we want to overcome these challenges, and we intend to continue to be at the forefront of this.

Cancer is an international problem. Globally, new cancer cases are expected to increase from almost 20 million in 2022 to 30.2 million in 2040. Collaborating internationally is key to tackling cancer and fostering innovative research. We will take action to ensure our research drives innovation and impact for patients and health care systems across the world including hard to reach populations.

Cancer is difficult to treat because there are over 200 cancer types, cancer is different between patients, and even within an individual tumour there is variation. We know that cancer is so difficult to treat because it is an extremely complex and diverse disease and constantly adapts and evolves. We now know that genome instability in a wide range of forms, including disruption of epigenetic processes, underlies this ability to evolve and adapt to allow cancer cells to survive, proliferate, and disseminate.

Cancers exhibit another layer of complexity; the cancer cells are surrounded by a collection of ‘hijacked non-cancer cells’ that create the tumour microenvironment. Cancer cells can recruit and influence the cells of this microenvironment to produce signals that sustain the cancer’s growth and survival. For instance, research has led to an increased understanding of the role of the immune system in the development of cancer and the response to treatments. Most cancers manage to avoid detection and destruction by the various arms of the immune system. The tumour microenvironment also contains other cells that sustain the cancer cell, and we now view cancer as part of an interconnected ecosystem, with cancer cells interacting through a combination of signals with each other, the surrounding tissue, and the immune system.

Unfortunately, cancer is not always caught early, and some diagnostic approaches can be slow and uncertain. Surgery and radiotherapy offer patients the best opportunity to cure cancer, and targeted drugs can extend patients’ lives although responses to treatment vary. Thus, there is a need to make therapies more precise to improve survival and spare patients unnecessary treatment. Cancer treatment is difficult for patients and their families physically, emotionally and in other ways too, and can have serious long-lasting side effects.

We have developed an ambitious strategy for world-class cancer research that will tackle the challenges of cancers across the globe. It builds on the foundations of our strong partnerships, our network of collaborators, patients, funders, supporters and our track record in delivering impact and improvements for those affected by cancer. With this support we can bring our laboratory research into the clinical setting ensuring that new diagnostics and treatments are both safe and effective for patients and apply insights from the clinic in the laboratory for further research. This research process is known as '*bench to bedside and back again'* which is a real strength of our partnership.

Our aims are to save more lives and ensure patients can live as well as possible, for as long as possible. This aligns with the NHS Long Term Plan's goal for cancer and international initiatives such as Europe's Beating Cancer Plan and USA Cancer Moonshot. We will learn from our latest scientific understanding of cancer, which sees cancer cells evolving within a complex interconnected ecosystem. Our scientists and clinicians will draw on fundamental discoveries about cancer from across The ICR and beyond and insights from the clinic, to find ways to prevent, diagnose, detect, and target cancer more effectively, and advance cancer treatment and care through our innovative programme of clinical and applied research. We will deepen our national and international partnerships to deliver change at scale and achieve global impact.

Reflections

The ICR and The Royal Marsden have worked in partnership for more than a century and the results of our discovery science research are translated into the clinic, saving lives and improving diagnostics and treatments for cancer patients. Fostering a more integrated way of working together [Insert Agreed Name in due course], will allow us to strategically work across the entire cancer research continuum and deliver new insights into cancer biology, innovative translational research and practice-changing clinical studies. Being patient centric institutions, we will also listen and learn from patients to inform future discoveries in our *'bench to bedside and back again'* approach. Using a continuous cycle of translating fundamental discoveries into clinical applications and using insights from patient care will bolster and enhance our research ultimately leading to improved and more personalised clinical impact.

Longstanding track record of impact

We have taken fundamental science research and translated into new drugs for cancer patients. The ICR has identified 21 new drug candidates since 2005 of which 13 have progressed into clinical trials. For example, we discovered and developed abiraterone, a life extending prostate cancer drug. We showed that prostate cancer growth was driven by an alternative source of androgens, rather than being truly hormone resistant and then designed, synthesised and developed abiraterone. Subsequent phase I, II and III clinical trials demonstrated prolonged survival and improved quality of life for prostate cancer patients. Hundreds of thousands of men with prostate cancer across the world are now able to live better and longer lives with a good quality of life due to abiraterone.

Based on the observation that breast cancer was common in some families, researchers around the world were searching for the genetic basis of this. We identified the breast cancer gene *BRCA2*, which laid the groundwork for our clinical trials of novel forms of therapy for BRCA-associated cancers. Mutations in the *BRCA2* gene increase an individual's risk of developing breast cancer and other cancers. After its discovery, we showed that BRCA2 is involved in a form of DNA repair called Homologous Recombination Repair. In 2005, we showed that compounds blocking the activity of a DNA repair protein called PARP could selectively kill cancer cells with a faulty *BRCA1* or *BRCA2* gene,

leaving normal cells relatively unharmed. We carried out the first phase I and II clinical trials of olaparib, the first PARP inhibitor. These trials underpinned the many later phase III trials of olaparib and other PARP inhibitors leading to their approval for the treatment of ovarian, breast, prostate and pancreatic cancer.

We solved the 3D protein structure of AKT, a kinase regulating cellular metabolism, and began a drug discovery research programme aiming to find AKT inhibitors informed by these 3D structures. This work was then translated by our drug discovery teams and in 2005, one lead series discovered by The ICR and in collaboration with the biotech company Astex Therapeutics was licensed to AstraZeneca. Capivasertib was discovered by AstraZeneca after a collaboration with Astex Therapeutics (and its collaboration with the ICR and Cancer Research Technology Limited). Trials we led showed the benefit of capivasertib alongside hormone therapy to treat patients with a certain type of breast cancer underpinning the national and international approvals of capivasertib alongside fulvestrant for these patients.

We have made major contributions to modern high precision radiotherapy techniques such as intensity modulated radiotherapy (IMRT), and image guided radiotherapy. We pioneered the application of mathematics to fine tune the shape of the radiation beam used to develop IMRT. This spares the surrounding tissue and allows higher intensities of radiation to be concentrated on the tumour. Building on these approaches, we suggested that breast cancer radiotherapy could benefit from a hypofractionated approach of fewer, larger fractions (the total dose of ionising radiation prescribed, divided into individual doses) over a shorter period. First showing 40 Gy (Gray, the unit of ionising radiation dose delivered) in 15 fractions was as effective as the previous approach of 30 fractions and subsequently, demonstrating that 26 Gy in five fractions over one week was as good as the new 15-fraction standard, changing clinical practice. This change to treatment schedules has reduced the number of hospital visits for patients which reduces time away from work, caring responsibility and improves quality of life. It also frees up capacity in radiotherapy units. We showed that the hypofractionated approach works in prostate cancer too, which is used across the world. We used IMRT for head and neck cancer, proving that it is associated with a significant reduction in side effects and establishing it as a new global standard-of-care treatment.

We have exploited advances in genomic technologies to improve diagnostics for patients. We developed tests to sequence over 200 genes that drive the progression of paediatric tumours. We then successfully worked to incorporate these genomic tests into the NHS England Test Directory, meaning that all children with cancer in England can now receive a comprehensive tumour genomic profiling as standard-of-care. These tests allow us to match children diagnosed with cancer to clinical trials of targeted drugs, personalising their treatment and maximising benefit. Furthermore, the tests have also proved effective and efficient for adult cancer diagnostics and are now widely applied via the NHS Genomic Medicine Service.

Recent research achievements

Insights into cancer biology. More recent, we demonstrated that non-repetitive non-coding 'junk' DNA may impair DNA replication and repair of the genome, we obtained structural insights into how the WNT signalling pathway contribute to cancer and demonstrated through structural studies how small molecule inhibitors bind to cancer-driving proteins that can help improve the future design of cancer drugs. Moreover, we have provided further understanding of how epigenetic proteins control how DNA is transcribed into RNA, increased the knowledge of how breast cancer cells can remain

dormant, and uncovered details about mechanisms underpinning metastasis**.** We demonstrated that a form of diffuse hemispheric glioma recapitulates various stages of interneuronal lineage development and from this found vulnerabilities which could inform new treatment approaches.

Developing new diagnostics. We have developed risk-stratified screening for those with high-risk inherited cancers such as Li Fraumeni and Lynch syndrome and a saliva test for prostate cancer. Our saliva test is more accurate at identifying future risk of prostate cancer for men with high genetic risk than other approaches and can be taken at home. To make diagnosis faster and safer, we built an artificial intelligence (AI) model that can accurately identify whether abnormal growths found on lung CT scans are cancerous. We also developed a new AI algorithm that could help tailor the treatment of some sarcoma patients more accurately and effectively than a biopsy. This AI tool could be around twice as accurate as a biopsy at grading the aggressiveness of the sarcoma. We showed that a new type of blood test can predict the recurrence of breast cancer in high-risk patients, months or even years before they relapse so treatment could be started much earlier, without waiting for incurable, advanced disease to develop and show up on a scan.

We were part of the largest genomic characterisation of clinically annotated rhabdomyosarcoma to date, which could be used to refine risk stratification and guide treatment decisions. We collected the largest series of infant gliomas assembled to date and presented an integrated classification system. These results have changed the World Health Organization's diagnostic guidelines, with high grade gliomas in infants to be classified separately from similar-looking tumours in older children.

Next generation of treatments. We are advancing the use of stereotactic body radiotherapy, dysphagia-optimised intensity-modulated radiotherapy and designed an approach to improve radiotherapy through AI-generated MRI images from existing CT scans.

We used proteolysis targeting chimera (PROTAC) technology to destroy RIPK1 in cancer cells. Targeting RIPK1 enhanced immune system activation after radiotherapy and immunotherapy in mice and improved response to treatment. We found that fadraciclib, a drug that was jointly discovered by The ICR with the company Cyclacel, selectively targets MYCN-amplified neuroblastoma. Our early phase trials showed the potential benefit of a combination of AZD5069, an experimental drug which prevents myeloid cell recruitment to tumours, and enzalutamide, in advanced prostate cancer and that an ICR-discovered cancer drug idetrexed, is safe and effective enough to enter phase II trials in ovarian cancer.

We developed a computational tool to predict which B cells were most likely to detect and target cancer cells and showed that head and neck cancer patients' response to treatment depends on the levels of PD-L1. Both studies have the potential to pave the way for personalised immunotherapy treatments. We contributed to the studies that led to the first oncolytic viral therapy, called talimogene laherparepvec, and the first cellular therapy, called lifileucel, receiving accelerated approval from the U.S. Food and Drug Administration for the treatment of advanced melanoma. Through a different study in myeloma, we showed that combining five existing drugs, along with a stem cell transplant, benefits patients with an aggressive type of myeloma.

The next five years

We are proud of our achievements, but we believe we can do more and better. Thus, over the next five years, The ICR and The Royal Marsden will work closer than ever before

through aligned strategic objectives, research priorities and resources to further accelerate the translation from groundbreaking research to personalised patient care.

Our vision is to have global impact by leading research that results in earlier and faster diagnosis and detection of cancer, safer and more precise treatments, better outcomes, and faster recovery strongly aligning with The NHS Long Term Plan's cancer priorities. We will tackle cancer's complexity and evolution through the central insight of this strategy – that cancer research is an ecosystem too. Our world-class research will run from '*bench to bedside and back again'* – linking fundamental research discoveries with our clinical insights. Throughout our research we will maximise the use of data science to integrate and interrogate our research and clinical data to understand cancers in ways that have not previously been possible.

Our overall approach is to ensure we are optimally structured, resourced and aligned to deliver cancer research across the fundamental science, translational, epidemiological and clinical continuum and to ensure that there is a continuous loop of our clinical experience informing our fundamental science to deliver more effective and personalised diagnostics and treatments. Ultimately, through our integrated comprehensive cancer centre we want to deliver improvements in cancer prevention and care. The ICR has an embedded team science approach running across all areas of research from fundamental biology, physics, and chemistry through to translational and clinical research. The Royal Marsden is a research active NHS Foundation Trust that delivers one of the largest portfolios of interventional cancer clinical trials in the UK, bringing many of these to partner hospitals from a wide range of settings, focusing on those with unmet needs. The Royal Marsden recruits more patients to early phase trials than any other NHS Trust. Working together as a comprehensive cancer centre we have joint infrastructure including an early phase drug development unit to seamlessly integrate preclinical drug discovery and our proof-of-concept phase I trials; NIHR Centre for Molecular Pathology bridges the gap between laboratory science and clinical care by integrating genomics, molecular biology, and pathology to inform the development of precision medicine strategies for cancer patients.; and Joint Department of Physics to develop advanced radiotherapy techniques through an interdisciplinary approach. We utilise this core structure to deliver impact and have established multidisciplinary Centres in areas of strategic importance to leverage existing strengths, streamline translation and deliver innovative, team-based research across the partnership (see Appendix).

Curiosity-driven molecular and structural biology is central to our strategy, because of its importance for detailed mechanistic understanding of how cancer develops and for developing better and new treatments. Biological research discoveries are expanding rapidly, as technologies to interrogate cancer continue to improve. We will exploit new opportunities for our partnership to accelerate the transition of these discoveries and technologies into clinical practice. We will perform multidisciplinary research to reveal the mechanisms by which cancer develops. We know that some of the most impactful discoveries come from curiosity-driven research such as the recent immune checkpoint inhibitors, a type of immunotherapy, which stimulates the immune system and have significantly increased survival in some cancers. We are advancing preclinical research models to support the development of our proof-of-concept clinical trials. We will take promising new diagnostics and treatments into later stage clinical trials that are patient centric and maximise the use of data and novel methods for impact. To reach our goals, we will work together and ensure close interactions between fundamental, preclinical, population health and clinical researchers.

We will

- Ensure the voice of patients and the public (including children and young adults) from all backgrounds is heard in everything we do.
- Listen to and learn from the experiences of patients, clinicians, and the wider community, and use this information to develop improved diagnostics and treatments that maximise quality of life and survival of cancer patients in the UK and across the world.
- Exploit advances in technology, data science (including AI), tissue analysis and experimental approaches to expand our knowledge of cancer as a complex ecosystem taking into account the role of the tumour microenvironment, the immune system and the body as a whole. We will use this knowledge to design new ways of targeting cancer that address cancer as a complex and evolving ecosystem.
- Develop the next generation of preclinical cancer models and computational methods to advance understanding of cancer evolution, identify new drug targets and guide diagnosis and therapy.
- Leverage our tissue sample collection during clinical trials and clinical care which can be studied to provide invaluable insights into how cancers develop, evolve, and respond to treatment.
- Enable early diagnosis through research into risk-stratified screening approaches, improving cancer survival with a focus on targeting underserved communities.
- Develop the next generation of biomarkers and diagnostic tools, and integrate molecular diagnostics with digital pathology, radiomics and clinical data.
- Improve radiotherapy through increased understanding of the underpinning cancer biology, and the physical parameters governing radiation dose delivery. We will optimise radiotherapy and surgery treatments aiming to increase cure rates in patients with cancers that are not usually treated with curative intent.
- Utilise the next generation of cancer biomarkers and diagnostic tools to accelerate clinical translation of promising targeted drugs for specific patient groups across cancers, improving outcomes, reducing side-effects, and streamlining resources.
- Expand the reach of immunotherapies to more cancer types and identify biomarkers that inform who will benefit to the greatest extent from different treatments. Moreover, we will develop and trial novel cancer immunotherapies, administered directly into the tumour (injectables) or directly into the blood stream, including cellular therapies, cancer vaccines, oncolytic viruses.
- Design, deliver, and learn from optimised clinical trials of emerging therapeutics, radiotherapy, and other treatments. We will combine methodological innovations in trial design with the latest discoveries to create novel, efficient, adaptive, and accessible high-quality clinical trials.
- Develop tailored, patient-centric follow-up approaches to assess the impact of therapies and to enable faster recovery and improved quality of life.
- Investigate and improve the quality, delivery, and efficiency of cancer services to improve the experiences, side effects, both acute and late, and recovery time for patients.
- Partner with experts in human factors and health economics to translate our innovations from early phase to real-world implementation.
- Continue our research into new diagnostics, treatment and supportive care strategies across a wide range of specific cancer types, in the major cancers breast and prostate, as well as rare tumours in the adult and paediatric populations.

We will achieve our vision through four research themes:

1 **Fundamental Science**
2. **Innovative Diagnostics**
3. **Precision Therapies**
4. **Transforming Clinical Care**

These are underpinned by four enablers:

1. **Ensuring financial and environmental sustainability of the research ecosystem**
2. **Attract, retain and grow our people**
3. **Maximising benefits from our partnerships**
4. **Enhancing our infrastructure**

Core Themes

1. Fundamental Science

We will reveal how cancers develop, adapt, and evolve as part of a complex ecosystem of signals, cells, tissues, and environmental stresses.

Now

Mechanistic studies into cancer have informed the development of novel treatments. Our discovery that PARP inhibition selectively kills cancer cells with *BRCA* mutations underpinned a transformative way of treating BRCA-mutated ovarian, breast, prostate and pancreatic cancer. The development of precision medicine will continue to be driven by the deep insights into the biology of cancer.

DNA contains genes which act as instructions that tell a cell what to do. Mutations in DNA are the main cause of cancer. These DNA changes vary within a patient, between patients and between different cancer types and influence how a cancer develops. We have uncovered many of the control mechanisms cells have in place to protect their DNA, and the acquired capabilities that help to sustain cancer cells. More recently, it has become clear that normal human tissues can have significant amounts of cancer-associated mutations through ageing, yet these cells still behave normally. This remarkable discovery indicates a central role for the epigenome, the collection of chemical modifications to DNA and histone proteins that regulate gene expression in a cell, in maintaining healthy tissues, and for epigenome dysregulation in enabling cancer growth.

Our knowledge of cancer's complexity is increasing and helped by the use of advanced new technologies in structural biology, genetics, genomics, single cell approaches, molecular pathology, and computation. The use of these approaches has led to mechanistic insights into the function of cancer drivers (including in the epigenome), identified potential new therapeutic targets for the treatment of cancer, and revealed some of the evolutionary trajectories in cancer development, metastasis, and treatment response.

We have a greater appreciation of that cancer cells interact with their cellular environment and that is increasingly important to understand how their growth is fuelled and their response to therapy.

We also know that a small proportion of cancer cells behave like stem cells which means they can develop into several different types of cells. This behaviour can shape the way the tumour develops, how it responds to treatment and lead to resistance to therapy. We are gaining knowledge about why some cells, despite receiving doses of radiation which kill most tumour cells, are resistant to this therapy.

Next

To better understand cancer initiation, progression and spread, to inform our translational and clinical research, we need to examine and understand cancer at unprecedented resolution. We will closely link our fundamental cancer research with our clinical expertise and observations. Moreover, we will ensure the integration of clinical data and materials for our discovery approaches.

We will further knowledge about the molecular mechanisms of genome stability and epigenome maintenance and how these processes differ in cancer cells. We will unravel the complexities of the features of cancer cells including changes to DNA structure and regulation (chromatin and epigenetics) as well as DNA sequence changes (mutations) and their role in cancer and its development. We will also explore ‘phenotypic plasticity’ which allows cancer cells to adapt to environmental changes by changing their phenotype, or cell state. Moreover, since metastatic cancer remains the biggest clinical challenge, we will focus on identifying the ways in which cells leave the initial tumour, disseminate and form tumours at other sites, including how cancer cells can remain dormant leading to relapse many years after ‘curative’ treatment.

We are going to increasingly focus on how tumours interact with the immune system and their microenvironment and how these interactions are influenced by drugs and radiotherapy. We need to understand more about how the delicate balance between tumour and tissue environment is influenced by other aspects such as the microbiome, inflammation, and other conditions.

We will

- Investigate how normal cells preserve the integrity of their genomes, and how genetic instability and epigenome dysregulation underpins cancer development, metastasis and response to radiotherapy and other treatments.
- Understand how normal cells become cancerous, by studying the role of identified genetic and epigenetic changes in cancer.
- Decipher the fundamental mechanisms that drive cancer and how mutations affect the structure and function of key proteins in processes that are disrupted in cancer development such as cell proliferation, DNA repair, metabolism.
- Study how tumour-initiating cells (a.k.a. cancer stem cells) shape genetic evolution and ‘phenotypic plasticity’ and how cancers evolve over time, disseminate, and spread through the body.
- Examine the role that ‘stem-like’ cells play within the cancer ecosystem – including how these cells progress, influence surrounding cells and resist treatment.
- Learn how to predict and shape the path of cancer evolution – as a means of preventing or overcoming resistance to treatment.

- Explore how the immune system is affected by cancer cells through investigating crosstalk between innate and adaptive immune responses, interactions between immune cells and cancer cells, and the effect of targeted treatment, chemotherapy, and radiotherapy on the immune response.
- Unravel the complex interactions between cancer cells and their tumour microenvironment, and how cancers shape and exploit normal tissue repair activities to support their survival and growth including in the context of radiotherapy and drug treatment.
- Further understand how cancers evolve, metastasise, respond, and develop resistance to radiotherapy, drugs, and other treatments to expose vulnerabilities of cancer cells to novel therapies.
- Investigate how to block cancer's radiation-induced DNA damage repair mechanisms, to maximise the cytotoxic power of radiotherapy and augment its ability to trigger sensor mechanisms that boost anti-cancer immune responses.
- Improve our understanding of cancer risk factors including genetic and lifestyle factors and how these risk factors influence cancer development and detection.

How

- Continue to invest in cutting-edge genomic, proteomic, epigenetic, microscopy, spatial and digital pathology technologies and develop AI approaches to examine cancer cells and their ecosystems at unprecedented resolution.
- Build world-leading expertise and infrastructure in developing new preclinical mouse models to help us understand the role of proteins in cancer, assess how tumours interact with their environments, and identify new drug targets.
- Create enhanced models of disease using patient-derived organoids and ex-vivo co-culture as well as advanced mouse models in our Centre for in Vivo Modelling.
- Enhance the Centre for Genome Stability and Translation to further our understanding of how cells maintain their genomes and respond to DNA damage – and the implications for cancer and its treatment.
- Build a single-domain antibody screening facility to generate DNA-repair related biomarker detection and intracellular antibody protein perturbation tools.
- Expand the impact of the Breast Cancer Now Generations Study to further the understanding of breast cancer aetiology, risk prediction and outcomes.
- Grow and nurture our scientific expertise and leadership in computational biology to unravel and model cancer's complexity, ecosystems, and evolution.
- Exploit our data science and informatics capabilities and our multidisciplinary expertise in fundamental cancer biology, data science, omic approaches to find ways to map and disrupt the cancer ecosystem.
- Capitalise on our access to patient data and material, such as tumour biopsies, blood samples, and other biological specimens, alongside data science expertise to further our fundamental science into the development of the disease and how it adapts to treatment.

Profiles

"The convergence of different scientific disciplines and recent revolutionary advances in the field of electron microscopy means it is now possible to study cancer at unprecedented resolution. We want to capitalise on these advances through a new method, Cryo-Correlative Light and Electron Microscopy (CLEM). This method enables us to study the structure of proteins very close to the natural state that they are found within cancer cells.

This means that we will be able to gain insights into how proteins work inside cells in a level of detail not possible before. For example, my group will use CLEM to better understand the large protein complexes involved in the WNT signalling pathway, which is frequently disrupted in cancer. CLEM is an exciting technology where we can look at protein behaviour in cells at unprecedented resolution to further understand how cancers forms and hopefully find ideas for new cancer drugs."– **Professor Sebastian Guettler**

"We really need radically new approaches to tackle the problem of drug resistance, which is about cancer evolution, to be able to dramatically increase the effectiveness of treatment. The Centre for Evolution and Cancer is using the ideas of evolution to understand how cancers change over time and through space as well as in response to treatment. Then, using our knowledge of what causes those changes, we can improve outcomes for patients by anticipating and prevent those changes and increase treatment effectiveness. The Centre combines expertise in evolutionary theory, mathematical modelling and bioinformatics, together with cutting-edge experimental techniques in genomics, single cell sequencing and molecular pathology. It is an exciting time as we can generate significant data at the individual cell level from patient-derived materials across the course of cancer development and treatment and we are pioneering new ways of getting meaning from this data." – **Professor Trevor Graham**

2. Innovative Diagnostics

We will diagnose cancer earlier, faster, and more precisely, and predict and identify initial signs of recurrence or resistance earlier by better understanding of cancer risk, using advanced risk stratification tools, diagnostic methods and digital approaches; and integrating data and data science methods to identify new biomarkers.

Now

Cancer is not a single disease but rather a group of over 200 types. Cancers interact with their environment and the immune system in a wide variety of ways. This means that apparently similar cancers can respond very differently to treatment. Diagnosing cancer as precisely as possible is critical to allow treatments to be tailored for each patient. It is also important to detect cancer as early as possible in the course of the disease since cancer is much easier to treat when it is still within its primary site.

Cancer epidemiology and population-based health approaches have increased our understanding of factors underpinning cancer risk, and the impact of lifestyle changes on prognosis to improve the lives and outcomes for patients.

Advances in technology are having a transformative effect on cancer diagnosis, notably in genomics. Now, we can classify cancers based on their patterns of mutation and molecular biomarkers. New 'liquid biopsies' can detect cancer DNA and other metabolites/cancer cell components in the bloodstream and pick up early signs of recurrence or drug resistance. These 'liquid biopsies' offer a tool for a faster and safer diagnosis, improving equality of access compared to tissues biopsies.

Although medical images are still largely evaluated by expert radiologists, it's increasingly possible to assess the smaller subunits that make up medical images using radiomic and AI-assisted computational approaches. This imaging data can then be used to discover features that may be linked to disease behaviour or outcomes. Sophisticated data analysis

provides more information about the factors which determine cancer risk, so those at the highest risk can potentially be screened to detect their cancers earlier.

Next

We now have an opportunity to exploit advances in technologies and computational approaches to create a new way of diagnosing cancer, considering not just genetic and molecular data but also the cancer's interactions in its ecosystem. As we develop new diagnostics, we will collect real-world patient data that we can use to further personalise cancer care.

Our aim is to integrate multiple data modalities, including patient records, radiology, tissue and 'liquid' pathology, genomic testing and more broadly, 'multi-omics' analysis which are captured, but not yet integrated in the hospital systems. Their integration alongside AI and other computational methods will have a transformative potential of providing a comprehensive, highly personalised picture of an individual patient's cancer and provide novel insights into cancer biology. Analysis of this molecular, immune, imaging, and clinical data could lead to the identification of new biomarkers for cancer's recurrence, treatment response and drug resistance.

We will also develop and implement new and more sensitive techniques to detect biomarkers in the blood and other bodily fluids, to diagnose cancer earlier, detect early signs of recurrence, and pick up residual disease when a cure is still possible. The detection of these cells through 'liquid biopsies' will move closer to the integration into routine clinical practice to identify which patients are cured after initial treatment and optimise treatment for those that are not.

We will utilise our large-scale research resources such as prospective cohorts, case-control studies, clinical studies, and real-word data. These approaches will help us exploit our knowledge of cancer risk to develop new strategies for targeted screening and early diagnosis. We will implement our research by developing new ways for faster diagnosis of patients suspected of having cancer through redesigning cancer referral pathways.

We will

- Characterise different cancer subtypes by recognising patterns of genomic mutations and protein expression.
- Identify and validate genetic and non-genetic biomarkers giving information about a cancer's behaviour, prognosis, and likely response to treatment.
- Develop new approaches to imaging a tumour's behaviour, metabolism, microenvironment, and interactions with the immune system both at the whole body and microscopic level.
- Understand how early cancer mutations and epigenetic changes arise and when it is first possible to detect them in patients.
- Detect cancer's initial onset, disease recurrence and residual disease as early as possible through use of 'liquid biopsies' and advanced imaging.
- Create next generation, multiscale (radiology to digital pathology) imaging biomarkers for minimally invasive insights into tumour biology and response to therapies.

- Integrate AI, imaging (digital pathology and radiology) and multi-omics to develop models that can accurately predict how patients will respond to treatments and streamline clinical trials for greater efficiency.
- Develop new ways to biopsy patients using novel precision tissue sampling techniques or non-invasive methods based on computational imaging approaches.
- Improve stratification of augmented cancer risk by analysing how genetic, epigenetic, and modifiable lifestyle factors interact in the development of cancer.
- Identify high-risk groups who will benefit most from: 1) targeted asymptomatic cancer screening or monitoring; 2) early symptomatic diagnosis and 3) primary/secondary prevention.
- Translate the risk-stratification models into novel cancer screening programmes that can help to diagnose cancer or risk of cancer earlier.
- Create next-generation diagnostics, tools, and algorithms, including 'integrated diagnostics' to help guide treatment in the clinic.
- Work through networks to demonstrate evidence of cost-effectiveness and societal benefit for new diagnostics.

How

- Advance use of 'multi-omics' techniques to profile cancers – using AI to integrate data from genomics, proteomics, and metabolomics.
- Use state-of-the-art profiling of tissue biomarkers, analysed using AI, to understand better how cancers respond to treatment and develop drug resistance.
- Evaluate new imaging modalities, including digital pathology, molecular, MRI- and ultrasound-based approaches to drive their translation into the clinic.
- Establish radiomics and machine learning pipelines to contribute towards a comprehensive data science ecosystem and the integrated diagnostics endeavours.
- Pioneer diagnostic technologies that exploit connections between cancer researchers, engineers, physicists, and mathematicians in the CRUK Convergence Science Centre at The ICR and Imperial.
- Design trials using 'liquid biopsies' to detect any residual cancer after surgery or radiotherapy treatments to accurately guide therapy.
- Explore how combining 'liquid biopsies' and imaging/clinical data approaches can refine screening of healthy, asymptomatic populations and patients with non-specific cancer symptoms.
- Build local and regional datasets that can be analysed by machine learning to improve understanding of factors that allow early and faster diagnosis in patients and pinpoint the most predictive diagnostic tools and symptom profiles, streamlining the journey towards optimal cancer triage pathways.
- Advance understanding of cancer risk and modifiable risk factors to inform prevention and early diagnosis strategies through the Cancer Epidemiology and Prevention Research Unit at The ICR and Imperial, and the Breast Cancer Now Generations Study and through our international network of research collaborators.
- Develop new trial methodologies to assess the effectiveness of targeted early detection and prevention strategies for cancer.
- Embed an information technology and computational framework that would unify access to hospital digital information silos and enable integration of multiple analytical data using machine learning methods.
- Implement clinical Machine Learning Operations programme to enable automation and operationalisation of machine learning processes, increasing capacity for proof-of-concept projects to be tested within a clinical environment.

- Work with partners to collect and analyse health economic data and routine healthcare data to show the value of new diagnostics strategies for society and support their uptake into routine healthcare.

Profiles

"We want to transform personalised cancer treatment through our Integrated Diagnostics and Discovery (IDD) programme. This programme has the ambitious aim to systematically link the research and clinical data across our organisations to improve research, innovation and care. There are various barriers to overcome such as data quality, governance, capacity, interoperability and technical issues. Through our IDD programme, we are developing a framework to tackle these challenges in order to integrate and interrogate this data at scale using AI. This would link together the vast data generated for each cancer patient in order to generate new insights. We will use these new insights to develop a new generation of integrated biomarkers, based on multiple data types, that we can translate to clinical care for improved diagnostics. We hope these new information-based, complex biomarkers would allow our patients to live longer and better lives." **Professor Manuel Salto-Tellez**

"Our Early Diagnosis and Detection Centre focuses on risk stratified early diagnosis. The Centre combines our experience in cancer genetics, our patient networks and the development of cutting-edge liquid biopsy biomarkers and AI early detection tools across various tumour types. We developed the PRODICT™ saliva test to enable the earlier diagnosis of prostate cancer in those at high risk. NHS England created Rapid Diagnostic Centres (RDC) for patients with non-specific cancer symptoms. Through our RDC-Bio study we examine the potential to discover high risk groups in RDC populations and we will collate data from RDCs across London and interrogate them using artificial intelligence with the aim to inform risk based early diagnosis strategies." – **Professor Rosalind Eeles**

3. Precision Therapies

We will exploit our understanding of cancer's complexity, ecosystems, and evolution to create innovative, kinder and more precise ways to target and treat local and metastatic disease and test these therapies for the first time in patients.

Now

As we understand more about cancer, we can identify new weaknesses that can be targeted with innovative advanced technologies and new drugs. Attacking cancer in radical new ways is essential if we are to make step-change progress against the disease – and to allow us to bring treatments with different mechanisms of action together in innovative combinations for even greater impact.

Local therapies: Surgery and radiotherapy can cure patients with early-stage disease before it has spread, although response varies amongst patients and can result in long-term side effects. We understand that the most successful local treatments target cancer before it has progressed and metastasised, and we are world leaders at using advanced physics and imaging to create new ways to deliver high-precision radiotherapy. Advanced forms of radiotherapy shape beams to the precise dimensions of a tumour and deliver doses in streamlined regimens. There is increasing interest in using highly directed forms

of radiotherapy (stereotactic body radiotherapy) even in patients with cancers that have spread.

Systemic therapies: Drugs that work throughout the whole body are called systemic therapies and have substantially increased rates of cure in some cancer types but there is more to do. Chemotherapy, hormonal treatment, targeted therapy, and immunotherapy remain the backbone of treatment for advanced cancer that has spread due to metastasis. However, since many patients still are resistant to treatment and relapse is common, we need to identify new and better treatments. We have one of the world's most successful academic centres for the discovery and development of new cancer drugs with a strong track record in discovering clinical candidates that progress into clinical trials.

We now monitor cancer's evolution over time, so we can find ways of combining treatments to keep resistance at bay. We also develop and test new targeted drugs and immunotherapies that attack specific weaknesses within a patient's tumour in early phase trials, with early emphasis on biomarkers of drug sensitivity and resistance. Our researchers are increasingly evaluating new drug combinations to hit multiple targets at once in cancers to prevent or overcome resistance. We are even working to target the evolutionary process itself.

Next

To improve local therapies, we will incorporate precision imaging and targeted molecular profiling with novel radiotherapeutic and surgical techniques to extend the envelope of cure beyond localised into locally advanced disease. We have international leadership in trials of therapies delivered by local injections into tumours, which we will use to complement surgery and radiation in the control of localised disease and the generation of systemic, immune-mediated responses.

The understanding that cancers evolve within a complex ecosystem can be used to develop exciting new approaches to treating cancer by targeting its weaknesses and dependencies. We aim to discover novel systemic therapies based on our fundamental research and clinical insights that provides the understanding of the way cancers evolve within an ecosystem, the interactions between cancer cells, the reliance of a tumour on the tissue and growth signals that surround it, and the immune system. We aim to identify and exploit the addictions, dependencies, and vulnerabilities of cancer cells to develop innovative small molecule drugs including targeted protein degradation approaches that work by destroying cancer-driving proteins within cells. We will explore the concept of targeting lineage-specific dependencies especially for cancers which hijack the normal developmental process. This likely provides a specific therapeutic window for targets that are otherwise not expressed in mature cells.

We will continue to translate these new therapies into biology-based, hypothesis-driven, and biomarker enriched early phase clinical trials to assess proof-of-concept. Increasingly, our work to treat cancer more precisely is informed by the early discovery of biomarkers to confirm mechanism of action, drug sensitivity and resistance.

We will integrate patient data into our research, from target discovery to clinical trials and treatment monitoring to accelerate the discovery and development of safer, more effective, and personalised cancer therapies.

We will

- Create treatments to overcome drug resistance by targeting evolutionary mechanisms within the cancer ecosystem – such as cancer's ability to cope with genetic instability.
- Explore ways of targeting cancers indirectly by disrupting their ecosystems and the support they receive from surrounding tissue.
- Develop ways to exploit our understanding of cell death to drive the immune system to attack surviving cancer cells.
- Develop new approaches to targeted protein degradation (PROTACs, molecular glues and exploring E3 ligases) and apply these approaches to create new treatments.
- Carry out experimental, biomarker-driven early phase I trials of novel cancer drugs and combinations in both adults and children contemporaneously studying disease evolution and treatment resistance.
- Implement novel, efficient, adaptive trial designs in early phase trials and design simpler trials with broader inclusion criteria and novel data collection and verification for technology-based trials.
- Accelerate the development of targeted therapies by identifying and using biomarkers of treatment response and drug resistance.
- Exploit advances in physics, engineering, and computer science to create advanced imaging technologies for targeting cancer with precision radiotherapy and surgery, and novel radiation dosing strategies.
- Create new forms of precision radiotherapy and investigate how they might be combined with other treatments.
- Develop novel approaches to locally advanced cancers through radiotherapy, robotic surgery, novel injectables or combinations of these technologies.
- Test novel approaches to precision radiotherapy and surgical treatments for cancers that have only a limited degree of regional spread or metastasis, and which could therefore be curable.
- Utilise molecular and imaging biomarkers for patient selection in radiotherapy and surgical trials.

How

- Realise the potential of fundamental discoveries across The ICR through our Centre for Target Validation aiming to bridge the gap between initial discovery of a potential cancer target and the decision to launch a drug discovery programme on that target.
- Develop the new Centre for Protein Degradation and through our extensive structural biology and screening capabilities develop new protein degradation approaches and apply them across drug discovery research at The ICR and as part of the Cancer Grand Challenge PROTECT team.
- Pioneer innovative new technologies and therapies to target cancer involving biologists, chemists, physicists, engineers, and mathematicians at the CRUK Convergence Science Centre.
- Seamlessly integrate preclinical drug discovery and proof-of-principle phase I trials through our joint infrastructure led by the Drug Development Unit and associated teams as part of the UK wide ECMC network.
- Develop new generation trials utilising cancer evolution aiming to prevent drug resistance and improve metastatic cancer outcomes.
- Use co-clinical trials with patient-specific avatars and organoids.

- Lead through the UK-wide RadNet network to marshal expertise and harness increased understanding in radiation biology to increase cancer cure rates.
- Further reduce the number of radiotherapy fractions needed for patients' cure through novel, more precise technologies such as MR-Linac.
- Define optimal robotic surgery resection margins to precisely guide/avoid adjuvant treatment.
- Develop innovative trials in surgery, proton beam therapy and high-precision radiotherapy by working collaboratively in clinical networks such the international MR-Linac consortium.

Profiles

"We cover every aspect of drug discovery and development, from cell and molecular biology through to chemical synthesis of new agents and their evaluation in clinical trials through a series of interconnected centres. We aim to exploit our preclinical science through the Centre for Target Validation which provides support to generate the decision-making data needed to launch a drug discovery project within our Centre for Drug Discovery (CCDD) or beyond. Our CCDD utilises innovative drug discovery technologies to discover novel mechanism-based prototype drugs. These new drugs are then translated into early phase clinical trials in our Drug Development Unit. These trials are underpinned by a scientific hypothesis with efficient and biomarker driven designs. A new angle to tackle cancer is provided by the Centre for Protein Degradation. Protein Degradation exploits cell's own protein disposal system to eliminate cancer-causing proteins. This means we can discover and develop drugs against cancer causing proteins that were previously thought to be undruggable." **Dr Olivia Rossanese**

"Through our Radiation Research Centre of Excellence (RadNet), funded by Cancer Research UK, we aim to cure more patients with fewer side-effects. Our RadNet Centre is trying to understand why some cancer cells don't die in response to receiving radiation treatment and how cells that surround the tumour and the immune system can be encouraged to boost the response to radiotherapy. We are also testing new ways of delivering radiotherapy, including giving very high doses very quickly (FLASH radiotherapy). Furthermore, we will investigate a brand-new agent, a type of nanoparticle, which makes radiation much more powerful close to where the nanoparticles are injected. Through understanding the science, we will lead clinical trials showing how best to treat different patients with radiotherapy, unlocking improvements in survival and better quality of life." **Professor Kevin Harrington and Dr Alison Tree**

4. Transforming Clinical Care

We will deliver benefits for cancer patients through generating the evidence for clinical adoption of precise diagnostics, treatments, and tailored supportive strategies and implementing them into care within the NHS and internationally.

Now

We play a crucial role in driving advances in cancer diagnosis and treatment for patients through innovative clinical studies. We translate the most promising targeted therapies and immunotherapies, including cellular immunotherapies, developed in our early phase work. These studies use biomarker tests to select patients for treatment and assess cancer over

time to monitor for early signs of resistance. These are kinder treatments that are not only more effective than older forms of chemotherapy, but often also have fewer side effects.

There has been dramatic improvement in survival of some advanced cancers through immune checkpoint inhibitors. However, these immunotherapies 'only' work on a subset of cancers and cancer patients, and the reasons behind this are not well understood. And we know that there is increasing potential for trials that test combinations of precision therapies hitting different cancer targets, as a means of overcoming drug resistance.

Combining methodological innovations in trial design with latest discoveries in cancer science enable the creation of novel, efficient, adaptive, and accessible high-quality clinical trials which support clinical and reverse translation.

Patients are living longer with a better quality of life, and many more are being cured. Having cancer can have an impact on every aspect of a patient's life and on those around them. Using qualitative approaches, we understand a person's experiences, perceptions and behaviour so we can continuously improve how we support people on, through and after treatment.

Next

We will implement screening technologies that ensure risk-stratified early diagnosis and work with traditionally underserved communities that are particularly vulnerable to later diagnosis and poorer outcomes.

We will accelerate the clinical development of a new generation of targeted drugs for specific patient groups across cancers – driven by patients' selection using biomarkers of treatment response and drug resistance. We will seek to transfer beneficial systemic therapies that are the backbone of treatment for advanced cancer to early-stage disease.

We will expand the reach of immunotherapies in multiple tumour types through clinical application of novel treatments, including cell-based therapies, oncolytic virotherapies and cancer vaccines, and identification of biomarkers for better selection of patients.

New trial methodologies will allow us to direct patients to the most suitable therapies, introduce treatment arms as new options become available, or adjust treatment over time to keep one step ahead of cancer. We will offer patients access to combinations of targeted drugs, radiotherapy, and immunotherapy. We will learn more from all our patients in clinical trials, collecting rich samples for translational science and implementing a '*bedside to bench approach'* in all our trials.

We will apply our clinical trial methodology expertise across disease areas and intervention type and use advancements in discovery science (biomarker-defined sub-populations, liquid biopsies, radiobiology) as our guide. There are increasingly more remote consultations and home health delivery to reduce the burden of hospital visits on patients and the NHS. This will change the way clinical trials are conducted in the future, with more remote or decentralised trials utilising electronic solutions to centrally manage trial delivery, remote patient enrolment and remote patient follow-up via e-health technologies and in non-clinical settings (i.e. blood pressure at home or use of community pharmacies).

As more than half of patients survive cancer for a decade or longer, we will identify, predict, and manage treatment toxicities; and develop risk-prediction tools for late effects to reduce acute events and improve overall quality of life. We will generate the evidence to support person-centred cancer care and improvements in quality of life outcomes.

We will develop models for the delivery of early palliative care, advance care planning, the use of outcome measures in service development and the use of routinely collected data in palliative care research.

We will work through national and international networks to ensure we can make trials available not only for patients with the most common cancers, but also for those with hard-to-treat or rarer kinds. Importantly, we will embed new technologies, treatments, and approaches into routine healthcare, by building an evidence base to support their adoption, leading through national and international networks, and influencing healthcare policymakers.

We will

- Generate evidence that supports the clinical use of technologies and approaches that diagnose and detect cancer early including consideration of how accessible and affordable approaches are so they can be scaled.
- Lead innovative late-stage clinical trials of systemic therapies that maximise analysis of data from multiple sources to generate practice-changing evidence with broader geographic reach and site placement targeted to areas of greatest disease burden.
- Work with partners to test innovative new cancer immunotherapies – including cellular therapies, oncolytic viruses, cancer vaccines, and combinations with targeted drugs and radiotherapy.
- Identify approaches to use existing immunotherapies more effectively and extend their use to new cancer types and identify biomarkers of response and resistance.
- Understand the biological mechanisms of toxicities of cancer treatments across tumour types, particularly novel agents and develop novel interventions mitigating against cancer treatment toxicities throughout the patient journey.
- Evaluate the immediate and long-term impact of cancer interventions using data relating to patient health status routinely collected from a variety of sources.
- Develop further trials using imaging and other biomarkers to identify those for whom treatment toxicity may be reduced whilst maintaining efficacy, such as in low-risk disease or oligo-metastatic settings.
- Develop personalised risk models for acute and long-term side effects of cancer treatments.
- Harness the power of ‘big data’ to ask personalised questions about the risks of acute and late side effects of cancer treatments.
- Deliver and learn from a unified and integrated view of the entire patient pathway through application of novel data science methodologies.
- Pursue opportunities for decentralised trial conduct, through more streamlined, efficient, innovative and patient-centric approaches enabled by data and digital tools.
- Innovate through novel trial methodologies including adaptive and platform designs and increasing prominence of patient reported outcomes and experiences.
- Develop interventions focusing on person-centred care, self-management approaches and improved ways to manage side-effects and the psychosocial consequences of a cancer diagnosis and treatment.
- Assess techniques that improve accuracy and precision of radiotherapy delivery as well as patient experience.
- Identify and improve patient inequalities in the radiotherapy delivery and improve patient experience during radiotherapy treatment through preparation and positioning innovations.

- Identify models for delivering cancer care that supports equity, safe practice, quality care and effective use of resources.
- Develop models of supportive and palliative care to ensure patients and their families can live as well as possible throughout their cancer journey.
- Evaluate digital systems for enhancing and coordinating communication across hospital, community, and primary health care settings.
- Embed health economics analysis in our studies to evaluate cost effectiveness of new diagnostics, treatments and other interventions to inform clinical adoption.

How

- Implement new risk stratification systems leading to faster diagnosis in clinical practice, reducing patient anxiety and leading to more efficient use of healthcare resources.
- Deliver trials using ‘liquid biopsies’ to detect early signs of recurrence or drug resistance to initiate treatment earlier, as a means of expanding their use in routine practice.
- Develop hypothetical and interventional clinical trials that test the ability of AI and novel imaging and/or digital pathology, and/or molecular biomarkers to change patient care and to drive findings into translating innovative models of clinical care.
- Establish a comprehensive integrated Centre for Immunotherapy of Cancer covering the full research spectrum from scientific discovery to the clinical evaluation of novel immunotherapies for the treatment of multiple tumour types.
- Capitalise on ‘big data’ from our large-scale trials, prospective studies, and the emerging NHS population-based treatment data linkages.
- Leverage the strengths and expertise of the ICR/Imperial Cancer Epidemiology and Prevention Research Unit to drive forward population-based research into cancer treatment long-term effects.
- Develop studies aiming to optimise patients’ condition prior to cancer treatments; minimise acute toxicities; and late treatment side effects.
- Modernise our clinical trial infrastructure so we can analyse a more diverse range of data and integrate trial data with other sources of information including clinical records and patient experience.
- Work in partnership with those affected by cancer to ensure our trials are equitable, address key questions for patients and maximise use of their data, including through use of patient-reported outcome measures.
- Extend our knowledge of routine data to maximise its use in trial design, impact assessment, health informatics and real-world data science.
- Embrace data-enabled trials, recognise emergence of integrated data in routine care delivery, and assimilate existing biological data sources with routinely collected data to streamline data collection and realise efficiencies in trial design.
- Evaluate how effective treatments are in real-world clinical practice through pragmatic clinical trials.
- Establish the Centre for Applied Cancer Research, bringing together multidisciplinary teams with public contributors committed to transforming the experiences, support, and care of patients and their families.
- Use digital tools and data in a meaningful way to improve the lives of patients living with and beyond cancer.
- Use routinely collected data from across the health service to examine effectiveness and costs of supportive care service delivery.

- Collaborate with cancer centres across the country to identify, develop, and test the most effective models of supportive and palliative care for patients with cancer.

Profiles

"The Centre for Cancer Immunotherapy integrates our immunotherapy research from scientific discovery, through translational research iteratively linking laboratory to the clinic to the clinical evaluation of established and novel immunotherapies for the treatment of multiple tumour types. Through the Centre we aim to increase the overall infrastructure to facilitate increased participation in clinical studies incorporating more translational, imaging and quality of life readouts. Through a NIHR Capital Award we are further extending our capacity for clinical trials of innovative cancer vaccines and cell-based therapies for patients who may have no other effective treatment options. This will enable us to carry out more translational research which will inform the design of the next generation of advanced therapies by deciphering mechanisms of response and resistance." **Professor James Larkin**

"Advance care planning is a dynamic component of high-quality end of life care which is endorsed in national policy and can lead to fewer interventions of limited clinical value, reduce emergency hospital admissions, fewer hospital deaths and increased rates of care and death at home. Electronic Palliative Care Coordination Systems (EPaCCS) are increasingly used to digitally share person-centred health data and advance care planning records to enable care coordination and to empower people at the end of life to record their goals and preferences. We are evaluating, for the first time in the UK, the benefits of EPaCCS for patients and examine their impact on healthcare outcomes, use and costs**.** This health informatics study will test and evaluate how real-world evidence can be used for research into improving patient outcomes." **Dr Joanne Droney and Professor Ceire Costelloe**

Enablers

1. Ensuring financial and environmental sustainability of research ecosystem

Financial

The broader financial climate is challenging for both organisations however we continue to have a strong financial foundation, and our new strategy and approach bring opportunities to further build on this. In the last two years, we successfully renewed our NIHR Biomedical Research Centre (£29 million /5 years), the NIHR Clinical Research Facility (CRF; £3.1 million /5 years) funding, Experimental Cancer Medicine Centre (£3 million /5 years) and the CRUK core funding (£6.5 million /5 years) for the ICR's Clinical Trials and Statistics Unit (ICR-CTSU), all supporting our experimental medicine infrastructure. The Royal Marsden Cancer Charity continue to provide important investment (£4 million a year) for this infrastructure. The ICR and Imperial Convergence Science Centre funding (£12.5 million /5 years) was also renewed by CRUK to support cross-disciplinary, cross-institutional research and a high-quality training programme. Our CRUK Radiation Network (RadNet) has been recently renewed for a further five years (£5.1 million).

The ICR has invested in research through a development fund (~ £42 million / 5 years) to support our Research Strategy, including £20million for Faculty Recruitment and £22milllion to support research priorities. From this, funding was allocated to 8 strategic research areas: Cancer at an unprecedent resolution, Centre for Genome Stability, Centre

for in vivo Modelling, Centre for Target Validation, Data Science, Integrated Pathology, Equipment Fund, Clinical Trials system.

We continue to secure substantial grant funding to support our strategic priorities. For example, our Breast Cancer Now Centre is a long-standing partnership with Breast Cancer Now (£50 million /5 years). Our Brain Tumour Research Centre of Excellence (£2.5 million /5 year) is working to find, test and validate new treatment options for paediatric-type diffuse high-grade gliomas). We have launched a new platform to understand immunotherapy response and its side effects in cancer, funded by £9 million from the Medical Research Council and the Office for Life Sciences, and £12.9 million in matched funds from industry partners. Through NIHR capital awards (£5 million), we are building capacity and capability in our immunotherapies programme and infrastructure to support development of faster multimodal, complex biomarkers to tackle new frontiers of integrated diagnostics.

Deepening our commercial partnerships to leverage funding and deliver patient benefit is a top priority for us. We have an extensive portfolio of collaborative interactions with >100 companies within the pharmaceutical, bio- and medical-technology sectors (40% SMEs, 60% large companies). Commercial partners provide resources and complementary expertise. 50% of our clinical trial portfolio has an industry partner.

Going forward, we aim to mitigate the financial risks by both increasing efficiency where we can and diversifying funding to increase our overall income as well as fundraising through our charities.

Environmental

We recognise that there is a climate emergency and an urgent need to tackle climate change, reduce carbon emissions and address human impact on the environment. We are committed to achieve net zero by 2040 and have plans to deliver on this. We aim to develop lower impact ways of undertaking our science, develop more efficient buildings and facilities, and reduce our impact on the planet. The ICR has higher carbon emissions per unit of floor area than any other UK Higher Education Institution due to the high energy consumption from laboratories and specialised equipment. Sustainable Discoveries is the ICR's action plan for responding to the climate crisis and other sustainability challenges. The Royal Marsden Green Plan aims to support the delivery of the best, most efficient and forward thinking healthcare. It considers how to minimise negative environmental impacts and maximise opportunities to support the local economy and community wellbeing.

2. Attract, retain and grow our people

Our strategy is ambitious, and only possible if we have the right people in the right roles to drive innovative and bold research. Our aim is to be the organisation of choice for all those training and working in cancer research. The cost-of-living crisis demands on our employees, the NHS, visa restrictions, skills shortage changing and insecure career pathways are all risks we must mitigate. Research is a challenging endeavour, and we want to recruit from across the world to ensure we have the best people to deliver our strategy.

We will take steps to ensure we attract, retain and grown the best individuals who will contribute to our mission of defeating cancer. Our reputation for world-class cancer research and state-of-the-art facilities serves as a significant draw for researchers but we have to continually enhance our efforts to continue attracting high quality researchers and support staff. Personal and career development is a priority for us, with a focus on

nurturing the growth and motivation of its employees and students. By investing in the development of our workforce, we aim to support individuals but drive innovation and progress in cancer research.

Ensuring an equal, diverse and inclusive culture is a priority. We have three equality networks, The Race Equality and Cultural Heritage (REACH) Forum, The LGBT+ Network and the Network for staff and students with disabilities and health conditions to advise on our initiatives and ensure we provide the support needed to address inequalities seen in cancer research.

We will have a partnership-wide approach to scientific recruitments and promotions at senior levels. Together, we will consider and recommend strategic priorities for these recruitments and appointments, advise on consultant appointments and job planning for research active clinicians and receive, consider and provide recommendations on appointments, career progression, and promotions.

3. Maximising benefits from our partnerships

We will maximise our partnerships with patients and the public through flexible approaches, and new digital opportunities to thoroughly embed the patient perspective in our research. We will improve inclusion of underserved groups through developing, testing and implementing a range of involvement and engagement activities and novel participation initiatives, alongside our well-established work. We will place cancer patients and their families at the heart of our research, by involving them at every stage of the research cycle. By identifying the issues most important to those affected by cancer and its treatments we aim to create research studies that are relevant and inclusive for all.

We will continue to play an increasing important role regionally, nationally and internationally as a world-leading specialised comprehensive cancer centre. To deliver our research strategy, we will lead and collaborate in various networks and initiatives to accelerate cancer research across the UK and internationally. We have an international approach to our research, between 2019 and 2023, 69% of all publications with an ICR or Royal Marsden author had at least one international co-author. We see collaboration with life science industry as essential to drive our innovations for patient benefit and we work with companies from across the world. Through our Centre for Global Oncology we connect researchers in low and middle income with their counterparts in high-income countries to enhance research activities globally. Our aim is to share resources and learning with researchers in low-middle income countries to explore ways to adopt innovative cancer research approaches.

Diffusion and widespread adoption of our innovations are essential. A key vehicle for real-world implementation is RM Partners West London Cancer Alliance (ten NHS Trusts, >4 million population, hosted by the Royal Marsden). Through our BRC, we partner with City St George's, University of London who bring health economics expertise to our trials to expedite evidence generation for implementation. Moreover, through our BRC we established an institutional partnership with the Clatterbridge Cancer Centre in northwest England to tackle unmet needs in contrasting populations that are ethnically diverse (London) as well as socio-economically deprived with comorbidities (Liverpool).

We are collaborating with the London Borough of Sutton to develop the London Cancer Hub, a major initiative to create the world's leading life-science campus focused on cancer research, treatment, education and enterprise in Sutton, south London. Once complete, it is projected to contribute around £1.2 billion per year to the UK economy. We welcome the

appointment of the insurer Aviva and developer Socius as partners to advance the development of the London Cancer Hub site.

Regionally, we broaden our reach to an ethnically and socio-economically diverse patient population of over 2.3 million and link with primary care through our membership of Imperial College Academic Health Sciences Centre. This collaboration extends further to northwest London through our partnership with Imperial Academic Health Science Network. The ICR/Imperial Cancer Epidemiology and Prevention Unit will advance research to understand the cancer continuum, from its causes to clinical outcomes and translate this knowledge into effective strategies for cancer prevention, early detection and survival. We will exploit the intersection of engineering, physics, life sciences and medicine through ICR/Imperial Convergence Science Centre. To translate our innovative diagnostics from early phase to real-world implementation, we are partnering with NIHR Imperial HealthTech Centre.

4. Enhancing our infrastructure

Research infrastructure and facilities

To deliver innovation and impactful research, we need state-of-the-art facilities and infrastructure that meets the needs of our researchers. We will ensure a common, partnership-wide approach is taken for the planning, development and management of research infrastructure. Moreover, the sharing of research infrastructure will be encouraged and supported and prioritisation for infrastructure investment will be aligned with this Research Strategy.

We aim to continually modernise our research infrastructure. ICR's £75 million Centre for Cancer Drug Discovery (CCDD, opened 2020) and is the largest academic cancer drug discovery and development group worldwide. CCDD is co-located with the joint Royal Marsden/ICR Drug Development Unit and the NIHR Clinical Research Facility, providing dedicated facilities for adult and paediatric first-in-human trials and subsequent later phase trials.

The Royal Marsden's £100 million Oak Cancer Centre (opened 2023), funded by The Royal Marsden Cancer Charity, will further enhance translation. This state-of-the-art research and treatment facility in the Sutton site brings more than 400 researchers and clinicians under the same roof helping us to accelerate the development of new cancer treatments and diagnose more cancers at an earlier stage in line with the early diagnosis agenda. The Royal Marsden is scoping a significant development at the Chelsea site to both expand and develop its facilities, including clinical research.

We will ensure our scientists have access to state-of-the-art research technologies in genomics, proteomics, flow cytometry, light and electron microscopy, and histology. Our facility staff work collaboratively with researchers to plan experimental approaches and sample preparation, develop a training programme and support data analysis.

We have significant clinical infrastructure including three complementary clinical trials units (CTUs): DDU, ICR-CTSU and Royal Marsden-CTU; imaging technologies (MRI scanners, PET/CTs, ultrasound and photoacoustics), advanced radiotherapy machines (state-of-the-art linear accelerators, MR Linac and CyberKnife systems), and three Da Vinci Xi surgical robots. We have recently digitalised our diagnostic histopathology. We acquired the Symani Surgical System, a robotic microsurgery platform to advance reconstructive solutions in oncology patients for faster recovery, less pain and a better patient experience.

Integrated diagnostics

We officially opened a new Integrated Pathology Unit which provides state-of-the-art facilities and equipment to drive their research programmes, which involve digital pathology and the use of AI to guide diagnosis. The AI Imaging Hub generates new knowledge, improves efficiency and increases diagnostic performance. These investments complement our NIHR Centre for Molecular Pathology (£18.2 million), which provides infrastructure to develop molecular diagnostics and biomarkers for personalised treatments, augmented by the Ralph Lauren Centre for Breast Cancer Research. Our CPA-accredited Clinical Genomics Research and Diagnostics laboratory is the primary provider of cancer genomic testing for the NHS North Thames Genomics Laboratory Hub.

We continued to invest in multi-omics, digital pathology, imaging and radiomics to support or research and create a platform for integrated diagnostics and personalised treatment. Throughout the patient journey significant data is generated through diagnostic scans and biopsies, genetic testing, treatment types and patient outcomes. This data can be valuable and potentially exploited for research into better diagnosis and treatments. We are pursuing an Integrated Diagnostics and Discovery programme (IDD) which is based on the concept that through curated, annotated, and integrated genomic, histologic, radiologic, and clinical data with evolved information technology, applied to a defined patient cohort, and resulting in a synergistic effect in the clinical value of the individual diagnostic tools. We expect the multimodal data linked through IDD will accelerate our discovery science and translational research leading to clinical impact at scale and speed.

Digital infrastructure

We will accelerate our world-class research, by supporting innovation, better data management, and improved digital platforms.

Recent major investments in health informatics capabilities, a cloud-based data warehouse and a new patient digital health record (Connect) underpin our strategy. Connect, powered by Epic, fully integrates patients' clinical trial data with their healthcare records, enabling tracking of research activity across The Royal Marsden, and e-consent (including remote e-consent) for patients on clinical trials.

Our informatics platform, BRIDgE, allows exploration and integration of multimodal data within a Trusted Research Environment. BRIDgE enables the secure analysis and collection of data for clinical trials with its cloud-based collaborative workspaces. It is linked to the data warehouse, enabling the secure transfer of real-world data from clinical systems and the XNAT data-curation platform for images, facilitating access to multimodal data. We are digitising our histopathology services to facilitate access to image and metadata for enhanced diagnostics. To accelerate our trials through digitisation, we developed a digital trial records solution. Furthermore, we increased patient involvement in research by the launch of the Cancer Patients’ Voice digital platform.

Appendix

How research is structured at The ICR and The Royal Marsden

ICR and The Royal Marsden are co-located across two sites within Greater London; one centrally located in Chelsea and the other in Sutton. The Royal Marsden has 4,500 members of staff and an annual research and development income of £52.6 million (23/24); The ICR has over 1,100 staff and an annual expenditure of £152.5 million (23/24) with 96% spent on direct research and research support costs.

There are currently 90 faculty members (group leaders) at ICR of which 24 are clinically trained. The ICR has an Honorary Faculty appointments process to recognise the academically active Royal Marsden-employed NHS consultants. Currently, 69 consultants have been recognised with an Honorary Faculty position and 28 as Associate Honorary Faculty.

The ICR is organised into the following eight scientific divisions, under the leadership of the Chief Executive, Professor Kristian Helin. Within these divisions are groups led by a group leader. Divisions act as management structures within ICR.

The Royal Marsden is organised by clinical units with specific research focus. Each unit has a dedicated research team responsible for delivery of the research in that area. In addition to its large portfolio of commercially and externally sponsored research, The Royal Marsden Clinical Trials Unit provides the infrastructure within the hospital for clinical research, through a combination of tumour specific and tumour agnostic trial management teams, with a particular emphasis on translational research.

The NIHR Royal Marsden/ICR BRC provides important infrastructure funding for taking ICR research findings and translate them to benefit patients. The priorities of the BRC have been updated in 2022 to map onto the entire patient journey. The BRC drives translation to tackle unmet needs in common and rare cancers across the cancer continuum, structured in eight themes: Early Diagnosis, Detection and Stratified Prevention, Precision Diagnostics and Cancer Evolution, Advanced Technologies for Cure, Early Phase Drug Development, Precision Therapeutics, Immunotherapeutics, Cancer Treatment Effects and Imaging and Data Science.

We have also established several ‘virtual’ cross-divisional Centres to promote collaborative research across disciplines on strategically important areas of cancer research. We are also considering setting up new collaborative centres in gastrointestinal cancers and metastasis.

- **Breast Cancer Now Research Centre (based in the Division of Breast Cancer Research)** represents a partnership with the Breast Cancer Now charity of more than 20 years and brings together scientists and clinicians to focus on breast cancer biology, diagnosis, and treatment.
- **Centre for Applied Cancer Research** has recently been established as part of our strategy to bring together our internationally recognised cancer experts, researchers and public contributors committed to transforming the experiences, support, and care of patients and their families.
- **Centre for Cancer Drug Discovery (CCDD, based in the Cancer Therapeutics Division)** is the largest academic drug discovery and development group worldwide. Its research teams cover every aspect of new drug discovery and development, from cell

and molecular biology through to chemical synthesis of new agents and their evaluation in clinical trials. To accelerate and support the work of CCDD we set up the Centre for Protein Degradation and the Centre for Target Validation (see later).

- **Centre for Cancer Imaging (based in the Division of Radiotherapy and Imaging)** opened in a 20M state-of-the-art building in 2016 and uses cutting-edge imaging techniques to understand cancer's development and response to treatment.
- **Centre for Childhood Cancer** has recently been formed to unite our researchers working on these cancers of unmet need to address their unique challenges through well-annotated data and AI-driven discovery, novel therapeutic approaches, and forward / reverse clinical translation.
- **Centre for Early Diagnosis and Detection** enables the earlier detection and diagnosis of cancer through risk stratification and increasing the clinical translation of early detection technologies in high-risk patient cohorts.
- **Centre for Evolution and Cancer** unites a multidisciplinary team of investigators to interrogate cancer afresh using evolutionary principles derived from ecology, enabled by state-of-the-art cellular, genomic and bioinformatic technologies. The Centre was established in 2014 with support from a Strategic Award from the Wellcome Trust.
- **Centre for Genome Stability Research and Translation,** a cross divisional initiative initiated in 2023, aiming to harness the breadth of expertise in genomic stability at The ICR and The Royal Marsden to develop new and better therapies against cancer.
- **Centre for Global Oncology** was established in 2021 to synchronise and coordinate multiple research projects, training, infrastructure building and fundraising activities taking place in Low- and Middle-Income Countries research.
- **Centre for Immunotherapy in Cancer** is a new Centre that builds on our previous Centre for Translational Immunotherapy which has been extended to cover all our fundamental, translational, and clinical research into cancer immunotherapy.
- **Centre for *In Vivo* Modelling** is a new Centre that will grow expertise in the development of in vivo modelling techniques, including advanced embryo manipulation, use of CRISPR gene-modelling and gene transfer technology, in vivo genetic forward screening and other advanced approaches.
- **Centre for Protein Degradation (based in the CCDD)** accelerates research into drug discovery using targeted protein degradation.
- **Centre for Target Validation** was created in recognition of the need to further bridge the gap between the initial discovery of a potential cancer target and the decision to launch a drug discovery programme of that target.
- **CRUK Children's Brain Tumour Centre of Excellence (CRUK-CBTCE)** is a joint initiative between the University of Cambridge and ICR and its mission is to forge an innovative four-stage pipeline that generates curative treatments for children with brain tumours. CRUK first funded this Centre in 2018 and it was renewed for another five years in 2024.
- **CRUK Convergence Science Centre** aims to develop new multidisciplinary approaches to solve clinically relevant, currently intractable cancer problems. In 2022, the Centre won renewed funding from CRUK, £12.5 million over five years.
- **CRUK Radiation Research Centre of Excellence** is delivering a programme of interlinked preclinical and clinical research themes with the direct aim of delivering translational clinical studies. The Centre is part of a CRUK radiotherapy networked, called RadNet which was launched in 2019.
- **Joint Sarcoma Centre** was established in 2019 to bring together the breadth of clinical, translational, and preclinical sarcoma research at The ICR and The Royal Marsden to promotes forward and reverse translation, with the ultimate goal of improving cure rates and reducing treatment associated toxicities in these rare cancers.

- **The Artificial Intelligence (AI) Imaging Hub** investigates the use of AI in cancer imaging and how it can help clinical teams gather better insight into the biological behaviours of the disease so that tailored treatments can be created and adapted to each patient's needs.
- **The International Centre for Recurrent Head and Neck Cancer** aims to create a centre of international excellence and set international standards in the curative treatment of recurrent head and neck cancers. Launched in 2022, this is the world's first centre for recurrent head and neck cancer.
- **The Brain Tumour Research Centre of Excellence** is working to find, test and validate new treatment options for paediatric-type diffuse high-grade gliomas (PDHGG). The Centre is linked to the International COllaborative Network for NEuro-oncology Clinical Trials (CONNECT) Consortium, which runs clinical trials for childhood brain tumour patients in the UK, North America, Europe and Australia.
- **Trials and Population Data Science Centre** aims to harness the power of data to reduce the burden of cancer by developing and applying rigorous research methodology. It will bring together researchers from across The ICR and The Royal Marsden to apply cutting-edge trials and population data science methods to strategically important areas of cancer research including cancer treatment effects, risk prediction and early detection.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 4.3
Title of Document: Digital, Data and Technology Strategy 2025/6 – 2028/9	**To be presented by:** Chief Information Officer

1. Status

2. Purpose:

Relates to:	
Strategic Objective(s)	*Trust clinical, research, genomics & people strategies*
Operational Performance	
Legal / regulatory / audit	
Accreditation / inspection	
NHS policy / consultation	*Lord Darzi's independent investigation of the NHS, operational planning guidance*
Governance	
Other	

3. Summary

The Digital, Data and Technology strategy sets out the priorities, principles and deliverables that will shape our digital evolution to support the Trust's clinical, research, genomics and people strategies.

Following extensive consultation with over 200 individuals (staff, patient groups and external stakeholders) this strategy sets out a vision for how growing digital maturity will drive benefits in safety, clinical outcomes, efficiency, and the experience of both patients and staff. It is built around the following themes:

(i) Digital Foundations
(ii) Digitally Empowering People
(iii) Data, Research and Insights
(iv) Innovation and Collaboration.

Affordability & sustainability, strong governance, culture and capacity are identified as key enablers for successful delivery of this vision and a capability roadmap provides a target timeline that is both ambitious but achievable.

4. Recommendations / Actions

The Board is asked to review comment and approve this strategy.

Digital, Data and Technology Strategy

2025/26 – 2028/29

Digital Services

Delivering digital excellence

The ROYAL MARSDEN
NHS Foundation Trust

Foreword

Following on from the publication of our 5 year clinical strategy in April 2024, I am pleased to introduce the Trust's Digital strategy for 2025/26 to 2028/29. This sets out the priorities, principles and deliverables that will shape our digital evolution to support the Trust's clinical, research, genomics and people strategies.

The Trust's previous digital strategy delivered significant steps forwards, increasing the digital provision across the Trusts growing estate and implementing two Trust-wide systems - the new Digital Health Record (Epic) and the new Data Warehouse with associated Trusted Research Environment (BRIDgE). The successful delivery of that strategy leaves us equipped with a good platform for digital growth and a set of capable and effective tools. Progress over the next four years will have a different shape with no implementations of the same scale, but with a strong emphasis on driving transformative change, maximising the benefits that can be achieved from digital tools & high quality data, and developing strong governance to ensure our ecosystem is secure and that systems work together as part of a single holistic design that meets the evolving needs of the organisation, our patients and staff. Identifying and removing digital friction from everyday life and so giving people back more time is one of our core deliverables.

Lord Darzi's Independent Investigation of the NHS in England from 2024 signalled a need for the NHS to move from "analogue to digital", underscoring the pressing need for a "major tilt towards technology to unlock productivity". This document identifies a number of ways we can transform practice to achieve productivity gains. But digital transformation is not merely replacing pen and paper with keyboard and screen, it involves re-thinking how we work empowered by technology. Upskilling and educating both staff and patients in the art of the possible, developing the confidence to work with computers hand-in-glove – these are key enablers for this strategy.

This is not a technical strategy as such, it is about ensuring people are supported by technology.

We all are responsible for thousands of data points collected in the Trust everyday. Sifting out valuable, accurate data and ensuring they are integrated and accessible will provide valuable insight, safeguards, and support decision making & planning.

We have never had more reliance on our data & digital tools. Ensuring extremely high system availability and resilience is essential. The threat of malicious cyber attacks is greater than ever and cyber-criminality evolves at an incredible pace. Security by design is a key facet of this strategy, ensuring our systems support and deploy the latest defences and monitoring tools. Training and awareness are also key to strong security - as humans we ultimately hold the keys to our valuable resources.

2025 finds us at a time of rapid technological development. AI, machine learning, large language models all offer significant potential to positively change the way we work, diagnose conditions and deliver healthcare. With much more work still to be done to ensure these tools can be safely implemented and delivered in a cost-effective way, it is important to have a strategy that can flex as our knowledge of these relatively untested solutions matures. This strategy will deliver a number of frameworks and governance structures to lead us safely through this new terrain.

Finally, we are not on this journey alone. We can get further faster by collaborating with our existing key partners, such as the ICR, RM Partners, Great Ormond Street Hospital and South West London ICS – but also by forging new relationships in both healthcare and industry sectors. Our digital maturity is currently level 4 on the HIMMS infrastructure model scale (1 to 7). As we follow this roadmap and increase our digital capability and resilience. I believe we will see tangible benefits across the whole hospital in terms of productivity, safety and clinical outcomes. We will hit HIMMS level 7 maturity by the end of year 2, which will confirm we are on track for a future where digital and data capabilities are seamlessly integrated into our every day lives, and we are masters of that technology.

Steven Francis
Chief Information Officer

Vision

We will harness technological capabilities to create a digital ecosystem that will empower staff & patients, enabling transformation that improves cancer outcomes, safety, efficiency and experience whilst optimising the availability and quality of data to drive insight & innovation for continued future advancement

National and Regional Alignment

What Good Looks Like

The What Good Looks Like (WGLL) programme builds on established good practice to provide clear guidance for health and care leaders to digitise, connect and transform services. The objective is to improve the outcomes, experience and safety of citizens by:

- Building strong foundations (secure & reliable)
- Promote safety by ensuring security resilience
- Enhance digital literacy of staff & citizens and ensure citizens are central to design.
- Use data and digital to re-think patient pathways.

SWL ICS Digital Strategy

The SWL ICS Digital Strategy aims to transform healthcare delivery by leveraging technology to improve service integration, efficiency, and accessibility. The goal is to enhance healthcare outcomes for citizens at all life stages by:

- Ensuring a standardised, robust and secure infrastructure.
- Create a shared care record an improve access to records for patients and clinicians.
- Develop a population health platform using integrated and unified data across SWL.
- Adopt new technologies and capabilities through digital innovation

Royal Marsden Digital Services are collaborating with NHSE and The SWL ICS and there is strong alignment in our common goals and objectives to help enhance the patient experience. These shared strategic objectives will create significant opportunities for convergence and collaboration, enabling us to leverage new possibilities such as resource sharing and joint procurements. This approach will drive economies of scale and foster standardisation through initiatives such as the NHS Shared Tenant, ultimately benefiting the healthcare system as a whole.

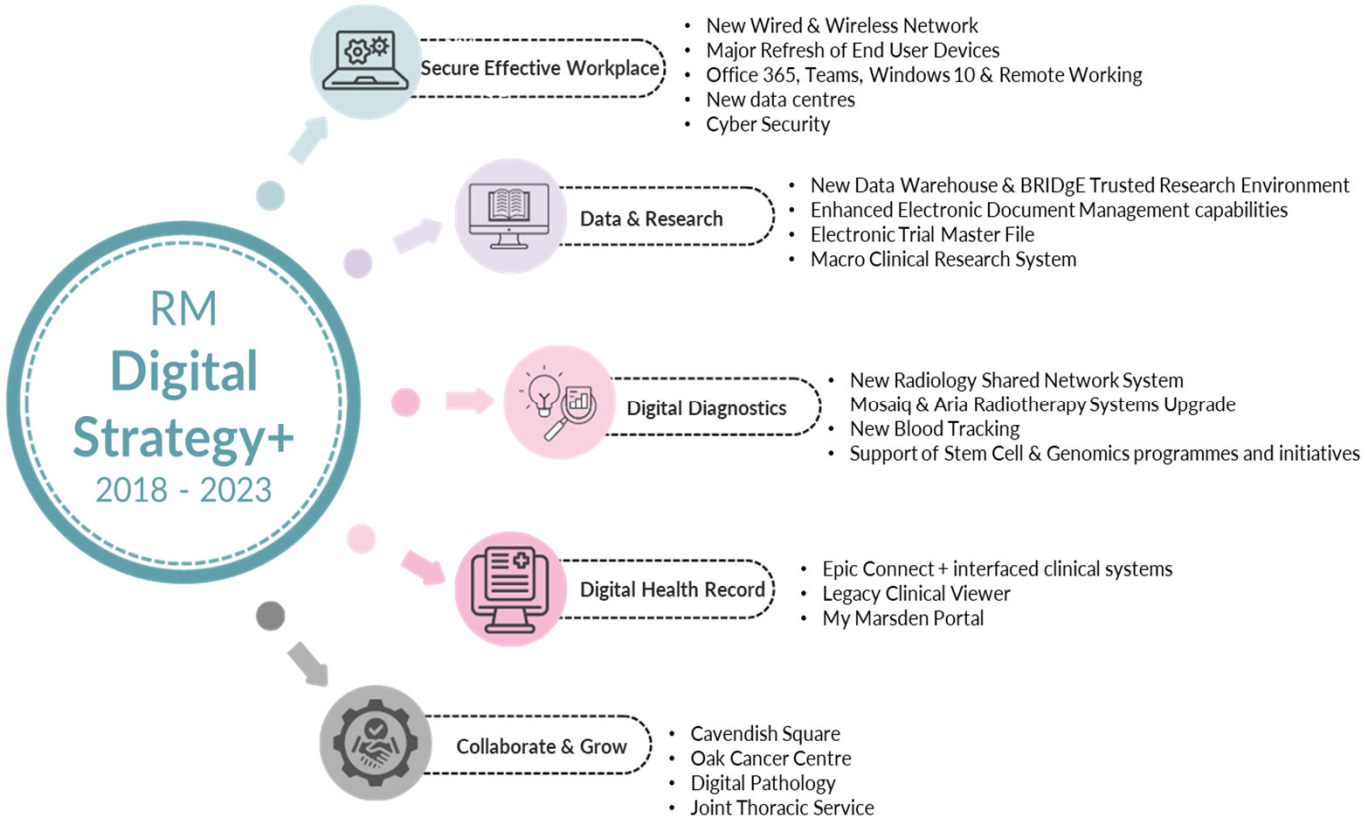
Our Digital Journey

The Trust's last digital strategy enabled us to safely replace our in-house legacy EPR with the Epic Digital Health Record in March 2023, sharing the system with Great Ormond Street Hospital. The system includes MyMarsden, a patient portal that provides patients with the means to view & interact with their clinical record, see results and appointments, access content and communicate with clinicians.

At the same time the Trust implemented a new cloud-based data warehouse as its primary repository for structured data, along with a new data reporting and visualisation tool, and a Trusted Research Environment, BRIDgE. Along with some upgrades to corporate systems and networks, and implementation of unified communications and digital pathology the Trust has undergone a large amount of digitally-led change in the last 5 years.

Whilst all these changes have created a strong launch-pad for our future, there is much to do to maximise the potential of these capabilities.

From hereon our challenge is to ensure we reap full benefits from our digital ecosystem, keep it safe and secure, and carefully design any further developments to compliment and enhance this infrastructure, delivering and embedding positive change for the organisation, staff and patients.



Digital Themes

Our strategy is built around these four themes

Digital Foundations

Enhance infrastructure, hybrid (cloud and on-premise) architecture providing resilience & scalability. Design out silos and work to reduce complexity. Strong cyber-security. Reliable hardware and devices that provide high performance regardless of setting. Networking that supports future uses across the estate. Safe for clinical care & fit for the future. Transformation will be easier and faster when the foundations are future-proof.

Digitally Empowering People

Enabling people to exploit the transformative power of IT. Upskilling staff through digital training and support to deliver digital confidence. Digital standards that make sense, solutions that fit around the way people work and live. Freeing up clinical capacity, creating time to care through better system design, We will be equipped to use digital tools to achieve a higher standard with less effort, releasing time to improve patient experience and outcomes.

Data, Research and Insights

Increasing availability of high quality, analysable, integrated multi-modal data. Building better data browser & catalogue tools and harnessing leading data standards, such as the Observational Medical Outcomes Partnership (OMOP) common data model to support data sharing and federation. Enhanced anonymisation tools and data controls to ensure data is shared safely & appropriately. Increasing data science capabilities and driving the reach of BRIDgE as a leading trusted research environment for cancer.

Innovation and Collaboration

Fostering innovation & creativity. Establishing an innovation hub to discover and develop new ideas. Identifying opportunities for digitally-led improvements, and the means of safely testing and implementing new technologies. A flexible toolset that allows for rapid solution-development to tackle present-day frustrations. A framework for collaborating and partnering to provide scale, efficiency and improved outcomes where possible.

Digital Foundations

Vision

Empowering our Trust with a resilient, secure, and innovative digital infrastructure to enhance operational performance, research and user experience.

Our journey to enhance our digital infrastructure within the Trust is guided by colleague feedback, emphasising the need to prioritise the basics. Our strategy focuses on building a strong architectural foundation that provides secure, accessible, and scalable systems with high-quality connectivity for our patients and staff.

A key element of our strategy is modernising endpoint devices. Ensuring we understand the equipment needs of our staff and patients, providing modern, portable, and effective devices that enhance efficiency and user experience.

We will adopt a future-proof, adaptive approach to infrastructure that allows us to quickly respond to changing business needs. By consolidating our backbone around cloud-enabled services and storage, we can adapt swiftly to evolving requirements and support cutting-edge services like genomics involving large volumes of data, enabling us to be at the forefront of regional and national initiatives.

Strong cybersecurity and comprehensive, fast network access – wired, wireless and cellular will provide resilience. It is essential to safeguard our services and patient safety while ensuring robust network connectivity so that colleagues and patients can access information anytime, anywhere.

Devices such as building management systems and medical equipment will be securely enabled with the appropriate bandwidth, and critical messaging services will be secure and reliable among clinicians.

Enhanced interconnectivity, both regionally and through partner networks like the ICR, will provide collaboration opportunities in research and within the broader NHS ecosystem. Growth through innovation is central to our strategy, but we can only innovate if our core systems are built on a solid infrastructure.

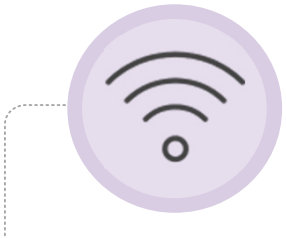
We will enhance our monitoring and management of facilities, estates and equipment in line with our net-zero ambitions. We aim to enhance the patient experience through Marsden-specific secure mobile applications. We will provide the underlying infrastructure to support cutting-edge initiatives such as ambient AI. A modern infrastructure platform will help support the Trust become a digital exemplar and excel with new initiatives such as the Chelsea development.

Holistic design governance will ensure we don't just 'bolt-on' new technology as it becomes available. We will work to maximise our existing resources, only adding new products where they can be seamlessly integrated and add value. We will need to upskill and right-size our specialist teams in system architecture, integration, data engineering and product ownership to ensure our digital estate keeps pace with organisational need. Importantly, we recognise the need to ensure we are resourced to support the varying and specific needs of each of our areas of business, such as genomics, private care and research.

Our commitment is to establish digital foundations that enhance network capacity and processes, leading to a more efficient, digitally enabled hospital.

Digital Foundations

Deliverables



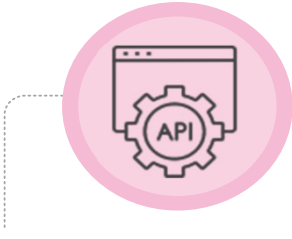
Improving Connectivity

Core Network: Rolling improvement to ensure modern, high performance resilient core networks providing connectivity, availability and capability will support the increasing capacity demands of modern digital systems.

Wi-Fi: Optimise the Wi-Fi infrastructure to provide ubiquitous access to systems and services facilitating collaboration from any device and location within the Trust for both staff and patients.

Mobile Coverage: Enhance cellular signal coverage for uninterrupted communication and access to digital resources for staff and patients alike.

Interconnectivity: Seamless working between regions and partner organisations such as the ICR and other organisations across the wider NHS ecosystem.



Advanced Technologies

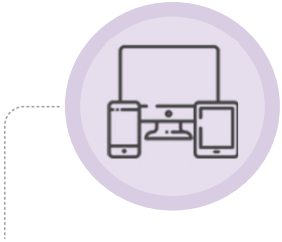
Access to scalable high-power compute: Ability to support technologies such as Artificial Intelligence (AI), the Internet of Things (IoT) and 'Big Data' through high powered compute, storage and network,

Flexible hybrid approach: Ensuring seamless integration and interoperability between different systems to enhance data sharing and collaboration.

Development Environments: Create test environments to support the development of innovative solutions.

Cloud Infrastructure: Continue moving data, storage, compute and research from on-premise to a cloud environment.

Quality of Service: Improve the quality of service for systems such as telephony, messaging and building management.



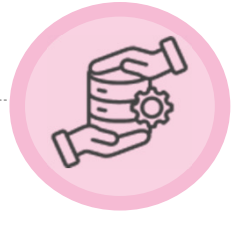
Devices

Device Refresh: Continual refresh and maintenance of endpoint devices to ensure that staff have access to modern and capable technology, improving efficiency and service delivery.

Device Suitability: Support the onboarding of new devices to encourage new ways of working.

Supporting Innovation: Support of future use cases such as remote monitoring of assets, patient tracking, way-finding and robotic devices.

Infrastructure Devices: Supportable and modern backbone infrastructure including resilient storage and network.



Data Management and Security

Data Protection and Security: Implement strong data protection and security measures to ensure patient privacy and regulatory compliance.

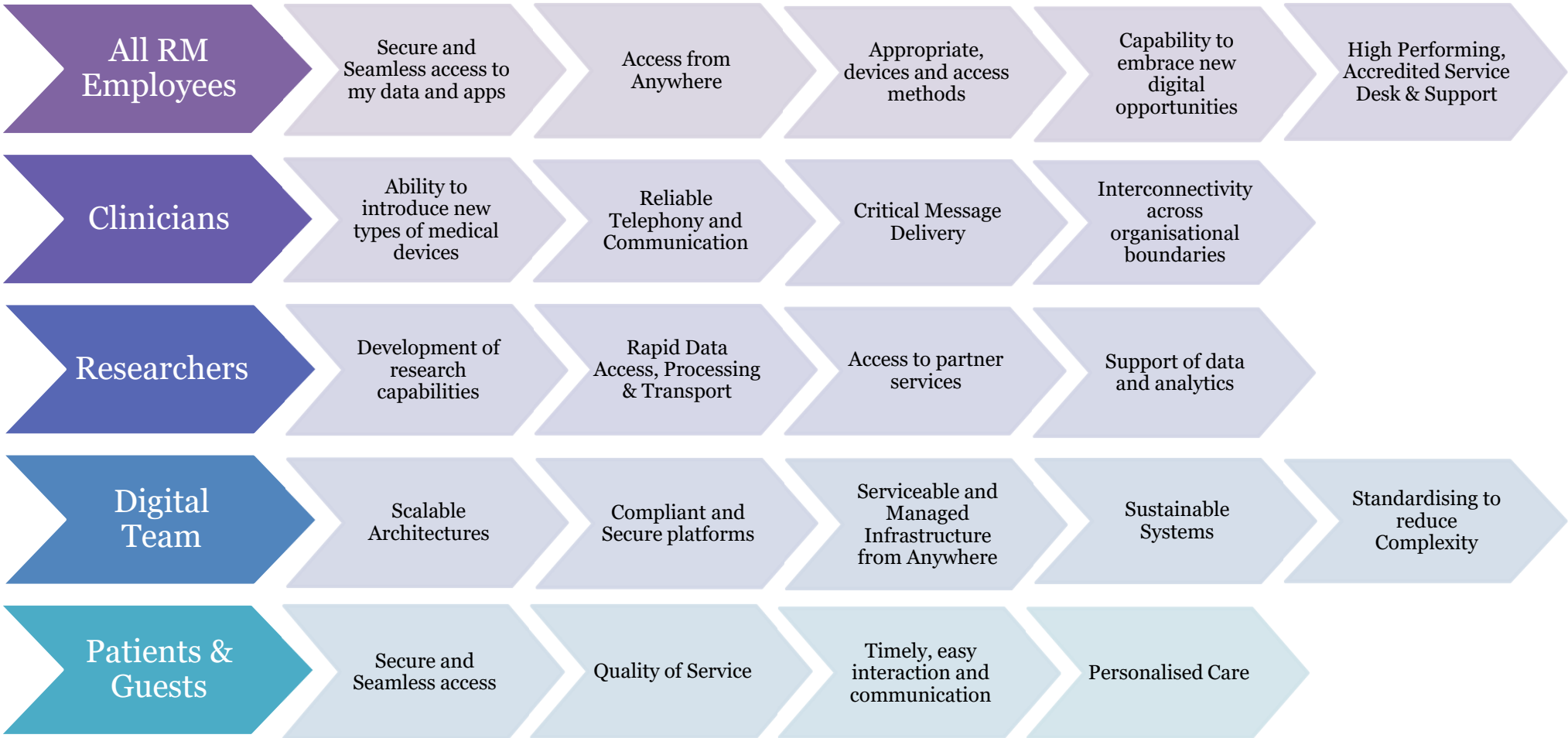
Secure Infrastructure: Develop a security strategy to design and implement a Zero-Trust architecture.

Cyber Defences: Develop Cyber capabilities both technical and human to protect Trust systems from evolving threats.

Critical Systems Resilience: Maintaining a map of all systems critical to delivery, with robust disaster recovery and business continuity processes in place, tested regularly.

Digital Foundations

What This Means



Digitally Empowering People

Vision

Delivering a positive user experience by providing the digital tools and opportunities for our patients and staff that enhance their work and care at the Trust.

Leveraging technology and information is essential to addressing the challenges faced by the NHS, its staff, and the patients it serves. However, successful transformation is not about imposing new technology; it is about understanding people and their needs.

By co-designing digital tools with input from staff, patients, and clinicians, we ensure that our digital services are focussed on addressing the real-world challenges, enhancing both user satisfaction and the overall quality of care.

We are committed to continually enhancing our MyMarsden Portal and working to integrate with the NHS App to empower patients as active partners in their care. This includes providing secure access to health records, allowing patients to interact with their data and appointments, and facilitating effective communication between patients and clinicians.

Recognising that digital capability and willingness vary among individuals, we will prioritise digital inclusion to ensure simple intuitive access for all.

Comprehensive, relevant and context-specific digital training will be provided across the board with support available to all staff and patients, building confidence and empowering all to fully exploit our digital solutions.

Training programmes built around best-practice standards will explain the ‘why’ as well as the ‘what’, building holistic knowledge, ensuring that all systems users understand their part in the whole digital pathway. Improving the experience for everyone.

Our digital platforms will be co-designed with diverse patient and staff groups to ensure intuitive navigation and accessibility. Features such as larger fonts, screen reader compatibility, and customisable content will support a broad range of needs and users.

Additionally, we will explore emerging technology to allow individuals to adjust the reading level of digital content, ensuring clarity and inclusivity that aligns with different needs.

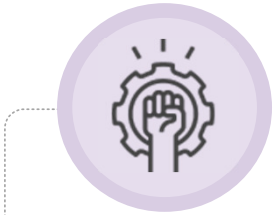
Our service design philosophy is centred around the needs of patients, their families, support networks, clinicians, and staff. To enhance their experience of the Trust, we will transform our processes through automation and enhanced self-service capabilities.

Our development team will create the type of intuitive applications that reflect the ease and functionality we experience in our personal lives to improve efficiency, promote wellbeing, and free up valuable time for patient care.

By harnessing the transformative power of technology and adopting corporate system design standards across our digital landscape, we will create a more efficient, effective, and user-friendly digital environment that supports exceptional care and a positive working experience across the Trust.

Digitally Empowering People

Deliverables



Patient Empowerment

Care Engagement: Supporting patients away from hospital with digital care plans, reminders, tracking data from the home. Facilitating patients symptom reporting and patient reported outcomes. Reducing unnecessary appointments and empowering patients to manage their care.

Patient Portals: Empowering patients to own and manage their health records. We will continue to develop MyMarsden to enhance patient engagement and support personalised care, while integrating with the NHS App allowing patients to manage all aspects of their healthcare.

Digital Confidence

Establish Digital Best Practice : Develop a set of digital best practice standards, informed by SMEs, to ensure standardised, secure, and robust use of digital tools across the Trust.

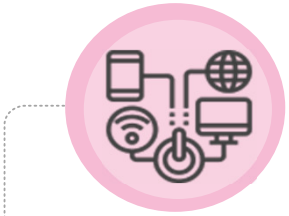
Training, Support & Awareness: Providing regular rolling training tuned to the needs of the individual, ensuring a holistic understanding of the pathways and the impact of data in successful outcomes. Supporting our people with the keys to understanding and using technology with accessible and intuitive training resources.

Investing in People

Digital Champions: Nurturing our network of department-level digital champions capable of supporting their colleagues in the best use of digital technologies.

Giving back Time: Technology will be used to unlock time for staff by eliminating routine tasks, boosting decision-making with smart insights, and empowering them to focus on exceptional patient care and the achievement of operational excellence.

Invest in Digital Leadership: Providing ongoing digital leadership to enhance business support and engagement.



Human-Centred Technology

Removing Digital Friction: We will make the Trust a digitally supportive environment by removing digital friction and optimising systems and processes to make every interaction seamless, and intuitive.

Co-Design: Ensuring our patients and staff influence the design of digital solutions resulting in user-centred, accessible products that meet real-world needs for delivering safe, effective, and personalised care.

Self-Service: Expanding self-service resources and options to provide access to information and solutions to staff and patients alike.

Digitally Empowering People

What This Means

"The user experience isn't just important for staff satisfaction. It's also important for patient safety"

For a Nurse

Sensors and non-intrusive monitoring devices allow continuous capture of clinical observations and blood measurements around the hospital, allowing the patient to rest and provide enhanced safety by alerting the nurse when intervention is required.

Predictive scheduling technology helps balance workloads across the ward, reducing stress and mitigating staff burnout.

Smart tracking technology ensures that vital medical equipment, devices and even people are always locatable, significantly saving time.

Automation of administrative tasks, such as patient discharge coordination, streamlines hospital workflows, speeds up patient flow, and allows staff to focus on direct care.

AI-powered sustainability measures, such as smart energy management and climate control, contribute to an environmentally friendly and cost-efficient hospital.

For a patient

AI-driven personalised care pathways provide patients with a visual timeline of their treatment plan, upcoming appointments, and helpful insights on what to expect.

Digital self-check-in and smart reminders allow patients to check in from their smartphones, removing the need for queuing or waiting.

Wayfinding technology guides patients to the right part of the hospital for their appointments, ensuring they arrive on time and relaxed.

AI-supported clinical summaries provide easy-to-understand insights on scan results, keeping patients informed and prepared for their next consultation.

Remote monitoring and data collection via patient questionnaires support tracking of post-treatment health, allowing the care team to intervene proactively when necessary—reducing any unnecessary hospital visits.

Seamless NHS App integration ensures patients have centralised access to their healthcare records, lab results, and treatment history across the NHS, but with the benefits of tailored content and full functionality of MyMarsden for their RM care.

Data, Research and Insights

Vision

Developing data acquisition tools, improving data linkage, accessibility and data science expertise will supercharge data-driven research, and support monitoring, planning and improved outcomes

Data is essential to achieving our clinical, research, and National objectives, but data only has value if it is accurate, timely accessible and analysable.

We will enhance our systems design to minimise the burden of real-world data capture. This will be achieved by defining standards for essential clinical data, streamlining, guiding and validating data-entry appropriately, supporting multiple data acquisition methods, including ambient AI.

Foundation and language models will be harnessed to acquire and classify structured data from unstructured sources. Locally contained and right-sized models will help manage the required compute and will ensure the model upgrades are controlled so as to support assurance of the outputs. Retrieval augmented generation will help tune outputs to the Trust's specific contexts.

Resource will be required to support the data validation and management but in return will allow us to substantially scale the number of data sources mined, including referral letters, medical histories, pathology and radiology reports.

Enhanced self-serve data reporting will improve data quality as greater visibility of data in tools like RM Insight and Slicer Dicer will help identify anomalies and drive correction. Reporting standards, data definitions and aligned terminology means users can access accurate & consistent reporting across the whole ecosystem.

Data curation and quality improvements will be targeted at source where possible to ensure maximum benefit across the Trust. Data triggers will generate push-reports and alerting supporting the Trust to stay ahead of any potential changes in Trust activity or data.

We will develop our data ecosystem around a cloud-based data lakehouse model to allow us to manage and service data rapidly and cost-effectively. This will allow us to link structured data with other modalities such as radiology, pathology and genomics to fully enrich our analysable data.

Upskilling and resourcing of data science specialists will allow us to develop in the field of predictive analytics and will provide essential support for a greater number of data-driven and machine learning initiatives.

Security is incorporated by design, with the development of enhanced anonymisation tools, a consent gateway linking our data model to national opt-out and patient consent data.

For many patients the Royal Marsden is not their only care provider, and so our data represents only part of the patients' care. By ensuring we have data pipelines and strong data sharing agreements with other data sources, such as the London Care Record, we can harness greater value for ourselves, our patients and the health system as a whole.

Presenting our data using recognised standards such as OMOP, we can share data as required and supports data federation where data can be analysed across organisational boundaries. Increasing the reach of BRIDgE will also drive greater insight, allowing researchers to apply a range of data science tools on RM data without that data ever leaving the Trust.

The NHS-wide platform for data federation is called FDP. We will connect with this service in-line with national expectation and establish data links with the platform where there are clear established benefits.

Data, Research and Insights

Deliverables

Advanced Data Infrastructure

Data Lakehouse: Enhanced data infrastructure supports a robust data management pipeline, including harmonisation and linkage of data from multiple sources and data modalities.

Secure and Legitimate Access: Robust anonymisation tools, consent gateways and regular testing ensure data is secure and levels of access are tightly controlled.

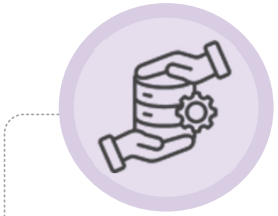
Trusted Research Environment: Growing our BRIDgE offering and increasing the data & tooling available. Exploiting opportunities for BRIDgE in national cancer research projects will secure the environments reputation as the SDE for cancer.

Data Science & Analytics

Data Sciences: Developing our data science capability to analyse complex datasets, generate actionable insights and support novel research and machine learning projects.

Predictive Analytics: Utilising predictive analytics to anticipate patient needs, optimise resource allocation, and improve patient and operational outcomes.

Self-Service: Continuing the development of our data and BI platform and training and supporting users to access and interpret the data. Creating triggers for push reporting and alerting to improve timely awareness and helping to see the 'wood for the trees'.

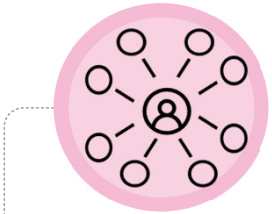


Data Acquisition

Reduce Data Burden: Enhance system design to reduce data entry burden. Exploit ambient and generative tools to save clinician time, reducing burden and 'burnout'.

Mine Unstructured Data: Harness NLP and small language model variants to create structure and classify data. Use retrieval augmented generation to fine tune outputs to local context.

Data Quality: Improve quality through mixed model of technology, cancer data experts, manual curation and audit. Increase visibility of data and reporting for clinicians to identify anomalies and drive correction at source.



Data Sharing

Data Governance: Improve data sharing with effective governance processes based on legitimacy and consent. Accelerate governance timelines and reduce admin burden by establishing fast-track approval pathways and whole-system pre-approval.

System Interoperability: Leverage system interoperability capabilities to ensure clinicians have access to relevant patient data across organisational boundaries.

Sharing & Federation: Support federation via OMOP for analysis at scale. Establish data pipelines to regional hubs such as London Care Record and regional Secure Data Environments where beneficial.

Data, Research and Insights

What This Means

For Researchers

Eligibility Flagging proactively alerts clinicians when a patient meets criteria for an available trial, based on patient clinical, demographic and genomic information.

Improved data availability provides richer, linked data for research, spanning multiple years and based on pre-defined standards of high utility data, harmonised and consistently classified.

Cohort Browsing solutions make it easy for researchers to identify the size, quality and features of data that meets their criteria for data driven research.

Trusted Research Environment allows researchers to work on data in a virtual environment where their selected anonymised dataset can be analysed with the latest data science tools, supported by data science experts.

Data Federation allows a researcher to obtain result-sets from data that spans multiple organisations, by applying standard queries to separate datasets which all conform to the same standards.

Data Provenance & Meta Data allow researchers to understand the source, quality and context of the data, and to therefore include or exclude certain categories of raw or curated data depending on need.

For Operational and Clinical Staff

Friction-free data entry designs mean clinicians are only required to enter essential information. Input methods are tailored to the individual.

Supervised Generative AI produces suggested responses to messages and clinical summaries based on real-time patient data, allowing clinicians to see the results and sign-off in a single click and reinforcing a complete and accurate patient record. Reducing the burden of documentation.

Intuitive Business Intelligence tools allow staff to easily access information be that real-time hospital data, historic trend analysis or future predictions.

Data-Defined Push-Reporting provides staff with reports or alerts direct to their inbox when certain hospital, department or activity criteria are met. This supports rapid responses, for example if there are not enough patients planned for discharge to accommodate the days expected admissions.

Real-time dashboards provide a constant colour-coded view of the hospital, including occupancy, waiting times, schedules.

Innovation and Collaboration

Vision "The team need that person they can kick their ideas around with who's digitally informed"

We will foster a culture of innovation and collaboration to drive transformation in healthcare and research.

The "Innovation and Collaboration" does not advocate racing towards all new technologies but looks to develop effective processes to select and integrate new capabilities carefully and to foster a culture where innovation thrives and collaboration becomes second nature.

Digital experts will adopt a business-partnering approach to identify where digital solutions might offer new capabilities to improve operations and deliver commercial advantages.

The future hospital of personalised medicine, remote monitoring systems and virtual engagements is underpinned by advancements in technology that provide a step-change in the way medical services are delivered, experienced and supported.

To realise this we will establish governance frameworks to assess emerging technologies, and new supplier engagements. These frameworks will ensure that technology adoption aligns with our strategic objectives, mitigates risk, and can be properly integrated into existing processes to provide clear benefits to staff and patients.

To drive operational efficiencies, we will deploy a flexible toolset that enables the rapid development of low-code applications, automation, and generative AI solutions. These technologies will reduce manual workloads, streamline processes, and free up clinical and administrative time to focus on patient care.

We recognise the importance of building a skilled and digitally fluent workforce. By developing our network of digital champions, we will embed a culture of innovation. These champions will serve as catalysts for change, ensuring that new digital tools and processes are embraced, while staff at all levels are supported in adopting these innovations.

To support these efforts, we will establish a collaborative innovation hub to foster idea-sharing, brainstorming, and rapid prototyping of new projects.

Purpose-built segregated digital environments will allow us to identify high-potential initiatives while ensuring that new technologies are rigorously tested before deployment.

Externally, we will explore strategic partnerships with leading technology firms, research institutions, and healthcare providers to introduce fresh perspectives and specialised expertise which will strengthen our position as a world-leading research and healthcare institution.

With streamlined procurement processes we can act more nimbly in a fast-changing digital landscape allowing us to rapidly adopt new technologies.

As we continue to innovate and develop new solutions, we need to ensure these can be safely implemented into the clinical setting, meeting all regulatory requirements. To this end we will design and implement an effective resource model for 'software as a medical device' (SAMD) deployment.

By embedding innovation as the norm and embracing digital transformation, we will continue to deliver high-quality, patient-centred care, ensuring the Trust remains adaptable and future-ready.

Innovation and Collaboration

Deliverables

Technological Enhancement

Use of Low-Code and Automation: Utilising digital tools to enhance the quality and efficiency of healthcare services

Establishing our role in SAMD: Assess and implement the best approach to new developments of software as a medical device

Increasing Time to Care (Intelligent Automation): Using digital tools such as intelligent automation and ambient voice technology and Natural Language Processing to reduce administrative burdens, increase quality and release time.

Fostering Innovation

Innovation Hub: Establishing an Innovation Hub to nurture and develop new ideas, technologies, and solutions in healthcare. Digital experts will triage, support, and chaperone new ideas

Commercial Development: Foster partnerships and commercial opportunities to drive digital health innovation and revenue generation

Safe Implementation

Clinical Safety: Appropriately skilled clinical safety officers, supported by strong safety governance to ensure safe and fully compliant systems throughout

Managed Introduction of New Tech: Strong governance to eradicate unofficial (shadow) IT, triage, and design processes to ensure technology compliments existing systems and workflows and meets our standards

Test Environments: Separate but representative test environments to support thorough and realistic testing of new technologies, algorithms, and products.

Frameworks for the Future

AI Governance: Create an AI framework to ensure all such advanced technologies are assessed for benefit, prioritised and safely deployed. Develop strong governance to monitor and ensure ongoing safety of deployed learning algorithms.

Partnerships: A framework for ensuring technology partners add value to the organisation and can work to Trust standards, complimenting and augmenting the RM digital ecosystem, not creating system tension and suboptimal workflows.

Innovation and Collaboration

What This Means

"for me, success is a safer hospital and that's what digitisation should help us deliver."

Reducing 'Shadow IT' and Inefficient Workflows

A robust governance framework ensures that all digital solutions are properly vetted, reducing the need for unofficial workarounds.

A Low-Code and Automation Hub empowers staff to co-design and automate repetitive administrative tasks safely and efficiently.

Seamless system integration eliminates the need for duplicate data entry, improving accuracy and reducing workload.

A structured process for submitting digital improvement ideas allows staff to collaborate with IT teams to develop solutions within a secure and approved environment.

Enabling Safe and Scalable Innovation

Dedicated, representative test environments mirror live hospital settings, allowing new applications, AI tools, and automation solutions to be rigorously tested before full deployment.

Improving safety and clinical outcomes through technology such as AI-detection of Pulmonary Embolisms.

A model for safe deployment means that experts in clinical safety and medical software regulation can support design, development and deployment of new digital solutions. Allowing projects to start with the confidence that they will be supported to safely meet their goals.

A framework for identifying high value partners will allow us to benefit from others who have shared goals and the knowledge or resource to accelerate our developments, whilst ensuring we do not waste effort on working with mis-aligned collaborators.

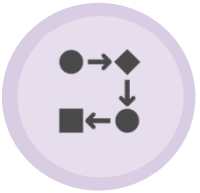
Structured stress testing ensures that new technology integrates smoothly with existing systems, reducing failures and clinical risks.

A governance framework for testing and validation provides a clear process for safely introducing and scaling digital innovations.

Key enablers for successful delivery

Digital Workforce Capacity, Structure & Skills

Digital maturity can deliver efficiencies, but a shift from analogue to digital requires a right-sized team of digital, data and technology experts, appropriately skilled to deliver optimised solutions. Beyond the core digital and data team, appropriately trained and resourced system owners, clinical safety officers and digital champions will ensure our systems work for us, and not the other way around.



Streamlined Governance

Clear governance arrangements for all digital and data assets will help to eradicate “shadow IT”, ensuring solutions support the Trust strategy and conform to Trust standards, avoiding ‘point-solutions’ and ‘work-arounds’. Designing governance systems that are effective and rapid will remove obstructions and cultivate innovation. Clinical safety, regulatory compliance and system resilience will be assured.

Affordable & Sustainable

Digital development requires investment but in a financially constrained system it has never been more important to ensure our digital estate provides value for money. Opportunities to reduce the cost of burden of digital development exist, and include commercial opportunities, driving efficiencies and identification of ancillary funding streams. Containing our digital footprint will also reduce cost and careful management of storage, compute and electronic devices can reduce environmental impacts.

Culture

We will grow to further embrace the opportunities that digital transformation can bring. Embedding digital problem-solvers into process re-design. Championing and prioritising the importance of timely accurate data. Re-thinking pathways and ensuring multi-disciplinary input into all design ensure we all see technology and technical governance as the solution and not the problem.

Capability Roadmap

01 2025/26

AI Framework
Ambient AI Pilot
SAMD & Clinical Safety Resource Model
Digital Standards & Training plan
Low Code Automation First of Type
Mobile & Network Resilience
Mining Unstructured Data Prototype
Clinical Communication Strategy
Administrative AI Use-Cases
Secure Endpoint Operating Systems
Endpoint Device Refresh
Critical Systems Control
Cyber Awareness Campaign

02 2026/27

NHS App integration
ICR Interconnectivity
FDP Compliance
Digital & Data Commercial Plan
Enhanced digital patient engagement
HIMSS 7
Zero Trust Security Architecture
Optimised Cellular & Network connectivity
Cross-site Critical Messaging
Additional AI Pilot
Increased Digital Confidence
Optimise Internet of Things capability
Enhanced Data Lakehouse
Integrated Discovery & Diagnostics
Federated Data (OMOP) Prototype

03 2027/28

Enhanced AI capabilities
Ambient AI Roll-Out Complete
Development Environments
Regional Interconnectivity & Interoperability Matures
Continual Cyber Maturity
Enhanced Clinical Safety Capability

04 2028/29

Enhanced Digital Standards
Enhanced Digital Support Capabilities
Intrinsic Cyber Awareness Culture
Available Innovation & AI Routes
Enhanced Quality of Service
Chelsea Build Digital Exemplar

A Digitally Mature Hospital

The digitally mature hospital of the future is a healthcare environment built to evolve and adapt as the world around us changes and as diagnosis and treatments advance, where the digital capabilities are so integrated into everyday life that they are almost invisible.

Real-time information boards, activity prediction models, self-serve apps, way-finding and tracking are already embedded in many other sectors and their adoption within healthcare has begun. Machine learning technologies will grow in reach to accelerate the pace and increase the accuracy of diagnostics, and real-time patient data and risk stratification algorithms will reduce unnecessary hospital visits or interventions, benefitting patient experience, hospital capacity and the health economy. Data will provide us with new information to improve care, treatment and quality. The technology exists today, but the journey is one of acceptance, confidence and proven safety.

In the public health setting, where cost will always be a factor, technology will be deployed only where it provides tangible benefits to safety, outcomes, productivity and experience. Just because a new technology exists does not mean it will pass the cost/benefit test. A digitally mature hospital, then has technology carefully designed and seamlessly embedded to meet specific needs.

The modern hospital is not constrained by bricks and mortar - it is a hospital where care extends beyond physical boundaries, ensuring that patients receive the right support, at the right time, in the most appropriate place. For patients and staff, the physical hospital will reflect their needs providing an environment where patients feel empowered, clinicians are supported, and technology enhances—not replaces—human expertise. Devices will be simple to use, frequently mobile, and discrete and digital systems will not be demanding. Systems will anticipate needs, remove inefficiencies, and place the patient and staff at the centre of the benefits that innovation brings.

This digital strategy provides the foundations for this future. By securing the resources needed we can improve our technology and our relationship with technology – putting ourselves in the best position to capitalise on new ideas and innovations as they arise.

Ultimately from the moment a patient or staff member connects with the hospital—whether physically or virtually—their experience will be personalised, intuitive, frictionless and enhanced by the work we will all do together to realise this vision.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 4.4
Title of Document: RM Partners Cancer Strategy 2025-2030	**To be presented by:** Susan Sinclair, Managing Director, RMP

1. Status **For approval**

2. Purpose:

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

3. Summary

This item is to present the context of and proposal for the RMP cancer strategy / priorities for NWL and SWL for the next 5 years, building upon what RMP have achieved in the past 5 years. The RMH Board is asked to consider and approve the approach.

- Together we have made strides in improving early diagnosis and improving care for patients across the diagnostic and treatment journey. The next RMP strategy has an even more ambitious approach, to make a step change in prevention, continue to improve early diagnosis, reduced the interval between referral and treatment and ensure equity in treatment, access to research and personalised care.
- Currently across RM Partners 38% of cancers are preventable, this increases to 42% by 2030 without focus on prevention. The Alliance will focus on tobacco cessation and also HPV vaccination, as this causes 3 cancers.
- There is strong alignment with emergent themes in the 10 year plan, with prevention, technology and care closer to home reflected in the approach.
- To deliver this we will need to continue to build on the strong partnership model created and extend into more formal partnerships with local authorities.

- Whilst Performance remains strong compared to National performance, continued focus is required to return to the Constitutional Standards, particularly the 62 day treatment standard.
- Whilst early diagnosis is an important prognostic factor, the role of genomic medicine and management of longer term disease are also important and therefore this strategy focusses on surviving stage.

Key Themes of the Strategy:

1. Prevention and Screening – Improving HPV vaccination uptake, tobaccos cessation rates, cancer screening coverage and surveillance, with equitable access
2. Early Diagnosis – Deliver or exceed the national ambition for early diagnosis of cancer, at stage 1 or 2 by 2030, with annual improvement and reduced variation
3. Reducing Time from Cancer Referral to Treatment – A minimum of 85% of patients within 62 days, with no variation by pathway or demographic
4. Treatment, Care and Survival – To be in the top decile internationally for cancer outcomes and survival

Inequity remains a significant issue within the cancer pathway and the strategy sets out our approach to reducing variation for our population throughout the cancer pathway, from cancer prevention to diagnosis, treatment and survival.

4. Recommendations / Actions

The Board is asked to approve the 2025-2030 RMP cancer strategy, which has been endorsed by each CEO in both ICSs and in each of our 9 Trusts.

RM Partners
NW & SW London Cancer Alliance

NHS

RM Partners Cancer Strategy for North West and South West London: 2025-2030

Together we will save more lives from cancer by enhancing prevention, early diagnosis and access to timely and personalised treatment, supported by our overarching commitment to eliminating variation and reducing inequality.

Hosted by The Royal Marsden NHS Foundation Trust

Context

Cancer Alliances established as part of Long Term Plan. RM Partners covers NWL and SWL ICSs, and partners with local authority, screening teams NWL and SWL acute providers and tertiary services to deliver at scale improvement in cancer outcomes for our population.

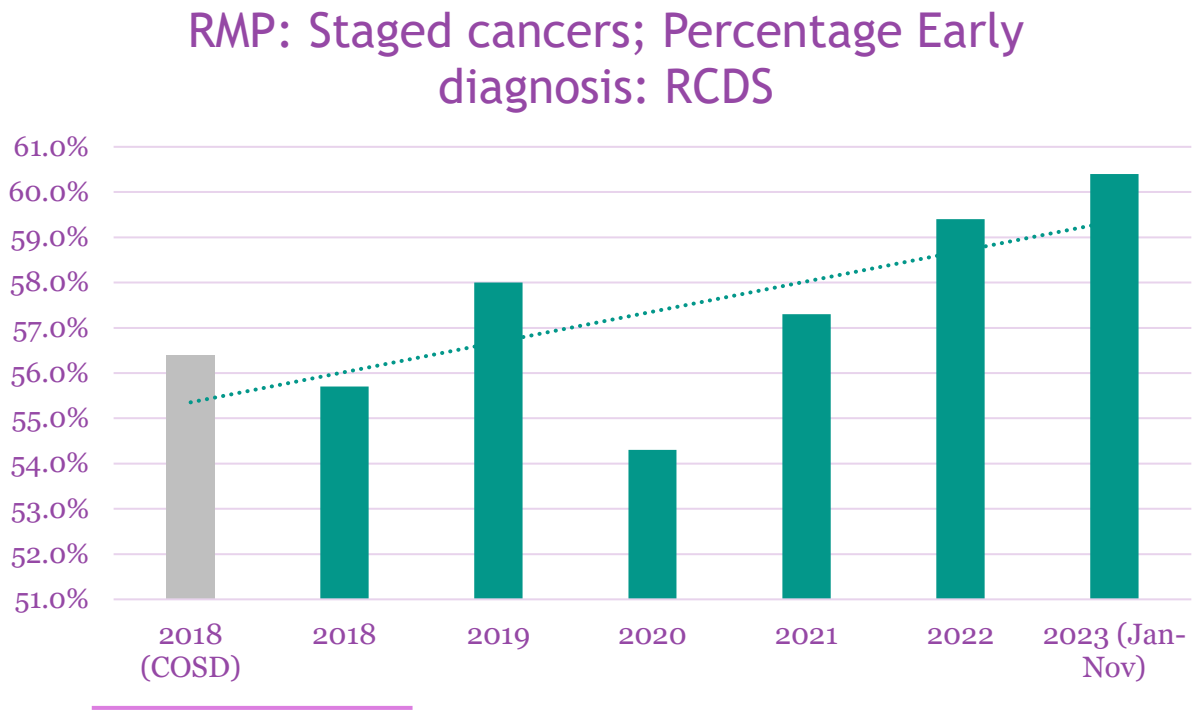
RMP cancer strategy 2021-2025 - adopted as cancer strategy across NWL/SWL ICSs. Particular emphasis on Early diagnosis because this is associated with significant survival benefit.

Seven work programmes were identified to deliver the strategy:

Covid-19 service recovery: Addressing cancer inequalities: Reducing variation in screening programmes and increasing uptake: Working with Place and PCN to diagnose cancer earlier: Improve diagnostic and treatment pathways: Personalised holistic care: Innovation spread and adoption

What have we achieved?

Our mission is to save more lives from Cancer through early diagnosis and reduced inequality



56.4% Early Stage 2018 COSD Gold Standard (Validated Data)

2018 COSD Staging Gold Standard (Validated Data)

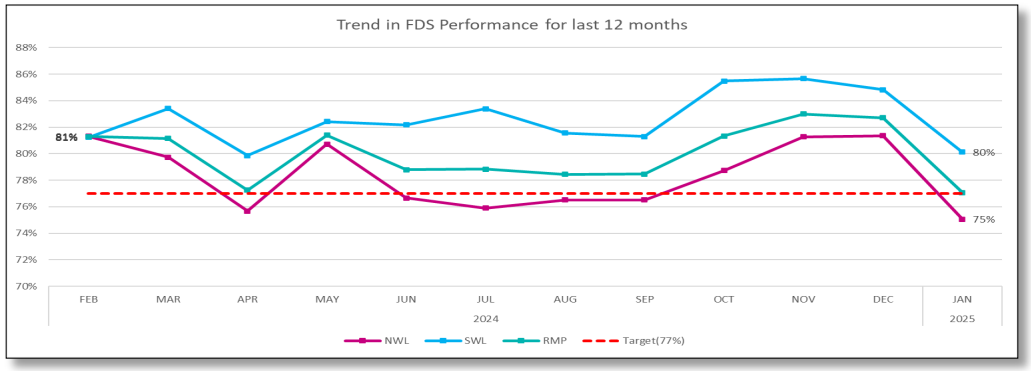
The Rapid Cancer Registration Dataset (RCRD), RCRD | CancerStats (ndrs.nhs.uk)

Using Rapid Staging data, RMP has had a 4% improvement in early stage cancer diagnoses as a % of staged cancers since 2018.

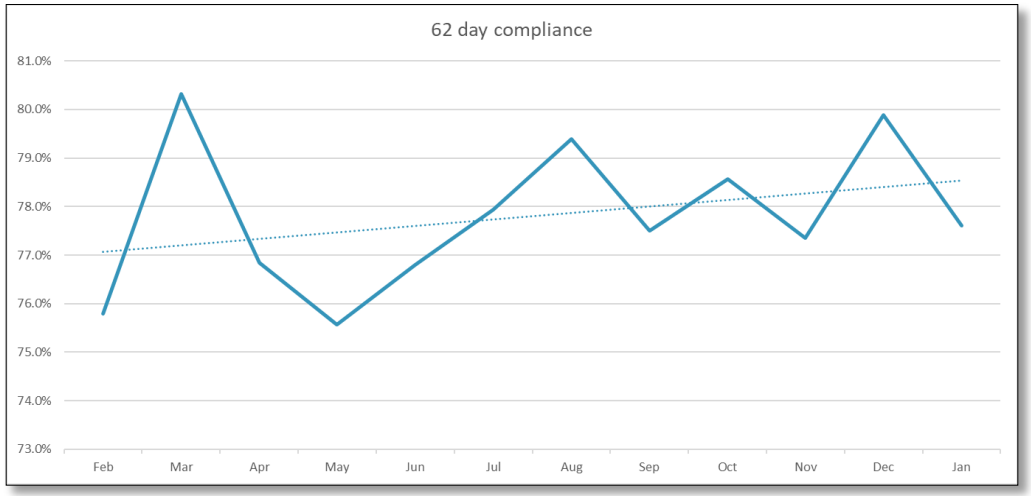
Analysis of routes to diagnosis indicates improvements in Early Stage Diagnosis as a percentage of staged cancers from 2018 seem to have been driven by the following changes:

- Lower GI: change from FOBT→ FIT- 5% more cancers detected from screening than in 2018
- Prostate: Prostate UK awareness campaigns, RMP recovery focus area
- Gynae: volume of referrals in routine and urgent increased, (40pc increase in USC since 2019) suggesting women are presenting earlier
- Lung: monitoring of nodules (not related to TLHC)

Performance Improvement



	2024											2025
Provider	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
NWL	96.2%	91.9%	93.1%	94.9%	95.3%	97.6%	96.9%	97.0%	97.8%	97.5%	98.1%	96.8%
SWL	95.4%	96.4%	94.3%	95.4%	95.3%	97.4%	96.9%	95.8%	96.2%	96.7%	96.5%	94.9%
Total	95.7%	94.6%	93.8%	95.2%	95.3%	97.5%	96.9%	96.3%	96.9%	97.0%	97.2%	95.7%



RMP is one of the consistent top performances in operational performance terms. For the whole of q4, RMP was top in all 3 of the constitutional standards nationally; in January it was top in 2/3.

Our **FDS performance** has been fully compliant at aggregate level since last May. By March, all providers need to deliver a 77% minimum performance. We are on track to deliver this target, with an expected blip in January.
Urgent Cancer referrals have increased by 23.4% since 2019/20 across RMP.

Our **31 day (new and subsequent) has reached near compliance** although stability at individual pathway and provider level remains an issue. There is a 18% increase in treatment volumes since 19/20.

Our **62 day** continues to track in **high 70's**, with trend indications that this is improving, and focus both by pathway and Trust to ensure continuous improvement.
Nationally, the ambition set was 70% in 24/25 and we have significantly exceeded this each month.

Wider Achievements

Early Diagnosis

- ✓ Delivery of FIT in Primary Care
- ✓ Roll out of Lynch testing (GI)
- ✓ Recovery + of breast screening interval
- ✓ Insights into population and general practice helping inform approach
- ✓ Targeted lung health check programme in place which will reduce stage inequity by deprivation. RMP have rolled out with an inequity first approach, prioritising the highest wards within each borough in 24/25
- ✓ Primary care insights project to understand factors which improve Early diagnosis, and subsequent Primary Care Improvement Programme base on findings- Croydon and Brent
- ✓ Community activation model to support wider awareness of signs and symptoms, with over 100 grass roots organisations engaged

Faster Diagnosis

- ✓ Variation in all performance targets has substantially reduced, by both tumour and hospital site
- ✓ Delivery of faster diagnosis target, ahead of time and on track for the 80% target
- ✓ Number of people waiting more than 62 days exponentially reduced
- ✓ Inter Trust Referrals programme creating clear clinical expectations for cross trust transitions

Treatment & Care

- ✓ Equitable access to radical treatment for prostate, and repeat operative rates stable
- ✓ Genetic waits improving
- ✓ SACT programme established
- ✓ Radiotherapy workforce report delivered and acted upon
- ✓ Pain pathway set up to harness expertise across RMP particularly for level 4 (highly specialist) support

Deprivation and its impact on the cancer pathway:

Deprivation negatively impacts our local populations across the cancer pathway:

- 35% of people in our most deprived population reported waiting more than 3 months until first seeing their GP after thinking something may be wrong
- 38% of our most deprived population reported seeing a primary care professional 3 or more times prior to their diagnosis, a 15% difference between the most deprived accessing timely cancer care in comparison to the least deprived, an increase in 6% compared to 2022
- There is a 17% discrepancy in bowel cancer screening uptake between our most and least deprived groups
- There is variation in early-stage diagnosis between our most deprived and least deprived populations. Improvement will in part be driven by the Targeted Lung Health Programme, but additional formal focus will continue
- Lower survival rates in deprived populations: nationally 10,400 more people would survive for 5 or more years if the least and the most deprived populations survival was matched.

Cancer Strategy 2025-30

Our strategy is based on local needs, but with clear alignment to the themes emerging from the 10-year plan:

- Cancer Prevention is a core programme, to reduce the number of preventable cancers from the current of 38%
- Technology and AI are cross cutting themes, with an expectation they will transform care across the pathway
- Close closer to home and Stratified Follow up continues to be a focus

Our guiding principles, established by our people and communities.

Cultural Humility

Listen to communities and trusted leaders to codesign services, and incorporate culture and faith into our care.

Community Integration

Put lived experience at the heart of our care creating connections and bridging gaps.

Use community assets

Embed and share messages, and utilise community and voluntary groups to share information.

Practical implementation

Ensure insights become practical strategies to remove care barriers.

Cancer Prevention

Commit funding and infrastructure to develop community led prevention campaigns, and culturally targeted advice including information on Shisha, chewing tobacco and diet.

Be trustworthy

Create trust through working side by side with communities listening, acting on concerns and providing information and support in the right language.

Be consistent

Ensure messages are consistent, and train community leaders to ensure they have the most up to date accurate information to help spread key messages.

Create accessible services

Use community settings where feasible, and support our communities to access care.

Our new strategy

Ambition 2025–2030:

Together we will save more lives from cancer by enhancing prevention, early diagnosis and access to timely & personalised treatment, supported by our overarching commitment to eliminating variation & reducing inequality.

Prevention and Screening

Improve HPV vaccination uptake, tobacco cessation rates, cancer screening coverage & surveillance, with equitable access.

Early Diagnosis

Deliver or exceed the national ambition for early diagnosis of cancer, at stage 1 or 2 by 2030, with annual improvement & reduced variation.

Reducing Time From Cancer Referral to Treatment

A minimum of 85% of patients treated within 62 days, with no variation by pathway or demographic.

Treatment, Care and Survival

To be in the top decile internationally for cancer outcomes & survival.

Vaccination uptake

Reduce variation in HPV uptake by 30%.

90% coverage across RMP.

Patient interval

Raise symptom awareness within populations.

Build trust to encourage early healthcare engagement.

Cancer FDS

77% of patients diagnosed with cancer are told by day 28, regardless of tumour group.

Treatment

Total cancer care, including management of metastatic disease, uses advances in genomics to improve treatments & is close to home, where possible.

Tobacco cessation

Reduce tobacco usage starting with those invited for a lung cancer screening.

Time to treatment

Delivering pathways which enable patients to meet the 62-day standard regardless of modality.

Referral interval

Address variation in referral interval through supporting direct access, continuing to evolve NG12 guidance and working with primary care.

Screening & surveillance

Deliver equitable access to existing & novel cancer screening programmes.

Secondary diagnostics

Sufficient, rapid & equitable diagnostic capacity is available across providers.

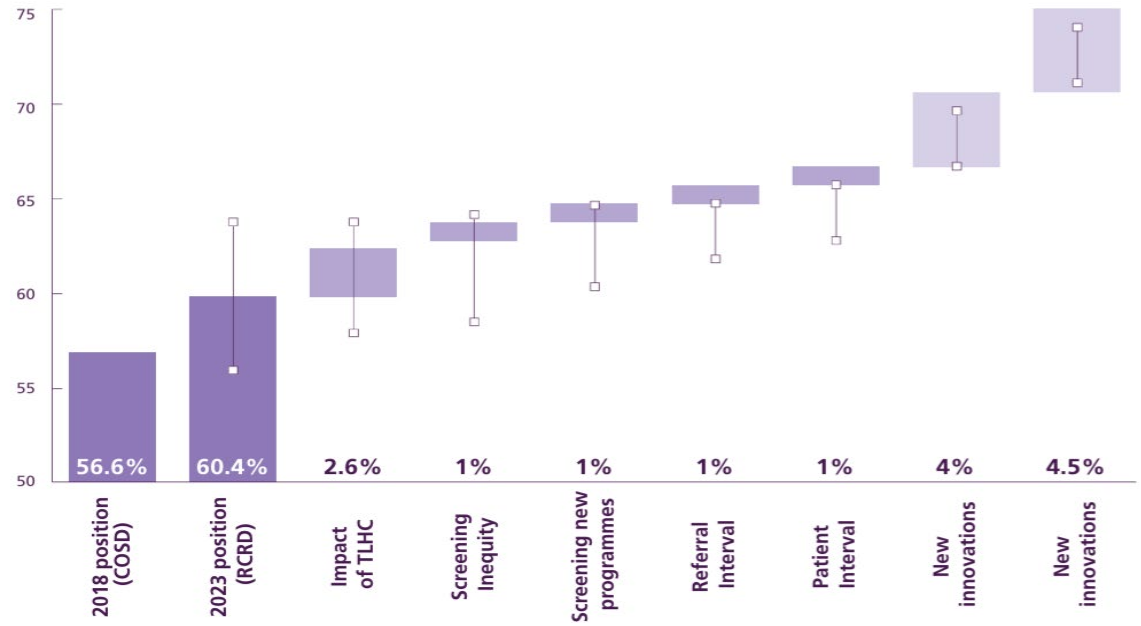
Care personalisation

Deliver patient centred care throughout the cancer journey.

Interventions to reduce short and long term impacts of cancer.

Our enablers:

- Care equity & co-design
- Data driven improvement
- Sustainable and resilient workforce & financial models
- Technology & AI
- Innovation, spread & adoption



RM Partners NW & SW London Cancer Alliance

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Focus 25/26

The patient interval

Awareness and accessing care

The referral interval

Clinical evaluation, diagnosis and staging

Access to treatment

Prevention and screening

- Make a step change in HPV coverage
- Provide enhanced smoking cessation opportunities through Lung Cancer Screening

Awareness of symptoms, seeking and accessing care

- Continue to roll out Lung Screening Programme
- Build on Community activation model to support awareness of sign and symptoms

Appropriate clinical review, first line investigations and referral to specialist care

- Implement Early Diagnosis Improvement Programme in Ealing, Wandsworth and Merton GPs to support Early Diagnosis
- Implement pancreatic case finding programme
- Continue to support awareness of direct access diagnostics

First line and specialist diagnostics

- Improve efficiency in referral→ treatment pathway through harnessing of technology and reducing unnecessary appointments
- Continue to roll out demand reducing protocols

Accessible and high-quality treatment

- Using data from SACT review, standardise oral and Sub cut treatment approach, and implement a virtual chemo appointment for high volume pathways, starting in Croydon
- Improve patient awareness of prehabilitation
- Implement SABR in the prostate pathway
- Improve cancer survival starting in the bladder pathway through use of international benchmarking data

RM Partners
NW & SW London Cancer Alliance

NHS

Thank you.
Appendices follow:

Key interventions; Prevention and Screening

Ambition	KPI	Metrics	Interventions	5-year plan
Prevention Address modifiable cancer risk factors focusing on HPV vaccination uptake and reducing smoking	**Vaccination uptake** Reduce variation in HPV vaccination uptake	**By 2030** 30% reduction in variation 90% HPV vaccination coverage across RMP	**Community awareness** Improve initial sign up, focusing on populations with least coverage **Catch up programmes in low uptake boroughs** **Work to reduce barriers to consent**	Deliver x3 boroughs per year catch up programme; x2 boroughs/ year primary coverage
	Smoking cessation Reduce smoking rates starting with those invited for a TLHC	**By 2030** 25% reduction in smoking rates among individuals invited for a TLHC	**Smoking cessation** Ensure meaningful quit support post TLHC **Access** Improve access to smoking prevention services for those on a USC pathway	5% improvement in quit rates for target populations per year
	Cancer prevention education Increase awareness of preventable causes of cancer	Improve preventable cancer mortality rate in under 75s	**Community awareness** Focus on culturally relevant messaging and engage with CVSO on cancer prevention, signs and symptoms	
Screening & Surveillance Adopt evidence based emergent screening and surveillance programmes Reduce screening uptake variation	**Targeted Lung Health Check** Improve early detection and treatment of lung cancers	**By 2030** 100% borough coverage across RMP Create a reinvite approach for non- attenders	**Highest risk** Focus on highest risk wards Work with national team to implement interval strategy **Population health approach** 60% minimum participation and tracking non-attenders to improve coverage	Deliver 20% per year coverage, and create non responder recall approach
	Emergent screening programmes Identify, deploy and embed new screening programmes that improve survival rate	**By 2030** Fully implement HCC programme, trial new methods of screening as technology developed	**Roll out novel screening, case finding and surveillance systems** Start with high risk populations and improve identification of high risk individuals **Ensure financial sustainability** of models exists to embed programmes	Fully resourced sustainable screening programme
	National cancer screening programmes Reduce variation in coverage	**By 2030** Reduce by 10% variance in coverage	**Population health** RMP screening dashboards to target efforts **Cervical**: lobby NSC implementation of self-swabbing **Bowel:** reduce the 17% deprivation difference in coverage **Breast:** improve NWL coverage to match SWL	Reduce variation by 10% by targeting low uptake segments

Care equity & co-design
Address inequity and ensure PCEI led provision of information to improve awareness of risks of heated tobacco

Data driven insights
Use data to understand populations less likely to engage with programmes and develop targeting initiatives to influence behaviour change and create a shift in uptake/ access

Financial & workforce sustainability
Ensure clearer pathways into smoking cessation, and model impact

Technology / AI
Use a multichannel approach to deliver targeted messaging and support

Innovation spread & adoption
Undertake research to address disparities in cancer incidence and outcome and to explore options for early diagnosis in late presenting cancers

RM Partners NW & SW London Cancer Alliance NHS

Ambition	KPI	Metrics	Interventions							5-year plan
Early Diagnosis Deliver or exceed the National ambition of diagnosing patients with cancer at stage 1 or 2 by 2030, through year-on-year improvement, and reducing variation by borough	**Patient interval** Work with populations to improve awareness of symptoms that may indicate cancer Build trust between our communities and healthcare systems to support early presentation	**By 2030** Reduction in variation in time to present across patient demographics from symptom onset to first GP consultation	**Community partnership** Improve symptom activation in deprived populations **Develop** meaningful, sustained interventions, including MECC, targeted proactive outreach & mass marketing **Pilot different models of first line care to** create trusted health service approach	**Population health** approaches to develop predicative awareness to reduce variation	**Care equity & co-design** Working alongside PCEI to develop and harness trusted relationships and disseminate messaging	**Data driven insights** Data driven approach to address inequity Partner with data & behavioural scientists to use population health data to create actionable insights to improve early diagnosis	**Financial & workforce sustainability** Enhance primary care workforce and accessibility through leveraging technology for efficiency and community engagement on when to seek help	**Technology / AI** Ensure PCEI led provision of information through multiple channels and formats, using technology such as advanced data analytics, mobile apps, and social media platforms Improve patient management systems to facilitate cross organisation communication and reduce admin burden	**Innovation, spread & adoption** Deliver research on improving early detection and diagnosis methods, with a focus on cancers with late-stage diagnosis	**Patient interval** Reduce variation in patient interval across RMP
	Referral interval Reduce disparity in the referral interval from primary care to specialist cancer care and eliminate systemic bias	**By 2030** Reduce variation in the number of times seen in primary care before USC referral is warranted, thus improving referral parity Reduction in referral disparities across patient demographics	**Continue to develop and enhance the Early Diagnosis Enhanced Support** approach to address variation in early diagnosis at primary care level							**Referral interval** Reduce disparity in time to referral across RMP Reduce variation in diagnosis rates by 20% over 5 years

Key Interventions; Early diagnosis

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Ambition	KPI	Metrics	Interventions								5- year plan
Reducing time from referral to treatment Ensure a minimum of 85% of patients are treated within 62 days, irrespective of the route to treatment and place of care. Eliminate the variation in RTT experienced by deprived groups	**Attainment of Cancer Waiting Times Standards** Delivery of all operational standards focusing on timely communication of cancer diagnosis and staging to patients	**By 2030** 77% of patients diagnosed with cancer are informed of their diagnosis by day 28, regardless of tumour group	**Enhanced focus on secondary diagnostics** Enable more efficient full diagnostic pathways to reduce time to treatment	**Demand reducing initiatives** Reduce USC demand by via Telederm, breast pain, unscheduled bleeding pathway	**Digital PTL** Implement real time mapping and active digital management of the PTL to reduce pathway time	**Care equity & co-design** Maintain an inequity first approach to improvement Raise awareness of deprivation as a clinical risk Understand and reduce barriers to accessing diagnostic and treatment appointments through working in partnership with our communities, and monitoring equity in the secondary care pathway	**Financial & workforce sustainability** Develop sustainable workforce solutions and collaborative practices through integrated working and collaboration to deliver at scale models. Ensure clear financial underpinning including approach to recording activity to enable sustainability	**Data driven insights** Evaluate care based on population health characteristics and deprivation to address diagnostic differences within our populations	**Technology / AI** Consolidate technology infrastructure to reduce costs and improve cross organisation communication Use novel diagnostic technologies to improve capacity, efficiencies, and experience whilst ensuring effective pathways for the digitally excluded	**Innovation, spread & adoption** Research, identify and implement evidence based innovations to reduce unwanted variation along the treatment pathway, including new technologies	**CWT** **FDS:** 77% 2025 **Cancer FDS**: 75% 2028, 77% 2030 **31-day DTT**: 96% 2025, 98% 2030 **62-day RTT**: 85% 2026, 90% 2030
	Specialist/ secondary diagnostic capacity & system efficiency Sufficient, rapid & equitable specialist diagnostic capacity,	**By 2030** Use of all appropriate diagnostic capacity, including CDCs Reduce DTT by 5 days through more rapid access and reporting of secondary diagnostics	**Inter trust referrals** Optimise RTT processes and enhance MDT efficiency to ensure patient readiness for care transitions	**Equity of access** Facilitate prompt secondary diagnostics, focusing on supporting the most vulnerable	**System capacity** Ensure use of full system capacity in a coordinated way to support rapid diagnosis and treatment						**Secondary diagnostics** **2027**: Secondary diagnostics by day 28 for prostate and breast **2028:** staging by day 28 for colorectal and skin **Reduce Days to DTT by 5**
	Utilisation of AI and digital technologies in diagnostic and patient pathways Harness AI and digital technologies to support diagnostics, pathology and patient facing pathways	**By 2030** Implement AI in minimum of 2 of diagnostic pathways Implement technology driven pathways to facilitate patient care through the cancer pathway	Partner with NICE to identify AI targets, supporting conversion of Early Value Assessment technology into business as usual Support wider imaging, pathology and CDC networks to partner where feasible to harness rapid adoption of technology that supports patient care and management								**AI** Implement at least 2 AI driven diagnostic technologies across RMP

Key Interventions; Time to treatment

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Ambition	KPI	Metrics	Interventions							5-year plan / target
Treatment, Care and Survival To be in the top decile internationally for cancer outcomes and survival	**Survival** Measurable improvement in 1,3,5 year survival and a reduction in survival variation by deprivation	**By 2030** 1 and 3 year survival by ICS and deprivation	**Data and benchmarking** Use data and international benchmarking to identify drivers of unwarranted variation in treatment and develop interventions to deliver improvement	**Care access** Delivery of optimal pathways which meet the needs of our population ensure equitable and rapid access to all cancer treatments and symptom management services Delivery of cancer care as close to home as feasible	**Care equity & co-design** Maintain an inequity first approach to improvement Deprivation as a clinical risk factor Evaluate care based on population health characteristics and deprivation to address survival difference within population	**Data driven insights** Through a collaborative data network use national audits GIFRT and SACT demand and capacity to create a step change in care Identify areas of treatment variation to develop strategy for improvement and then demonstrate change over time	**Financial & workforce sustainability** Understand current and future needs to ensure capacity aligns to demand and efficient use of available resources adopting best practice, cross site working and shared learning Support recruitment and retention of cancer specific staff	**Technology / AI** Work in partnership with NICE to trial and implement emergent technology Rapid adoption of new technology supporting cancer care Ensure effective pathways for the digitally excluded	**Innovation, spread & adoption** Through the RMP innovation fund support the development of interventions focusing on improved survival, reduced treatment variation and enhanced quality of life	**Survival** 1 year survival matches best in England, for colorectal, UGI, breast and uterine cancer, and closing deprivation survival gap in these tumour groups
	Treatment Rapid adoption of new technology and genomic assisted treatment Improve trial participation and treatment for those with metastatic disease. Standardise time to access emergent NICE treatments	**By 2030** Optimal treatment scheduling to improve outcomes Adoption of new treatments and technology Improve genomics TAT to reduce time to treatment	**Genetics and personalised medicine** Improve genetic testing access, TAT and support personalised medicine. Effective roll out of new tests and treatments **Time to treatment irrespective of modality** Deliver pathways that ensure patients meet 31-day DTT regardless of modality and line of treatment							**Treatment** **31-day DTT** 2025: 96% 2030: 98% (first + subsequent) Minimum of 2 new treatments and technologies adopted by 2030 Genomics TAT 14 days from sampling to results
	Personalised care Universal access to personalised treatment, care and support to address short and long term impacts of cancer focusing on sleep, anxiety, specialist pain services, prehabilitation, and rehabilitation	**By 2030** Ensure equitable, supportive services across cancer pathway Implementation of a sustainable equitable prehabilitation approach	**Prehabilitation** A sustainable and funded prehabilitation offering targeting physical activity, nutrition, psychological well being **Living with cancer** Universal access to specialist pain services, and support with sleep and anxiety							**Personalised care** Universal access to personalised care treatments proven to improve outcomes

Key interventions; Treatment care and survival

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Delivering the cancer strategy: risks and mitigations

Risk	Mitigations
Failure to tackle variation: Not making a substantial difference to variations in access, time to treatment and survival, which will mean we do not deliver our strategy	– Co-design with communities to understand how to develop services that will provide equitable access and support. – Ensure interventions are financially sustainable to ensure sustained delivery over time. – Ensure real time monitoring of change to enable iteration of approaches to reduce inequity.
Financial: Failure to deliver financially sustainable services will mean strategies do not bed in	– Where long term funding will be required ensure post pilot financial model is clear at the outset and align long term financial model to NHS Payment Tariff (or successor), and track savings where services have been improved. – Where short term intervention, ensure that exit strategy clear to ensure no stranded costs. – Where novel funding models are required, engage financial leadership from both ICSs and Trusts to ensure buy in and stress testing before embarking on change.
Workforce: Failure to create compelling workforce models or deliver them in practice will negatively impact on strategic aims	– Use lead nurse forum to underpin any decisions or focus on new nursing AHP roles. – Work with local HR teams to ensure case for change and agreed models are fully implemented. – Bridge funding and training period to ensure at scale delivery.
Coordination challenges: Inefficient communication and coordination between primary care providers and secondary care specialists can lead to delays in diagnosis and treatment, impacting patient outcomes.	– Continue to have Primary and Secondary care represented on all pathway groups, at decision making groups and, in the SMT. – Work with Communities, Trusts and Place teams to create pathways that improve care and reduce handoffs and inefficiency across both primary and secondary care.
Stakeholder alignment: Conflicting priorities and goals among various stakeholders may affect speed of delivery and longer-term success	– Ensure focus on high impact interventions that deliver strategy, where there is a clear case for change. – Ensure interventions deliver wins for all parties to support engagement.

RM Partners
NW & SW London Cancer Alliance

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Thank you

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 4.5
Title of Document: Our People Strategy 2025-2030	**To be presented by:** Chief People Officer

1. Status For approval

2. Purpose: Our People Strategy sets out how we will develop our workforce to deliver our clinical strategy over the next five years and beyond.

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

3. Summary

Our People Strategy has been created as result of widespread conversations throughout the Trust and set out how we will deliver the clinical strategy core themes of a compassionate, committed and excellent workforce.

- Building on our progress to date, the Strategy expands three pillars which represent our People Priorities, namely:
- Attract: Create a compelling offer built on our strong brand and offer new routes into healthcare
- Retain: Recognise, reward and develop our workforce within a compassionate and inclusive culture
- Grow: A skilled, sustainable workforce that will deliver our future clinical ambitions

The strategy sets out the focus areas that we have collectively identified as having the potential to deliver the highest impact. Delivery will be across the different levels of the organisation, setting out as far as possible, the right place to deliver the ambitions.

4. Recommendations / Actions

The Board is asked to approve the People Strategy.

The ROYAL MARSDEN
NHS Foundation Trust

Our People Strategy 2025–2030

NHS

Contents

1.

Foreword

Why are our people so important to the delivery of our clinical service ambitions?

Over the last five years, changes in the global healthcare workforce profile, exacerbated by the COVID 19 pandemic, demographic and generational change, have reminded us that without the best people, we cannot deliver the very best services to our patients. We need to nurture and value our people now, and in the future, so that we can attract, keep and grow the most compassionate, committed and excellent workforce to deliver our clinical service and research ambitions.

This is because:

- The growing gap in worldwide workforce supply and changing generational aspirations means that we must look differently and more creatively at how we attract, keep and transform our people to remain at the forefront of cancer care and research globally
- There is increasing worldwide pressure on healthcare workforce supply. Pre pandemic predictions of a 20 percent shortage worldwide by 2030 are likely to increase. Exacerbated by the growth of artificial intelligence and digitalisation, hybrid working and new roles, the shape, skills and size of the workforce will change
- The challenging economic climate in UK means that it is currently a less attractive place for overseas workers. We need to be more proactive and creative in securing the people we need now and for the future from our domestic market. It is likely that our ability to sponsor overseas workers in future will be linked to demonstrable investment in the development of domestic workforce
- The NHS financial position will be a constraint and the drive to increase the productivity of our staff will continue to grow. This is not just about doing more with less but doing it differently
- From boomers to the zeds – we are experiencing unprecedented generational differences in the workplace and how people want to live their lives. We need to respond and accommodate as an employer; if we don't, others will
- Artificial Intelligence and genomics are set to transform treatment and diagnostics, our patients are living longer and have more complex conditions. Our staff will need to work differently and adopt new skillsets to deliver cancer care in this rapidly evolving landscape.

Our People Strategy 2025–2030

Eve Allan, Matron and Divine Uy, Staff Nurse in the Olayan Day Care Unit, Oak Cancer Centre

Our People Strategy 2025–2030

Which means that we need to:

- Modernise our approach to how we manage hiring, talent, succession planning and career transitions to provide flexible and meaningful employment at all stages of life
- Create and articulate tangible pathways to develop our future workforce, aligned to NHS Long-term workforce plans and aspirations
- Understand what really matters to our people, both personally and professionally, and provide the very best employee experience
- Balance the benefit of the collective with the importance of personalisation. This means creating a strong and diverse workplace community which can respond to specific individual needs and circumstances
- Ensure that workforce models are assessed for productivity and aligned to meet demand, with a ‘right clinician, right place, right time’ approach that focuses consultant time on the most complex patients and optimises the potential for lower complexity patients to be seen by another specialist clinician
- Strive to provide an inclusive and equitable environment for all, free from discrimination, exclusion or marginalisation and where everyone feels a sense of belonging and is supported to realise their full potential.

Anchored in the ambition of our Five-Year Clinical Strategy launched in 2024, our People Strategy is the result of a collaborative effort and co design across our organisation. It addresses the breadth, depth and diversity of the workforce challenges that we face and how we will meet these.

Kirsty Scates, Core Radiographer/Mammographer, Oak Cancer Centre, Sutton

2.

Executive summary

Our People Strategy sets out how we will develop our workforce to deliver our clinical strategy over the next five years and beyond. We will do this by:

- Assessing the current workforce and understanding its relationship to activity and finance, using data, intelligence and insights, noting current challenges in recruitment supply, retention, capacity, capability and productivity
- Determining future requirements, how the workforce needs to grow and/or change over the next 3–5 years and beyond, to model how the roles, skills and number we will need to deliver our strategic ambitions
- Identifying where continuing with our current workforce models and ways of working is likely to lead to gaps in skills and numbers in the future, and prioritising areas for action
- Implementing initiatives to attract, retain and grow the right talent to meet the requirements of our clinical strategy.

The overall aim is to create a meaningful set of initiatives that will help to secure our workforce for the future, which aligns to the delivery of the current NHS 10 Year Plan, the outcome of its review by the newly appointed Labour Government, the NHS Long Term Workforce Plan and the People Promise as well as our own aspirations.

We will also:

- Enhance our reputation as an excellent employer, delivering high quality care in environments where staff can thrive
- Deliver new care models which maximise the application of staff skills and fulfilment for the benefit of our patients and the wider cancer community
- Drive social responsibility to create the conditions for a good life for our local communities including meaningful employment opportunities
- Place equality, diversity and inclusion at the heart of everything we do. All who encounter our Trust, including our workforce and the communities we serve, will be treated with dignity and respect.

To deliver this, The Royal Marsden People Strategy will:

- Deliver the clinical strategy core theme of a compassionate, committed and excellent workforce, combining our clinical and people themes to drive productivity and quality improvement for our patients
- Align with the Clinical Research and Education Strategies which are being developed with the ICR as our partner, as well as our own digital and estates strategies
- Be consistent with the themes of the NHS Long Term Workforce Plan, the NHS 10-year plan and any revisions
- Understand and harness the four forces which shape workforce strategy which are:
  - Specialisation: what expertise will we need and when, and how will we get this
  - Scarcity: where are our gaps/ deficits, supply of people and skills and how we will fill them
  - Our brand: what is our employer proposition, how do we differentiate ourselves as an employer. Why should people work for us? What does our employer brand represent?
  - Our organisational culture and purpose, and our place in the wider community.

The strategy sets out the focus areas that we have collectively identified as having the potential to deliver the highest impact. Delivery will be across the different levels of the organisation, setting out as far as possible, the right place to deliver the ambitions.

Callum Loader, Scientific Officer, pipetting in the Ralph Lauren Centre for Breast Cancer Research

Charles Owusu Ansah, Cleaner

3.

People, provision, patients

The Royal Marsden has two hospitals, one in Chelsea, London and another in Sutton, Surrey. It also has a Medical Day Unit at Kingston Hospital and a private care diagnostic and treatment centre in Cavendish Square, central London.

The Trust is the founder and host of RM Partners Cancer Alliance, which includes St George's University Hospitals NHS Foundation Trust, Imperial Healthcare NHS Trust, and other trust and Integrated Care Board (ICB) partners across north west and south west London.

Our workforce is critical to our success, and we hire and invest in the best, from local, national and international sources. However, as recognised by the World Health Organisation, there is a significant global healthcare workforce shortage. The UK has a national shortfall and faces strong national and international competition for a skilled and qualified healthcare workforce.

The clinical strategy we have set ourselves is ambitious, and only possible if we have the staff to sustain and grow our services. Furthermore, in a changing healthcare landscape, our workforce career pathways will need to be innovative to align to developments in research, education and healthcare technology. If we are unable to attract or upskill staff to work with emerging technologies, such as artificial intelligence or genomic testing advances, we will find it challenging to continue to deliver the innovative and pioneering healthcare for which we are known.

Our Clinical Strategy sets out to build our position as a global employer of choice for the cancer workforce so that we can deliver on our clinical ambitions in a compassionate working environment.

Our longer-term ambitions include service expansion at Chelsea because of the increase in capacity provided by the Chelsea redevelopment plan and potentially through the Cancer Hub plans at Sutton. This will require the early design of innovative workforce models, including new roles and working patterns to ensure that these are deliverable within the projected financial envelope.

In response, The Royal Marsden will attract, retain and grow its workforce within resources available. This will be supported appropriately across all disciplines to rise to the challenge of delivering healthcare in the 21st century to support our patients locally, nationally and globally. The Trust has established a People Board, chaired by the Chief Executive, to oversee our People Strategy and to drive these initiatives forward.

Progress so far

Our most recent comprehensive Workforce Strategy Aspiring to Excellence covered the four year period 2016–2019. The creation of the subsequent strategy from 2020 was interrupted by Covid, and was then superseded by the launch of the national NHS People Promise, the aim of which was to respond to the workforce challenges exacerbated by the pandemic. In the autumn 2020, The Royal Marsden developed our own People Plan with the primary purpose of supporting the people response to the pandemic and, as a result, this was predominantly operational in nature.

The focus was on the extension of staff numbers, flexibility and development, on wellbeing and on creating an inclusive and compassionate community for all our people.

The four pillars of our people plan were:

- Workforce; working together differently to deliver patient care
- Development: growing our people for the future
- Wellbeing: looking after ourselves and each other
- Creating a culture of inclusion and belonging.

These themes corresponded to areas of work which had already been progressed by the Trust's previous Workforce Strategy. In September 2022, the Trust Board agreed a programme of interventions to lay the ground for the next stage of our strategic plans. This reinforced our priorities as the following:

- Reframe the workforce planning debate from numbers of posts to one of productivity
- Support health care professionals to practice at the upper limits of their clinical competence
- Stimulate digital possibilities to increase the time available for care and productivity and upskill our workforce to be able to optimise our investment in technology and become more agile, to gain competitive advantage and maximise staff wellbeing
- Continue to enhance the leadership, development and coaching of individuals and teams so that all have the necessary clarity of purpose and energy, and benefit from proven approaches which increase motivation and productivity, and create a positive tone in the workplace
- Concentrate on getting the best staff, developing them and keeping them
- Create an inclusive and equitable environment where every individual is valued, respected and supported to contribute to our collective success.

Our People Strategy 2025–2030

Ms Marielle Nobbenhuis, Head of Surgery

We have made significant progress against this framework since 2019. We have delivered an increase in flexible working models, we have created and resourced new workforce teams at Cavendish Square, and the Oak Cancer Centre, we have strengthened our health and wellbeing provision through our internal Occupational Health Service and a comprehensive 24/7 Employee Assistance service which now includes online GP services which is immediately available to our entire workforce. Most importantly we have nurtured workplace communities which value and promote diversity and inclusion, and excellent workplace relationships, over the most contentious industrial relations period in a generation. These are reflected in our improved workforce metrics and satisfaction ratings from our staff.

In the context of the most challenging labour market and financial conditions, we have achieved significant growth in our workforce profile. Our metrics in April 2019 show a total establishment of 3,900 FTE (Full Time Equivalent), with just over 3,500 people in post. Our vacancy rate was 8.5% and our voluntary turnover rate was 13.4% By September 2024, our workforce establishment had grown to just under 4,900 FTE, with just over 4,500 FTE in post, and an overall vacancy rate of 7.5% and voluntary turnover rate of 8.9%. Our nursing vacancy rate in particular is below 3% and our retention continues to improve.

These statistics demonstrate that the Trust has, to date, been highly successful in attracting and retaining staff but this level of growth is unlikely to be sustainable going forward due to funding constraints and shortages in the labour market. The focus will need to shift towards productivity, introducing new workforce models and growing our own pipeline of staff.

April 2019

Staff group	Establishment FTE	Staff in post FTE	Vacancy %	Turnover %	Voluntaty turnover %	Sickness %
Add Prof Scientific and Technic	227.98	191.87	15.8%	20.5%	19.8%	2.7%
Additional Clinical Services	318.46	298.37	6.3%	17.1%	16.4%	5.0%
Administrative and Clerical	1077.19	997.81	7.4%	18.3%	16.8%	3.2%
Allied Health Professionals	290.30	253.75	12.6%	12.1%	10.3%	3.2%
Estates and Ancillary	264.64	243.29	8.1%	6.9%	6.0%	4.7%
Healthcare Scientists	235.77	211.02	10.5%	8.4%	6.7%	3.4%
Medical and Dental	442.88	405.03	8.5%	3.1%	1.7%	1.2%
Nursing and Midwifery Registered	1050.63	976.04	7.1%	15.7%	14.5%	3.3%
Grand total	3907.85	3577.18	8.5%	14.7%	13.4%	3.3%

September 2024

Staff group	Establishment FTE	Staff in post FTE	Vacancy %	Turnover %	Voluntary rurnover %	Sickness %
Add Prof Scientific and Technic	237.88	230.95	2.9%	11.8%	10.5%	2.2%
Additional Clinical Services	489.74	425.12	13.2%	14.3%	14.0%	6.7%
Administrative and Clerical	1435.40	1308.08	8.9%	11.2%	8.5%	3.6%
Allied Health Professionals	380.11	337.97	11.1%	13.1%	12.0%	3.1%
Estates and Ancillary	250.08	215.93	13.7%	9.1%	4.0%	4.0%
Healthcare Scientists	293.93	279.79	4.8%	6.3%	5.9%	3.6%
Medical and Dental	572.43	530.04	7.4%	4.1%	3.4%	0.5%
Nursing and Midwifery Registered	1231.47	1194.41	3.0%	10.7%	9.4%	4.7%
Grand total	4891.04	4522.31	7.5%	10.7%	8.9%	3.7%

Our staff survey results are consistently improving. Our people tell us that our learning and development, our wellbeing offer, and opportunities for career progression are particularly appreciated and are our greatest differentiators in a far more challenging labour market than we have ever experienced before.

They tell us that they come to us for learning and development opportunities, and the majority of those who leave are “happy leavers” who have enjoyed working with us and are leaving to progress their careers in the wider cancer care community. They appreciate our health and wellbeing offer which provides support on a 24/7 basis. Many would like to return and act as advocates for us the in the wider cancer workforce community to enhance our reputation as a top employer. This is the baseline for our People Strategy going forward.

Equality, diversity and inclusion

We have much more work to do in relation to equality, diversity and inclusion. Our metrics show that we have made progress over the last five years in creating a more inclusive and welcoming workplace for people with protected characteristics. While our gender split remains constant at 75% female throughout the workforce, which is not unusual for an NHS employer, we have a positive representation of female leaders at the highest level.

Representation of BME staff in our workforce has increased from 33.5% in April 2019 to 41.9% in September 2024 as shown below across the main staff groups.

April 2019

Ethnicity by staff group	BME - Asian	BME - Black	BME - Other	Not Stated	White - British	White - Other
Add Prof Scientific and Technic	18.5%	8.3%	13.2%	1.5%	41.5%	17.1%
Additional Clinical Services	15.7%	17.6%	12.9%	0.6%	35.5%	17.6%
Administrative and Clerical	12.3%	12.6%	8.2%	1.3%	55.2%	10.3%
Allied Health Professionals	11.5%	10.1%	6.3%	0.3%	60.8%	10.8%
Estates and Ancillary	10.2%	22.3%	8.7%	1.9%	44.7%	12.1%
Healthcare Scientists	12.3%	7.9%	6.6%	3.5%	49.3%	20.3%
Medical and Dental	19.0%	0.9%	13.5%	5.5%	36.6%	24.5%
Nursing and Midwifery Registered	11.7%	8.4%	10.0%	1.0%	48.5%	20.4%
Grand total	13.3%	10.5%	9.7%	1.8%	48.3%	16.4%

September 2024

Ethnicity by staff group	BME - Asian	BME - Black	BME - Other	Not Stated	White - British	White - Other
Add Prof Scientific and Technic	22.6%	10.7%	15.5%	2.4%	33.3%	15.5%
Additional Clinical Services	16.8%	20.5%	12.1%	2.2%	33.4%	15.1%
Administrative and Clerical	16.0%	11.4%	9.4%	2.6%	49.0%	11.6%
Allied Health Professionals	19.8%	12.1%	8.2%	1.1%	44.9%	14.0%
Estates and Ancillary	13.0%	20.3%	10.4%	2.6%	40.7%	13.0%
Healthcare Scientists	23.4%	9.9%	8.6%	2.6%	38.5%	17.1%
Medical and Dental	23.4%	1.8%	15.1%	9.1%	31.5%	19.2%
Nursing and Midwifery Registered	21.3%	8.0%	15.3%	3.5%	36.9%	15.0%
Grand total	19.3%	10.6%	12.1%	3.4%	40.2%	14.5%

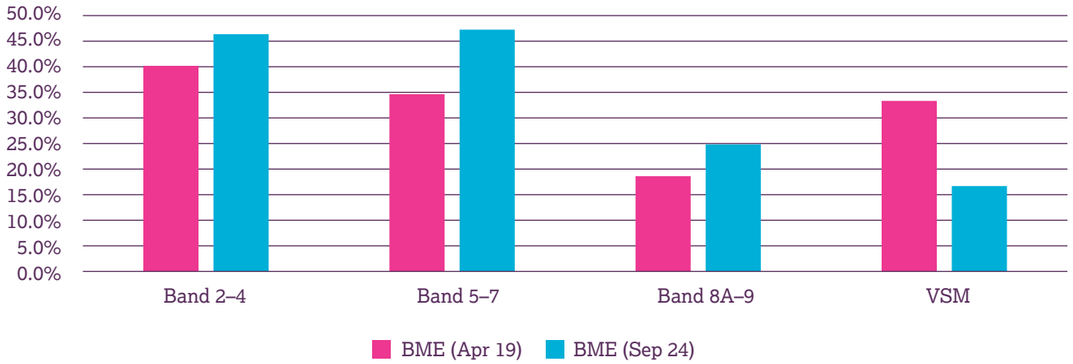
Our workforce profile by other protected characteristics, including:

- 4.9% of the workforce has declared a disability
- where religion and belief is disclosed, most staff identify as Christian, with 28% choosing not to declare, followed by 17% declaring another religion or belief, for example, Islam, Hinduism or other.
- 32% of staff are aged between 31 and 40, with 7% of staff over 60
- 3.7% of staff identified as being from the LGBT+ community (lesbian, gay, bisexual, trans or other) compared with 70.7% identifying as heterosexual and 25% of staff not disclosing

However, staff from a black, Asian or other minority ethnicity remain under-represented in senior roles within the Trust. So although representation across all bands up to Band 9 continues to increase, it is important that we accelerate this progression to improve our senior leadership pipeline and improve visibility at the most senior leadership level. Recruitment and development will be our prime areas of focus.

In the staff survey results, staff at The Royal Marsden report experiencing more discrimination on the grounds of race and feel less confident that career progression is fair and equitable, compared to other similar Trusts. Therefore, commitment to our EDI programme of work is woven through all three pillars of our People Strategy and the principles of equal opportunity, inclusion, individuality, respect and belonging underpin all aspects of this strategy. In addition, we prioritise our EDI strategy and biannual work programme, with progress reported as part of our Annual Equality Report through the EDI Steering Group to the Trust Board.

BME by grades



Our People Strategy will also align to the requirement set out by NHS England's equality, diversity and inclusion improvement plan to help us create an inclusive workplace.

Specifically, we will:

- adopt an intersectional approach to the elimination of pay gaps
- seek to eliminate bullying, discrimination, harassment and physical violence at work.

Nursing staff Hamenan Dibi, Jully Kumari and Stanly Lutao in Burdett Coutts ward

4.

Our strategic ambitions

Our strategic ambitions are set out in the Five-Year Clinical Strategy and create a vision of a workplace where colleagues enjoy meaningful work, have multiple careers within The Royal Marsden, work at the top of their skillset and have the flexibility they need so that their work is complementary and supportive of their roles and purpose outside the workplace.

The evolving world of work and how people were already choosing to live and work differently, now means that flexibility, opportunity, value creation and ability to thrive are more important to people than the traditional single career or lifelong organisational commitment. We need to embrace the opportunity to create meaningful and rewarding careers that attract staff from different industries, providing new specialisms and innovative practices for our workforce whilst strengthening collaboration and integration across professional groups.

The People Strategy partners with the Estates and Digital Strategies as the primary enablers for the delivery of our plans and it is imperative that the three are consistent and complementary.

Fay McMeckan, Medical Secretary

The three pillars representing our People Priorities are:

Attract

Create a compelling offer built on our strong brand and offer new routes into healthcare

- attract the best and most diverse talent
- engage and inspire young people to consider a career in healthcare
- modernise our approach to recruitment
- create jobs people want to do.

Retain

Recognise, reward and develop our workforce within a compassionate and inclusive culture

- inclusive teams and compassionate leadership
- meaningful progression pathways for all professions
- flexible worforce models and environments that meet the needs of our intergenerational staff
- a powerful health and wellbeing offer.

Grow

A skilled, sustainable workforce that will deliver our future clinical ambitions

- new skills to deliver new treatment and care models
- train and educate our staff differently
- evolve new broader models of care and enable more innovative ways of working
- promote digitisation to all our people.

5.

Our people priorities

Our new Royal Marsden People Priorities integrate existing projects, utilising the progress and momentum established over the last few years, and establish a new set of activities to deliver a step-change in pace and impact.

We are committing to making a tangible difference to our workforce and their wellbeing, development and employee experience, whilst driving improved patient care, and research outcomes. We will take a systematic approach to the workforce productivity position, triangulate financial, workforce and action-led data in order to identify where there is opportunity for redesigning the workforce model. This will be supported by a set of enablers focused on our understanding of what is needed to deliver our ambitions.

Planning our future workforce requirements

The first priority is the development of workforce plans to be delivered by our clinical groups – by clinical expertise/ specialty, tumour group or patient pathway. Using the Five-Year Clinical Strategy to inform our understanding, key workforce priorities need to be identified as follows:

- Intelligence gathering on current workforce gaps and future challenges. We need to understand the current relationship between our people and the activity they deliver
- Build the plans for each staff group demonstrating differentiated approaches for attraction, retention and workforce development. What will work for our top medical talent will not necessarily be appropriate for other groups
- Model the workforce by clinical expertise group that will deliver future activity differently within the financial envelope available. This may mean different ratios between qualified and support clinical workforce and the adoption of new roles to improve our productivity
- Continue to introduce new advanced and enhanced roles that offer new progression pathways for clinicians and enable top-of-the-licence working through distribution of responsibilities
- Gather information on a trust wide level to analyse how the shape of the whole workforce will change based on future requirements and potential gaps in supply
- Determine the resulting priorities for education – both for The Royal Marsden as a commissioner and The Royal Marsden School as a provider. Creating new support or extended roles means we will need to articulate the education required and commission this appropriately
- This will need a sound understanding of baseline activity and future demand modelling – therefore consultant job planning is a priority. This is the key group which drives our activity and reputation
- Commitment to succession planning for business-critical roles for the future
- Continue to understand our current issues with Equality Diversity and Inclusion using a range of data sources and deliver a programme of work that is designed to achieve positive and sustainable change

In order to deliver on an organisation wide shift, we are prioritising the areas within each of our three pillars that we believe will have the highest impact.

Lovely Varghese, Senior Staff Nurse, and Jacqueline Cooper, Healthcare Assistant, in the West Wing Clinical Research Centre

5.1 Attract

Workforce planning over 3–5 years to identify what is needed to inform recruitment, retention and transformation plans. Improved workforce planning will help to better understand the skills and numbers needed. Annual Recruitment Plans by division/tumour group. Recruitment ambassadors by specialty. Supply strategy for each professional group. Assess and plan for the impact of site developments and capacity increase.

Proactive recruitment strategies to broaden candidate pool, service specific marketing materials. Strong employer branding and social media activity to strengthen labour market presence. Come to work in Cancer, more specifically than NHS careers, to promote the positive developments in the cancer care workforce. Promote our magic in a compelling way, share the potential of new site developments at Chelsea and Sutton.

Widen participation. Build on our partnerships to create strong relationships with local schools and education providers. Develop professional ambassadors to speak to young people about their roles in order attract young people careers in the cancer workforce. Create a pre-apprenticeship pipeline, through work experience, T-levels and placement schemes, ensuring that we create opportunities for diverse populations to enter cancer healthcare employment. Consider how to attract Young Talent who are looking for different incentives.

Use **apprenticeships** to offer new routes into healthcare professions where undergraduate education supply is not meeting demand; offering young people the opportunity to earn while they learn will attract a more diverse group of people into healthcare and provide a local supply of healthcare professionals for the future.

Modernisation of workforce processes, we will streamline our processes and digitise where possible, adopt Artificial Intelligence to drive efficiency balanced with human oversight to ensure ethical responsibility. This will include the modernisation of consultant appointment process and extend our inclusive recruitment principles to broaden the diversity of applicants, particularly those from under-represented groups.

Create **new employment models** which include joint appointments with other trusts and partnerships with other NHS partners/other organisations. We have opportunities to combine NHS, Academic and Private Practice employment to create jobs which are attractive to the very best medical staff whom we want to attract. Use imaginative career pathways to capitalise on our strength in clinical research as our most powerful attraction and retention factor, creating more pathways into research for all clinical professions.

Flexible worker arrangements including attractive bank arrangements for those for whom substantive employment is not currently an option, encourage more movement between working models. Enhance existing flexible options to balance with organisational need and frame bank working as an attractive career option. This will be consistent with legislative changes expected due in 2025/26.

Ensure all our recruitment processes are **inclusive, fair and equitable** through enhanced recruitment training and eliminating as far as possible, bias and favouritism in decision-making. Our recruitment campaigns and recruitment processes will be more inclusive allowing staff from all backgrounds to demonstrate their capabilities and suitability to the full extent.

Maximise the specific features of our **workforce community.** We are privileged to have many staff who have chosen to work with us for a long time and feel they are part of the organisational community.

We also have staff who leave but remain connected to the organisation and return into a more senior post. We will nurture relationships with all “happy” leavers who are keen to stay in touch in order to encourage a return. These staff hold organisational knowledge and history and can connect us more strongly to both local and wider, sometime global communities through the creation and extension of networks and influence. We will build on this by enhancing current The Royal Marsden Alumni and other networks to increase our impact and influence.

Measures of success:

- Improved workforce metrics: vacancy, time to hire.
- Better Workforce Race Equality and Disability Equality Scheme performance
- Presence and awareness in local community, improved employer brand recognition
- Control of workforce cost through intelligent use of flexible workforce resource
- Increase take up of apprenticeships
- Positive feedback from the NHS staff survey and other surveys
- Annual Trust Education Report.

5.2 Retain

Design jobs that people want to do: balanced job plans, which reflect NHS activity, PP and clinical research for doctors, encourage all senior clinical roles to balance NHS service, research, teaching and other activities to create fulfilling and attractive jobs. How we maximise the talent of our medical staff so that they work as happily and as effectively as possible will be key to our continued success.

Induction and onboarding: enhancing onboarding positively impacts on the retention of staff. Particularly focussing on supporting newly qualified clinicians through their early stages of a career in cancer care using more experienced professionals to support and educate them so they join us and stay.

Promote flexibility to meet staff aspiration for work life balance and patient/organisational need. Hybrid working, flexible working/ sabbaticals and career breaks. Introduce new working patterns – 24/7 working to maximise capacity. Upskill managers to lead hybrid teams. This will build on the legislative changes to be introduced in 2025/26.

Mainstream **equality, diversity and inclusion:** to ensure that all staff feel welcome, that representation of those with protected characteristics improves both in terms of metrics and experience. Advance our work to create a truly inclusive place to work where diversity is championed, and all staff feel able to belong and realise their true potential. Leaders to continue to reach out, appreciate disadvantages, and to commit to creating local workplaces where discrimination and inequity are actively eliminated.

Engage our people: everyone has a voice. Consultant engagement to be positively encouraged through the establishment of a Clinical Cabinet so that our key clinicians have influence over everything we do. We will continue to build healthy and positive relationships with our staff/Trades Union representatives through formal and informal partnership and support our active staff networks (REACH, PRIDE, DAWN). Encouragement of face-to-face connection to balance increased use of digitisation in the workplace and enhance sense of humanity. Extension of responsive ways of finding out what people think and want. Our Freedom to Speak Up framework will continue to provide a confidential route through which people can raise concerns or seek advice.

Talent management: Access to learning and development for all. This includes personal and professional development and growing our leadership skills. We will spot and nurture our rising stars, help people understand how to manage their career progression and how to access all that the Trust has to offer.

Succession planning for all business-critical roles ensuring no cliff-edge loss of skills. Identify key roles by profession and team and single points of failure. Introduce later-career conversations as standard to understand intentions and preferences. Support different working models as staff transition to retirement ensuring that we are harnessing the experience of pre-retirement clinicians.

Nursing vision: Through an assessment of programme workstreams we will deliver on our commitment to nurses as set out in out Five-Year Nursing Vision which has the aim of improving nurse retention through wellbeing, inclusion and development.

Privilege professional fulfilment and wellbeing culture through a dual strategy of practice support and personal wellbeing. This includes promoting civility in how people behave towards each other and respect and kindness. Staff spaces and facilities, lockers, changing rooms, food, preventing burnout and psychological support are all vital to ensuring a safe and healthy workspace. As is protection from sexual misconduct. Staff requirements need to be prioritised in our capital developments, for example in the Chelsea Development.

Reward and recognition: we will continue to acknowledge staff achievements, long service and celebration of our people. Encourage local appreciation events to balance the trust wide rewards and look to encourage local discretion within a trust wide framework. Explore local compensation strategies to enhance attractiveness of national pay framework wherever possible and ensure competitive rewards.

Compassionate and inclusive leadership that enables all our staff to feel valued, recognised, able to contribute and be developed to their full potential, within a clear leadership framework. A focus on wellbeing so that early stage burnout is recognised quickly and steps taken to address concerns at a local level.

Support engaged, **high performing teams** through a range of organisational development interventions including team-workshops, team-coaching and bespoke interventions where there are issues or opportunities for growth.

Measures of success:

- Metrics: reduced unplanned turnover, increased appraisal rates, training take up, job plans. EDI/WRES/WDES metrics improvements
- Improvement in absence rates/in work wellness
- Positive feedback from NHS annual staff survey indicating improvements in experience
- Introduce targeted surveys to measure more immediate impact in specific areas.

5.3 Grow

Develop a world class clinical education offer to which all staff have access. To support clinical excellence, enhance professional satisfaction and contribute to the improvement of The Royal Marsden clinical services and research. A priority will be programmes to deliver the new roles identified by our workforce planning process.

Investment in improved workforce planning will identify the size and shape of our future workforce. We will use the Growth and Skills Levy (previously the Apprenticeship Levy) to create **'grow your own'** schemes that support a sustainable pipeline of trained workers across all disciplines. This will be consistent with the new government's focus on building domestic supply to reduce reliance on overseas recruitment and increase participation across local communities.

Create **visible career pathways** encompassing a variety of progression routes; use these to support recruitment and retention. Encourage lifelong learning so that people can develop horizontally into new areas of practice.

Embed the **cancer career and education development programme (ACCEND)** framework to support the development and improve the supply of the cancer health care professional workforce.

An open and transparent focus on **inclusive talent identification** and development where all staff are having career conversations and are supported in meeting their future aspirations. Delivering talent programmes that target under-represented groups will support this programme of work. Furthermore we will develop our staff to create inclusive services for our patients with protected characteristics.

Drive forward the **Systemic Anti Cancer Therapy (SACT) strategy** through analysis by disease group of where there is greatest potential to advance the usage of non-medical prescribing and embed new models of care where this is appropriate. Focus on longer-term planning to identify successors to Non Medical Prescribers and Advanced Practitioners and safeguard against loss of skills and experience.

Maximise the medical workforce: secure a robust and attractive staffing model which blends doctors in training and physician support posts to support the development and well being of our top talent consultant workforce. Particularly important in the non oncology specific specialties i.e. diagnostic and surgery as the focus on early diagnosis is strengthened.

Increase the organisation's **digital skills development** from basic through to proficient, in order to improve efficiency and productivity, and prepare the organisation for the next level of digital working e.g. as part of hospital at home and the introduction of AI. Build enhanced data and digital skills in key roles as part of the EPIC optimisation programme of work.

Embed the skills to manage people, teams and services effectively across the organisation at all levels from aspiring manager through to Clinical Director. Ensure a focus on the **The Royal Marsden Leadership Behaviour Framework** to encourage self-reflection and continuous learning and support managers in holding compassionate but courageous conversations that support wellbeing and retention through self-assessment and feedback, training and coaching.

Develop the **skills and capacity for transformation and change,** ensuring new developments in treatment and diagnostics are operationalised with minimal delays. Skills needed include data modelling and interpretation, supply and demand modelling, experience-based co-design with patients and systems thinking and leadership.

Establish apprenticeships as an integral part of our internal education offer by raising awareness of the large range of apprenticeship programmes relevant to our staff, working with education providers to develop new programmes to meet emerging skills needs and support professions and departments to develop meaningful career pathways for all staff, supported by apprenticeship qualifications.

Deliver a **programme of genomics education** that embeds the skills for mainstreaming the delivery model of genomics-informed diagnostics and treatment by tumour type and supports the development of a competent workforce to deliver.

People and thought leadership development: grow our capability to support our people and teams: team facilitation and mediation, coaching, development advice, big conversation events. This will support personal and professional development and enhance our organisational ability to horizon scan and think strategically.

Measures of success:

- Improved productivity gains within existing financial envelope.
- Increased use of apprenticeship levy/ increased number of apprentices.
- Enhance our use of the apprenticeship levy to provide future workforce pipeline
- Staff satisfaction as measured through our Annual Survey and other surveys.

6.

How we will deliver

Delivery will be enabled by resourcing and partnering to deliver the People Strategy priorities. Phasing delivery will enable us to flex our approach to ensure resource requirements are appropriately identified.

Priorities will be delivered across the organisation, with the requisite governance and oversight and will be connected to our Clinical Strategy outcomes.

We want to set out a clear ambition whilst retaining agility and the ability to flex resources to support in-demand areas of the workforce. Our work programme will adopt the following framework:

Year 1 2025/26	Years 2 and 3 2027/28	Years 4 and 5 2029/30
– Laying the foundations – Pilot new initiatives – Priority deliverables	– Accelerating the change/productivity benefits through specific intervention	– Transforming the workforce – Scale up and spread of pilot initiatives to increase impact

Then, year on year priorities will be determined by each pillar and agreed by our People Board.

Work to improve productivity through a redesign of the clinical workforce model. Will be overseen by the Transformation Board, and delivery will be supported by resource from the finance and transformation team to ensure that potential risks are managed closely and quality remains the top priority.

Role of the workforce directorate in delivering the People Strategy

The delivery of the The Royal Marsden People Strategy is the job of everyone working in our organisation. We all fulfil multiple roles as leaders or managers of teams, members of multiple teams, professional colleagues or personal support for each other. We all share a collective responsibility to make our workplace as good it can possibly be.

The Workforce Directorate has a specific role in the delivery of the People Strategy. As the representatives of all aspects of the People Profession for the Trust, Workforce has responsibility for providing leadership and expertise in delivering the programmes of work set out in this Strategy, in four different ways as shown below.

Leading

- A modern and flexible employment framework
- Slick and efficient recruitment practices
- Promotion of EDI expertise
- Pay and planning processes
- Provision of fair development processes.

Partnering

- Workforce planning at tumour/specialty level
- Embedding the best people management in practice
- Working with our people to embed all aspects of EDI
- The best possible employee experience throughout our hospitals.

Planning

- Future workforce supply through the apprenticeship route and other supply sources
- Support to operational managers to undertake effective and timely long term workforce planning.

Prioritising

- Compliance with statutory and mandatory training requirements
- A safe and positive workplace
- Promotion of the RM employer brand
- An open and constructive culture where everyone is safe and has a voice that matters.

Immediate work will concentrate on defining the deliverables against the year one priorities for 2025 and determining how best to deliver the various elements of the strategy:

1. Divisional workforce plans to be created by divisional leadership teams from 2025 onwards aligned to the Clinical Strategy and the Chelsea Development project. These need to model the future workforce shape, that set out divisional workforce priorities and short and longer-term deliverables under the attract, retain, grow headings.

2. Mapping all existing work currently being delivered across the Trust under the three workforce pillars; attract, retain and grow.

3. Scope enhanced data analytics to determine improved workforce metrics to improve our understanding of our workforce behaviour and productivity.

4. Identification of high impact programmes of work that could unlock care delivery i.e. advanced clinical practice, extension of the use of non medical prescribing.

5. Identify opportunities to accelerate, enhance and scale innovation across the Trust.

Katie Stebbing, Highly Specialist Musculoskeletal Physiotherapist, in the physiotherapy gym with team member

7.

Next steps – laying the foundations

To socialise our objectives, The Royal Marsden Workforce colleagues will undertake a period of engagement, during which the People Strategy priorities will be communicated to key stakeholders across the Trust.

This exercise will help us to identify existing or planned activity and will give our service partners the opportunity to develop and shape their own strategic plans and align them to the Trust People Priorities.

Delivery boards will be established for each of the three pillars. These delivery boards will be tasked with driving the work that aligns to the respective pillar objectives.

Representation for the delivery boards will be sought from across a broad range of partners in The Royal Marsden to maximise the breadth of knowledge, learning, delivery and opportunities for collaborative working. Progress against the delivery of the strategy priorities will be brought back to The Royal Marsden People Board on a regular basis and reviewed annually to ensure they remain current and relevant in the context.

Mohammed Ahmed, Lead Procurement and Systems Pharmacy Technician with RM Medicines robotic dispensing system in Sutton

Our People Strategy 2025–2030

Appendix 1

Initial five year delivery plan

Objectives	Year 1	Year 2	Year 3
Attract	– Provide planning support to operational managers to undertake longer term workforce planning as part of the business planning process – Develop our approach to schools engagement piloting approaches with a small number of local partners and wider participation with our community – Develop our recruitment brand and a suite of recruitment marketing materials that capitalise on our strengths and value proposition – Expand the number of apprenticeship opportunities for entry-level staff throughout our organisation – Introduce supportive internships for under-represented staff – Redesign our consultant recruitment model – Deliver the alumni programme to encourage returners into the workplace and expand our wider community alumni.	– Workforce planning is embedded across all areas of the Trust with particular focus on site and service developments – Create specialised programmes of outreach with partner schools – Implement medical ambassadors by specialty charged with attracting our future medical workforce – Design an international fellowship programme to share Marsden expertise globally – Introduce T-levels for appropriate staff groups eg pathology, digital – Pilot degree apprentice schemes that sit alongside undergraduate education to secure our future pipeline of registered healthcare professionals – Introduce proactive, digitally driven approaches to inspire and attract current and future generations into roles at The Royal Marsden.	– Introduce AI-led workforce practices that free up time for value-added activities – Embed pipelines from school to career in select professions, including work experience, internships/summer placement schemes and degree apprenticeships – Develop new ways of working across the organisation in preparation for the replacement of the national HR/payroll system.
Retain	– Introduce ‘later-career’ conversations model for succession planning – Reignite our approach to Job Planning for medical staff to improve, take up and reflect the complexity of our service delivery model – Develop succession plans for all business critical roles – Launch the Leadership Behaviours framework and embed in training, recruitment and 1:1/appraisals – Review our EDI programme of work and launch a new three-year programme focusing on those initiatives that have made a difference to our metrics. Particular attention will be given to recruitment, promotion and development – Develop EDI approaches to neuroinclusion – Introduce a Clinical Cabinet to boost medical staff engagement	– Create a model for clinical staff to enter into research and use for recruitment and retention – Embed education delivery capacity in all workforce models – Embed self-rostering, team-rostering or annual rostering across all wards and clinics – Embed anti-racist learning into the EDI curriculum and introduce targeted work where there are prevailing issues – Ensure there are visible career pathways and regular career discussions taking place across all levels of the organisation – Embed a support programme for staff so they embrace new ways of working including the Chelsea development and paediatric, TYA and haematology developments.	– Develop capacity, capability and a support for the next phase of major change in line with Chelsea and Sutton developments and the paediatrics move – Develop a differentiated retention strategy for different generations through extensive engagement and train managers in how to meet the needs of different staff.

Our People Strategy 2025–2030

Objectives	Year 1	Year 2	Year 3
Retain	– Create more enhanced and advanced clinical practice roles to ensure there are interesting and varied career pathways across all professions – Embed the Trust approach to sexual safety across the organisation ensuring a safe space for staff to work – Ensure our internationally educated workforce are fully supported in adapting to working in the UK and encouraged to think about career growth early in their employment.		
Grow	– Develop workforce intelligence dataset and metrics to inform workforce planning and productivity improvement – Develop a digital skills curriculum against a proficiency baseline – Expand the thrive programme to optimise EPIC user experience and unlock system potential – Identify where there is scope to introduce more sustainable and productive workforce models to meet increasing demand – Pilot 'grow your own' apprenticeship-funded programmes in a number of professions – Create a genomics education hub that brings together all existing genomics education resources – Develop a tailored international education offer initially through our partnership with Dubai.	– Understand the skills needed for the organisation to introduce AI into treatment and diagnostics – Deliver clinical workforce planning and succession planning model for doctors and ACPs/NMPs to enable early identification of successors to specialist clinical staff – Embed ACCEND into career planning and development for all nurses, AHPs and clinical pharmacists – Further develop the genomics curriculum and embed genomics education in our clinical training curriculum – Introduce inclusive talent identification and development approach to support succession planning and ensure a pipeline of diverse talent into senior roles – Develop a new The Royal Marsden international medical fellowship for international clients – Introduce a programme to develop applied research skills across our organisation.	– Develop improvement fellow roles to lead on transformation – Deliver new cancer-specific MScs – Develop cancer-specific VSIM scenarios to support our internal and external education offer – Offer degree apprenticeship opportunities in all key professions to replace a proportion of undergraduate student placements – Design and deliver a significant programme of training in identifying and addressing health inequalities and embed targets through divisional, team and individual objectives.

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The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 5.1
Title of Document: Staff Survey Results 2024	**To be presented by:** Chief People Officer

1. Status For noting

Purpose: The 2024 National NHS Staff Survey took place between September and November 2024, with results released publicly in March 2025. This report provides a summary of the outcomes and outlines our plans for responding to the issues which have emerged.

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

3. Summary

Our 2024 Staff Survey results show an improvement on our 2023 scores across all 9 categories with significant improvements in six out of nine categories. Our highest themes were “we are compassionate and inclusive” and staff engagement. Our areas of focus going forward are Diversity and Equality, Musculoskeletal Problems and “we work flexibly”.

4. Recommendations / Actions

The Board is asked to note the outcomes of the Staff Survey 2024 and the next steps which have been identified.

The ROYAL MARSDEN

Staff Survey Results 2024

Briefing Paper: March 2025

Contents

1. Introduction

The 2024 National NHS Staff Survey took place between September and November 2024, with results embargoed until 13th March 2025. This report provides a summary of the outcomes and outlines our plans for responding to the issues which have emerged.

As in 2021, the survey questions were aligned with the NHS People Promise to track progress against the ambition to improve the experience of working in the NHS for everyone. Our overall results are presented in the format of the seven People Promises and two overarching themes:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Theme: Staff Engagement
- Theme: Morale

Our results are compared internally in relation to last year's scores and shown against relevant external comparators.

2. Executive summary

Overall, the Trust performed positively against all the People Promise and Themes. The results show increases across all categories with 6 out of 9 having significantly improved. One of the key areas to focus on for improvement in is Diversity and Inclusion. Performance against the national average is most significantly different for 'we work flexibly'.

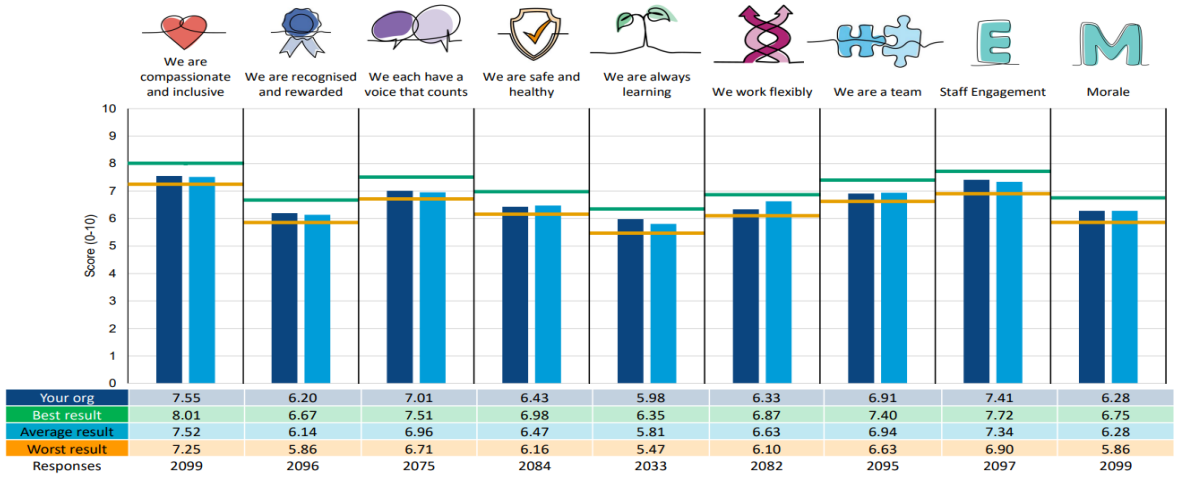
3. Context

There was a 43.8% response rate in 2024, which was below the 2023 rate at 47.9%.

4. Results summary

Overall, compared to the 2023 scores, the Trust HAS performed significantly better against 6 of the 9 categories and slightly better in 3 categories. The table below provides the scores and a visual overview.

People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sector Score
Theme – Staff engagement	7.25	Significantly Improved	7.42	Significantly Better	7.26
Theme – Morale	6.07	Significantly Improved	6.28	Significantly Better	6.19
We are compassionate and inclusive	7.51	Not Significant	7.55	Not Significant	7.53
We are recognised and rewarded	6.07	Significantly Improved	6.20	Not Significant	6.13
We each have a voice that counts	6.90	Significantly Improved	7.01	Significantly Better	6.92
We are safe and healthy	6.28	Significantly Improved	6.43	Not Significant	6.39
We are always learning	5.77	Significantly Improved	5.98	Significantly Better	5.84
We work flexibly	6.24	Not Significant	6.33	Not Significant	6.39
We are a team	6.91	Not Significant	6.92	Not Significant	6.91



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.55	6.20	7.01	6.43	5.98	6.33	6.91	7.41	6.28
Best result	8.01	6.67	7.51	6.98	6.35	6.87	7.40	7.72	6.75
Average result	7.52	6.14	6.96	6.47	5.81	6.63	6.94	7.34	6.28
Worst result	7.25	5.86	6.71	6.16	5.47	6.10	6.63	6.90	5.86
Responses	2099	2096	2075	2084	2033	2082	2095	2097	2099

The highest theme scores - 'we are compassionate and inclusive' (2024 7.55% / 2023 7.51%) and staff engagement (2024 7.41% / 2023 7.25%).

The lowest theme scores – 'we are always learning' (2024 5.98% / 2023 5.78%) and 'we are recognised and rewarded' (2024 6.20% / 2023 6.08%).

27 (25%) questions scored significantly better than the sector, 4 (4%) questions scored significantly worse than the sector and 77 (71%) showed no significance in relation to the sector average.

The Trust has also received Free Text comments which are being analysed and summarised into key themes which will support Divisional plans/activity.

5. Our performance against national average and other comparators

The Trust has performed better against 4 out of 7 People Promises. We are slightly lower on 'we are safe and healthy' and 'we are a team'. The most significant difference is 'we work flexibly' (RMH 6.33% / Average 6.63%).

Comparatively against the themes 'staff engagement' the trust scored higher, and 'morale' was consistent with the average.

Benchmarking within the Acute specialist sector

The Trust is benchmarked against the 'Acute Specialist Hospitals' sector. There are 13 organisations in this group. Specifically, the table below shows our performance against some of our main comparators within this sector:

Acute Specialist Trusts	We are compassionate and inclusive	We are recognised and	We each have a voice that	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Royal National Orthopaedic Hospital NHS Trust	7.47	6.10	6.97	6.47	6.04	6.68	6.99	7.34	6.29
The Christie NHS Foundation Trust	7.82	6.49	7.13	6.60	6.10	6.81	7.15	7.52	6.53
The Clatterbridge Cancer Centre NHS Foundation Trust	7.90	6.56	7.23	6.65	6.09	6.66	7.30	7.39	6.41
Royal Papworth Hospital NHS Foundation Trust	7.43	6.05	6.80	6.27	5.63	6.76	6.81	7.24	6.06
Great Ormond Street Hospital for Children NHS Foundation Trust	7.45	6.03	6.79	6.27	5.81	6.27	6.82	7.21	6.05
Moorfields Eye Hospital NHS Foundation Trust	7.25	5.92	6.73	6.37	5.73	6.14	6.74	7.16	6.11
The Royal Marsden NHS Foundation Trust	7.55	6.20	7.01	6.43	5.98	6.33	6.91	7.41	6.28

In summary:

- We performed better than GOSH and Moorfields across all 9 categories. Both Trusts operate in the London labour market. Our results were also higher than Papworth in every category apart from 'we work flexibly'.
- The Christie performed better than the Trust across all 9 categories, which was the same in 2023. The Christie is based in Manchester and operates in a different labour market to RMH.
- The Clatterbridge, based in Liverpool, also performed better than the Trust in every category apart from 'engagement' where we received the second highest score.
- Comparatively, in 5 out of 9 categories the Trust ranked third and in 2 out of 9 categories ranked fourth.
- The lowest ranking for the Trust was fifth for 'we work flexibly'.

6. Our results benchmarked against other London trusts

SWL ICB

SWL ICB	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Kingston Hospital NHS Foundation Trust	7.35	5.98	6.78	6.11	5.86	6.07	6.85	7.06	6.03
Croydon Health Services NHS Trust	7.06	5.86	6.60	5.99	5.46	5.94	6.67	6.87	5.77
St George's University Hospitals NHS Foundation Trust	7.11	5.81	6.62	5.98	5.55	5.92	6.67	6.91	5.75
Epsom and St Helier University Hospitals NHS Trust	7.21	5.94	6.66	6.23	5.52	6.15	6.71	6.93	5.92
The Royal Marsden NHS Foundation Trust	7.55	6.20	7.01	6.43	5.98	6.33	6.91	7.41	6.28

- The Trust was the highest performing across all 9 categories, which was consistent with the previous year.

Wider London Trusts

Wider London Trusts	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Great Ormond Street Hospital for Children NHS	7.45	6.03	6.79	6.27	5.81	6.27	6.82	7.21	6.05
Barts Health NHS Trust	7.06	5.74	6.59	5.94	5.59	5.97	6.67	6.82	5.75
Royal Free London NHS Foundation Trust	7.21	5.93	6.69	6.03	5.90	6.22	6.82	6.95	5.92
Guy's and St Thomas' NHS Foundation Trust	7.35	5.99	6.89	6.15	5.86	6.25	6.81	7.15	6.01
King's College Hospital NHS Foundation Trust	6.96	5.64	6.43	5.80	5.67	5.69	6.59	6.58	5.54
University College London Hospitals NHS Found	7.51	6.19	6.99	6.24	5.99	6.59	6.92	7.35	6.23
The Royal Marsden NHS Foundation Trust	7.55	6.20	7.01	6.43	5.98	6.33	6.91	7.41	6.28

- The Trust scored the highest in 6 out of 9 categories and second highest in 3 out of the 9 categories.

7. Breakdown by staff group

The table below shows the Trust staff survey results for 2024 by staff group:

People Promise/ Theme/ Question	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
We are compassionate and inclusive	7.33	5.92	7.70	7.02	7.22	7.23	7.21	7.53
We are recognised and rewarded	5.89	6.04	6.41	6.27	5.76	5.88	6.10	6.14
We each have a voice that counts	6.75	6.95	7.10	6.12	6.73	6.75	6.80	7.11
We are safe and healthy	6.06	7.27	6.83	5.41	6.48	6.16	6.11	6.13
We are always learning	5.10	6.26	5.91	6.89	5.03	5.37	5.79	6.38
We work flexibly	5.65	7.54	6.89	7.47	6.08	5.82	5.75	6.36
We are a team	6.88	6.14	7.13	6.21	6.38	6.25	6.26	6.97
Theme – Staff engagement	7.12	6.78	7.39	7.64	7.26	7.04	7.40	7.55
Theme – Morale	5.80	6.48	6.39	6.09	6.11	5.63	6.24	6.39

This section of the paper provides a summary of results by each staff group compared to 2023 performance.

Add Prof Scientific and Technic

Add Prof Scientific and Technic	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
2023	7.24	5.64	6.29	5.73	5.03	5.34	6.72	6.76	5.29
2024	7.33	5.89	6.75	6.06	5.1	5.65	6.88	7.12	5.8
Change	↑	↑	↑	↑	Not Significant	↑	↑	↑	Not Significant

Additional Clinical Services

Additional Clinical Services	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
2023	7.41	6.01	6.85	6.46	5.51	5.97	6.78	7.2	6.32
2024	5.92	6.04	6.95	7.27	6.26	7.54	6.14	6.78	6.48
Change	↑	Not Significant	↑	↑	↑	↑	↑	↑	↑

Administrative and Clerical

Administrative and Clerical	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
2023	7.7	6.41	7.1	6.83	5.91	6.89	7.13	7.39	6.39
2024	7.63	6.27	6.97	6.56	5.64	6.65	7.11	7.28	6.11
Change	↓	↓	↓	↑	↑	↑	Not Significant	↑	↑

Allied Health Professionals

Allied Health Professionals	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
2023	7.63	6.01	7.06	6.18	6.06	5.61	6.8	7.36	6.14
2024	7.02	6.27	6.12	5.41	6.89	7.47	6.21	7.64	6.09
Change	↓	↓	↓	↑	↓	↑	↑	↑	↓

Estates and Ancillary

Estates and Ancillary	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
2023	7.09	5.69	6.54	6.37	5.11	5.92	6.31	6.89	6.05
2024	7.22	5.76	6.73	6.48	5.03	6.08	6.38	7.26	6.11
Change	↑	↑	↑	↑	↓	↑	Not Significant	↑	↑

Healthcare Scientists

Healthcare Scientists	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
2023	7.21	5.79	6.71	6.07	5.4	5.79	6.3	7.17	5.61
2024	7.23	5.88	6.75	6.16	5.37	5.82	6.25	7.04	5.63
Change	Not Significant	↑	Not Significant	↑	Not Significant	↑	Not Significant	↓	Not Significant

Medical and Dental

Medical and Dental	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
2023	7.29	5.92	6.7	6.1	5.63	5.66	6.48	7.23	6.13
2024	7.21	6.1	6.8	6.11	5.79	5.75	6.26	7.4	6.24
Change	Not Significant	↑	Not Significant	Not Significant	↑	↑	↓	↑	↑

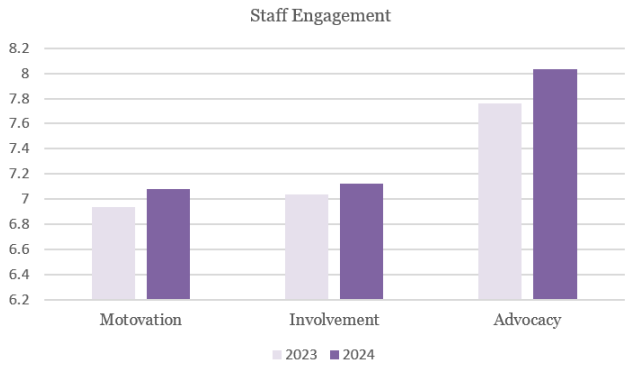
Nursing and Midwifery Registered

Nursing and Midwifery Registered	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
2023	7.54	6.04	6.98	6.02	6.25	6.4	7.04	7.3	6.08
2024	7.53	6.14	7.11	6.13	6.38	6.36	6.97	7.55	6.39
Change	Not Significant	↑	↑	↑	↑	Not significant	↓	↑	↑

8. Changes since 2024: the internal comparison

Staff Engagement

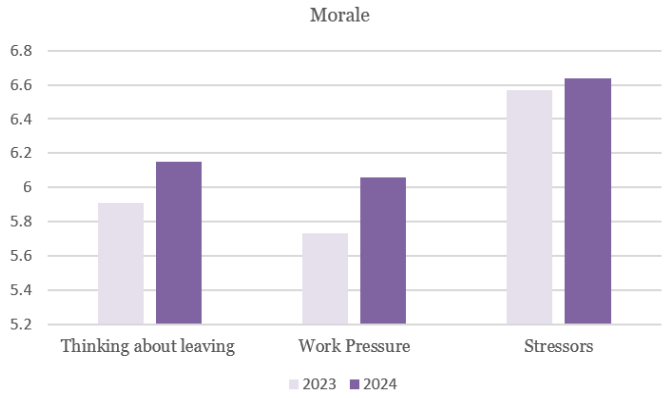
Staff engagement significantly improved and is significantly better than the sector score. 2 of the 3 questions in the sub theme 'motivation' showed significant improvement. The sub theme 'involvement' scored significantly better than the sector score. Finally, scores for 'advocacy' all significantly improved and were significantly better than the sector.



	Motivation	Involvement	Advocacy
2023	6.94	7.04	7.76
2024	7.08	7.12	8.03

Morale

Morale scores significantly improved and were significantly better than the sector; 1 of the 3 questions on the sub theme 'thinking about leaving' significantly improved ('I often think about leaving this organisation'). 'Work pressure' scores for all questions significantly improved and were significantly better than the sector. Overall, 'stressors' showed no significant scoring however, the question 'I have unrealistic time pressures' significantly improved and was significantly better than the sector.

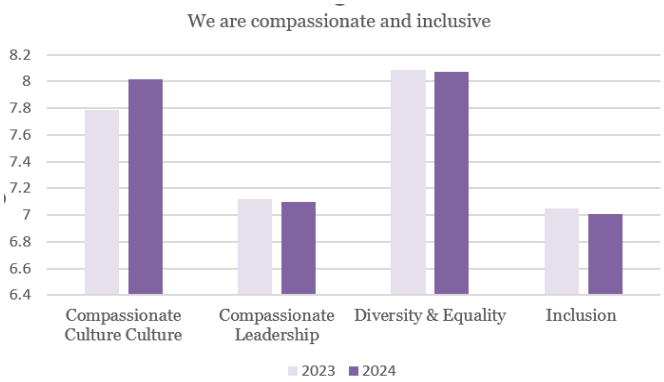


Morale	Thinking about leaving	Work Pressure	Stressors
2023	5.91	5.73	6.57
2024	6.15	6.06	6.64

We are compassionate and inclusive

Scores for 'we are compassionate and inclusive' were not significant; sub scores for 'Compassionate culture' significantly improved but not comparatively against the sector.

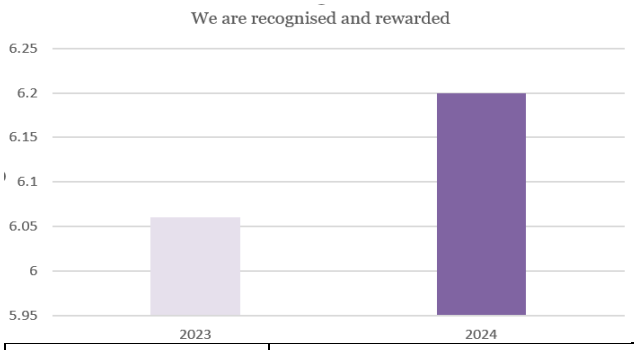
'Diversity and equality' scores were not significantly different from 2023 to 2024 however, the results are significantly worse that the sector score (2 out of 4 questions were significantly worse).



	Compassionate Culture	Compassionate Leadership	Diversity & Equality	Inclusion
2023	7.79	7.12	8.09	7.05
2024	8.02	7.1	8.07	7.01

We are recognised and rewarded

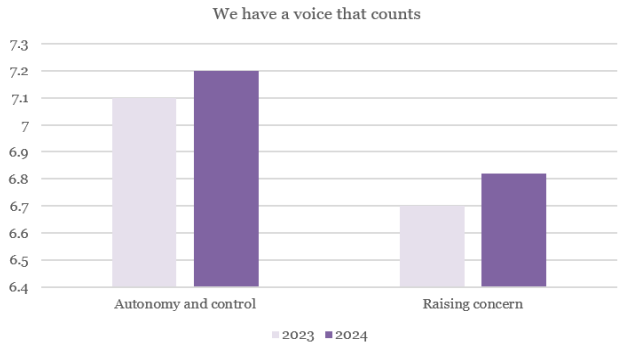
'We are recognised and rewarded' significantly improved specifically in 2 out of 5 questions. Whilst the overall results were not significant compared to the sector they were significantly better in 2 out of 5 questions.



	We are recognised and rewarded
2023	6.06
2024	6.20

We each have a voice that counts

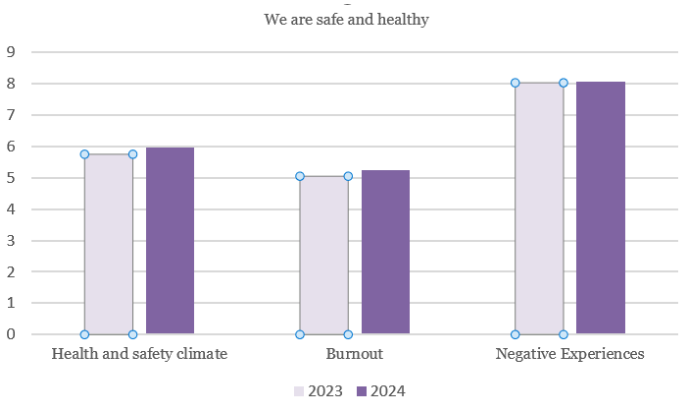
Scores for 'we each have a voice that counts' were not significant; the sub theme 'raising concerns' however significantly improved in 3 out of the 4 questions.



	Autonomy and control	Raising concern
2023	7.1	6.7
2024	7.2	6.82

We are safe and healthy

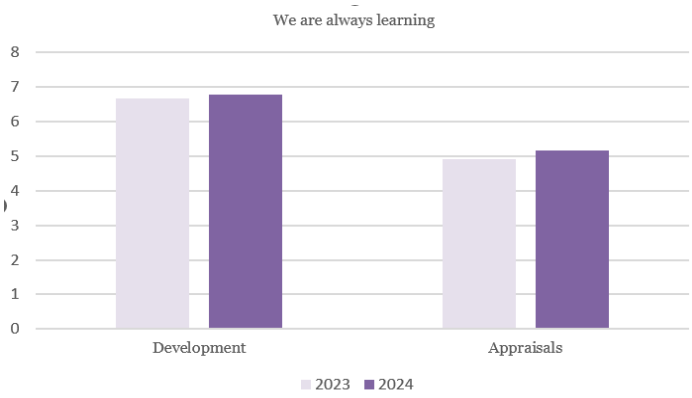
The subtheme 'burnout' showed significantly improved scores. Scores for 'negative experiences' were not significantly different but were significantly worse against the sector scores. Specifically, the question on 'in the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities' scored 8.06% which was significantly worse than the sector score at 8.15%.



	Health and safety climate	Burnout	Negative Experiences
2023	5.75	5.05	8.03
2024	5.98	5.24	8.06

We are always learning

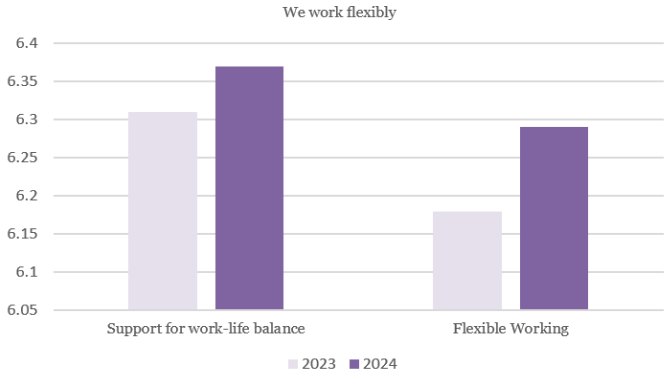
'We are always learning' and the subtheme 'development' scores all showed significant improvement and were significantly better than the sector.



	Development	Appraisals
2023	6.66	4.9
2024	6.78	5.16

We work flexibly

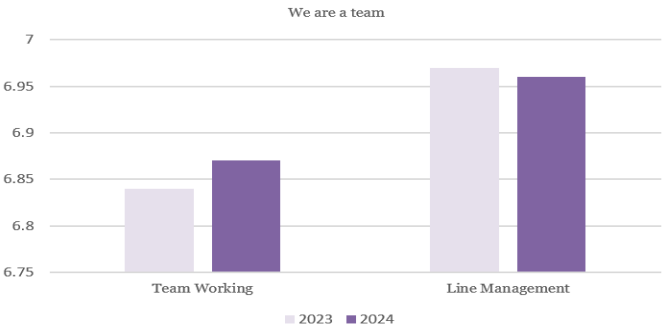
Overall 'we work flexibly' as well as the sub themes 'support for work life balance' and 'flexible working' scores were not significantly different.



	Support for work-life balance	Flexible Working
2023	6.31	6.18
2024	6.37	6.29

We are a team

'We are a team' and 'team working' scores were not significantly different however, there was significant improvement in 2 out of 8 questions.



	Team Working	Line Management
2023	6.84	6.97
2024	6.87	6.96

9. Conclusion

Overall, it is important to celebrate our results in the context of another challenging year at the Trust. We have seen an increase across the seven People Promises and two themes for 2024. We significantly improved in six out of the nine categories. We have performed well against the National Average and within Specialist Acute sector. We have done well against our SWL ICB colleagues and many London Trusts. It is particularly pleasing that we have improved in two out of the three priority areas identified last year namely raising concerns and staff morale.

Whilst this is positive, we recognise there is work to be done specifically in the following areas:

Equality Diversity and Inclusion – Although we have been working on making improvements in this area, there needs to be a continued focus on improving the experience of our staff who have reported a negative experience due to a protected characteristic. 'Diversity and equality' scores were significantly lower than the sector scores and should remain a key area of focus for action planning/improvement.

Specifically, on the question regarding Musculoskeletal problems (MSK) the scores were also significantly lower than the sector and require improvement.

We need to continue to focus on promoting flexible working options that balance personal individual priorities, and service needs. Although our internal scores have improved for 'we work flexibly', our result is below the average sector scores.

10. Next Steps

We will now develop a Trust wide plan to address identified themes with particular focus on diversity and equality alongside the continued focus on flexible working. In past years, the Action Plan consisted of three Trust wide Themes supported by Division specific and division specific action plans. This year the intention is to use the People Strategy as the framework to ensure alignment and organisational consistency.

Each Division will be tasked with reviewing its results in order to develop a meaningful plan with specific actions and timelines. This will be presented at the Workforce Education Committee in May 2025. Divisional plans should give particular priority to diversity and equality, and flexibility. The resulting Trust Action Plan, and monitoring arrangements will then be approved by the People Board.

11. Recommendation

The Trust Board is asked to note the outcomes of the Staff Survey 2024 and the next steps which have been identified.

March 2025

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 5.2
Title of Document: Month 11 Finance Report	**To be presented by:** Chief Finance Officer

1. Status **For noting**

2. Purpose:

Relates to:

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

3. Summary

The report presents the Trust financial performance as at 28th February 2025.

Key Headlines

- Trust Financial Position reports YTD surplus of £0.6m in line with plan, an improvement in month £2.9m from the position reported in January. The Trust has received £3.2m (full year effect) additional Income which will offset the the shortfall in Paediatric Support funding £1.5m and the unfunded NHS element of the pay award £1.7m.
- The Trust has revised its forecast from £2.1m surplus (£3.2m adverse to plan) to £5.3m surplus in-line with plan.
- The financial position includes CIP performance £21.0m YTD, £0.1m favourable to Plan.
- Capital programme is behind plan by £0.4m YTD and expected to be materially in line with plan by year end.
- Cash position YTD £115.3m, £36.6m behind plan for the year.

4. Recommendations / Actions

The Board is asked to note the position set out in the report.

Financial Performance Report
28th February 2025

The ROYAL MARSDEN
NHS Foundation Trust

1. Introduction

The paper provides a summary of the financial position as at 28th February 2025.

The Trust Board has approved the following financial plan targets for 2024/25:

- A **£5.35m surplus control total**;
- A **£29.2m capital plan**, of which £18.8m was Trust funded and £10.4m charitably funded;
- A cash position of **£154.9m** as at 31 March 2025.

2. Summary Financial Position

Key headlines

As at 28th February 2025, the key headlines are as follows:

- The Trust reported a control total £0.6m surplus in line with plan YTD. The statutory position, which adjusts for the impact of donated asset income and depreciation, reports a surplus of £1.8m on plan YTD. This represents an improvement on the previous month of £2.9m due to the Trust receiving additional non recurrent Income to cover the deficits previously reported. The Trust received £3.2m from the SWL ICB to cover the shortfall in the NHS Paediatrics support funding of £1.5m and the unfunded NHS element of the pay award of £1.7m.
- Following the receipt of the additional income the Trust has revised its internal year end forecast to £5.3m in line with plan and in line with the forecast reported externally to NHSE.
- Income reports a favourable position £14.5m YTD. NHS Income is the main driven of the favourable position, £9.4m variable income overperformance (relating to overseas visitors, variable and ERF activity). Private care income reports £0.5m adverse to plan YTD, due to lower than expected activity at this stage of the year.
- Commercial trial income continues to overperforming in month by £0.2m and £1.8m YTD, offset by R&D income underperformance, and is behind plan by £0.6m YTD.
- Grant Income is behind plan driven by the lower drawdown of the CNB grant in year by £2.9m offset by higher RMCC SPF drawdowns of £1.6m.
- Temporary staffing usage remains stable through the year, with agency costs low at 1.2% of pay spend in comparison to the NHSE Agency cap of 3.2%.
- Total capital spend year to date is behind plan by £0.4m overall. Trust funded spend (CDEL) is behind plan by £1.6m, although expect to be on plan by year end. Grant funded schemes are ahead of plan by £1.2m. The Trust expects to be broadly on plan by year end.
- The reported cash position is £115.3m as at 28th February 2025 £36.6m behind plan for the year. This is driven by slower than expected recovery of PP related debt £20.4m, and an increase in NHS Income accruals £14.1m.

2. Income & Expenditure February 2025

Status	Jan-25	Feb-25
	●	●

February				Year to Date			Annual Budget	Forecast	Variance
Budget £'000	Actual £'000	Variance £'000		Budget £'000	Actual £'000	Variance £'000	£'000	£'000	£'000
(26,770)	(29,499)	(2,729)	NHS Acute Income	(293,726)	(308,581)	(14,855)	(321,371)	(336,290)	(14,919)
(14,232)	(13,299)	933	Private Patients Income	(166,977)	(166,428)	550	(182,878)	(183,457)	(579)
(41,002)	**(42,798)**	**(1,796)**	**Total Patient Care Income**	**(460,704)**	**(475,009)**	**(14,305)**	**(504,250)**	**(519,747)**	**(15,498)**
(1,149)	(1,101)	49	R&D income	(12,644)	(11,985)	659	(13,794)	(12,537)	1,258
(2,128)	(2,354)	(226)	Commercial clinical trials	(23,409)	(25,244)	(1,834)	(25,539)	(27,565)	(2,026)
(2,121)	(2,673)	(552)	Grants income (Charitable contributions to Income)	(22,181)	(20,956)	1,225	(24,304)	(19,499)	4,804
(881)	(1,658)	(776)	Education income	(7,051)	(8,433)	(1,382)	(7,871)	(8,216)	(344)
(7,912)	(4,909)	3,003	Other Operating Income	(59,605)	(58,488)	1,117	(65,874)	(68,173)	(2,298)
(14,192)	**(12,695)**	**1,497**	**Total Other Income**	**(124,891)**	**(125,105)**	**(215)**	**(137,383)**	**(135,989)**	**1,393**
(55,194)	**(55,493)**	**(299)**	**Total Operating Income**	**(585,594)**	**(600,114)**	**(14,520)**	**(641,632)**	**(655,736)**	**(14,104)**
28,466	27,646	(820)	Substantive	313,940	298,646	(15,293)	342,396	325,344	(17,052)
14	1,370	1,356	Bank	158	15,170	15,012	173	16,462	16,289
14	244	230	Agency	158	3,751	3,594	172	4,188	4,016
28,494	**29,260**	**765**	**Total Operating Pay**	**314,256**	**317,567**	**3,312**	**342,741**	**345,994**	**3,253**
9,346	9,632	286	Drugs	105,681	113,032	7,351	115,331	122,413	7,082
4,654	4,163	(491)	Clinical Supplies	50,804	50,358	(446)	55,512	54,950	(563)
1,008	1,123	114	Non Clinical Supplies	11,198	11,734	536	12,208	12,741	533
2,164	290	(1,873)	Premises	25,501	19,459	(6,042)	27,618	21,532	(6,086)
7,717	6,261	(1,456)	Other Non Pay	61,233	68,569	7,336	65,240	73,744	8,504
24,890	**21,470**	**(3,420)**	**Total Operating Non Pay**	**254,418**	**263,153**	**8,735**	**275,909**	**285,380**	**9,471**
53,384	**50,729**	**(2,655)**	**Total Operating Expenditure**	**568,673**	**580,720**	**12,047**	**618,650**	**631,374**	**12,724**
(1,810)	**(4,763)**	**(2,954)**	**Total Operating (Surplus)/Deficit**	**(16,921)**	**(19,394)**	**(2,473)**	**(22,982)**	**(24,363)**	**(1,381)**
428	521	93	PDC	4,710	5,732	1,022	5,138	5,138	(0)
(659)	(387)	271	Finance (income)/Costs	(6,061)	(4,379)	1,682	(6,719)	(5,490)	1,229
(354)	(962)	(608)	Donated Asset Income	(8,008)	(8,816)	(808)	(11,807)	(11,066)	741
2,345	2,273	(72)	Depreciation	25,883	25,052	(831)	28,229	28,566	337
1,760	**1,440**	**(320)**	**Total Non operating Income and Expense**	**16,524**	**17,607**	**1,083**	**14,841**	**17,144**	**2,303**
(49)	**(3,323)**	**(3,274)**	**Total (Surplus)/Deficit**	**(397)**	**(1,786)**	**(1,390)**	**(8,141)**	**(7,219)**	**922**
354	962	608	Deduct: Donated Asset Income	8,008	8,816	808	11,807	11,066	(741)
(767)	(706)	61	Add back: Depreciation on Donated Assets	(8,239)	(7,650)	589	(9,006)	(9,197)	(191)
(462)	**(3,068)**	**(2,606)**	**Control Total (Surplus)/Deficit**	**(628)**	**(621)**	**7**	**(5,340)**	**(5,350)**	**(10)**

3. Income and Expenditure

Income – In month: £55.1m, £0.3m favourable to plan. YTD: £585.6m, £14.5m favourable to plan.

NHS Acute income reports £2.7m favourable in month, and £14.8m favourable YTD, this is driven broadly from the overperformance year to date of Variable activity £9.4m, and high cost drugs of £5.7m.

The Trust received an additional £3.2m from SWL ICB in February to cover the shortfall in the NHSE Paediatric support funding £1.5m, and the NHS element of the unfunded pay award £1.7m.

Private Patient income was £0.9m adverse in month and £550k adverse YTD. Activity levels in month were lower than expected reducing income by £0.4m. In addition a contractual rebate to a sponsor organisation, was higher than expected adversely impacting the position by £0.5m.

R&D Income - broadly on plan in month, YTD adverse variance £0.6m driven by under delivery of BRC programme (£0.5m), the remainder relates to minor timing differences on R&D programmes.

Commercial Trials in month £0.2m overperformance on commercial trials within R&D as commercial activity has increased. YTD £1.7m favourable variance also driven by Commercial clinical trials.

Grant Income reports a favourable variance in month driven by £0.7m RMCC recoded from other operating income. YTD £2.9m adverse variance relating to the lower than planned drawdown of the CNB project grant, this is offset by over performance of central R&D £1.6m due to RMCC SPF drawdowns.

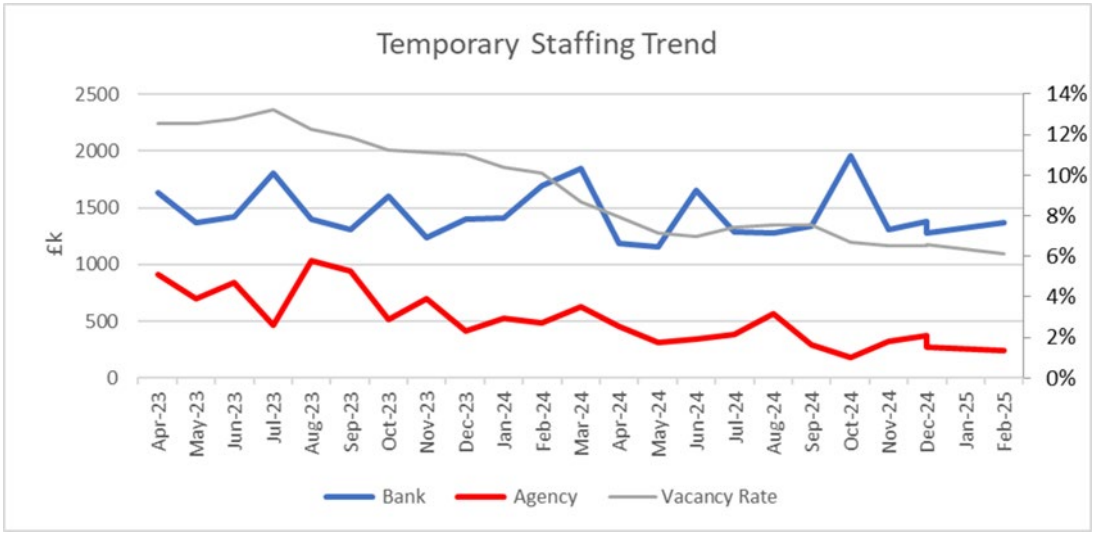
Other operating Income adverse variance relating to lower RM Partners income £2.5m (matched by lower non pay expenditure) plus £0.7m transfer RMCC income transferred to Grant income. This is offset by favourable movements to the Guardant programme and other P2P income.

Pay expenditure – In month expenditure £29.5m, £0.8m adverse to plan, YTD £317.6m, £3.3m adverse to plan.

The deficit position is driven by high levels of maternity leave and long-term sick leave covered by temporary staff in Cancer services c£1.8m. As previously reported, the junior doctor rotas are under resourced in the budget, with work continuing with Kendall Bluck to review of Junior Doctors rotas in the division. This has generated a cost pressure of c£2.6m YTD created through temporary staffing cover. The cost pressures in Cancer Services have been offset by underspends in the clinical services division £4.1m. Pay costs relating to SPF funded schemes have added a further £1.3m to the deficit YTD, which is offset by Income.

Substantive WTEs have increased by 186 WTE since 31 March 2024, this has been partially offset by a reduction in bank (43.9 WTE) and agency (22 WTE). Total increase has been 120 WTE and reflects the falling Trust vacancy rate and operational over performance.

Temporary Staffing



The use of bank and agency remains stable through 2024/25. Agency costs are low at 1.2% of pay spend, compared to the national agency cap of 3.2%, and has continued to fall during 24/25. Bank usage is averaging at £1.4m a month which is lower than 23/24 (£1.5m per month), but remains flat whilst vacancies have fallen in year.

Attention has also now switched to other high areas of spend including medical, with a review of medical rosters having been commissioned through SWL ICB.

Non-pay expenditure – In month non-pay costs were £21.5m, £3.4m favourable to plan, YTD £241.7m, £8.7m adverse to plan.

The key driver for the favourable movement in month related to RM Partner report underspends of £2.5m, and the release of a prior year accrual £1.7m.

YTD Drugs activity is over plan by £7.1m YTD, but this is largely offset by income over performance. The impact of the unfunded pay award is £3.2m. It should be noted the Trust have secured additional income from the SWL ICB to cover £1.7m of this shortfall, which is reported under the Income section above. A legal provision has been established of £5.3m, and restricted funds (matched by Income) £1.3m. These are partially offset by a surplus in Premises of £4.2m relates to lower utility prices, RM partners £2.5m and release of the PY accrual £1.7m.

4. CIPs

In order to deliver the Trust's planned surplus in 24/25, the Trust committed to a challenging 5.5% CIP target of £25m.

Schemes are monitored using the following classification codes:

Red: Unidentified, Amber: opportunity, Green: plans in progress, Blue: fully identified

The below table shows our proportion of planned recurrent versus non recurrent schemes as at 28th February 2025. The full £25m programme has been identified at a scheme-by-scheme level with varying degrees of development:

	Recurrent £'000	Non-Recurrent £'000	Total M11 £'000	Total M10 £'000	Movement from M10
Blue	13,755	8,820	22,574	22,571	3
Green	2,041	372	2,413	2,413	0
Amber	0	0	0	0	0
Red	0	0	0	0	0
Total	**15,796**	**9,192**	**24,988**	**24,984**	**4**

The following table shows the YTD actual position as at 28th February 2025. The overall CIP plan is on track to deliver in full by year end. A number of the original schemes are unlikely to deliver in year, but other schemes have over delivered to compensate for this shortfall. The Genomics project II, Procurement & Commercial trial income are behind plan in year, this is offset by ERF overperformance, improvements driven by the Trust's transformational programme.

	Recurrent			Non-Recurrent			Total		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Blue	12,594	9,516	- 3,077	6,142	11,554	5,412	18,736	21,070	2,335
Green	1,855	- 0	- 1,855	341	-	- 341	2,196	- 0	- 2,196
Amber									
Total	14,449	9,516	- 4,933	6,483	11,554	5,071	20,932	21,070	138

5. Capital Expenditure

Total capital expenditure as at 28th February 2025 was £25.8m, which is £0.4m behind plan for the year overall. There was a more marked variation between Trust-funded (CDEL), £1.6m behind plan, with Charity-funded schemes £1.2m ahead of plan.

Within the Trust funded projects, the Estates programme is broadly on plan YTD, but forecasts to be £1.7m behind plan by the end of the year. The main areas likely to under deliver are the PP MDU and Aseptic projects. The ICT programme is behind plan for the year, however this largely due to timing difference and is expected this programme will be ahead of plan by year end. The contingency is expected to be fully utilised by year end, with additional investments made in ICT (£0.8m) and medical equipment (£0.9m).

Within Donated spend, the YTD variance is a combination of £604k underspend in Estates relating to Oak and £1.9m overspend in medical equipment. The overspends in the latter are mainly due to Juniper linac being acquired through a RMCC grant.

The expectation is by year end both Trust-funded and Donated capital will be materially in line with plan.

1. Capital plan by funding source

Funding source		Year to Date Plan	Year to date Spend	Year to Date Variance	Full Year Budget	Full Year Forecast	Forecast Variance
		£000	£000	£000	£000	£000	£000
Purchased		17,099	15,504	(1,596)	18,756	18,604	(152)
Donated		8,709	9,881	1,172	10,398	10,223	(175)
Grand Total		**25,808**	**25,385**	**(424)**	**29,154**	**28,827**	**(327)**
PDC		0	0	0	115	115	0
Additional CDEL awarded	ICT	0	0	0	801	801	0
Additional CDEL awarded	IFRS 16	0	0	0	290	290	0
Total		**25,808**	**25,385**	**(424)**	**30,360**	**30,033**	**(327)**

2. Summary position by Directorate

Funding source	Directorate	Year to Date Plan £000	Year to date Spend £000	Year to Date Variance £000	Full Year Budget £000	Full Year Forecast £000	Forecast Variance £000
Purchased	Estates	10,348	10,431	83	13,601	11,856	(1,745)
Purchased	ICT (incl. DHR)	1,561	1,337	(224)	1,800	2,557	757
Purchased	Medical Equipment	0	688	688	0	866	866
Purchased	Contingency	1,866	0	(1,866)	30	0	(30)
Purchased	IFRS 16 Leases	3,325	3,048	(277)	3,325	3,325	(0)
Purchased Total		**17,099**	**15,504**	**(1,596)**	**18,756**	**18,604**	**(152)**
Donated	Estates (incl Oak)	1,200	596	(604)	1,200	596	(604)
Donated	Medical Equipment	4,386	6,319	1,933	5,791	6,651	860
Donated - NIHR	Medical Equipment	3,123	2,966	(157)	3,407	2,975	(432)
Donated Total		**8,709**	**9,881**	**1,172**	**10,398**	**10,223**	**(175)**
Total		**25,808**	**25,385**	**(424)**	**29,154**	**28,827**	**(327)**
PDC		0	0	0	115	115	0
Additional CDEL awarded	ICT	0	0	0	801	801	0
Additional CDEL awarded	IFRS 16	0	0	0	290	290	0
Total		**25,808**	**25,385**	**(424)**	**30,360**	**30,033**	**(327)**

6. Cash and Debt

Cash - The Cash position as at 28th February was £115.3m which is £36.6m behind plan for the year. The major driver of this adverse variance is Private care accrued income and debt levels which are c.£20.4m higher than expected at this point in the year, NHS Income accruals are also £14.1m higher than anticipated.

Debt – Debt have decreased in year overall by £3.3m. This is driven by improvements in the Private patient billing process and debt collection over this period, reducing by £13.7m in year. However, NHS and Non-NHS debt have increased by £4.0m and £5.4m respectively, the Trust is working with SBS to improve our aged debt position in this area.

7. Conclusion

The Trust has reported £0.6m surplus as at 28th February 2025 at the control total level, which is line with plan YTD. This represents an improvement of £2.9m on last month's reported position. The Trust has received £3.2m in additional income from SWL ICB to cover the shortfall in Paediatric support funding £1.5m, and the NHS element of the unfunded pay award of £1.7m. As such the Trust has revised its 2024/25 forecast to £5.3m surplus in line with plan, and consistent with its externally reported position.

The capital programme is £0.4m behind plan YTD overall. Trust funded schemes (CDEL) are behind plan by £1.6m, with Grant funded schemes ahead of plan by £1.2m. The Trust funded schemes are expected to deliver plan by year end, with the overall capital programme to be behind plan by £0.3m.

The CIP programme was ahead of plan as at 28th February 2025. There has been slippage in some schemes through the year, these have been offset by other non-recurrent schemes over delivering. The CIP programme is expected to meet its target at year end.

The reported cash position of £115.3m remains significantly behind plan (£36.6m), due to a slower recovery of PP debt (remains £20m behind normal levels), also an increase in NHS Income Accruals of £14.1m.

8. Recommendation

The Trust Board is asked to note the position set out in the report.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 5.3
Title of Document: Performance Report Q3 • Q3 2024/25 Board Balanced Scorecard Report • Appendix A: Q3 Board Balanced Scorecard	**To be presented by:** Chief Operating Officer

1. Status **Information / Discussion**

2. Purpose:

Relates to:

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

3. Summary

The report provides an update on the Trust's performance for quarter 3 2024/25.

4. Recommendations / Actions

The Board is asked to note and discuss the quarter 3 position.

The ROYAL MARSDEN
NHS Foundation Trust

24/25 Q3 Performance Report

1. Executive Summary
2. Infection Prevention and Control
3. % of SACT/MDU infusion patients starting treatment < 1 hr of appointment
4. Other red-rated metrics
5. Appendix : Scorecard

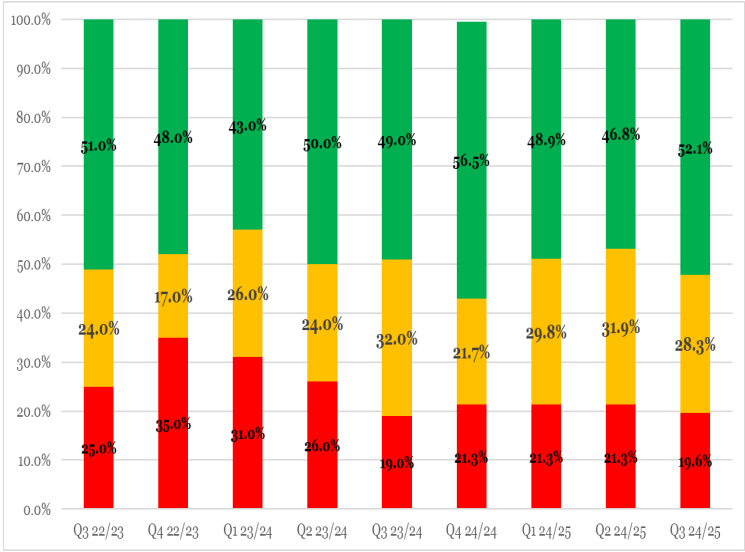
NHS

Executive Summary

Key headlines:

- Q3 has seen improvements in performance across several metrics. This includes the Trust vacancy rate, which was green rated in Q3 for the first time this year. Additional progress was made in staging completeness, and the Trust successfully recruited the first patient for two global trials.
- The Trust has exceeded the NHS England thresholds for 24/25 infection control metrics for C.diff, Klebsiella and P.aeruginosa. The patient cohort (disease and treatment) is impacting the ability to stay below thresholds. Actions are in place.
- SACT/MDU infusion on the day waiting times has remained amber.
- Q3 achieved 70.6% compliance with the 62-day cancer waits target. While the Trust did not meet the full 62-day standard in Q3, the national ambition of 70% compliance was met for the second consecutive quarter.
- HSMR: Telstra, who provide the HSMR figure for RM have changed their methodology resulting in the exclusion of a significant number of common cancers. Whilst the KPI with the new methodology remains green-rated for Q3, the numbers of admissions excluded has reduced the meaningfulness of the metric. RM has therefore removed this from the Board scorecard for Q3 and Q4 and is discussing internally and with Telstra an approach to mortality metrics for 25/26.

Scorecard KPI performance:



Areas of improvement:

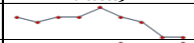
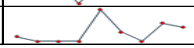
- Staging completeness has continued to improve, maintaining a green rating for the second consecutive quarter.
- The Trust's vacancy rate has also improved, in Q3 this is reported as 6.6% which is within the 7% target for the first time this year.
- The rate of written complaints per 1,000 Full-Time Equivalent (FTE) staff has improved, moving from amber to green this quarter.
- The sepsis audit has moved to above the 90% target in Q3. RM has also assessed the audit using the updated NICE guidance, which also achieved full compliance. Education and process changes have supported this improvement. However, due to the volume of patients in the audit remaining relatively low and variable there may still be fluctuation in this KPI going forward and improvement work continues.
- Improvements have also been made in two finance metrics: PP Activity Income Variance YTD (£000) and Capital Expenditure (CDEL) Variance YTD (£000), now green-rated.

Key highlight - research:

- The number of first global patients recruited in the last 12 months has sustained a green rating, with the Trust successfully having recruited the first patient for two global trials.
- The first study is being led by DDU and the second by the head and neck team.
- The Research team has now formally implemented a new expedited process to further enhance the Trust's ability to recruit more first global patients. The Trust expects performance to remain strong going forward into Q4.
- The research team is reviewing the current targets to stretch performance further in 25/26.

Infection Metrics (C.diff, P.aeruginosa and Klebsiella)

	Target	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25
Ψ C Diff - Number of Reportable Cases (COHA/HOHA) (at YTD)	40	33*	43*	17*	37*	46*
Ψ Number of Hospital Associated (HOHA/COHA) P. aeruginosa cases (at YTD)	21	20*	23*	7*	15*	24*
Ψ Number of Hospital Associated (HOHA/COHA) Klebsiella spp. Cases (at YTD)	29	23*	31*	7*	22*	35*

Latest data January 2025	Trend (exc. latest data)	Forecast
TBC		
TBC		
TBC		

Update since previous quarter:

- In Q3, the Trust exceeded the NHS England thresholds for the 2024/25 infection control metrics for C. difficile, Klebsiella, and P. aeruginosa.

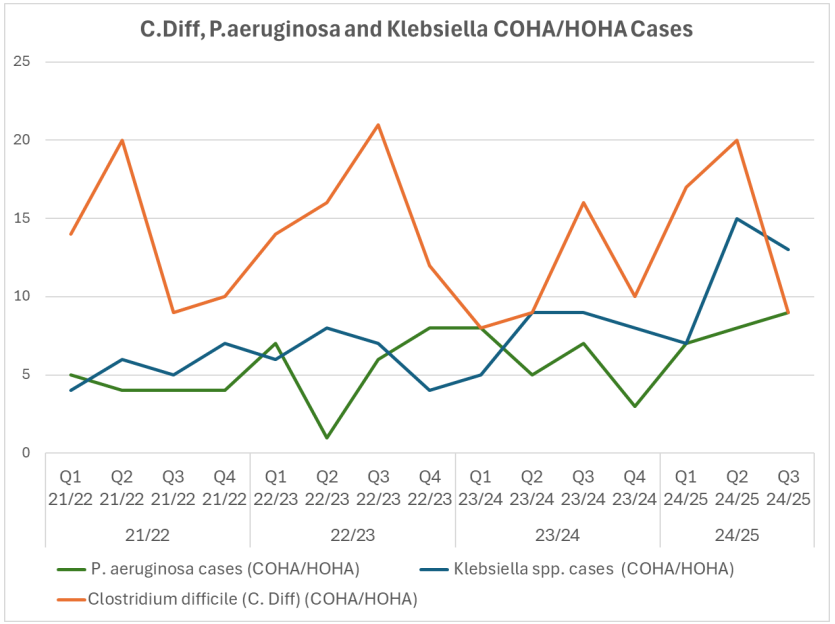
Key issues and causes:

- Patient cohort: The patient population at RM presents several known risk factors, including cancer diagnosis, treatments for cancer, age, prior healthcare or hospital attendances, use of antimicrobials, proton pump inhibitors, as well as enteral feeding.
- The RM Patient cohort is more likely than a non-cancer cohort to be colonised prior to being admitted/tested.
- Isolation can be challenging due to capacity issues relating to side rooms.
- NHSE thresholds do not provide comparable items such as number of samples taken per Trust.

Actions/next steps:

- The Trust has implemented a C. difficile action plan focused on enhancing early identification, sampling, isolation, and cleaning procedures to prevent transmission.
- A C.diff working group has been rolled out fortnightly for oversight of positive cases enabling collaborative working with the Gastroenterologist.
- Quality improvement project to reduce the time required for remedial actions on Pseudomonas-positive water outlets, therefore lowering environmental risks.
- The Trust is extending the auditing of 'High Impact Interventions' (HII), Central Venous Access Device (CVAD), Peripheral vascular access device (PVAD) and Indwelling urinary catheters (IUC) to all inpatient wards and units.
- GI flag on Epic has been implemented, flagging symptoms that require isolation.
- All positive blood cultures and environmental swabs for P. aeruginosa bloodstream infections are sent to UKHSA for typing.
- Two ward teams each week meet with Deputy Chief Nurse and Deputy Director of IPC to discuss their IPC performance/cleaning and MEG audit results.
- One of the drivers of the new NICE guidance for sepsis is to better manage antimicrobial usage on a risk basis.

Trends:



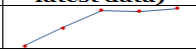
- RM reviews published benchmarking data for IPC. The treatments/disease means cancer specialist Trusts tend to benchmark higher. The Trust is working with the other specialist trusts to be better able to benchmark against peers.

Forecast:

- The Trust is also at risk of exceeding the threshold for E. coli in Q4.

% of SACT/MDU infusion patients starting treatment < 1 hour of appointment time

	Target	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25
Percentage SACT Infusion patients starting treatment < 1 hour of appointment time	≥85%	72.7%	77.2%	78.2%	81.7%	81.5%

Latest data January 2025	Trend (inc. latest data)	Forecast
82.3%		

Update since previous quarter:

- Performance was at 81.5% in Q3 (similar to Q2). Performance has recovered back to the pre-epic mean, however it remains below the 85% target.
- The average waiting time has improved over time and was 36 minutes in December (compared to 1 hour 3 minutes in June 2023).
- Improvement has been seen across all branches and units since April 2023. In December, Chelsea MDU, Chelsea PP MDU, Children's day unit, Sutton PP MDU and West Wing all met or exceeded their pre-epic average.

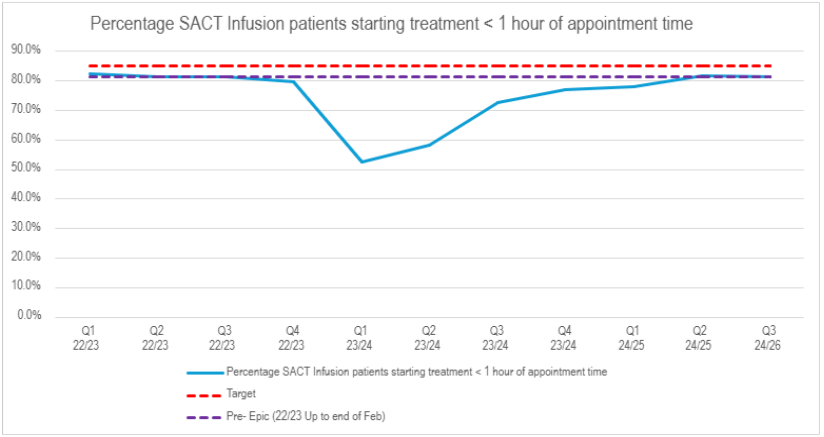
Key issues and causes:

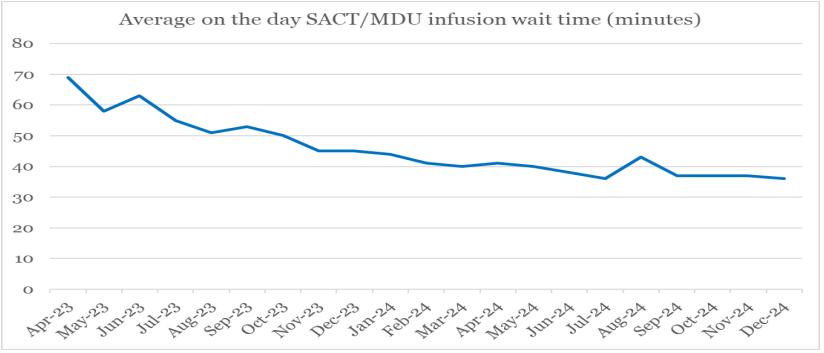
- Olayan day care unit continues to be the focus for improvement with several areas identified:
- Complexities in cannulation for some patient cohorts.
- Patients presenting with symptoms on the day, which require medical review.
- Clinical review was too close to the treatment appointment time.
- Pathway of drugs prepared on the unit.
- Scalp cooling time.

Actions/ Next Steps:

- Additional training on US-guided canulation for senior nursing staff, Olayan (Q4).
- Review impact of scalp cooling and effect on the data (Q4)
- Review pathway for drugs prepared on the unit, for example Zometa (Q4)
- Deep dive - standard of care drugs vs trial pathway and unit specific delays (Q4)
- Operationalise new report (launched in Aseptics and Chelsea MDU) to proactively follow up clinical fit to treat (Q4)
- Review Kingston waits as part of the Partnership Board (Q4) .
- SACT/MDU infusion waits continue to be monitored closely through the SACT group.

Trends:

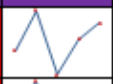
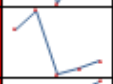
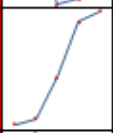
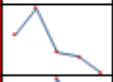
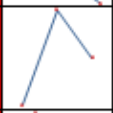
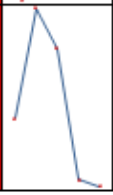




Forecast:

- Progress towards the end of Q4 trajectory is being monitored through the SACT group, with any amendments to the trajectory submitted to QAR. Early sight of January data puts performance at 82.3%, with three of the four branches now above the 85% target (Chelsea, Cav Square and Kingston).

Other red-rated metrics to note

Metric	Target	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Trend	Forecast	Narrative
Cash (£m)	YTD Plan	99.2	109	93.5	102	106		●	Cash in bank is behind plan largely due to challenges with PP billing earlier in the year. Actions relating to PP debt recovery are detailed below against the PP aged debt KPI.
Delivery against planned control total YTD (£m) - variance to plan	YTD Plan	6	8.4	0.7	1.4	2.3		●	The main drivers of the adverse variance against the control total are the non-payment of the paediatric funding from NHSE and a pay award funding shortfall.
PP Aged debt at >6months	Q3 £10,000,000	6.2	7.1	13.8	22.8	24.6		●	PP aged debt has increased slightly in recent months due to the volume of invoices generated between January and May 2024, as part of the PP billing recovery. Some sponsors are taking longer than others to process the invoices due to the quantity involved and errors on invoices requiring extensive rebilling. Embassy debt is a particular challenge and the PP Exec team are meeting the main Embassy accounts to try address issues and prioritise payments to RM and we are expecting a reduction in the aged debt number at the end of Q4.
Non-PP Debtors >6 Months (£m) - absolute value at month end	<£2.5m	7.2	8.7	6.3	6.0	5.2		●	The Trust has set a challenging target to return to pre-Epic levels of debt. This is being worked through with SBS although progress is slower than targeted.
18 wks pathways - patients waiting > 65 wks. (distinct patients across the quarter) Shadow metric until September 2024)	0			0	4	2		●	The Trust reported two pathways >65 weeks in Q3, both were benign cases. One was treated in December, the other was a very late referral to the trust (received in week 68) and has treatment booked in March.
Number of patients moved to Patient Initiated Follow Up/Open Access against trajectory	Q3≥441	438	490	471	409	406		●	406 patients were added to OAFU pathways in quarter 3, below the trajectory of 441. The trajectory set was based on 23/24 numbers and this included the start of testicular OAFU, where there was an influx of additions which has now stabilised. In addition, data quality issues at the start of Epic (which are now resolved) impacted the accuracy of the trajectory prediction. As such, the Trust expects to be just below the Q4 trajectory. The Trust will consider this when setting 25/26 trajectory to ensure it is realistic and achievable for Q1. A business case was approved to substantiate Testicular and expand the model to prostate. The Trust should therefore see a further increase in numbers in 25/26.

Appendix A

The Royal Marsden NHS Foundation Trust

Balanced Scorecard Q3 24/25 Published 14th February 2025

Key

* denotes Year To Date (YTD) figures

Blue-shaded KPI denotes metric linked to BAF stategic framework

Ψ denotes NHS England metric

	1. Safe Care	Target	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Trend	Forecast
Ψ	MRSA positive cultures (cumulative)	0	0	0	0	0	0		
Ψ	Number of Hospital Associated (HOHA/COHA) E. Coli Bacterium (at YTD)	51	37*	54*	15*	27*	42*		
Ψ	C Diff - Number of Reportable Cases (COHA/HOHA) (at YTD)	40	33*	43*	17*	37*	46*		
Ψ	Number of Hospital Associated (HOHA/COHA) P. aeruginosa cases (at YTD)	21	20*	23*	7*	15*	24*		
Ψ	Number of Hospital Associated (HOHA/COHA) Klebsiella spp. Cases (at YTD)	29	23*	31*	7*	22*	35*		
Ψ	% screened positive for sepsis who received IV abx within 1 hr (inpatients & emergency)	90%	81.1%	82.6%	84.2%	80.8%	100.0%		
	Number of Inicidents reported on Datix	>1248 < 1379			1207	1430	1230		
	Mortality audit	G	G	G	G	G	G	N/A	
	30 day mortality post surgery	≤0.4%	0.48%	0.51%	0.34%	0.36%	0.13%		
	30 day mortality post chemotherapy	≤1.4%	1.28%	1.17%	1.53%	1.13%	1.67%		
	100 day SCT mortality (Deaths related to SCT)	≤5%	5.80%	0.00%	0.00%	4.55%	1.45%		
	Staging data completeness (1 qtr in arrears)	≥80%	69.5%	73.5%	74.7%	83.9%	86.4%		
	2. Effective Care	**Target**	**Q3 23/24**	**Q4 23/24**	**Q1 24/25**	**Q2 24/25**	**Q3 24/25**	**Trend**	**Forecast**
Ψ	28 day Faster Diagnosis Standard (FDS): All Cancers	≥75%	85.3%	87.5%	88.8%	88.3%	89.4%		
Ψ	31 Days (Cancer Waiting Time Target)	≥96%	93.9%	94.4%	94.9%	96.5%	96.4%		
Ψ	62 Days (Cancer Waiting Time Target)	≥85%	67.1%	69.2%	65.7%	71.9%	70.6%		
Ψ	18 wks pathways - patients waiting > 52 wks. (distinct patients across the quarter)	≤6 a quarter	6	5	5	10	6		
Ψ	18 wks pathways - patients waiting > 65 wks. (distinct patients across the quarter) Shadow metric until September 2024)	0			0	4	2		
Ψ	6 week diagnostic waiting times (DMO1)	95%			95.2%	94.6%	95.4%		
	Cash (£m)	YTD Plan	99.2	109	93.5	101.9	105.8		
	Delivery against planned control total YTD (£m) - variance to plan	YTD Plan	6	8.4	0.7	1.4	2.3		
	Achievement of Efficiency Programme YTD (%)	On or > plan	103.0%	100.0%	83.6%	104.6%	109.3%		
	Agency Spend as a % of total pay bill	3.20%			1.35%	1.44%	1.32%		
	PP activity Income Variance YTD (£000)	B/even or > plan	5961	9301	1488	109	433		
	PP Aged debt at >6months	Q3 £10,000,000	6.2	7.1	13.8	22.8	24.6		
	Non-PP Debtors >6 Months (£m) - absolute value at month end	<£2.5m	7.2	8.7	6.3	6	5.2		
	Capital Expenditure (CDEL) Variance YTD (£000) - variance to plan in £m	90%-100%	-6.2	-2.5	-1.8	-5.3	-0.9		
	Bed occupancy - Chelsea	≥82% ≤87%	91.5%	87.6%	87.2%	88.8%	90.1%		
	Bed occupancy - Sutton	≥82% ≤87%	81.5%	82.8%	78.0%	82.5%	80.5%		
	Bed occupancy - Critical care Chelsea	≥67% ≤75%	75.1%	72.4%	63.4%	70.6%	71.4%		
	Session theatre utilisation - Chelsea	≥85%	88.7%	88.8%	86.8%	87.5%	83.8%		
	Session theatre utilisation - Sutton	≥70%	75.7%	75.7%	69.5%	65.5%	69.7%		
	Research: Confirmed No. of 1st UK pts recruited in last 12 months	1	10	10	18	24	28		
	Research: Confirmed No. of 1st European pts recruited in last 12 months	1	2	2	5	4	4		
	Research: Confirmed No. of 1st global pts recruited in last 12 months	1	0	0	1	1	2		
	% of commercial contract interventional trials where RM is lead NHS site	≥35%	60.3%	60.0%	54.9%	49.0%	54.6%		
	3.Caring	**Target**	**Q3 23/24**	**Q4 23/24**	**Q1 24/25**	**Q2 24/25**	**Q3 24/25**	**Trend**	**Forecast**
	Friends and Family Test (Inpatient and Day Care): % overall experience	≥95%	97.7%	98.9%	99.3%	99.19%	99.2%		
	Friends and Family Test (Outpatients) : % overall experience	≥95%	90.7%	97.5%	96.1%	96.4%	96.6%		
	Percentage SACT Infusion patients starting treatment < 1 hour of appointment time	≥85%	72.7%	77.2%	78.2%	81.7%	81.5%		
	4. Responsive	**Target**	**Q3 23/24**	**Q4 23/24**	**Q1 24/25**	**Q2 24/25**	**Q3 24/25**	**Trend**	**Forecast**
	Number of patients moved to Patient Initiated Follow Up/Open Access against trajectory	Q3 ≥441	438	490	471	409	406		
	Rate of written complaints per 1,000 Full Time Equivalent (FTE) staff	≤2.21	2.65	2.78	1.78	2.44	1.59		
	5. Well Led	**Target**	**Q3 23/24**	**Q4 23/24**	**Q1 24/25**	**Q2 24/25**	**Q3 24/25**	**Trend**	**Forecast**
	Vacancy rate	≤7%	11.0%	9.7%	7.3%	7.6%	6.6%		
	Voluntary staff turnover rate	≤12%	11.2%	11.3%	10.0%	8.9%	8.7%		
	Sickness rate	≤3%	3.8%	4.0%	3.7%	3.8%	3.8%		
	Consultant appraisal (number with current appraisal)	≥95%	95.0%	95.0%	94.0%	94.0%	94.0%		
	Appraisal & PDP rate	≥90%	86.7%	87.7%	78.4%	82.0%	83.8%		
	Completed induction	≥85%	77.9%	82.6%	85.4%	84.0%	83.2%		
	Statutory and Mandatory Staff Training	≥90%	91.6%	93.6%	91.5%	92.2%	92.9%		

BAF Strategic Objectives

Research and innovation

BAF 1. Revisiting and Strengthening the RM/ICR relationship. This includes developing an ambitious plan to function as a joint comprehensive cancer centre with a fully integrated governance and service delivery model.

BAF 2. Improving Patient Outcomes globally through the active research and development of new ways to diagnose and treat patients across the full cancer patient journey.

Compassionate, committed and excellent workforce

BAF 3. Attract: Develop a strong employer brand to maintain and promote RM's position as a globally competitive, 'employer of choice' for clinical and non clinical staff wishing to work in oncology.

BAF 4. Retain: Introduce differentiated retention and inclusion strategies to secure a skilled and sustainable workforce

BAF 5. Grow: Develop robust plans to grow our staff skills through provision of our own world class clinical education offer and access to the best non clinical learning support possible.

Pioneering and personalised diagnostics, treatment & Care

BAF 6.Provide leadership in introducing personalised and innovative diagnostics, treatment and care into standard of care patient pathways, pulling through the latest advances in technology and techniques from research into practice.

BAF 7.As the host and an active member of RM Partners, the West London Cancer Alliance, we will support the development and deployment of initiatives across the whole patient pathway aimed at improving patient outcomes for the wider regional population.

BAF 8. Maintain a high quality specialist paediatric service and minimise disruption to global leading paediatric research until this service is relocated to an alternative provider in line with the NHSE decision.
There is currently an integrated service and research model on the RM Sutton site which cannot be easily replicated.

BAF 9. Maximise existing and future investment in digital capabilities and available data to support innovation & productivity which benefits patient's diagnosis, treatment & care.

BAF 10. Address capacity constraints at our Chelsea site, particularly in inpatients with a short, medium and long term plan that seeks to expand and realise efficiencies in existing facilities, and seeking off site capacity opportunities.

Sustainable investment through effective use of resources

BAF 11. Work with stakeholders at the Sutton site to develop a new site strategy which maximises the opportunities for improving the quality and efficient use of the whole site for the benefit of patients, staff and the local community, including a strong element of positive 'placemaking'.

BAF 12. Deliver the Private Patients and wider commercial strategy, ensuring a high-quality offer which meets demand and generates returns that are reinvested into the Trust.

BAF 13. Deliver the overall financial plan, ensuring efficient use of resources, diverse but clearly contracted income streams and the ability to reinvest capital into infrastructure.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 5.4
Title of Document: Quality Account – February 2025	**To be presented by:** Chief Nurse

1. Status **For noting**

2. Purpose:

Relates to:

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

3. Summary

Effective Care:
Percentage of SACT/MDU infusion patients starting treatment < I hour of appointment: Performance was 82.3% in January, with the average waiting time of 35 minutes. Of those waiting more than 60 minutes, the majority start within 90 minutes of the appointment time.

Safe Care
Healthcare Associated Infections (hospital and community onset): We have exceeded NHSE thresholds for Clostridioides Difficile Infection, and both blood stream infections (BSI), Klebsiella and Pseudomonas aeruginosa. While still within the E.coli threshold it is predicated we will exceed shortly. This month, two of the E.coli BSIs are patients who had experienced a previous BSI in December. However, due to the reporting requirements (if greater than 14 days) these are reported again. The IPC team have been working closely with the Haematology wards due to recognition of possible increased environmental risks in relation to the estate and mould.

Patient Falls: 24 actual falls, there were no moderate harm incidents. Local harm free care huddles have been implemented.

Medication incidents: Given the number of CD errors, there is continued training and education as well as publication of the new CD Action card to be sent out to all clinical areas this month with important reminders and updates including illustrating how documentation in the controlled drugs register must be clear especially when errors are corrected and the importance of wearing red tabards is being further highlighted.

Hospital Acquired Pressure Ulcers (HAPU): Nine acquired pressure ulcers (Cat 2 and above), although the monthly incidence continues to decline (for sixth consecutive month).

Deteriorating Patient: Two Calls for Concern one in Chelsea and one in Sutton. Development of training and education on new NICE sepsis guideline (NG51), in addition to the implementation of new changes to EPIC sepsis timer

Caring and Responsive
Patient experience and complaints: Outpatient (FFT): December 2024 is the latest published national data - 95% of respondents would recommend RM, this is above the national average of 94%.

Inpatient (FFT): December 2024 is the latest published national data – 99% of respondents would recommend RM, this is above the national average of 94%. To support F&F, new noticeboards have been installed on Bud Flanagan West and the ward are currently developing education leaflets/information which will be provided upon admission. Complaints: Secretarial administrative teams to attend communication skills training specifically for non-clinical staff dealing with people affected by cancer and distress.

Well led:
Nursing Recruitment, Turnover & Retention: The Trust's nurse vacancy rate decreased by 0.4% to 2.8%, remaining below the Trust's target for the twelfth consecutive month. To address demand in Sutton and reduce reliance on agency staff, we will be hosting a recruitment day specifically targeting HCSW bank workers.

Multi-professional Vacancy rates and Recruitment: The Trust's vacancy rate remains 6.6%, continuing to stay below the Trust target of 7%.

4. Recommendations / Actions

The Board is asked to review and note the Quality Account.

The Royal Marsden

The ROYAL MARSDEN
NHS Foundation Trust

February 2025
Quality Account (January 2025 data)

1. Executive Summary
2. SACT/MDU infusion waiting times
3. Healthcare Associated Infections and Hand Hygiene
4. Falls
5. Medication Incidents
6. Hospital Acquired Pressure Ulcers (HAPU)
7. Deteriorating patient
8. Patient Experience and patient complaints
9. Nursing Recruitment and Turnover & Retention
10. Multi-professional Vacancy rates and Recruitment

Appendices 1-3b

- 11 & 12 Scorecards
- 13 Patient feedback
- 14 &15 Safer staffing tables

NHS

Executive Summary

Key headlines:

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The Royal Marsden –FEBRUARY 2025 (JANUARY 2025 DATA)

Patient % SACT/MDU infusion patients starting treatment < I hour of appointment

Update

- Performance was 82.3% in January (similar to December - 82.0%). In total this equates to 3,781 infusions starting < 60 minutes and 813 > 60 mins.
- As reported previously, performance has recovered to pre-epic mean but remains below the 85% target.
- The average waiting time for January was 35 minutes. This is a significant improvement on the figure in June 2023 when it was 1 hour 3 minutes. Of those waiting more than 60 minutes, the majority start within 90 minutes of the appointment time.
- The branch breakdown: Chelsea (90.6%); Cavendish Square (86.5%); Sutton (76.6%); Kingston (85.2%). Three of the four branches were above 85% target in January.

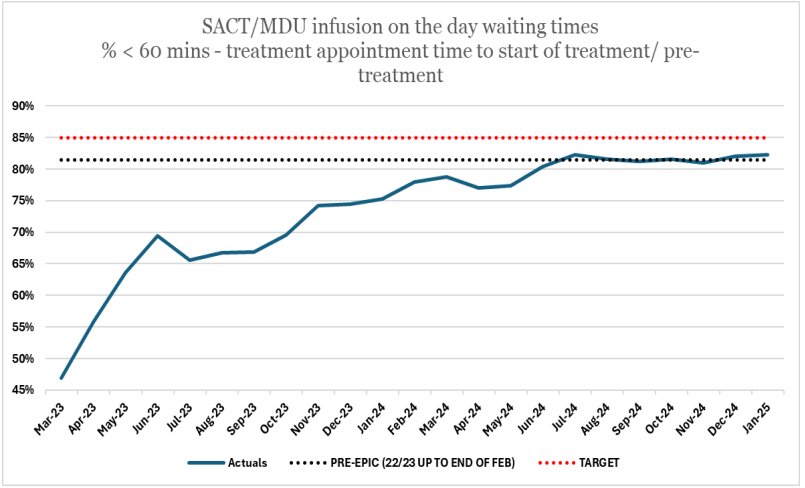
Key issues and causes:

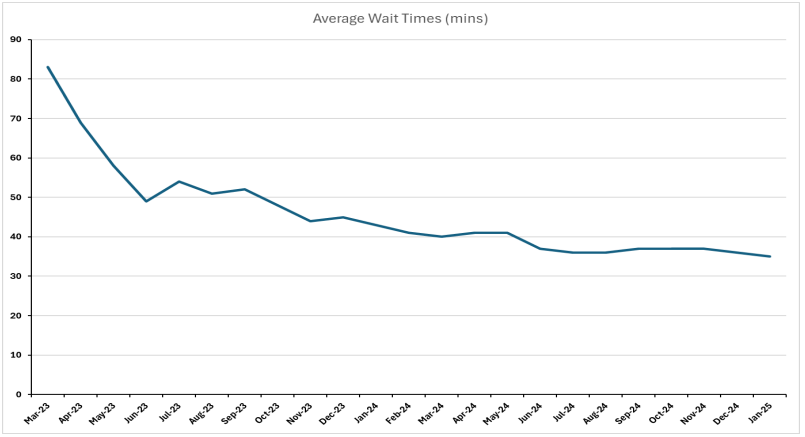
- Olayan day care unit continues to be the focus for improvement with several areas identified:
- Complexities in cannulation for some patient cohorts.
- Patients presenting with symptoms on the day, which require medical review.
- Clinical review was too close to the treatment appointment time.
- Pathway of drugs prepared on the unit.
- Scalp cooling time.

Actions/next steps:

- Additional training on US-guided canulation for senior nursing staff, Olayan (Q4).
- Review impact of scalp cooling and effect on the data (Q4)
- Review pathway for drugs prepared on the unit, for example Zometa (Q4)
- Deep dive - standard of care drugs vs trial pathway and unit specific delays (Q4)
- Operationalise new report (launched in Aseptics and Chelsea MDU) to proactively follow up clinical fit to treat (Q4)
- Review Kingston waits as part of the Partnership Board (Q4) .
- SACT/MDU infusion waits continue to be monitored closely through the SACT group.

Trends:



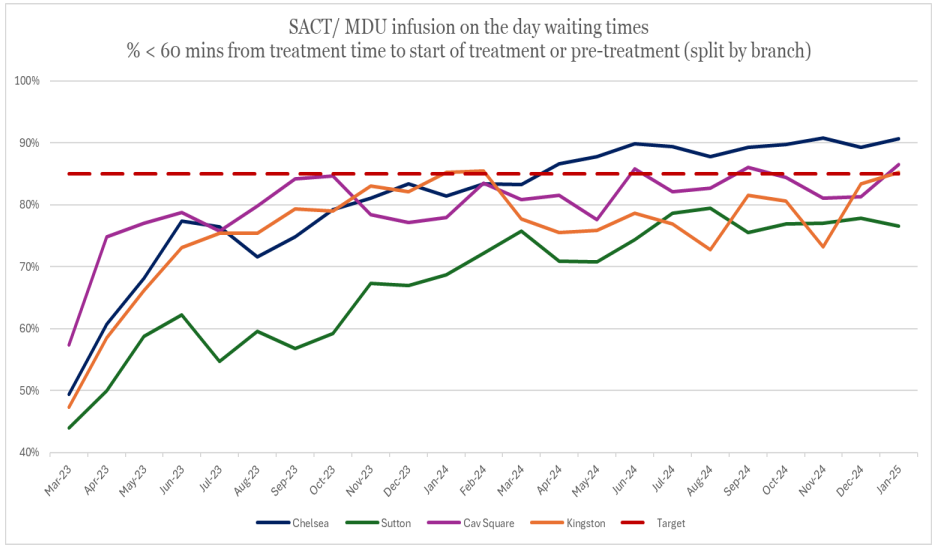


Forecast:

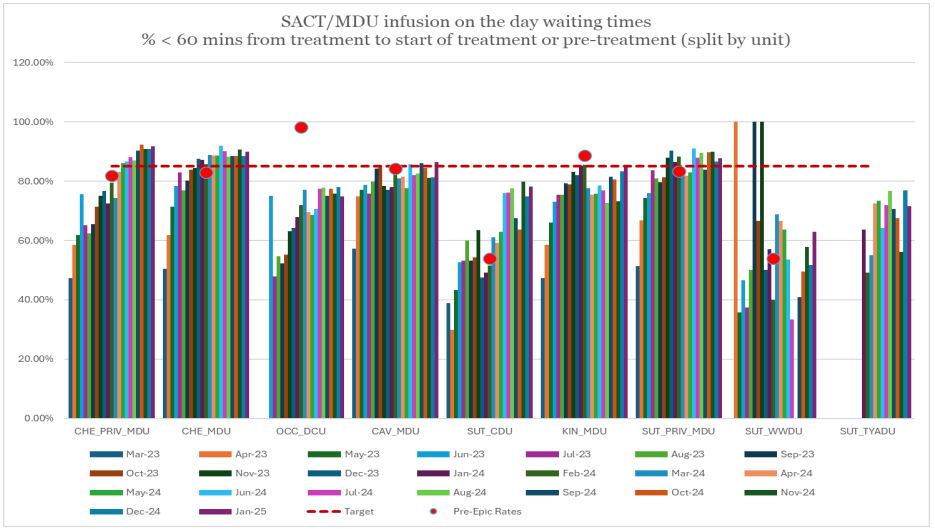
- Progress towards the end of Q4 trajectory is being monitored through the SACT group.

SACT % /MDU % infusion metric 2/2

Branch level data:



Unit level data:



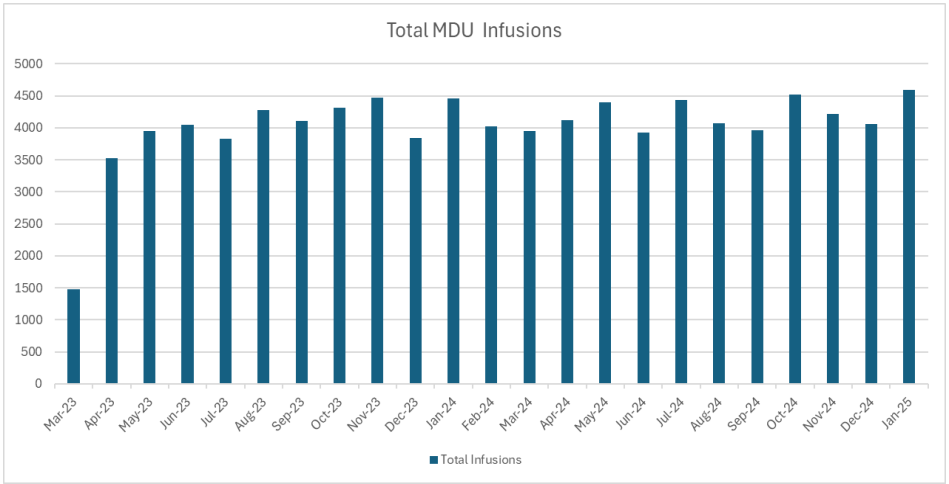
NHS Medical Day Units:

- Chelsea MDU has been above the Trust target of 85% since December 2023, reporting performance of 90.0% in January 2025.
- Kingston MDU also reported above 85% in January at 85.2%
- The remaining NHS units are below the Trust target. However, West Wing, Children's day Unit and TYA are all above their respective pre-epic means.
- Olayan was 74.9% in January.

Private Medical Day Units:

- All Private MDUs were above the Trust target of 85% in January.

MDU infusion volumes:



Healthcare associated Infections (hospital and community onset) (1/2)

Summary:

•**Clostridioides difficile infection (CDI):** The Trust exceeded the NHS England threshold for CDI in October. As of January 2025, 52 cases have been reported, surpassing the threshold of 40.

•***Klebsiella* species Blood Stream Infection (BSI):** In November, the Trust exceeded the threshold for *Klebsiella* species BSI. As of January 2025, 36 cases have been reported, exceeding the threshold of 29. This represents an increase of 12 cases compared to the same period last year.

•***Pseudomonas* aeruginosa BSI:** The *Pseudomonas* aeruginosa BSI threshold was exceeded in December. As of January 2025; 25 cases have been reported, against a threshold of 21. This marks an increase of 2 cases compared to the same period last year.

•**E.coli BSI:** The Trust has not yet exceeded the E.coli BSI threshold. As of January 2025, 47 cases have been reported, approaching the threshold of 51. Given the Trust's average of 5 reported cases per month, it is likely the threshold will be surpassed in the coming months.

E.coli BSI:

Five healthcare associated cases reported for January, this is an increase of one on the previous month. Two of the E.coli BSI reports in January are patients who had experienced a previous BSI in December. However, due to the reporting requirements if greater than 14 days these are reported again.

Cancer Diagnosis	Primary Focus of Infection
Haematology	Hepatobiliary
Upper Gastro	Uknown
Upper Gastro	Hepatobiliary
Upper Gastro	Gastrointestinal or intraabdominal collection (excluding hepatobiliary)
Urology	Genital system(including prostate if male)

Klebsiella species BSI:

1 healthcare associated cases reported for January, a decrease of four on the previous month.

Cancer Diagnosis	Primary Focus of Infection
Haematology	Hepatobiliary

Pseudomonas aeruginosa BSI:

One healthcare associated case reported for January a decrease of four on the previous month.

There is now a process in place that all positive blood cultures for *Pseudomonas* aeruginosa are routinely sent to UKHSA for typing. A Standard Operating Procedure (SOP) is also in place to conduct internal indication sampling on outlets where patients are cared for who have a suspected hospital onset healthcare associated Pseudomonas BSI. One of the reported cases in December the patient was transferred during the period of admission to an alternative hospital for care. This is however not recorded as a discharge and re-admission and so is reported as a Hospital Onset Hospital Acquired (HOHA) case.

Cancer Diagnosis	Primary Focus of Infection
Lower Gastrointestinal	Gastrointestinal or intraabdominal collection (excluding hepatobiliary) The patient had previous history of Pseudomonas Aeruginosa positive wounds. The estates team carried out indication sampling of the water in the area to assure the Trust of the environment, results returned negative results.

Healthcare associated Infections (hospital and community onset) (2/2)

Clostridioides difficile Infection (CDI):

Six healthcare associated cases reported for January, this is an increase of four on the previous month.

Haematology	4 Cases in patients over 18 years
Haematology	2 Cases in patients under 18 years. 1 patient has had 3 episodes of CDI infection in the reporting year.

The Consultant Microbiologist received typing results of 6 cases of CDI for paediatric previous patients which identified all differing types with no link to transmission. The CDI working group takes place fortnightly on a Tuesday and is supported by the Consultant Gastroenterologist, Antimicrobial Pharmacist, Consultant Microbiologist and the Infection Prevention Team. The clinical areas are invited to share the case history of the patients and review interventions.

Continued actions and themes:

Continued collaborative working in supporting the Estates team in undertaking remedial works in clinical areas to reduce the risk of environment *Pseudomonas* aeruginosa.

Develop the CDI working group to include clinical areas and use evidence gathered to support the CDI reduction action plan and the Trust Antimicrobial Reduction strategy.

Planning for Link Practitioner training to include learnings from outbreaks and the actions to take when unable to isolate a patient.

Ventilation requirements reviewed including the review of air changes and air testing of areas that see a higher prevalence of respiratory viruses and fungal risks to support the use of mobile hepa air filters.

Incidents and Outbreaks:

The IPC team have been working closely with the Haematology wards due to recognition of increased environmental risks in relation to the estate and fungal risk.

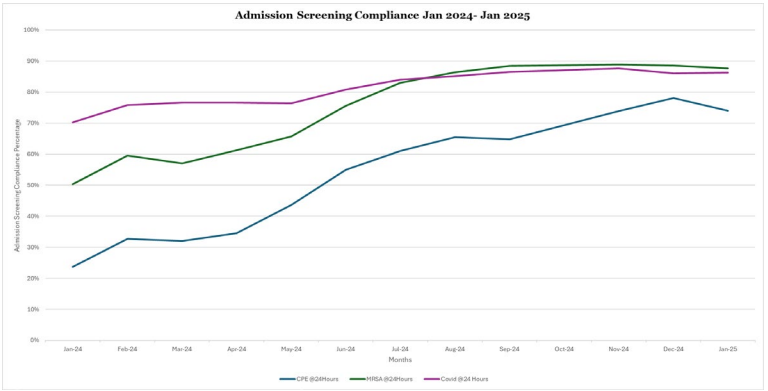
An Outbreak meeting was held for Respiratory Syncytial Virus (RSV) outbreak in January in Smithers ward. One index case and 2 contacts were positive for RSV. The timing of the outbreak was consistent with a national increase in the prevalence of respiratory viruses. The outbreak occurred in a shared accommodation bay and the symptomatic patient was unable to be isolated due to the lack of available capacity of side rooms. The lack of isolation capacity is on the risk register.

Admission Screening Compliance:

The Trust policy is to screen all admissions for CPE, MRSA COVID-19.

Monthly measurement/audit is carried out to demonstrate compliance with MRSA, CPE screening guidance. This recommendation follows UKHSA guidance on the how to reduce the risk of transmission. The Trust compliance for COVID-19 was agreed to mirror the MRSA, CPE compliance. All patients should be screened within 24 hours of admission.

The screening compliance for CPE had dropped in January had a small drop. The graph below shows the increase in compliance from January 2024



The Royal Marsden – FEBRUARY (January 2025 data)

Patient Falls

Update since previous quality account:

•32 fall incidents in January (including slips, trips and near misses), of which 24 were categorized as an actual fall.

- 4 fall from the same level.
- 12 fall from a height (chair, bed, toilet).
- 6 guided assisted fall.

•There was no moderate harm incidents, 7 low harm incidents and 25 no harm incidents.

•The split between divisions: cancer services (22); clinical services (2); private care (8) and corporate(0).

•Incidents by site: Chelsea site (15) and Sutton site (17).

•Increase in % of all fall incidents compared to the previous 12 month period, 5.3%.

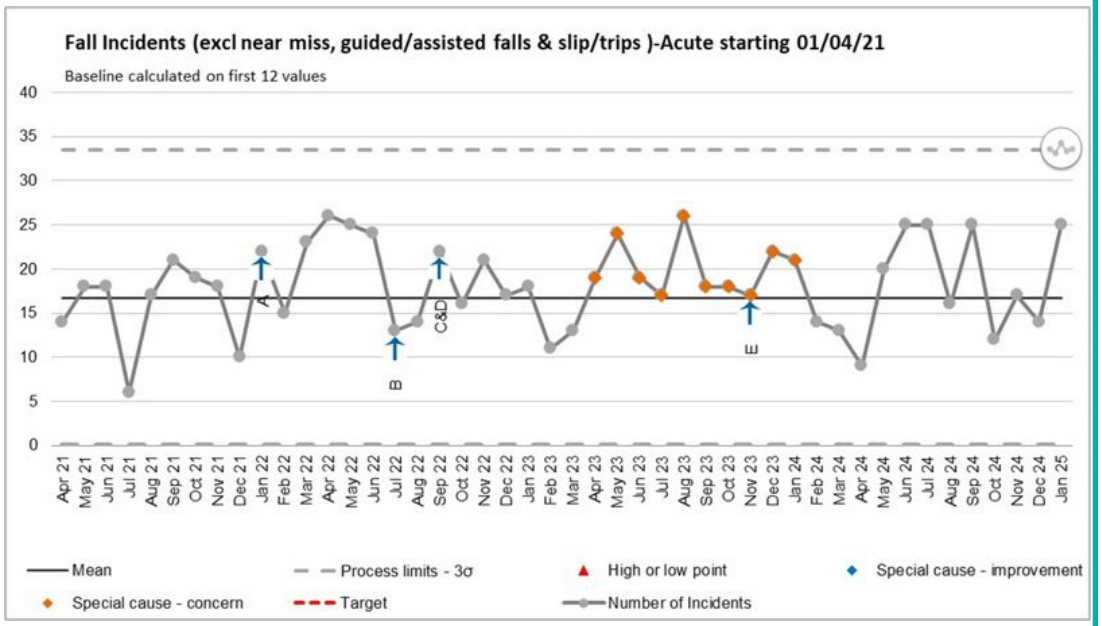
•Decrease in % of actual fall incidents compared to the previous 12 month period, 6.5%.

•6/1000 falls per bed days.

Actions / next steps:

- Terminology and subcategories for incident reporting relating to falls to be reviewed and agreed by Falls steering group.
- Refresher training from nursing teams regarding EPIC document timing to ensure reports accurately reflect timing of patient harm free care assessments.
- Review use of EPIC ward manager dashboards and reporting capacities relating to regarding falls assessments, care plan implementation timings and post fall assessments and care plans.
- Thematic review to be undertaken.

Trends:



Key Interventions	
A	QI RAG Fall Pilot currently in Robert Tiff and Wiltshaw Ward
B	Adjustable height chairs trial on Smithers Ward
C	The Eat Drink Move project on Smithers utilising Volunteers
D	Introducing Twilight Volunteers on the Bud Flannagan wards
E	Fall prevention equipment trial in Sutton

Key issues:

- Incident subcategories to be reviewed to reflect nature of clinical incidents.
- Raizer chair training roll out.
- Implementation of local harm free care huddles.
- Deep dive into bathroom related incidents

Medication incidents

Update since previous quality account:

- 151 medication incidents in January, 21% (n=32) were due to SACT adverse reactions when used as intended.
- 102 no harm, 48 low harm

Key issues and Themes:

- **Controlled Drug Incidents (21)**
- Patient involved incidents were the main theme (13) which included prescribing errors (2), administration of the wrong dose (8), administration of wrong formulation, a patch was removed earlier than 72 hours and a delayed dose due to a pharmacy stock dispensing issue.
- 6 accounted for losses which included 3 recording errors, 2 running balance discrepancies and a spillage.
- 2 governance incidents which included an outer broken lock on a CD cupboard and no second signature for CD administration on the MAR.
- **Omitted and delayed medicines (16)**
- There were 12 SACT administration delays which were due to 8 aseptic preparation delays, a line inadvertently clamped, LFT test not taken prior, and 2 screening confirmations delays due to dose change/query.
- 3 supportive care incidents which included omission of the first day of steroids on a treatment plan as unable to be released to the MAR.
- 1 critical medicine incident (low harm) where insulin was missed for a patient who had a total pancreatomy which resulted in high glucose levels the following day.

Actions/next steps:

- New CD Action card to be sent out to all clinical areas this month with important reminders and updates including illustrating how documentation in the controlled drugs register must be clear and errors corrected and importance of wearing red tabards.

Trends:

Table 1: Controlled Drug Incidents

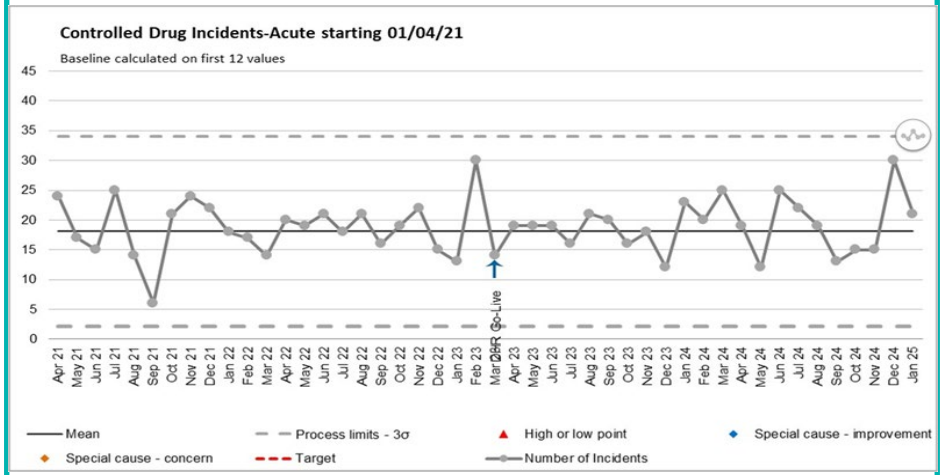
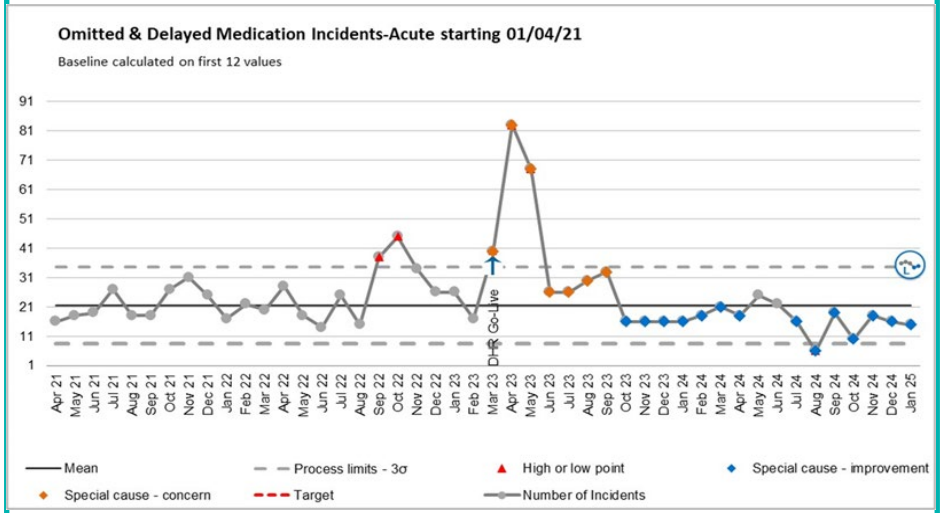


Table 2: Omitted and Delayed Medication Incidents



The Royal Marsden – FEBRUARY (January 2025 data)

Hospital Acquired Pressure Ulcers (HAPU) - excluding category 1

Update since previous quality account:

- Nine patients with Trust attributable pressure ulcers (cat 2 and above).

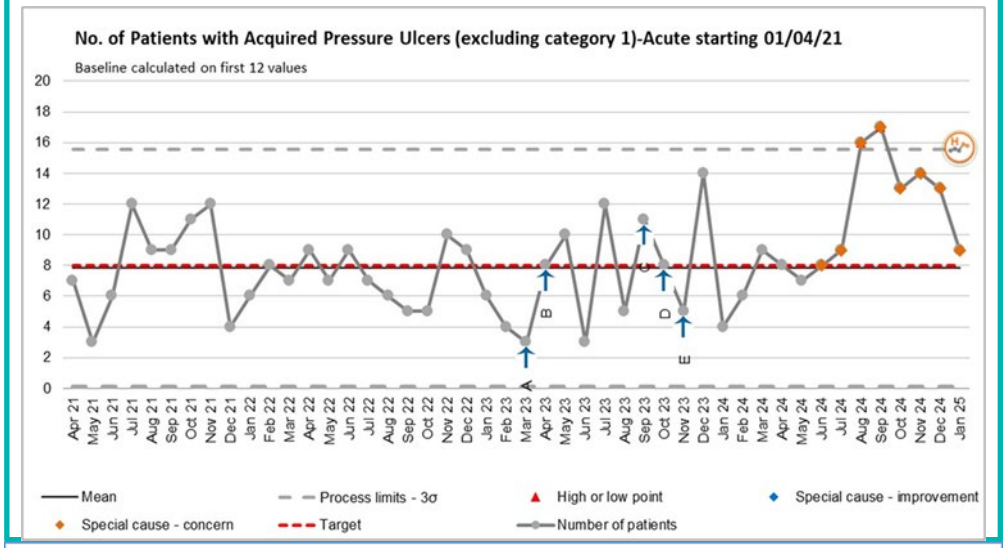
Cat	No.
2	6
3	1
4	0
U/S	2
DTI	0
MDRP	2

- The Trust had seven category 1 PUs reported.
- Nine (cat 2 and above)- continues above SPC limit
- Two related to med device PU (Lary Tube, O2)
- No moderate harms in month

Key issues and Themes:

- PU's exceeded SPC target at 9, although incidences continue to decline (for 6th consectitve month)
- Potential for PU review delays due to ongoing TVN staffing shortage.
- Some miscatogorasation of pressure ulcers noted with delays in referrals.
- PSIRF Guidelines on investigations to be finalized.
- The quality of image on remote reviews can be problematic. Chairs of PUPG considering how best to support initial PU validation

Trends:



Key Interventions

A	Implementation of PURPOSE T pressure ulcer risk assessment (replacing Waterlow)
B	Trust started CQUIN: assessment and documentation of pressure ulcer risk for 23/24
C	Implementation of Pressure Ulcer Review Group
D	Tissue Viability Study Days now on Learning Hub
E	Stop the Pressure Events trustwide

Actions/next steps

- Still waiting outcome of deep dive into device related PUs for last year- themes and emerging risks.
- Wound snapshot audit Feb completed, March 5 & 6 March 2025
- TVN champion monthly meeting, dates on TVN intranet page.
- TVN Level 1 & 2 training dates TBC

Forecast:

- Target: zero acquired category 4 pressure ulcers- (n=1)- awaiting PSIRF response guidance Patient Safety Incident Investigation vs After Action Review
- Target: for attributable PUs to remain at target/below higher process limits.
- Pressure Ulcer Prevention group – key priority in terms of PSIRF system learning to MAP service and interdependencies and organisational action plan.

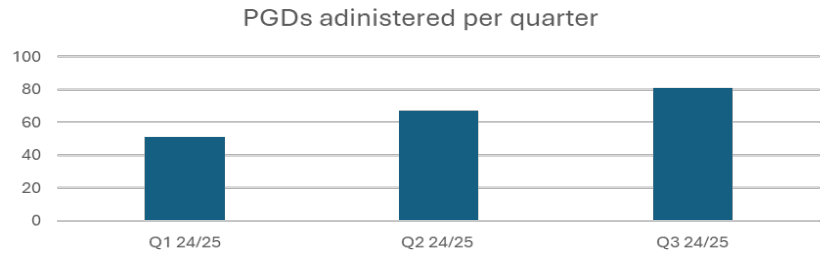
Deteriorating Patient

CCOT data:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 25
Total CCOT reviews	283	263	289	277	278	242	278	313	284	256
CCOT referrals/ reviews	168	136	121	148	162	127	149	184	168	132
CCOT reviews following CCU Step down	112	127	168	129	117	115	129	129	116	124
Unplanned admissions post CCOT reviews	15	16	16	24	7	16	17	12	18	18
Sutton Step Up only admissions	0	1	5	3	3	0	0	1	3	0
CCU admissions from Step Up only	2	3	1	2	4	3	8	3	3	5
Re-Admissions					0	1	1	0	3	1
Ward CCOT Consultations with SBAR (CCOT)					83.1 % (44.74%)	87.69% (48.2%)	82.94% (52.32%)	85.48% (66.30%)	87.69% (61.31%)	84.31% (61.36%)

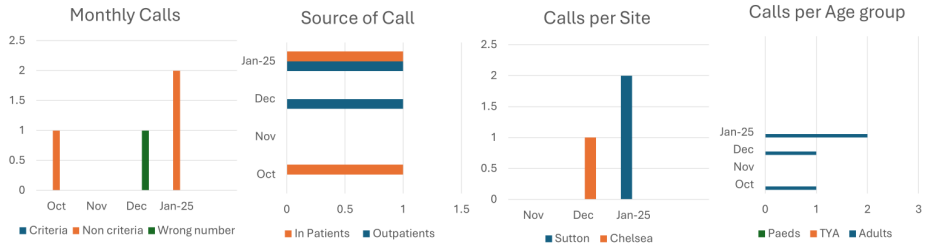
Sepsis PGD training and administered :

- 14 staff trained
- x2 PGD workshops cancelled due to poor registration
- 25 Sepsis PGDs administered for January
- PGDs administered, Piperacillin tazobactam (17) Normal saline (6) Aztreonam (2).
- 1 full sepsis study day January 7 staff attended, 3 spaces not booked.



Call for Concern
Jan 2025

2 Calls



Key actions update:

- Validate number of PGD givers for sepsis
- Update NEWS2 guidelines and work*flow*
- Implementation of new SBAR workflow
- Launch new Epic "PLY" area
- Continuation of outpatient/ inpatient Epic workflows

Next steps

- Development of training and education on new sepsis guidelines (NG51).
- Implement new changes to EPIC sepsis timer
- Monitor new training model implemented January 2025 workshop vs study day
- Ongoing validation of data sets
- Identify options for Martha's Rule component 3

Patient experience and Complaints

Update since previous quality account:

- **Complaints:** 14 new complaints were opened in January 2025: Cancer Services (8), Clinical Services (2), for Private Care (4).
- **Outpatient Friends and Family Test (FFT)**: December 2024 is the latest published national data - 95% of respondents would recommend RM, this is above the national average of 94%.
- **Inpatient Friends and Family Test (FFT)**: December 2024 is the latest published national data – 99% of respondents would recommend RM, this is above the national average of 94%.

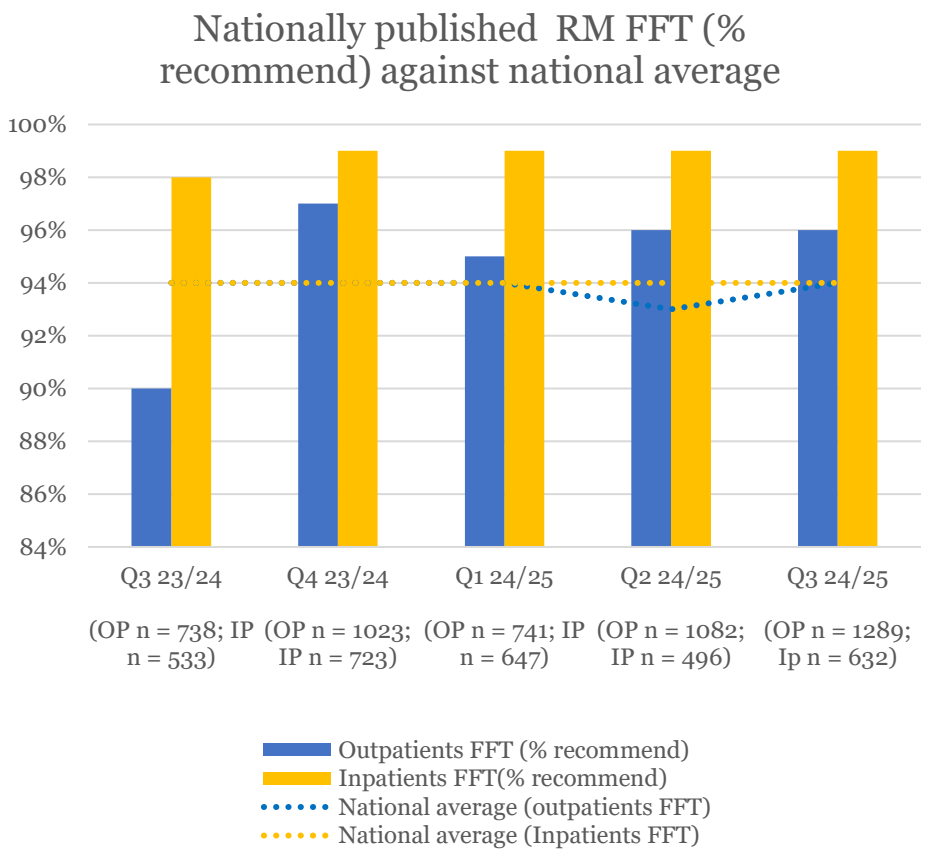
Key issues and themes:

- **Complaints:** Current themes surrounding clinical treatment of patients inclusive of appropriate communication and their care.
- **Friends and Family test:** The key issues related to communication and waiting times (refer to comments in Appendix 2).

Actions/next steps:

- Complaints: Secretarial administrative teams to attend communication skills training specifically for non-clinical staff dealing with people affected by cancer and distress.
- Complaints: Ensure teams are aware a prior private patient referral does not affect NHS eligibility.
- Friends and Family Test: new noticeboards have been installed on Bud Flanagan West and the ward are currently developing education leaflets/information which will be provided upon admission. The team will also do a quality check to ensure all mandatory posters/information is displayed.

Trends:



- Across the last four quarters, satisfaction has consistently remained above the national average.

Nursing Recruitment and Turnover & Retention

Update since previous quality account:

The Trust's nurse vacancy rate decreased by 0.4% to 2.8%, remaining below the Trust's target for the tweflth consecutive month. To address demand in Sutton and reduce reliance on agency staff, we will be hosting a recruitment day specifically targeting HCSW bank workers. Currently, there are 36.9 WTE nurses in the recruitment pipeline.

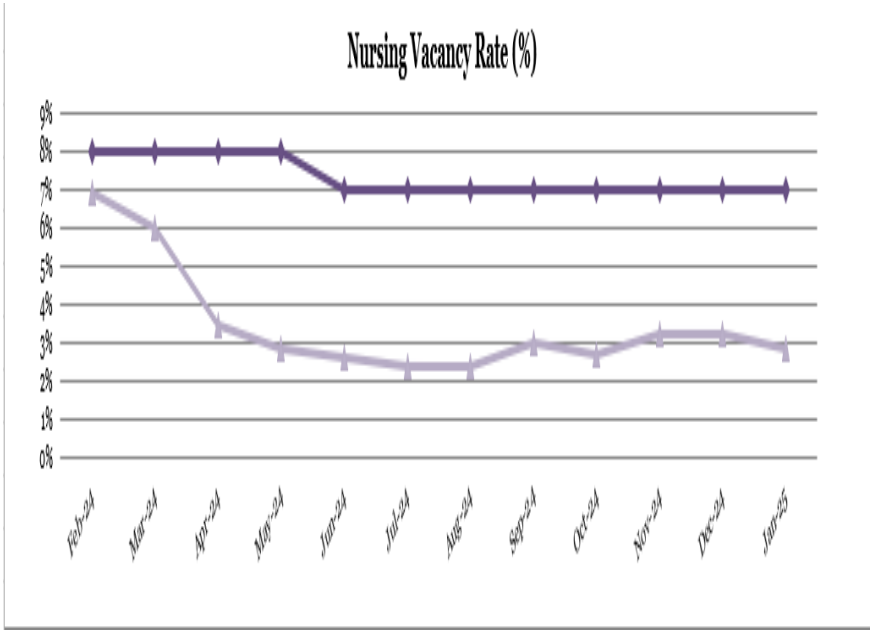
Key issues and Themes:

The nursing turnover rate reduced to 8.7% and remains below the Trust target of 12%.

Actions/next steps:

- Strengthen Domestic Recruitment Pipelines – Expand nursing apprenticeships and promote nursing careers through targeted outreach in Universities, colleges and schools.
- The current priority is to recruit into Healthcare Support Worker (HCSW) roles, both on a substantive and bank basis, to reduce dependency on agency staffing in anticipation that the NHS will expect Trusts to stop using agency for lower banded roles.

Trends:



Forecast:

- The nursing vacant rate remain stable and below target.

Multi-professional Vacancy rates and Recruitment

Update since previous quality account:

The Trust's vacancy rate remains steady only increasing slightly to 6.6%, continuing to stay below the Trust target of 7% for the fourth consecutive month. The staff groups with the highest vacancy rates are as follows: Estates and Ancillary (14%), Additional Clinical Services (11.2%), and Allied Health Professionals (8.7%).

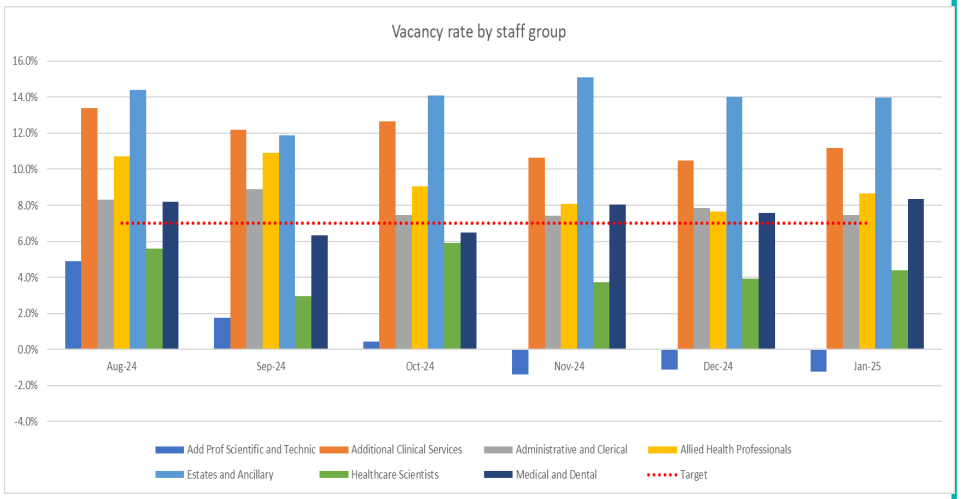
Key Issues and Themes:

There are 111.6 WTE candidates in the recruitment pipeline, with 59.1 WTE candidates have confirmed start dates.

Actions/next steps:

- We will be attending a refugee recruitment fair in May, organised via Jobcentre Plus in the Royal Borough of Kensington and Chelsea. The aim is to establish a clear pathway for refugees to enter the workforce and address existing barriers, particularly in attracting and retaining talent within the Trust.
- To further enhance the candidate experience, we are actively exploring areas of the onboarding process that can be streamlined and optimised through digital solutions. From January, we have introduced Trust ID so that applicants do not have to travel to site for ID checks.

Trends:



The Trust vacancy rate currently is below target at 6.6%.

Appendix 1 - Quality Account Scorecard (1/2)

The Royal Marsden NHS Foundation Trust
Quality Account 24/25
Janary 2025 Data

Key
* denotes Year To Date (YTD) figures
Blue-shaded KPI denotes metric linked to BAF stategic framework
Ψ denotes NHS England metric

	Safe Care	Target	Q1 24/25 Apr-24	May-24	Jun-24	Q2 24/25 Jul-24	Aug-24	Sep-24	Q3 24/25 Oct-24	Nov-24	Dec-24	Q4 24/25 Jan-25	Feb-25	Mar-25	Trend	YTD	23/24
	Mortality audit	Green	G			G			G						N/A	N/A	N/A
	30 day mortality post surgery	≤0.4%	0.34%			0.36%			0.13%							0.3%	N/A
	30 day mortality post chemotherapy	≤1.4%	1.53%			1.13%			1.67%							1.4%	N/A
	100 day SCT mortality (Deaths related to SCT)	≤5%	0.00%			4.55%			1.45%							2.0%	N/A
	% screened positive for sepsis who received IV abx within 1 hour	90%	84.2%			80.8%			100.0%							88.3%	84.9%
	Number of Incidents reported on Datix (Reported Date)	>1248 < 1379	1207			1431			1229							3867	N/A
Ψ	Number of diagnoses of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia	0	0	0	0	0	0	0	0	0	0	0				0	0
Ψ	Number of diagnoses of Methicillin-sensitive Staphylococcus aureus (MSSA) (HOHA/ COHA)	6	0	0	0	0	2	1	0	1	0	1				5	5
Ψ*	Clostridium difficile (C. Diff)- Number of COHA and HOHA (at YTD)*	40	6 *	11 *	17 *	23 *	31 *	37 *	42 *	44 *	46 *	52 *				52	43*
	Clostridium difficile (C. Diff)- Number of COHA and HOHA (monthly)	N/A	6	5	6	6	8	6	5	2	2	6				52	43
Ψ*	Number of (COHA/HOHA) E. Coli Bacterium (at YTD)*	51	5 *	11 *	15 *	19 *	23 *	27 *	32 *	38 *	42 *	47 *				47	54*
	Number of (COHA/HOHA) E. Coli Bacterium (monthly)	N/A	5	6	4	4	4	4	5	6	4	5				47	54
Ψ*	Number of (COHA/HOHA) P. aeruginosa cases (at YTD)*	21	1 *	4 *	7 *	7 *	10 *	15 *	18 *	19 *	24 *	25 *				25	23*
	Number of (COHA/HOHA) P. aeruginosa cases (monthly)	N/A	1	3	3	0	3	5	3	1	5	1				25	23
Ψ*	Number of (COHA/HOHA) Klebsiella spp. Cases (at YTD)*	29	3 *	5 *	7 *	9 *	18 *	22 *	24 *	30 *	35 *	36 *				36	31*
	Number of (COHA/HOHA) Klebsiella spp. Cases (monthly)	N/A	3	2	2	2	9	4	2	6	5	1				36	31
	Falls- Attributable Moderate Harm Incidents while patient under RMH care	≤1 per month	0	1	4	0	1	0	2	0	0	0				8	9
	Falls- Attributable Major Harm Incidents while patient under RMH care	0	0	0	0	0	0	0	0	0	0	0				0	0
	Falls- Attributable Death Incidents	0	0	0	0	0	0	0	0	0	0	0				0	0
	Number of patients with attributable pressure ulcers- Number of Patients	No Target	8	10	9	9	17	18	15	18	17	16				137	116
	Number of patients with attributable pressure ulcers: Medical Device Related	No Target	1	1	2	1	5	4	1	6	3	4				28	N/A
	Number of patients with attributable pressure ulcers: Mucosal	No Target	0	1	3	1	2	0	1	2	2	1				13	N/A
	Number of patients with attributable pressure ulcers- Category 1	No Target	0	3	1	0	1	1	2	4	4	7				23	19
	Number of patients with attributable pressure ulcers-DTI	No Target	0	0	0	3	1	0	1	1	1	0				7	5
	Number of patients with attributable pressure ulcers- Category 2	No Target	5	2	5	2	11	6	7	12	12	6				68	56
	Number of patients with attributable pressure ulcers- Category 3	No Target	1	4	0	2	1	1	0	0	0	1				10	22
	Number of patients with attributable pressure ulcers- Unstageable	No Target	2	1	3	2	3	10	2	1	0	2				26	8
	Number of patients with attributable pressure ulcers- Category 4	0	0	0	0	0	0	0	1	0	0	0				1	0
*	Number of attributable medication incidents with moderate harm and above	≤1 per month	1	0	1	0	0	3	0	0	2	1				8	12*
	VTE Risk Assesment	95%	98.5%	98.3%	98.3%	98.6%	97.8%	98.4%	98.3%	97.7%	97.3%	98.1%				98.1%	98.7%

Appendix 1 - Quality Account Scorecard (2/2)

The Royal Marsden NHS Foundation Trust

Quality Account 24/25

January 2025 Data

Key

* denotes Year To Date (YTD) figures

Blue-shaded KPI denotes metric linked to BAF stategic framework

Ψ denotes NHS England metric

Effective Care	**Target**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Trend**	**YTD**	**23/24**
% SACT Infusion patients starting treatment within 1 hr of appointment time- Chelsea	85%	86.6%	87.8%	89.7%	89.4%	87.8%	89.2%	89.8%	90.8%	89.3%	90.6%				89.1%	71.3%
% SACT Infusion patients starting treatment within 1 hr of appointment time- Sutton	85%	70.8%	70.8%	74.1%	78.7%	79.5%	75.6%	76.9%	77.0%	77.8%	76.6%				75.8%	58.1%
% SACT Infusion patients starting treatment within 1 hr of appointment time- Kingston	85%	75.5%	75.9%	78.5%	76.8%	72.7%	81.5%	80.6%	73.2%	83.3%	85.2%				78.3%	72.7%
% SACT Infusion patients starting treatment within 1 hr of appointment time- Cav Sq	85%	81.5%	77.6%	85.2%	81.7%	82.7%	86.0%	84.4%	81.1%	81.3%	86.5%				82.8%	74.3%
Caring	**Target**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Trend**	**YTD**	**23/24**
RMH Inpatient Friends and Family Test: % overall experience	95%	99.2%	99.1%	99.5%	99.4%	98.9%	99.3%	99.2%	99.1%	99.4%	99.4%				99.3%	98.6%
Friends and Family Test (Inpatient and Day Care) Number of Reponses	No Target	126	330	212	165	185	146	242	223	167	167				1963	N/A
RMH Outpatient Friends and Family Test: % overall experience	95%	84.6%	95.4%	97.6%	90.8%	98.2%	97.8%	97.7%	96.3%	94.9%	96.9%				84.6%	N/A
RMH Outpatient Friends and Family Test: Number of Responses	No Target	13	658	416	238	384	460	573	383	333	388				3846	N/A
Responsive	**Target**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Trend**	**YTD**	**23/24**
% of complaints responded to in required timescale	81%	16.7%	66.7%	70.0%	100.0%	100.0%	92.3%	88.9%	100.0%	60.0%	25.0%				72.0%	76.55%
Rate of written complaints per 1,000 Full Time Equivalent (FTE) staff	2.21	2.46	1.78	1.11	3.61	1.55	2.19	1.74	2.16	0.87	3.02				2.05	2.43
Well-Led	**Target**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Trend**	**YTD**	**23/24**
Relative likelihood of white staff being appointed from shortlisting across all posts (WRES 2 Indicator)	0.8-1.25	1.57			1.64			TBC (Avaliable in March)						N/A	1.61	N/A
Number of Freedom to Speak Up (FTSU) Alerts	No Target	19			22			36							41	96
Trust vacancy rate	7%	7.9%	7.0%	6.9%	7.6%	7.5%	7.6%	6.7%	6.5%	6.5%	6.6%				7.1%	11.5%
Trust Sickness rate (rolling 12 month average)	3%	3.7%	3.7%	3.7%	3.7%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%				3.7%	3.7%
Trust voluntary staff turnover rate	12%	10.4%	10.1%	9.6%	8.9%	9.1%	8.9%	8.7%	8.7%	8.8%	8.5%				9.1%	12.2%
% Compliance with Phase 1 of Oliver McGowan training	90%	N/A	80.6%	83.8%	85.5%	87.0%	88.4%	90.1%	91.1%	91.7%	92.7%				87.9%	N/A

*at YTD figures show the running total for the YTD against each month.

Appendix 2 - Patient feedback

- The patient comments below are captured via our paper Friends and Family Test (FFT) comments cards in December 2024.
- Information is fed back directly to ward teams. Ward Sisters, Matrons and clinical leads review the data as it arrives and action appropriately.
- The information is also reviewed at the CBU Performance Review meetings and the monthly Divisional Quality, Safety and Risk meetings.
- The Trust patient experience webpage is updated quarterly to include examples of 'you said, we did' and information displays throughout the Trust are updated.

Positive Patient Comments:

RDAC, Chelsea.
- Every member of the team was welcoming, knew their role and delivered their part with enthusiasm, positivity and tenderness. The quality of note taking by key staff, which was easily accessible by your customer focused IT system, allowed me to understand each intervention and equally importantly what was the next step in an otherwise bewildering pathway. Bravo!

Radiotherapy, Chelsea.
- All staff were friendly and made me feel completely relaxed. the overall impression was of a highly professional team with utmost excellence in every respect.

Critical Care Unit, Chelsea.
- Nurses and doctors have been exceptional, treated with utmost care and all staff accommodated personal needs. Overall, brilliant care.

Endoscopy OCC, Sutton.
- Approachable/helpful reception staff, caring and compassionate nursing staff and the doctor gave clear information on what the procedure would involve and was caring throughout

McElwain, Sutton.
- All the nurses and team are always very friendly and helpful and are always able to help with anything. They always have a smile and make my child happy and comfortable.

Medical Day Unit, Kingston.
- All staff are amazing, polite and caring to individual patients. They are ready to spend time with each of us as needed.

Patient Comments requiring Action:

Outpatients, Chelsea.
- Almost every time I attend the blood clinic; I find that my blood tests have not been ordered causing an additional delay whilst the nurse goes to find out what blood tests are needed.

Outpatients, Sutton.
- There seems to be little communication between the Outpatients reception and the clinic team - it would help patients to know when they have any delay to their appointments.

Bud Flanagan West ward, Sutton.
- Information on arrival to the ward was slim.

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

Appendix 3a - Safer Staffing (Inpatients)

Data Owner: **Sharyn Crossen Safe Staffing Lead**

Occupancy - Remains constant – Ellis lower due to ward closure for works over holiday period.

Carter metrics – Roster approvals continue to be monitored on monthly basis

Sickness % - remain high across both sites Sisters are being supported by Matrons and HR

Fill % - Red units 0 . Good staffing levels across all units. Ellis staff redeployed . High use of specials continue particularly on Sutton wards.

CHPPD – Reflects acuity and need for specials.

Red Flags - Linked to high acuity on wards

Skills – Good coverage of SACT trained nurses across all units.

				Ward/Activity		Carter Metrics	Workforce			Temporary Staffing				Staffing metrics							
Jan-25	Budgeted Establishment (WTE)	Establishment Actual (WTE)	Variance (WTE)	Bed Number	Occupancy	Roster sign off >6 wks Y/N	Sickness Total %	Vacancy Rate %	Turnover (all)	Temp staff total WTE	Bank WTE	Agency WTE	SACT Competent WTE	Fill Rate Registered %	Fill rate HCA %	Registered CHPPD (Hrs)	HCA CHPPD (Hrs)	Total CHPPD (Hrs)	Red Flags	Enhanced Care (Shifts)
Cancer Services																				
Burdett Coutts	27.12	23.33	3.79	15	89%	Y	4.70%	14.00%	9.40%	4.2↓	3.8	0.4	9.5	102%	114%	6.6	2	8.8		10
Ellis	24.19	26.93	-2.74	14	62%	Y	2.80%	50.00%	16.30%	2.8↑	2.4	0.4	10.92	92%	89%	7.6	2.4	10	4	5
Wilson	28.65	26.02	2.63	16	90%	Y	4.50%	9.20%	7.70%	3.9↑	3.7	0.3	10.9	102%	98%	6.7	1.8	8.6		16
Bud Flanagan East	41.17	38.03	3.14	16	77%	Y	3.80%	7.60%	7.10%	9.1↑	7.3	1.8	26.03	96%	164%	10.7	4.6	15.3		60
Bud Flanagan West	35.4	31.69	3.71	15	76%	Y	9.00%	10.50%	2.00%	8.1↑	6.8	1.3	23.1	97%	155%	8.2	2.9	11.1		38
Kennaway	24.27	23.93	0.34	11	81%	N	9.80%	1.40%	3.80%	4.4↓	3.3	1.1	9.5	100%	157%	7.3	2.1	11.4		35
Mc Elwain	38.26	39.66	-1.4	18	71%	N	5.10%	-3.70%	12.30%	2.2↑	2.1	0.1	16.1	97%	91%	9.7	1.8	11.5		0
Oak Ward * all Day care	50.21	47.57	2.64	9	52%	N	4.80%	4.70%	6.30%	0.1↓	0.1	0	10.6	94%	109%	20	2.1	22.1		0
Smithers	34.66	35.1	-0.44	19	82%	N	4.50%	-1.30%	0.00%	8.3↓	6.2	2.1	6.7	106%	133%	6.6	2.7	9.4	3	22
Teenage & Young Adult	22.66	22.06	0.6	9	91%	Y	5.30%	2.60%	8.90%	3.7↑	3.4	0.3	8.2	104%	128%	9.2	2	11.3		2
Clinical Services																				
CCU	107.63	96.93	10.7	16	82%	Y	6%	10%	15%	9.5↑	9.5	0.0	12	92%	89%	27.2	2.5	29.7	0	0
Horder	31.8	30.93	0.87	12	89%	Y	6%	3%	12%	4.7↓	4.7	0.0	10	100%	100%	8.7	3.2	12	0	1
Private Patients																				
Granard House 1	19.04	18.6	0.44	7	91%	Y	4.70%	2%	0%	0.8↓	0.80	0.10	*6.61*	97%	104%	8.7	3.4	12	0	
Granard House 2	18.04	17.21	0.83	7	79%	Y	4.90%	5%	3%	2↓	1.90	0.10	*10.6*	102%	100%	10.2	4.1	14.4	0	3
Granard House 3	19.04	18	1.04	7	83%	Y	3.80%	6%	6%	2↓	1.90	0.10	7	101%	100%	9.6	4	13.6	0	
Markus	19.74	19.73	0.01	8	87%	Y	6.80%	0%	23%	1.5↓	1.20	0.30	6	101%	100%	8.7	3.3	11.7	0	
Robert Tiffany	33.05	28.91	4.14	13	92%	N	2.90%	13%	7%	4.9↑	4.40	0.60	*16.15*	102%	107%	8.6	3.1	11.6	0	9
Wiltshaw	40.58	39.42	1.16	17	95%	Y	3.40%	3%	8%	5.9↑	4.70	1.20	*17.31*	101%	140%	8.4	3.2	11.6	2	44

Appendix 3b: Safe Staffing: (Day Areas)

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

Data Owner: Sharyn Crossen, Safer Staffing

Fill % - . Good staffing levels across all units during January.
Red Units - O
Carter metrics – Roster approvals low this month reminders sent to Matrons and monitored by DND
Sickness % - Sickness remains high across most units
Red Flags – Increase in red flag reporting in OPD Chelsea
Skills – Good SACT coverage across all units

	Establishment						Temporary Staffing				staffing metrics		
Jan-25	Budgeted Establishment (WTE)	Establishment Actual (WTE)	Roster sign off >6 wks Y/N	Sickness Total %	Vacancy rate WTE	Turnover	Temp staff total WTE	Bank WTE	Agency WTE	SACT Competent WTE	Fill Rate Registered %	Fill rate HCA %	Red Flags (open)
Target (If applicable)			100%	<3%	7%	12%					>95%		
Cancer Services													
CDU	27.25	26.46	Y	7.6%	2.90%	2.40%	2.0	2.0	0	*16.99*	87%	38%	
MDU C	36.81	37.99	Y	5.6%	-3.2%	48.50%	2.0	2.0	0	*19.76*	96%	91%	
MDU K	17.01	15.53	N	6.5%	8.70%	27.50%	2.0	0.8	1.1	*7.27*	101%	86%	
MPS	3.95	3.91	Y	2.6%	1.10%	0.00%	1.1	1.1			136%		
Olayan	50.18	54.4	Y	4.9%	-8.40%	3.20%	1.7	1.7	0	*32.91*	100%	73%	2
Oak DU	metrics combined with Oak ward		N				0.1	0.1		*6.8*	94%	76%	
West Wing	26.38	25.51	N	10.10%	3%	7%	0.2	0.2		*9.89*	96%	98%	0
Clinical services													
APU C	13.91	12.99	Y	6.4%	6.6%	0.0%	0.0	0.2	0		85%	81%	
APU S	4.56	3.81	y	23.2%	16.4%	0.0%	0.3	0.3			88%	73%	
CUC L	22.32	20	y	2.7%	19.4%	38.1%	2.2	2.2			99%	118%	
CUC Oak	10.3	8.81	y	2.7%	14.4%	32.4%	0.3	0.3			92%	92%	
DSU	12.56	11.48	y	7.0%	8.6%	0.0%	0.4	0.37			101%	56%	
Endoscopy chelsea	20.6	19	Y	4.1%	7.8%	16.7%	0.6	0.6			85%	110%	
EndoscopyOak	16.52	12	N	5.2%	27.4%	36.4%	0.0	0.0			85%	110%	
OPD C	37.45	34	Y	3.60%	9.2%	18.3%	4.2	3.6	0.6		99%	93%	9
OPD Oak	51.33	46.72	N	5.30%	10.4%	17.1%	3.1	3.1			86%	125%	
RDAC C	17.53	15	Y	3.7%	14.4%	8.0%	0.1	0.1			98%	83%	
RDAC Oak	9.7	8.2	Y	9.1%	15.5%	0.0%	0.1	0.14			85%	67%	
Theatres C	97.09	89.91	N	4.7%	7.4%	14.0%	8.2	8.2	0.0		96%	71%	
Theatres S	24.56	22.8	N	3.8%	7.2%	0.0%	0.6	0.5	0.1		101%	93%	
Private Pts													
Cavendish Square	28.2	26.51	N	4.60%	6.0%	10.5%	0.0	0.0	0.0	*8*	85%	101%	
PPMDU C	25	21.15	N	4.80%	15.4%	28.4%	0.0	0.0	0.0	*16.15*	92%	70%	
PPOPD C	19.5	21.93	N	16.7%	-12.5%	0.0%	1.3	1.3			87%	92%	
PPMDU S	16.31	15.49	Y	10.9%	5.0%	0.0%	0.89	0.89		*11.65*	99%	70%	
PPOPD S	6.19	6.89	Y	16.0%	-11.4%	0.0%	0.9	0.9			99%	59%	
PPDSU	6.63	6.61	Y	2.9%	4.7%	31.1%	1.8	1.8			103%		

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 6.1
Title of Document: Mortality Review Q3	**To be presented by:** Chief Medical Officer

1. Status

2. Purpose: To give assurance that all inpatient deaths have been reviewed appropriately

Relates to:

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

3. Summary

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

There were 65 inpatient deaths between 1st October 2024 and 31st December 2024. Of the 65 inpatient deaths all 65 were reasonably expected. 5 deaths were referred to the coroner.

4. Recommendations / Actions

The Board is asked to note that overall, from the review of the data the Trust is RAG-rated Green for the period between 1st October 2024 and 31st December 2024.

The Royal Marsden NHS Foundation Trust

Quarterly Hospital mortality review audit, 1st October 2024 and 31st December 2024.

1.0. Background

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

1.2 The National Mortality Case Record Review Programme from the Royal College of Physicians (RCP) outlines using the 'Structured Judgement Review' to conduct an in-depth 'case record review' of certain deaths. There are three levels of scrutiny that the Trust applies to the care provided to someone who dies; (i) Medical Examiner review of death certification; (ii) case record review; and (iii) investigation. They do not need to be initiated sequentially, and an investigation may be initiated at any point, whether or not a case record review has been undertaken. Medical Examiners within the trust also now review the medical notes after discussion with the attending doctor to agree the cause of death and whether a coroner referral is necessary. The consultants undertaking the reviews have attended training on how to conduct a 'Structured Judgement Review'.

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

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

2.0 Audit methodology

The data was reviewed at the quarterly mortality review meeting on 11 February 2025.

3.0 Conclusions

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

There were 65 inpatient deaths between 1st October 2024 and 31st December 2024.

Conclusion: inpatient deaths were reasonably expected therefore 65 out of 65 patients met the standard. 5 deaths were referred to the coroner.

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

Conclusion**:** In 6/6 deaths there an identifiable reason outside the control of RM as to why their preferred place of death was not achievable.

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

Conclusion: Of the 65 deaths, 61 patients were discussed and reviewed by the Symptom Control and Palliative Care team before their death, 94% - this standard was achieved.

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

Conclusion: In 12 (100%) of patients no problems in care were identified

4.0 The Learning Disabilities Mortality Review (LeDeR)

Conclusion: No patients were identified as having Learning Disabilities

5.0. Children's cases

Of the 65 deaths in this quarter, there was 1 paediatric death reported.

6.0. Significant Incidents

Of the 65 deaths in this quarter, none were investigated as a significant incident under PSIRF.

Reasons for SJRs

There were 12 deaths in this quarter that had a 'Structured Judgement Review' (SJR) conducted. The 12 deaths were selected for SJR's for the following reasons:

Reasons for SJR	October	November	December	Total No of Deaths
Coroner referral	1	3	1	5
Family concern		1		1
Klebsiella in blood cultures			1	1
2222 arrest call	2			2
Deprivation of Liberty Safeguard (DOLS)	1			1
Safeguarding pressure ulcer		1		1
Hospital acquired COVID-19		1		1

7.0. Numbers of deaths caused by problems in care

For all 12 that had an SJR, 11 deaths were indicated as definitely not avoidable.
1 death was graded as 'Slight evidence of avoidability' This was due to the potential contribution of the Hospital Acquired COVID-19 to the death, but in the context of advanced malignancy driving the overall deterioration.

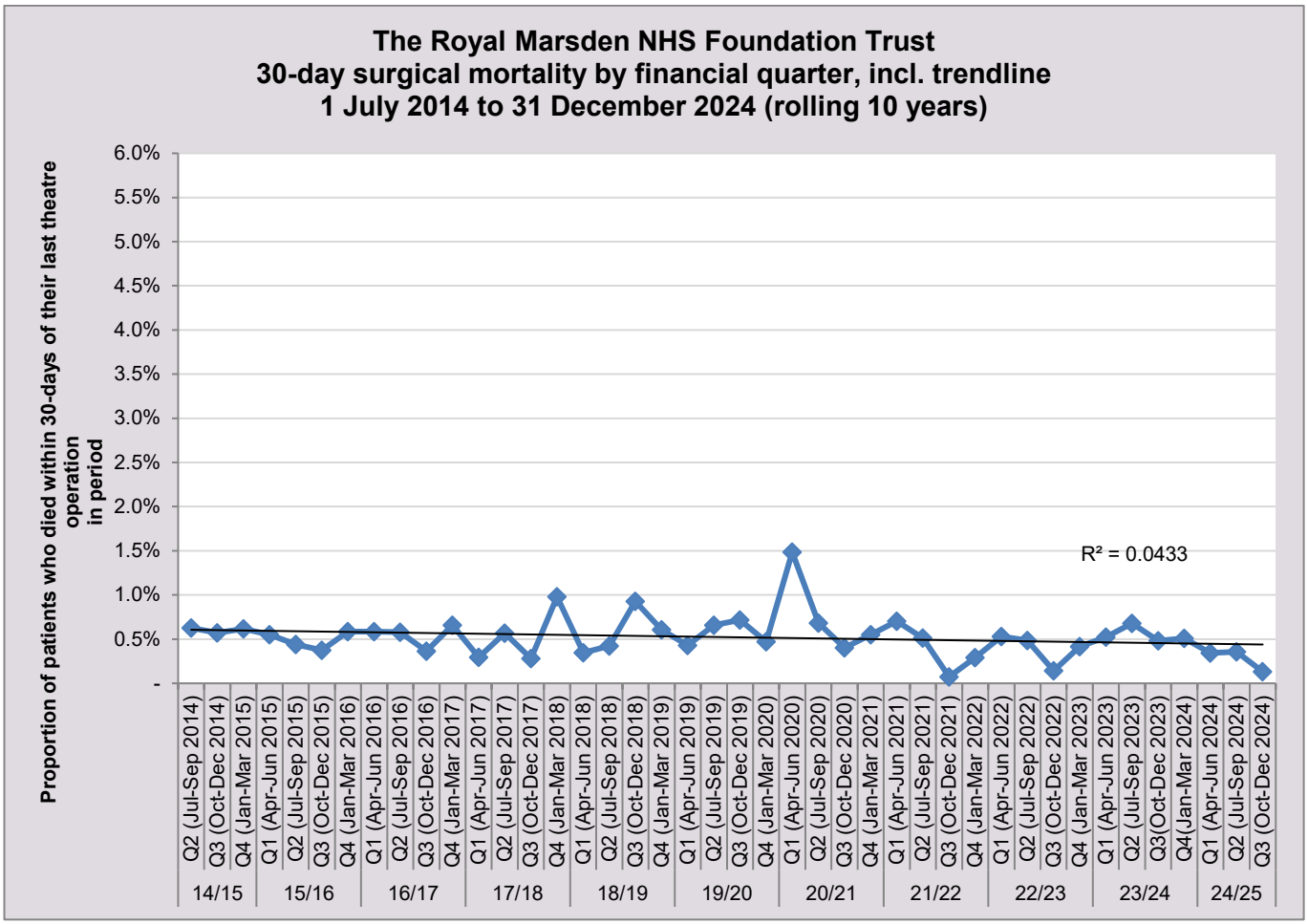
8.0. The review found that of the 65 inpatient deaths there were 46 deaths from metastatic disease, 19 deaths from haematological malignancies and 0 deaths from non-metastatic disease.

9.0 Number of COVID-19 related deaths reported

There was 1 hospital acquired COVID-19 related death reported between the 1st October 2024 and 1st December 2024.

10.0 30-day surgical mortality

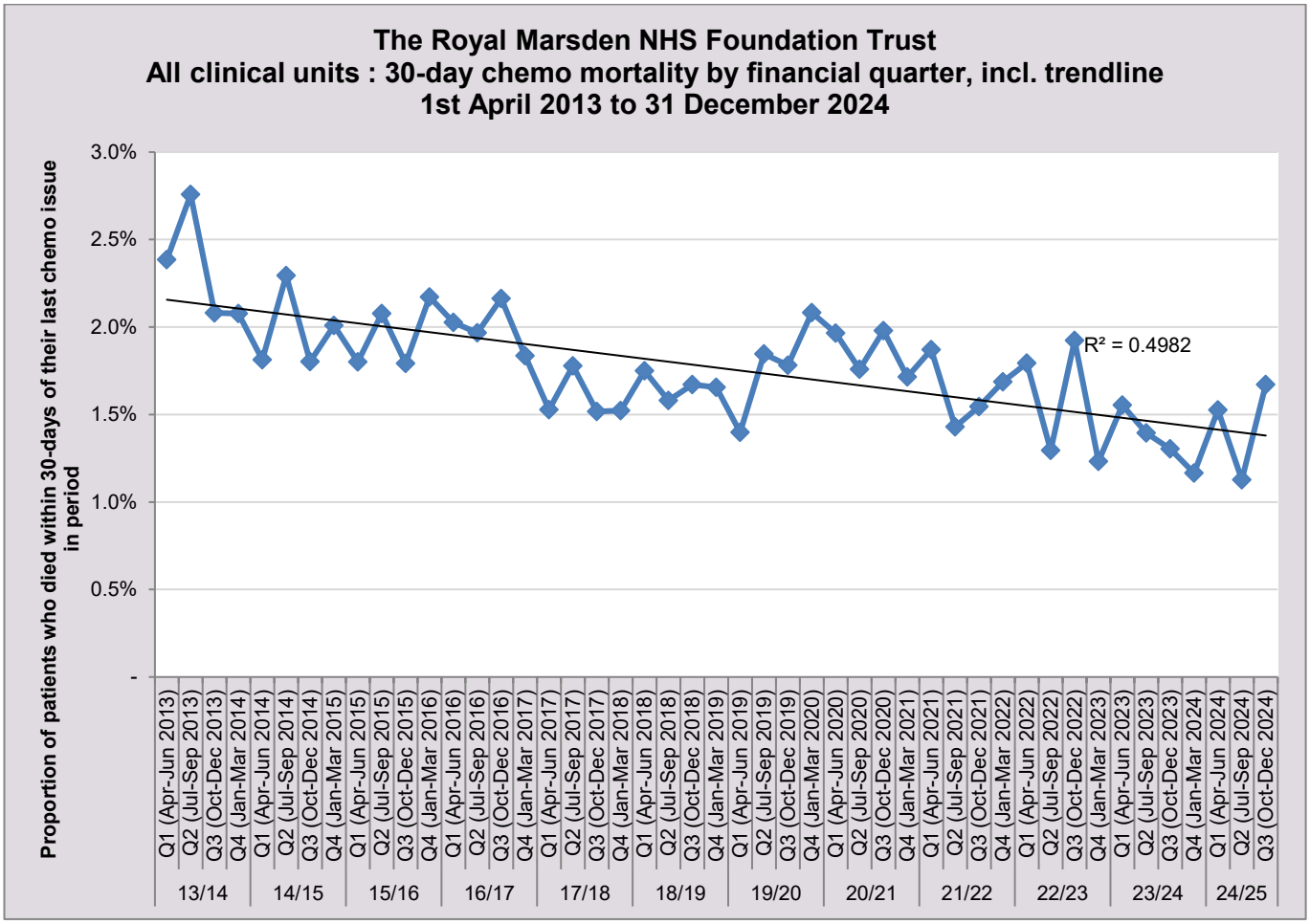
Deaths within 30 days following all surgery and anaesthesia procedures in operating theatres are reviewed and monitored at the Surgical Audit Group. In Q3 there were 2 such deaths out of 1,517 patients (0.1%). The overall 30-day death rate is stable, as shown in the chart below which covers a rolling ten year period.



11. 30-day chemotherapy mortality

Deaths within 30 days following administration of chemotherapy are reviewed and monitored at the 30-day Mortality Group. The figure for Q3 was 1.7%, representing 85 deaths out of 5085 patients.

The ten-year data is shown in the chart overleaf.



12.0 Themes, trends and learning points

There is evidence of good practice identified:

- Family discussions taking place regularly and from senior clinicians, particularly around the time of patient deterioration

Potential areas for development:

- Ensuring the 'discharge as deceased'medical note (letter to GP) completed for all patients who have died
- Ensuring that DNACPR discussions are held with patient where capacitous and not only relatives

13.0 Summary

The Trust Board is asked to note that overall, from the review of the data the Trust is RAG-rated Green for the period between 1st October 2024 and 31st December 2024. The table below shows the RAG ratings from previous quarters:

Quarter	RAG rating
Q3 2024- 2025	Green
Q2 2024- 2025	Green
Q1 2024- 2025	Green
Q4 2023- 2024	Green

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 6.2
Title of Document: Board Evaluation Report	**To be presented by:** Company Secretary

1. Status: For Approval

2. Purpose:

Relates to:

Governance	*Board development*

3. Summary

Section 4.5 of the NHS Code of Governance states that there should be a formal and rigorous annual evaluation of the performance of the Board of Directors, its committees, the Chair, and individual directors.

In line with this guidance, the Trust Board has completed its review against the newly launched CQC Single Assessment Framework (2024), focusing on the Well-led domain. The results are enclosed for Board discussion.

4. Recommendations / Actions

The Board is asked to review the findings and approve the Board Evaluation report, along with the proposed action plan arising from the self-assessment.

The ROYAL MARSDEN
NHS Foundation Trust

Board Evaluation Report: Summary of Responses and Action Plan

Contents

1. Introduction

This report evaluates the performance of the Board in relation to the newly launched CQC Single Assessment Framework (2024), specifically focusing on the Well-Led domain. The Well-Led domain assesses leadership, governance, culture, and organisational practices that contribute to the delivery of high-quality care in a dynamic healthcare environment.

The revised Well-Led domain reflects current challenges and priorities in the healthcare sector. The framework emphasises the following key aspects of leadership and governance:

- Shared Direction and Culture
- Capable, Compassionate, and Inclusive Leaders
- Freedom to Speak Up
- Workforce Equality, Diversity, and Inclusion
- Governance, Management, and Sustainability
- Partnerships and Communities
- Learning, Improvement, and Innovation
- Environmental Sustainability – Sustainable Development

This report evaluates how well the Board has met these expectations and identifies areas for improvement. It also provides an action plan based on feedback received from Board members. The findings will guide future developments in leadership, governance, and culture at The Royal Marsden, ensuring the ongoing delivery of excellent patient care, fostering a positive workplace culture, and maintaining strong governance and accountability.

2. Summary of Board Responses

The Board evaluation was conducted using a self-assessment survey, with Board members rating their responses to each domain on a scale of 1 to 5 (1 = strongly disagree, 5 = strongly agree). The results have been summarised below.

Overall, Board members rated the performance of the Board positively, with average scores across all domains above 4. The highest-rated area was Board Governance with a score of 4.9, followed by Shared Direction and Culture, Capable, Compassionate, and Inclusive Leaders, and Partnerships and Communities, each receiving a score of 4.7.

Key themes from the feedback include:

Shared Direction and Culture: Board members expressed satisfaction with the collaborative spirit at all levels of the organisation and the high quality and very experienced NEDs were praised. The Trust's vision and strategy were also positively highlighted, with the recent review of the Five-Year Trust Strategy being described as comprehensive and ambitious. Members felt that the strategy had been well communicated internally, including at staff webinars and the Annual General Meeting (AGM), ensuring that it was clearly communicated and embedded at all levels of the organisation.

Capable, compassionate and inclusive leaders: Board members highlighted the effective teamwork within the Board, noting that members display behaviours that reflect the Trust's values. The Board's culture of inclusivity was particularly praised, with multiple perspectives being actively sought and valued during discussions. It was suggested that local cultural surveys could help better capture the mood and concerns of staff, as national surveys may not fully reflect the specific needs of the local workforce.

Freedom to Speak Up (FTSU): The Freedom to Speak Up (FTSU) initiative was positively reviewed, with members noting that FTSU reports are regularly reviewed at the Quality Assurance and Risk Committee (QAR), resulting in meaningful actions. However, there was a suggestion to increase the visibility of staff concerns and encourage more direct interaction between the Board and employees to better understand their perspectives on the safety and effectiveness of the process. While the QAR provides detailed reviews, members felt that the Board should allocate more time to discussing FTSU reports to ensure staff issues are fully explored and appropriately addressed.

Workforce Diversity, Equity, and Inclusion (EDI): The Board's commitment to workforce diversity, equity, and inclusion (EDI) was noted positively, with some members highlighting the Reverse Mentoring Programme as a good example of the Board's commitment to these issues. However, there was a recommendation for additional training in diversity and inclusion at Board level, with members stating that this would enable a more proactive approach in addressing these issues. It was also suggested that more regular assessments of the effectiveness of EDI initiatives would provide clearer insights into the Trust's progress in these areas. Further, members suggested the Board should engage

more directly with a broader cross-section of the workforce, particularly focusing on underrepresented groups to ensure the diversity of perspectives is fully represented in decision-making.

Governance, Management, and Sustainability: Board members agreed that the Board maintains strategic oversight of financial sustainability, with deep dives into areas of concern as needed, primarily through the Audit & Finance Committee (AFC). Some members felt the Board doesn't monitor workforce issues as closely as it should.

Partnerships and Communities: The Trust is regarded as a real asset to the UK, especially in terms of collaboration. However, there was limited discussion on partnerships within the Board, apart from with the Institute of Cancer Research (ICR). The Board was noted for building strong relationships with external stakeholders, but there is room to expand this focus further.

Learning, Improvement and Innovation: Board members were generally positive about the Trust's efforts in promoting continuous learning and quality improvement, with specific mention of the EPIC implementation review as an excellent example of learning from reviews to improve performance. The Board also praised the widespread and effective improvement initiatives, with several examples from researchers, surgeons, and scientists updating the Board on their innovative work.

Environmental Sustainability: The feedback on environmental sustainability was mixed. While Board members acknowledged the Trust's plans for new developments that prioritise sustainability, some noted that this topic is not discussed regularly in Board meetings. There was a suggestion to include more explicit reporting on sustainability to better align the Trust's operational strategies with long-term environmental goals, as this issue becomes increasingly critical in healthcare.

Board Meetings: Board members expressed general satisfaction with the structure and length of meetings, stating that they are well-organised and allow for meaningful discussion. It was highlighted that there is a good balance of topics, ensuring that all relevant matters are addressed, and that papers are circulated well in advance, allowing ample time for preparation. The Board Governance team was described as outstanding for their support and organisational skills. Several members suggested that more time could be allocated to larger topics and complex discussions, especially when significant matters need deeper review. It was also noted that the patient voice could be more strongly integrated into the discussions, ensuring that this perspective is more consistently represented.

Sub-Committee Effectiveness: The feedback highlighted the effective role of sub-committees in providing clear, structured updates. Members praised the work of the sub-committees but suggested that the Private Care Sub-Committee could offer more detailed updates, particularly in relation to the implications of private care at the Board level. In addition, it was mentioned that digital and IT-related issues should receive more dedicated focus during sub-committee discussions to ensure that proper oversight is maintained as these areas evolve. Some members also pointed out that more time should be allocated to discussing the role and impact of the sub-committees, especially given that these updates often occur towards the end of meetings when time is limited.

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

Domain	Focus	Average score 2025	Risk Rating
Shared Direction and Culture	Clear vision and engagement with organisational culture	4.7	
Capable, Compassionate, and Inclusive Leaders	Leadership promoting inclusivity and operational excellence	4.7	
Freedom to Speak Up	Creating a culture where staff feel safe to raise concerns	4.6	
Workforce Equality, Diversity, and Inclusion	Promoting an equitable and diverse workplace	4.6	
Governance, Management, and Sustainability	Reviewing effectiveness of governance structures	4.3	
Partnerships and Communities	Engagement with external stakeholders to enhance services	4.7	
Learning, Improvement, and Innovation	Continuous quality improvement and innovation	4.4	
Environmental Sustainability – Sustainable Development	Integrating sustainability into operations and strategy	4.6	
Board governance	Board operations and governance	4.9	

Key:

4-5 score – Green

3-4 score - Amber Green

2-3 score - Amber Red

1-2 score - Red

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

3. Proposed Action Plan

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

Domain	Action	Responsibility	Timeline
Shared Direction and Culture	Ensure the Trust's vision and values are communicated and embedded at all levels. Foster more opportunities for staff at all levels to contribute to strategic discussions.	Board & Leadership Team	Ongoing
Capable, Compassionate, and Inclusive Leaders	Increase leadership training and development in areas of compassion and inclusivity. Ensure that these values are consistently upheld across the organisation. Continue Board development in key areas such as diversity, inclusion, and digital expertise.	Chief Executive/Chief People Officer	6-12 months
Freedom to Speak Up	Allocate more time during Board meetings to review and discuss reports from Freedom to Speak Up (FTSU) Guardians to ensure continuous action and improvement. Increase opportunities for NEDs to engage with staff and hear directly from a broader cross-section of the workforce.	Chairman/Chair of QAR	Ongoing, with quarterly reviews
Workforce Equality, Diversity, and Inclusion	Deep dive into the effectiveness of current EDI initiatives and ensure a more comprehensive review and monitoring system is put in place. Focus on increasing engagement with underrepresented groups.	Chief Executive/ Chief People Officer	6-12 months
Governance, Management, and Sustainability	Strengthen the Board's oversight of workforce issues. Ensure more frequent reviews of workforce data, including retention, diversity, and inclusivity metrics.	Chief Executive/ Chief People Officer	6-12 months
Partnerships and Communities	Expand discussions on partnerships beyond ICR, focusing on building relationships with a wider range of external stakeholders. Strengthen the Board's role in fostering collaborations that enhance patient care and service delivery.	Chairman	6-12 months

Learning, Improvement, and Innovation	Develop a framework to integrate continuous quality improvement more strategically across the organisation. Ensure that learning from audits and reviews is used to drive innovation.	Chief Nurse/Executive Directors	6-12 months
Environmental Sustainability – Sustainable Development	Increase focus on integrating sustainability into the Trust's strategy and operations. Ensure that environmental goals are aligned with long-term development plans, particularly in new developments.	Chief Operating Officer	6-12 months
Board governance	-Allocate more time to larger, complex topics and significant matters that require deeper review. -Allocate additional time to discussing the role and impact of sub-committees. -Ensure the patient voice is more strongly integrated into Board discussions and consistently represented. -Increase focus on digital and IT-related issues during sub-committee discussions to ensure sufficient oversight.	Chairman	Ongoing

4. Conclusion

This Board Evaluation Report, based on the newly launched CQC Single Assessment Framework (2024) presents a comprehensive assessment of the Board's leadership and governance performance. It highlights areas of strength, including a clear organisational vision, strong leadership, and effective engagement with stakeholders. However, it also identifies areas for improvement, particularly in workforce diversity and inclusion, Freedom to Speak Up, and environmental sustainability. The action plan outlined above will inform the Board's future development.

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

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
26 March 2025	6.3
Title of Document:	**To be presented by:**
Risk Appetite Statement 2025/26	Company Secretary

1. Status **For Noting**

2. Purpose:

Relates to:

Governance	*X*

3. Summary

The risk appetite statement sets out the amount of residual risk the Trust is willing to accept, tolerate, or justify when delivering its healthcare, education, training, and research. It is recognised that delivering healthcare carries inherent risks that can never be completely eliminated.

At least once a year, the Board should set specific limits for the levels of risk the Trust is able to tolerate in pursuit of its strategic objectives. The Board should also review these limits during periods of increased uncertainty or adverse changes in the environment.

In May 2024, the Board approved the Risk Appetite for 2024/25 in line with the new clinical strategy. Every year, the risk appetite is presented in a summary format in the Trust Annual Report. For 2025/26, the Risk Appetite has been reviewed, and it is proposed that no changes be made to the existing risk tolerances, which remain valid in the current climate. However, an amendment is proposed regarding cybersecurity.

Following a training on cybersecurity, a recommendation was made to include cybersecurity in the Risk Appetite. This addition is highlighted in the attached document under "Sustainable Investment through Effective Use of Resources." Cybersecurity risks threaten the Trust's digital assets, data security, and continuity of services in the face of cyber threats. These include risks arising from cyberattacks, system vulnerabilities, and data breaches. The risk tolerance for cybersecurity is set to low, reflecting the Trust's limited tolerance for risks that jeopardise patient data and the security of its systems. All actions to mitigate cybersecurity risks are prioritised at the senior level, with a strong commitment to maintaining robust security protocols, conducting regular assessments, and having immediate response plans for emerging threats.

Once approved, the updated Risk Appetite and associated risk tolerances will inform the Board Assurance Framework.

4. Recommendations / Actions

The Board is asked to review and approve the Risk Appetite Statement for 2025/26.

Risk Appetite 2025/26

Headline Risk Appetite Statement

The Trust seeks to employ a risk framework to identify and understand the inherent and operational risks that could impact the safe delivery of its core services and to reduce residual risk as far as possible through the application of control processes and mitigating actions to within agreed tolerances. This risk appetite statement sets out the amount of residual risk the Trust is willing to accept, tolerate or justify when delivering its healthcare, education, training and research. It is recognised that delivering healthcare carries inherent risks that can never result in an absence or elimination of risk. The Trust will not accept residual risk that cannot be mitigated, which materially impacts on patient safety, the viability of the Trust (through the capacity and capability for the work), the health and safety of its built environment or its responsibility to safeguard public funds but has a higher appetite to take risks in pursuit of other strategic objectives. The Trust also recognises and accepts that, even in the best control environments, tail events can occur which evade established control processes; such events are regarded as critical learning experiences.

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

How risk appetite is then defined

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

- The Royal Marsden and the Institute of Cancer Research joint Research Strategy.
- Workforce.
- Diagnostics Treatment & Care.
- Investment & sustainable use of resources.

Risks can have more than one category, e.g. a risk may be linked to both treatment and care and modernising infrastructure. The tolerances against appetite are derived based on the definitions from the Good Governance Institute (GGI) (see Appendix 1) as follows:

• **None**: Avoid – the avoidance of risk and uncertainty is a key Trust objective.

• **Low**: Minimal – the preference for ultra-safe delivery options that have a low degree of inherent risk and very limited loss potential.

• **Moderate**: Cautious – the preference for safe delivery options that have a low degree of inherent risk and only limited loss potential.

• **High**: Open – being willing to consider all potential delivery options which involve an acceptable level of loss potential and represent value for money.

• **Significant**: Seek – to be eager to be innovative and to choose options which involve accepting higher loss potential within a well defined controls framework. This can also be described as ‘mature’ - being confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

The risk appetite is made up of a statement about the Board's view of risks in these areas and its appetite to take those risks and then linked to a risk tolerance based on the scale identified above. The risk appetite can therefore be summarised as:

Risk Appetite Statement 2025

Objective / Risk Appetite	Risk Tolerance
Research and innovation: Seamless, systematic and rapid transition from scientific research to translational clinical research, developing smarter kinder treatments and embedding innovative treatments in the clinic.	
Risks that threaten the RM/ICR relationship to develop an ambitious plan to function as a joint comprehensive cancer centre with a fully integrated governance and service delivery model.	Moderate tolerance (in respect of risks that threaten the optimisation of joint resources and the alignment of strategy to common research goals)
The risk appetite for research and innovation is broad, depending on the nature of the research or innovation being proposed. It has a flexible view of innovation that supports quality, patient safety and operational effectiveness and improves patient outcomes globally. This means that it will support the adoption of innovative solutions that change the way care is delivered as well as supporting implementation of approaches that have been tried and tested elsewhere, which challenge current working practices and involve systems/technology developments as enablers of operational delivery. Research will be supported which is operated in a controlled way and has appropriate ethical and supervisory oversight and is delivered with regards to the appropriate safety protocols.	High tolerance (across all aspects of research and innovation)
Those risks that threaten the achievement of the Trust's objective related to research and innovation due to reduction in research funding.	Moderate tolerance (in respect of risks associated with delivering the research and innovation objective due to reduction in funding)
Risks associated with loss of key specialist research and clinical trials due to changes in service model.	Low tolerance (in respect of risks associated with loss of key specialist research)
A compassionate, committed, and excellent workforce	
Those risks that threaten the achievement of the Trust's objective to develop a strong employer brand to maintain and promote RM's position as a globally competitive and 'employer of choice'. This includes risks to the Trust's ambition of broadening the diversity of applicants and appointments made and from creating an inclusive workplace.	Moderate tolerance (in respect of risks associated with building a strong employer brand and attracting top talent)
Those risks that threaten the achievement of the Trust's objective to retain its workforce. This includes those that threaten the principles of maintaining Equality, Diversity and Inclusion and supporting staff wellbeing.	Low tolerance (in respect of risks associated with workforce safety, equality, and management).
Threats to the development of robust plans to grow our staff skills through our education offer.	Moderate tolerance (in respect of risks associated with growing our workforce)
Pioneering and personalised diagnostics, treatment and Care	
<u>New interventions - Pioneering and Personalised</u> Risks that threaten the Trust's objective in introducing innovations in diagnostics treatment and care, using the latest advances in technology and techniques from research into practice. These also encompass the following: The development of digital capabilities, data and other facilities that support innovation & productivity which benefits patient's diagnosis, treatment & care cannot be done without risk, but will be managed with decision making at a senior level.	High tolerance (in respect of risks in adding and testing new innovations into our clinical pathways or supporting the delivery of innovation to the wider system via RM Partners)

The approach to systems leadership, through initiatives such as RM Partners, the West London Cancer Alliance in developing initiatives across the whole patient pathway aimed at improving patient outcomes for the wider regional population.	
<u>Core services – Diagnostics, Treatment and Care</u> Risks to existing core services against the three domains of quality – safety, effectiveness, and patient experience. It includes those risks which have the ability to negatively affect patient care and may cause harm to the patient. This covers anything related to the diagnosis, treatment and achieving the best outcome for each patient. Psychological harm or distress is also included. Barriers to offering equality of access to all our patients.	Low tolerance (in respect of risks associated with patient safety, including non-compliance with safeguarding and patient experience or clinical outcomes).
Risks that threaten the Trust's ambition to modernise, enhance and expand capacity to meet patient activity needs, and develop a site strategy which maximises utilisation of the Trust's existing resources.	Moderate tolerance (to include plans for decant, incremental growth and significant new developments)
Risks associated with the loss of key specialist services due to changes in the service model that impacts patient care.	Low Tolerance
Health and safety risks include risks that affect the environment of care and risks that could cause injury or ill health to any person in connection with the Trust's activities. This includes fire, security, environmental and health and safety issues.	Low tolerance (in respect of risks associated with patient safety issues)
Sustainable investment through effective use of resources	
Those risks which have the ability to affect the financial well-being of the Trust and the efficient use of resources. Financial decisions impacting on quality and patient safety will be subject to rigorous quality impact assessments.	Low tolerance (to financial risks to safeguard public funds).
The Board has a balanced view of commercial and capital risk. It will support low-risk opportunities in established business areas and markets and in areas where it has significant commercial strength over its competitors and/or wishes to secure continuity to the benefits and outcomes to the Trust's patients and the wider community it operates in. More novel or contentious propositions need a cautious approach to the commitment of Trust resources.	Moderate tolerance (to commercial or capital risks in areas of proven operation and to novel commercial or capital propositions).
Those risks that threaten the Trust's digital assets, data security, and the continuity of services in the face of cyber threats. This includes risks arising from cyberattacks, system vulnerabilities, and data breaches.	Low tolerance (The Trust has a **low tolerance** for risks that compromise patient data and the security of its systems. All actions to mitigate cybersecurity risks are prioritised at the senior level, and there is a commitment to maintaining strong security protocols, regular assessments, and immediate response plans to emerging threats.)

Appendix 1

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

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

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

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
26 March 2025	6.4
Title of Document:	**To be presented by:**
Board Assurance Framework (BAF)	Company Secretary

1. Status: For Approval

2. Purpose: The purpose of the Board Assurance Framework (BAF) is to present the Trust's risk assurance framework in the context of the strategic objectives based on the 5-year Clinical Strategy 2024/25 – 2028/29.

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

3. Summary

The Board Assurance Framework (BAF) was last reviewed by the Board in November 2024. Since then, several revisions have been made to the key controls, assurances, and action plan. The risk scores have remained unchanged, which is typical for the BAF, given the strategic nature of the risks.

There are currently 13 risks on the BAF, 5 of which exceed the risk tolerance threshold, as outlined below. Mitigations are in place for all these risks. The risks exceed the threshold partly due to the Board's adoption of a low-risk tolerance and external factors beyond the Trust's control.

BAF Risk 3 - Attract: Develop a strong employer brand to maintain and promote RM's position as a globally competitive, 'employer of choice' for clinical and non-clinical staff wishing to work in oncology.

BAF Risk 4- Retain: Introduce differentiated retention and inclusion strategies to secure a skilled and sustainable workforce.

BAF Risk 8 - Maintain a high-quality specialist paediatric service and minimise disruption to global leading paediatric research until this service is relocated to an alternative provider in line with the NHSE decision. There is currently an integrated service and research model on the RM Sutton site which cannot be easily replicated.

BAF Risk 10 - Address capacity constraints at our Chelsea site, particularly in inpatients with a short, medium and long term plan that seeks to expand and realise efficiencies in existing facilities, and seeking off site capacity opportunities.

BAF Risk 13 - Deliver the overall financial plan, ensuring efficient use of resources, diverse but clearly contracted income streams and the ability to reinvest capital into infrastructure.

4. Recommendations / Actions

The Board is asked to review and approve the Board Assurance Framework, a summary of which will be included in the Trust's 2024/25 Annual Report.

Board Assurance Framework: March 2025

1.0. Purpose

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

2.0. Summary of current position

Strategic Objective	Initial Risk Score (L x C)[1]	Residual Risk Score (L x C)	Risk Tolerance[2]	Risk exceeding tolerance	Trust Risk Register Corresponding Risk	KPIs included in 24/25 Board Scorecard RAG rating is based on Q3 24/25
Research and innovation						
1. Revisiting and Strengthening the RM/ICR relationship. This includes developing an ambitious plan to function as a joint comprehensive cancer centre with a fully integrated governance and service delivery model.	**16** (4 x 4)	**12** (3 x 4)	Moderate Tolerance (12-15)			**Research metrics** -Number of 1st patients recruited in previous 12 months (UK)(G) -Number of 1st patients recruited in previous 12 months (Europe) (G) -Number of 1st patients recruited in previous 12 months (Global (G) -Trials led by RMH (G)
2. Improving Patient Outcomes globally through the active research and development of new ways to diagnose and treat patients across the full cancer patient journey.	**16** (4 x 4)	**12** (3 x 4)	Significant Tolerance (25)		CLIN.423 Radiology - Increased Reporting Turnaround COR.007 Failure to achieve on aspects of performance (T550) RND.018 CT Pharmacy Capacity RND.037 Clinical research finance RND.043 Delivering an academic portfolio as sponsor – UK wide and local challenges	
Compassionate, Committed, Excellent Workforce						
3. Attract: Develop a strong employer brand to maintain and promote RM's position as a globally competitive, 'employer of choice' for clinical and non clinical staff wishing to work in oncology.	**20** (4 x 5)	**15** (3 x 5)	Low Tolerance (6-10)	✓	CLIN.423 Radiology - Increased Reporting Turnaround IT.112 Lack of IT resources RND.018 CT Pharmacy Capacity	**Workforce productivity and quality and development metrics** -Vacancy rate (G) -Voluntary staff turnover rate (G) - Sickness rate (A) -Consultant appraisal (A) - Appraisal and PDP rate (A) - Completed induction (A) - Statutory and mandatory staff training (G)
4. Retain: Introduce differentiated retention and inclusion strategies to secure a skilled and sustainable workforce	**20** (4 x 5)	**15** (3 x 5)	Low Tolerance (6-10)	✓		
5. Grow: Develop robust plans to grow our staff skills through provision of our own world class clinical education offer and access to the best non clinical learning support possible.	**16** (4 x 4)	**12** (3 x 4)	Moderate Tolerance (12-15)			
Innovative and Personalised Diagnostics, Treatment and Care						
6. Provide leadership in introducing personalised and innovative diagnostics, treatment and care into standard of care patient pathways, pulling through the latest advances in technology and techniques from research into practice.	**20** (5 x 4)	**16** (4 x 4)	Moderate Tolerance (12-15)		CLIN.423 Radiology - Increased Reporting Turnaround COR.007 Failure to achieve on aspects of performance (T550) COR.120 Trust Procurement Support	
7. As the host and an active member of RM Partners, the West London Cancer Alliance, ensure the Cancer Alliance is at the forefront of improvements in performance and outcomes in Cancer Care through harnessing the combined strength of the respective partners, and ensuring as the Host partner RM delivers top quartile performance and outcomes.	**16** (4 x 4)	**12** (3 x 4)	Moderate Tolerance (12-15)		CLIN.423 Radiology - Increased Reporting Turnaround COR.007 Failure to achieve on aspects of performance (T550) COR.120 Trust Procurement Support	
8. Maintain a high quality specialist paediatric service and minimise disruption to global leading paediatric research until this service is relocated to an alternative provider in line with the NHSE decision. There is currently an integrated service and research model on the RM Sutton site which cannot be easily replicated.	**20** (4 x 5)	**15** (3 x 5)	Low Tolerance (6-10)	✓	COR.007 Failure to achieve on aspects of performance (T550)	
Sustainable investment						
9. Maximise existing and future investment in digital capabilities and available data to support innovation that benefits patients and staff, productivity gains and the Trust's green plan ambitions (e.g. reduction in waste). Maintaining strong cyber protection, disaster recovery and business continuity to protect against ever evolving cyber threats and ensure the Trust can continue to offer high quality diagnosis, treatment and care.	**16** (4 x 4)	**12** (3 x 4)	Moderate Tolerance (12-15)		COR.007 Failure to achieve on aspects of performance (T550) COR.091 Telephony Platform and transition to Unified Comms	Number of patients moved to PIFU Theatre Utilisation Bed Occupancy
10. Address capacity constraints at our Chelsea site, particularly in inpatients with a short, medium and long term plan that seeks to expand and realise efficiencies in existing facilities, and seeking off site capacity opportunities. The Chelsea development should also support the Trust in making tangible progress on its green plan and the NHS net zero target.	**25** (5 x 5)	**20** (4 x 5)	Moderate Tolerance (12-15)	✓	CLIN.423 Radiology - Increased Reporting Turnaround CLIN.082 IR - Capacity, Space & Facilities CLIN.360 Deficiencies in Aseptics Facilities (Sutton) CLIN.373 PET/CT Capacity Chelsea COR.007 Failure to achieve on aspects of performance (T550) RND.018 CT Pharmacy Capacity	**Effective Care Metrics** -Bed Occupancy Chelsea (A) -Session Theatre Utilisation (A)
11. Work with stakeholders at the Sutton site to develop a new site strategy which maximises the opportunities for improving the quality and efficient use of the whole site and supports our green plan including progress towards Net Zero. The site should be developed to benefit patients, staff and the local community, including a strong element of positive 'placemaking'.	**16** (4 x 4)	**12** (3 x 4)	Moderate Tolerance (12-15)			
12. Deliver the Private Patients and wider commercial strategy, ensuring a high-quality offer which meets demand and generates returns that are reinvested into the Trust and remains at an appropriate scale to our NHS activity (i.e. NHS remains larger).	**16** (4 x 4)	**12** (3 x 4)	Moderate Tolerance (11-15)		PP.027 Recoverability of Embassy Aged Debt	**Finance, productivity, and efficiency** -PP activity Income Variance YTD (£000) (G)
13. Deliver the overall financial plan, ensuring efficient use of resources, diverse but clearly contracted income streams and the ability to reinvest capital into infrastructure. Financial efficiency schemes should align to other strategic benefits (e.g. improving the efficiency of patient pathways or supporting green plan objectives).	**20** (4 x 5)	**15** (3 x 5)	Low Tolerance (6-10)	✓	COR.007 Failure to achieve on aspects of performance (T550) COR.120 Trust Procurement Support FIN.010 Financial Sustainability (T1189) FIN.031 Capital Spend PP.027 Recoverability of Embassy Aged Debt RND.037 Clinical research finance	**Finance, productivity, and efficiency** -Cash (£m) (R) -Delivery against plan (R) -Achievement of Efficiency Programme YTD (%) (G) - PP activity income variance (G) -PP aged debt at > 6 months (R) -Non-PP Debtors > 6 months (£m) - absolute value at month end (R) -Capital Expenditure Variance (G)

1. **L x C = Likelihood x Consequence**
2. **Risk Tolerance is determined by the Risk Appetite – No risk tolerance (1-5), Low Tolerance (6-10), Moderate Tolerance (12-15), High Tolerance (16-20), Significant Tolerance (25)**
3. **R= Red; A=Amber; G=Green;**

I = Initial Risk R = Residual Risk T = Risk Tolerance

No	Strategic objective, Lead Director & Board ownership	Strategic Risk(s)	Risk scores	Key controls and assurances	Action plan and timescales for completion
	Research and innovation				
1.	Strengthening RM/ICR relationship. Developing an ambitious plan to function as a joint comprehensive cancer centre with a fully integrated governance and service delivery model. CEO RM Board of Directors	Failure to maximise joint resources and align strategy to common research goals that match national and global priorities present a risk to RM and ICR's continuing position as global cancer research leaders. This would have a consequential risk for the sustainability of both institutions from a workforce and funding perspective.	**I = 16** (4 x 4) **R = 12** (3 x 4) **T = 12-15**	ICR/RM Board-to-Board underway to consider how to best develop the future partnership which resulted in commitment to much closer alignment. Refreshed and strengthened joint governance – to align research strategy and financial/resource planning for research. Joint branding is being developed to be underpinned by three new joint and linked strategies - a Clinical strategy, refreshed Research strategy and new Education strategy. New RM clinical strategy launched in April 2024. New formal IP agreement jointly agreed. A new IP Agreement is being drafted with Heads of terms agreed by the RM and ICR Boards. Discussions have begun on harmonising long term strategic estate plans, particularly at Sutton. This is being led by the ICR Director of Estates with the RM Director of Strategy.	Joint governance began from late 2023. Joint investments made through Joint Finance & IP Committee including XNAT and Academic Radiography. New Joint Research Strategy drafted, pending release. Strategies for removing barriers implemented • Overarching data sharing agreement signed and operationalised. • Overarching tissue transfer agreement signed and operationalised • Joint Operational Policy for equipment sharing signed and implemented ICR and RM aiming for Sutton site masterplan by April 2025.
2.	Improving patient outcomes globally through the active research and development of new ways to diagnose and treat patients across the full cancer patient journey.	Failure to prioritise, support and attract resources and talent to the areas where RM/ICR can deliver the greatest research impact risks a decline in the quality of research outputs.	**I = 16** (4 x 4) **R = 12** (3 x 4) **T = 25**	Clear milestones and deliverables are set and monitored by a steering committee across all themes of RM's flagship Biomedical Research Centre award. The RM/ICR Research Strategy Board monitors and advises on the prioritisation of workforce recruitment and allocation of available pump priming for new areas of R&D investment.	BRC steering committee reporting to Joint RM/ICR Research Strategy Board - Ongoing Joint Research Strategy including priorities for new investment to be identified drafted, pending release Proposal for next RMCC grant cycle drafted in collaboration with RMCC and submitted.

I = Initial Risk - R = Residual Risk - T = Risk Tolerance

No	Strategic objective, Lead Director & Board ownership	Strategic Risk(s)	Risk scores	Key controls and assurances	Action plan and timescales for completion
	Director of Clinical Research / DCEO RM Board of Directors			RMCC research funding approach has been refreshed to provide greater links between funding and expected outcomes which in turn supports greater fundraising. Work will continue to seek opportunities for improving fundraising through joint RM/ICR programmes. Continue to build strategic collaborations with other healthcare providers including community providers (e.g. Clatterbridge & Imperial) to broaden impact and opportunities for researchers. There is an increased focus on growing commercial trial work as well as continuing an IP working group to increase commercial development of IP produced by RM/ICR research. Both of these increase funding and impact. Appointment of Prof Nick Turner as the new Director of Clinical Research	Proposals for new trial inpatient facilities being progressed as part of Chelsea development programme – Included as part of the OBC due in Q2 2025/26 Initial pilot demonstrated feasibility of short - medium term inpatient capacity for clinical trials at Sutton, now expanded to a larger pool of trials and patients. IP and Trial income growth targets to be set annually in business planning and improved visibility of forecasts from ICR – Q1 25/26. Number of commercial trials opening per month has increased from 8 per month to 10 per month. Commercial trial income exceeding monthly target over past 6 months and record number of UK, European and Global first patients recruit achieved. Cancer vaccine task force funding secured to support cancer vaccine trials.
	Compassionate, Committed, Excellent Workforce				
3.	Attract: Develop a strong employer brand to maintain and promote RM's position as a globally competitive, 'employer of choice' for clinical and non-clinical staff	Global shortage of healthcare staff exacerbated for UK by the impact of Brexit and the Pandemic. Potential short- and medium-term pressure on recruitment of staff. Organisational positioning and profile amid growing	**I = 20** (4 x 5) **R = 12** (3 x 4) **T = 6-10**	Focus on creating a compelling offer to external candidates highlighting the benefits and opportunities from working with RM as a leading specialised cancer healthcare and research institution. Active focus on broadening supply sources of substantive and flexible clinical staff, both locally and in partnership.	Reposition resourcing activity to sharpen brand positioning and streamline recruitment process. Develop new supply sources including closer working with the local community and having an apprenticeship pipeline, particularly for nurses – ongoing.

I = Initial Risk - R = Residual Risk - T = Risk Tolerance

No	Strategic objective, Lead Director & Board ownership	Strategic Risk(s)	Risk scores	Key controls and assurances	Action plan and timescales for completion
	wishing to work in oncology. Director of Workforce/ Chief Nurse RM Board of Directors	sectorisation may result in weakening of employer brand and position in the labour market.		Central forward plan on staffing requirements, particularly consultants. Reporting of progress through Workforce and Education Committee /QAR and regular visibility by the Board. New Strategic Workforce Committee (People Board) chaired by the CEO been set up since Q1 24/25. Committee will oversee development and delivery of a detailed workforce strategy over 24/25 which underpins the new Clinical and Research Strategies.	Extend robust flexible staffing provision through the Bank to provide additional supply stream, potential gateway to substantive employment and significant reduction in agency usage which is well below NHS cap. – ongoing 5-year People Strategy completed in Q3 and ready for launch Q4.
4.	Retain: Introduce differentiated retention and inclusion strategies to secure a skilled and sustainable workforce Director of Workforce/ Chief Nurse RM Board of Directors	Demographic changes and differing expectations in the workforce require modernisation of the workplace and employment offer in the face of increasing national and global competition for skilled healthcare workforce or we risk losing key talent.	**I = 20** (4 x 5) **R = 15** (3 x 5) **T = 6-10**	A high-quality workforce model which provides the best training and employment experience and is confirmed by workforce metrics. To include ongoing monitoring of vacancy and turnover rates and qualitative feedback from staff survey. A blended employment model for staff which supports NHS patient care, research and PP. To include ongoing monitoring of vacancy and turnover rates and qualitative feedback from staff survey. Staff recognition scheme including quarterly and annual 'above and beyond' awards – supported by RMCC grant. Ongoing engagement with local union representatives to maintain constructive relations. Reporting of progress through Workforce and Education Committee /QAR and regular visibility by the Board.	Utilising data from Great with Talent to identify further drivers to retain staff - Q4 24/25 Focus on improving retention and staff satisfaction through local staff survey action plans to see improvement in 2024 survey results – Q1 25/26 for next set of staff survey action plans. Launch of Sexual Safety Programme and training in Q2/Q3. Showcased health and wellbeing offer via Health and Happiness week in January 25. Veteran Gold Award reaccreditation successfully achieved Q3. Create an attractive and inclusive workplace by delivering EDI action plan 22-24. ongoing Annual review and submission of RMCC grants to support staff – delayed to Q4 Q3 24/25 All industrial disputes settled for 24/25.

I = Initial Risk - R = Residual Risk - T = Risk Tolerance

No	Strategic objective, Lead Director & Board ownership	Strategic Risk(s)	Risk scores	Key controls and assurances	Action plan and timescales for completion
					Management of increasing number of employee relations cases and potentially high-profile employment tribunal cases.
5.	Grow: Develop robust plans to grow staff skills through provision of own world class clinical education offer and access to the best non clinical learning support possible. Director of Workforce/ Chief Nurse <u>RM Board of Directors</u>	A failure to appropriately develop our staff will leave us unable to implement the increasingly complex cancer diagnostics, treatment and care and thus unable to take the lead in innovation	**I = 16** (4 x 4) **R = 12** (3 x 4) **T = 12 - 15**	Ongoing role of the Learning and Development Team and the RM School to train and educate our clinical staff to ensure supply. RM School Board reinstated with external scrutiny on curriculum relevance and ongoing internal review meetings to ensure financial sustainability. Workforce and Education Committee to oversee progress.	Extension talent management, leadership development and succession planning to grow and retain the best people. – Q3 24/25 Launch of Clinical Leadership Programme for Medical Staff in Q3 External review of the Trust's clinical education offer and opportunities presented to July Board. The recommendations are being developed into an action plan which will report into the People Board and Workforce and Education Committee. The Joint Education strategy with the ICR will commence in 2025/26. when the Director of Education is in place.
Innovative and Personalised Diagnostics, Treatment and Care					
6.	Provide leadership in introducing personalised and innovative diagnostics, treatment and care into standard of care patient pathways, pulling through the latest advances in technology and techniques from	Financial, capacity and staffing constraints prevent RM from continuing to develop and deploy latest innovations that benefit patient care and act as a local, national and global exemplar.	**I = 20** (5 x 4) **R = 16** (4 x 4) **T = 12-15**	New 5 year Genomics Strategy approved by Trust Board in February 2025. A Genomics Strategy Board chaired by the COO is in place to oversee the programme for growing the genomic laboratory hub service including leadership on new regional and national innovations including liquid biopsy (ctDNA) and inherited risk (germline). Ongoing Oak Cancer Centre benefit monitoring to ensure new / expanded diagnostic services delivered.	Implementation plan drafted for Genomics strategy and being monitored at the Genomic Strategy Board. This is aligned to the North Thames GLH strategy which has been developed with RM and Great Ormond Street (GOS) input – *Review ongoing*. Contract negotiations for 24/25 aimed to address gap on baseline Genomics funding (c. £2m) and transition to new sustainable tariffs. The transition to tariffs has been delayed due to NHSE funding constraints and the GLH has begun an

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No	Strategic objective, Lead Director & Board ownership	Strategic Risk(s)	Risk scores	Key controls and assurances	Action plan and timescales for completion
	research to practice. COO/Chief Nurse/ Medical Director <u>RM Board of Directors</u>			RMCC grant programme used to support new equipment/service innovations. With rolling equipment replacement plan maintained by clinical engineering Transformation Board (chaired by Deputy CEO) oversees allocation of resource and progress on delivery of significant novel service developments/changes Continuing engagement with Commissioner's Clinical Quality Review Group (CQRG) to gain support for new pathway innovations. Ongoing Quarterly Divisional PRG process to review new proposals, opportunities and risks.	arbitration process with NHS England in Q4 24/25, resolution expected by Q1 25/26. ctDNA M360 expansion plans approved internally. Pathway for Breast cancer rapidly stood up in January 2025 to support NICE approval of a new treatment. NHSE to run rapid expression of interest process in March 2025 for next phase and in negotiation to take space for expansion in planned refurbished ICR Haddow laboratories. Settled plans expected by end of Q1 25/26. Transformation team support in place to introduce new approved service innovations including, expansion of Senior Adulty Oncology, Digitisation of Histopathology and assessing Haematology 'hotel model'. Monitored at Transformation Board – *update on Transformation programme to come to Trust Board in first half of 25/26.* Careful costing for new innovations to ensure sustainable funding - *ongoing* RMCC grant plan for short and medium term to reviewed by Executives in *Q4 24/25.*

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No	Strategic objective, Lead Director & Board ownership	Strategic Risk(s)	Risk scores	Key controls and assurances	Action plan and timescales for completion
7.	As the host and an active member of RM Partners, the West London Cancer Alliance, ensure the Cancer Alliance is at the forefront of improvements in performance and outcomes in Cancer Care through harnessing the combined strength of the respective partners, and ensuring as the Host partner RM delivers top quartile performance and outcomes. COO/ Medical Director RMP Exec Oversight Board & RM Board of Directors	Risk that pressures on current performance impact on wider partnership and overall performance of Cancer Alliance Risk of balancing wider strategic and partnership wins with internal sustainability Bandwidth to support engagement and ensure RM is viewed as a good partner and strategic leader in Cancer Care and transformation 25% funding reduction for all cancer alliances 25/26	**I = 16** (4 x 4) **R = 12** (3 x 4) **T = 12-15**	Continued participation in RMP Governance Understanding of RMP work programme through attendance of RMP MD at RM Exec Boards. Continued focus on performance to ensure maintain position as National lead in Cancer Services. Monthly RMP interface meetings in place at senior operational level to ensure alignment and delivery. Includes increased scrutiny of programmes with committed funding. Partnering working evidenced by new EBUS pathway, and support for TLHC through PET consortium. Working with RMP MD on refreshed strategy/plan given funding reductions	New RMP strategy has used Trust Strategies as starting point and will be taken through EB and RM business planning. Improvement in Inter Trust Referral Pathways Focus on delivery of yearly Alliance Plan, which is based on local need, and National strategy Board level oversight of performance and comparative performance The continuation of a small, operational resilience fund (c.£200k) to support in year performance. Supporting clinical and non-clinical leadership structure in RMP through formal management arrangement TLHC delivery is being overseen as part of the Joint Thoracic Service structure.
8.	Maintain a high quality specialist paediatric service and minimise disruption to global leading paediatric research until this service is relocated to an alternative provider in line with the NHSE decision. There is currently an integrated service	NHSE decision has been made to relocate paediatric oncology services to Evelina London (part of GSTT) by October 2026. There is a material risk that the services will not be able to transfer by the proposed date. The service is currently safe, high quality and in modern purpose-built facilities which will need to be replicated by the provider chosen to manage	**I= 20** (4 x 5) **R = 15** (3 x 5) **T = 6-10**	Formal transition PTC Programme Board has been established, chaired by GSTT. Several workstreams are in progress to deliver the operational requirements of the move to Evelina. This includes as focus on workforce, capital requirements, clinical pathways, research and JACIE accreditation. Regular internal reviews being undertaken to ensure service and workforce sustainability. Ongoing support being provided to paediatric team with regular all staff meetings and 1:1 HR meetings. Workforce metric score card developed in December 2024 to track workforce issues and implement actions to remediate	Regular recruitment drives are in place to ensure that all posts are filled. TYA service review completed (Jan 2025) and shared with NHSE (March 2025). Awaiting feedback from NHSE on next steps. Full transition plan and risk assessment is underway overseen by PTC Programme board on a monthly basis – ongoing. Research Board established to understand impact to clinical trials - ongoing. New RMCC supported research grant implemented in 24/25. Joint research strategy

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No	Strategic objective, Lead Director & Board ownership	Strategic Risk(s)	Risk scores	Key controls and assurances	Action plan and timescales for completion
	and research model on the RM Sutton site which cannot be easily replicated. CEO/Medical Director <u>RM Board of Directors</u>	this service in the medium term. Loss of national and global leadership of paediatric research and reduced access to novel treatments for paediatric patients.		as necessary. Leavers meetings taking place to understand cause of any staff leaving – ongoing. An estimate the financial deficit at which the service is running has been produced using PLICS. This information has been independently assured and shared with NHSE. An initial estimate of the 'stranded' costs following the transfer has also been produced using PLICS and shared with NHSE. Further discussions with NHSE are expected on the funding that will be provided to cover the 'stranded' costs. Research collaborators contacted and advised that paediatric research continuing at RM and that RM will support the continuation of research throughout the process of any potential transfer to another provider (likely to be 2027 at the earliest). RMCC bid to OAK foundation to renew support for research grant was successful.	with ICR refreshed as part of overall research strategy refresh – Launch due in *Q1 254/265* NHSE have currently signalled that they will not address any of the under-funding of the service in 2025/26 and beyond despite previously providing transition support. Once the 25/26 contract position is confirmed, the Board may need to consider a formal response to NHSE given the very significant financial risk that this poses. Q1 2025/26
	Sustainable investment				
9.	Maximise existing and future investment in digital capabilities and available data to support innovation that benefits patients and staff, productivity gains and the Trust's green plan ambitions (e.g. reduction in waste). Deputy Chief Executive/ CIO <u>AFC & Board of Directors</u>	Investment in digital transformation becomes an ongoing and growing cost pressure without compensating patient, staff and efficiency benefits and quality of care worsens.	**I = 16** (4 x 4) **R = 12** (3 x 4) **T = 12-15**	Post implementation Epic Connect governance processes in place including input from partner Great Ormond Street (GOS). Post implementation benefits delivery is being monitored and reported through the Audit and Finance Committee. Connect optimisation plan for 2024/25 agreed with both Epic and GOS Digital transformation resource embedded in wider transformation team to ensure priorities aligned to wider Trust strategy.	Data, Digital and Clinical Systems Strategy to be approved and published -*Q4 24/25* New transformation prioritised workplan developed as part of business planning 24/25, to be reviewed quarterly. Joint RM and ICR decision to be made on future direction of the Integrated Diagnostics and Discovery (IDD) programme - Q4 24/25

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No	Strategic objective, Lead Director & Board ownership	Strategic Risk(s)	Risk scores	Key controls and assurances	Action plan and timescales for completion
10.	Address capacity constraints at our Chelsea site, particularly in inpatients with a short, medium and long term plan that seeks to expand and realise efficiencies in existing facilities, and seeking off site capacity opportunities. The Chelsea development should also support the Trust in making tangible progress on its green plan and the NHS net zero target. Deputy CEO/COO <u>Board of Directors and AFC</u>	Failure to provide the right estate infrastructure to support the Trust's long term clinical service ambitions at its Chelsea site. Current capital spend aspirations significantly exceed SWL ICS CDEL budget.	**I = 25** (5 x 5) **R = 20** (4 x 5) **T = 12 - 15**	Initial outline proposal for a Chelsea development prepared and shared with the Trust Board and RMCC trustees. Programme of positive external engagement on the Strategic Case for the development including with SWL and NWL ICS leads, the local council, local residents and NHS England (including support from the Joint Investment Committee) A Chelsea Programme Director, programme team, architects and professional advisors have all been appointed and are now in place with a mature programme governance structure and programme board chaired by the CEO. Previously separate work in interim capacity options ahead of a new build has been combined with the Chelsea Programme and is developing a number of options for investment. An internal capacity board focused on a transformation team led programme of efficiency within the current bed base is still in place and chaired by the DCEO. First phase public consultation on Chelsea development was completed in at the end of 2024.	Chelsea site development design work (RIBA stage 3) ongoing approved by Trust Board and RMCC trustees and will begin and report back via the Chelsea Programme Board - ongoing Second phase public consultation on Chelsea development to begin in Spring 2025 Internal Capacity workstream with significant transformation team support looking to maximise existing capacity including efficiency opportunities and options to expand bed base in current facilities as well as exploring off site capacity opportunities. This group will report regularly at the Finance & Performance Committee– *ongoing over 24/25*
11.	Work with stakeholders at the Sutton site to develop a new site strategy which maximises the opportunities for improving the quality and efficient use of the whole site and supports	Failure to engage with strategic planning of the Sutton estate could lead to neighbouring developments that are sub optimal for the Trust and fail to address long term ambitions for that site.	**I = 16** (4 x 4) **R = 12** (3 x 4) **T = 12-15**	Engagement with Epsom St. Helier's New Hospitals Programme paused due to delay in programme but maintaining Exec led dialogue at DCEO level with Epsom St. Helier's senior team. External Consultant - Studio Egret West, have developed of a high level strategic master plan for the Sutton site that will underpin key decisions going forward including future car parking strategy, laboratory expansion and future inpatient accommodation improvements.	Specialist Emergency Care Hospital (SECH) engagement stood down and alternative options for long term Haematology inpatient provision under consideration. – *Ongoing* Updated Sutton Estates Master plan to go to Trust Board in March 2025 for approval. Haematology short and long term estates improvement options being developed under umbrella of new Haematology Transformation

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No	Strategic objective, Lead Director & Board ownership	Strategic Risk(s)	Risk scores	Key controls and assurances	Action plan and timescales for completion
	our green plan including progress towards Net Zero. The site should be developed to benefit patients, staff and the local community, including a strong element of positive 'placemaking'. Deputy CEO <u>AFC / Board of Directors</u>			New Sutton Estates Group, accountable to the Executive Board and chaired by the Deputy CEO, formed from March 2025. Group to oversee and drive the application of the new Sutton Estates master plan to both short and long term decisions New RM/ICR strategic estates working group set up reporting into the new joint governance structure to oversee collaboration opportunities. Contact established with funders (Aviva) and developers (Socius) of London Cancer Hub site and agreement to align strategic goals with regular Executive Director level contact.	Programme, with Director of Cancer services as SRO. – *Update expected by Q2 25/26.* Dialogue set up with Aviva (funders of London Cancer Hub) and agreed to explore feasibility of working together to fund developments. – ongoing but update expected by Q2 25/26. Potential car park solution worked up in adequate detail to go to tender when required. To review timeframe and scale in new Sutton Estates Group – Review in Q1 25/26 Progressing short and medium term plans with ICR including Genomics partial move to Haddow laboratories (aiming for Q4 25/26) and exploring options for working together on ICR's potential new 'collider' building to include short term accommodation, nursery, café and meeting facilities (*Q4 25/26).*
12.	Deliver Private Patients strategy, ensuring a high quality offering which meets demand and generates returns that are reinvested into the Trust and remains at an appropriate scale to our NHS activity (i.e. NHS remains larger). CFO/MD of Private Care	Volatile international patient demand together with increased central London provider competition and the ability of PMIs to direct patients to preferred providers presents a short to medium term threat to revenue. Lack of Private capacity due to historic growth and the demands of NHS activity threatens sustainability. Consultant concentration creates over dependency and risks new consultants	**I = 16** (4 x 4) **R = 12** (3 x 4) **T = 11-15**	As noted in objective 10 there is a Trust wide capacity planning workstream. This ensures close consideration of balance and efficiency of capacity allocation for PP and NHS use in any new external facility or freed up internal capacity. Commercial & Operational plans updated quarterly to account for new risks and opportunities in a changing market. A commercial strategy is in place to identify and develop opportunities outside of Private care to deliver additional income or efficiency benefit through commercial collaboration. The expansion of the Genomics service through commercial collaborations and offers (both domestic and international) is a key part of this strategy and the opportunity of developing early diagnostics is also being explored	Commercial and operational plans, risks and contingencies developed and updated regularly for Board review -*ongoing* Direct links/contracts with Gulf Referral institutions formed to improve patient flow – *ongoing* Divisional Medical Director regularly reviews consultant participation and key clinical risks - *ongoing* Reporting of Private Care activity and financial performance occurs quarterly to the Private Care Board and quarterly to the Performance Review Group - *ongoing* Billing lag has returned to normal levels.

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No	Strategic objective, Lead Director & Board ownership	Strategic Risk(s)	Risk scores	Key controls and assurances	Action plan and timescales for completion
	AFC / RM Board of Directors	establishing private practice with competitors.			Account plans have been developed for the main Embassy accounts to deliver recovery of the debt position. Wider strategic initiatives, capacity cases and updates are taken to the Board / EB for approval - *ongoing* Current commercial focus is on collaborations and offerings within the Trust's genomic service that is helping to grow income and improve efficiency. Other opportunities continue to be monitored especially around education and training requirements in Middle East
13.	Deliver the overall financial plan, ensuring efficient use of resources, diverse (including, NHS, commercial and research) but clearly contracted income streams and the ability to reinvest capital into infrastructure. Financial efficiency schemes should align to other strategic benefits (e.g. improving the efficiency of patient pathways or supporting green plan objectives). CFO/AFC/Board of Directors	Failure to maintain financial sustainability in the current very challenging financial environment.	**I = 20** (4 x 5) **R = 15** (3 x 5) **T = 6-10**	Finance & Performance Committee (FPC) monitors divisional performance against the plan on a monthly basis. The quarterly Performance Review Groups (PRGs) review the forecasts in detail with individual Divisions, with additional focus on efficiency/additional income schemes. Enhanced controls in place as agreed by PRG and EB: - Vacancy control panel; - Review of agency, overtime and bank usage; - Enhanced non pay controls in place; Business plan and significant business cases signed off by FPC, EB and Board. Monthly financial PRGs in place for areas not meeting the plan to ensure it is achieved. The Trust delivered a £10.5m surplus in 2023/24 and a similar NHS financial framework is in place in 2024/25. NHS commissioning contracts have been signed for 2024/25, providing assurance over NHS revenue streams.	The 23/24 performance was supported by a number of non-recurrent items and the Trust has a small underlying deficit. Business planning for 24/25 identified efficiencies to leave the Trust at a £5.35m surplus plan which does however include a number of risks including an ambitious efficiency plan. Cost Improvement Plans are being monitored closely through divisional review meetings and the monthly Finance and Performance Committee – *ongoing* Divisional Reforecasts are performed quarterly, providing assurance over the delivery of the surplus financial plan for 2024/25 - *ongoing*

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Risk Rating Matrix

Likelihood	Consequence					
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)	
Almost certain (5)	5	10	15	20	25	Significant
Likely (4)	4	8	12	16	20	High
Possible (3)	3	6	9	12	15	Moderate
Unlikely (2)	2	4	6	8	10	Low
Rare (1)	1	2	3	4	5	None

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The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 7.1
Title of Document: Communications Briefing	**To be presented by:** For information

1. Status: For Information

2. Purpose:

Other	Board Briefing

3. Summary

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

4. Recommendations / Actions

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

Communications Briefing – December 2024 to February 2025

THEIR ROYAL HIGHNESSES, THE PRINCE AND PRINCESS OF WALES, ANNOUNCED AS JOINT PATRONS OF THE ROYAL MARSDEN

Her Royal Highness The Princess of Wales, visited The Royal Marsden, Chelsea on 14 January to meet patients undergoing treatment and to thank staff for their work and all that they do for patients and their families, every day. During the visit, it was announced that The Princess is joining His Royal Highness, The Prince of Wales, as Joint Patron of The Royal Marsden.

The visit attracted significant coverage on the day and throughout the rest of January. Highlights included coverage on the 6pm and 10pm news broadcasts, with broadcast interviews featuring Dame Cally Palmer, Chief Executive, on BBC, ITV and Sky News as well as BBC radio. Further interviews were held with Professor Nick Van As, Chief Medical Officer, and with a Pets As Therapy (PAT) volunteer Nicola Roche, who met Her Royal Highness The Princess of Wales with her dog Scout during the visit. There were also front-page articles in almost all mainstream newspapers and widespread interest in lifestyle magazines over the following days.

The visit and patronage announcement were reported across the world with more than 7,000 pieces of coverage recorded. Approximately 130 were printed articles, with news items featuring in all the national newspapers. 1,500 were broadcast pieces, mostly across BBC radio regional stations and all ITV regions and mainstream UK based broadcast media. There have also been more than 5,000 online pieces.

DEPARTMENT FOR SCIENCE, INNOVATION AND TECHNOLOGY VISIT

Sir Patrick Vallance, Minister of State for Science, Research and Innovation and Baroness Gillian Merron, Parliamentary Under-Secretary of State for Mental Health and Women's Health Strategy visited our Sutton site on 4 February.

They were given a tour of the NIHR Centre for Molecular Pathology, heard from a patient who has benefitted from pioneering immunotherapy research and were briefed on The Royal Marsden's plans for further innovation, with the Francis Crick Institute, to better understand immunotherapy response and side effects in cancer as part of the new UK-wide programme, titled MANIFEST (Multiomic Analysis of Immunotherapy Features Evidencing Success and Toxicity). MANIFEST is funded through a £9 million grant provided by the Medical Research Council and the Office for Life Sciences, and £12.9 million in matched funds from industry partners. The visit coincided with World Cancer Day and the Government's announcement of its new Cancer Strategy.

RESEARCH & INNOVATION

The Daily Mail Online ran a feature relating to ovarian cancer treatment and the importance of research breakthroughs such as the RAMP 201 study, in December. The piece featured Royal Marsden patient Nadia Le Tiec. Nadia is being treated for ovarian cancer under the

care of Mr John Butler, Consultant Gynaecological Oncology Surgeon, and Professor Susana Banerjee, Consultant Medical Oncologist and Gynaecology Unit Research Lead.

A BBC Documentary aired in December about Royal Marsden patient Eleanor Stollery. Eleanor, 13, has a brain tumour which was diagnosed when she was just four years old. The tumour has resulted in her being visually impaired. The 30-minute documentary, filmed in late 2023 and early 2024, includes scenes shot within the Oak Centre for Children and Young People and in the MRI department in Sutton.

The Royal Marsden achieved widespread coverage of a study into the use of smart biopsies, led by Dr Ed Johnston, Academic Consultant in Oncological Interventional Radiology in early January. The study, part funded by The Royal Marsden Cancer Charity, hopes to provide better understanding of the differences across different parts of a sarcoma, predict growth and gather more vital information about a particular tumour before treatment. Our press release was issued through Press Association and was covered in The Mail Online, The Independent, The Irish News, Bury Mercury, and Chronicle Live as well as across numerous regional titles. It was also covered via broadcast on Sky News and regional radio.

National and regional coverage was secured for the new Symani Surgical System in February. The Royal Marsden is the first in the UK to be using the Symani system for reconstructive cancer surgery, and the three-year lease of the system was funded by The Royal Marsden Cancer Charity. The story was shared exclusively with Press Association, and led to pieces in BBC Online, The Independent, The Daily Mail and the Standard. There was also print coverage in the i newspaper, Daily Express and Metro. There have been over 150 pieces of syndicated regional coverage across the UK.

A joint study by The Institute of Cancer Research and The Royal Marsden that suggests that hormone delivery through a skin patch may ease prostate cancer treatment side effects was covered in The Mail Online in February. Professor of Prostate and Bladder Cancer Research, Dr Nick James, who is leading the trial, talks about how transdermal estradiol, currently used for menopausal hormone therapy, is a potential alternative approach to traditional Androgen Deprivation Therapy (ADT) with fewer side effects. The results of the trial were presented at the 2025 American Society of Clinical Oncology (ASCO) Genitourinary Cancers Symposium.

Dr Nick James was featured again in The Mail Online in February as part of an article about the rise in prostate cancer. The piece highlights figures released by NHS England demonstrating that prostate cancer has now overtaken breast cancer as the most commonly diagnosed cancer in England.

STAFF PROFILING

Professor James Larkin, Consultant Medical Oncologist at The Royal Marsden, was featured on ITV Meridian in December as part of a piece about Claire Turner, a patient undergoing treatment for stage 4 melanoma. Professor Larkin highlighted improvements in outcomes for melanoma patients in recent years, thanks to research and treatment developments.

Declan Cahill, Head of Urology at The Royal Marsden, spoke with The Express in February after hitting the milestone of completing 3,000 robotic proctectomy operations. Mr Cahill spoke about his career and his continued love for the job.

Also in February, Mr Ricky Bhogal, Consultant Hepatobiliary Surgeon, was interviewed by The Daily Mail and discussed advances in surgery techniques which have resulted in some patients surviving for at least five years. The interview was part of a wider feature about pancreatic cancer.

The Daily Mail also spoke with three Royal Marsden consultants, Professor Richard Lee, Professor Chris Parker and Dr Sophie McGrath, in February to discuss what readers can do to reduce their chances of getting cancer. The consultants also outlined to The Mail on Sunday what it is that they do to reduce their own chances of getting cancer, including staying active, reducing alcohol intake and not using their wood burning stove.

PRIVATE CARE

The Royal Marsden was referenced in industry title Health Tech Digital News as a good example of a trust which has used its surplus from its integrated NHS and Private Care model to fund pioneering research and treatments that benefit both private and NHS patients.

THE ROYAL MARSDEN CANCER CHARITY

The opening of the new Interventional Radiology (IR) Suite in Chelsea was celebrated with a private visit by members of Dame Deborah James' family in early December. The Royal Marsden Cancer Charity received £1million of funding for the IR suite from Dame Deborah James' Bowelbabe Fund. The suite includes state-of-the-art technology with the most advanced software and hardware incorporated. It will substantially improve the quality of the care provided to patients as well as enhance our research program in IR with innovative procedures and trial planning.

We publicised the opening of the Interventional Radiology Suite with an exclusive in The Sun later in the month. There was significant media attention as funding for the suite came from The Royal Marsden Cancer Charity via the BowelBabe Fund for Cancer Research UK. The Bowelbabe Fund was established by Dame Deborah James, a Royal Marsden patient who sadly died in 2022, to raise funding and awareness of bowel cancer. After featuring in The Sun, the story was picked up by numerous national and regional media outlets resulting in close to 500 individual pieces of coverage, including live coverage on BBC Breakfast featuring Dame Deborah James's consultant Dr Nicos Fotiadis on Sunday 29 December.

Also in December, we arranged an interview between patient Rebecca and south west London local radio station, Radio Jackie, as part of promotion of the Celebrate A Life events, and supported filming in the Ever After Garden for BBC London News, featuring interviews with Anya Hindmarch (Designer and Trustee of The Royal Marsden Cancer Charity) and Dr Irene Chong (Head of Clinical Oncology at The Royal Marsden). There were also two pieces of coverage about the garden in Time Out as well as in Londonist and Jewish Tribune.

The Ever After Garden has now raised over £1.2 million since it first began in 2019, and the Charity's fundraising announcement, issued in January, was covered by Charity Times, UK Fundraising, Mayfair Times and Charity Digital.

We supported Lady Garden Foundation (LGF), which funds gynaecological cancer research at The Royal Marsden through the Charity, with media opportunities linked to Cervical Cancer Prevention Week in January. Royal Marsden patient Vikki and Mr John Butler, Consultant Gynaecological Oncology Surgeon at The Royal Marsden and LGF's Medical Director, featured in the Mirror Online and OK! Magazine, helping to raise awareness of the importance of attending cervical screenings.

In February, the news that Anuj Ranjan, Chief Executive Officer of Brookfield's Private Equity Group and Brookfield Business Partners, has been appointed as a new Trustee of The Royal Marsden Cancer Charity was covered by Civil Society.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 7.2
Title of Document: Senior Medical Appointments	**To be presented by:** For information

1. Status: **For Noting**

2. Purpose:

Relates to:

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

3. Summary

The Trust has appointed fifteen new consultants between October 2024 and March 2025. Details regarding the backgrounds of these newly appointed consultants are outlined in the attached document.

4. Recommendations / Actions

The Board is asked to note these appointments.

Senior Medical Appointments – October 2024 to March 2025

Mr Kai Tai Derek Yeung
HPB Surgeon - Gastrointestinal Unit (Chelsea)

Mr Kai was appointed by an AAC interview panel to the post of HPB Surgeon - Gastrointestinal Unit (Chelsea) on 06th November 2024, he will start in his new role on 01st April 2025.

Mr Yeung trained at The Royal Marsden, King's College, and Hammersmith Hospitals, specialising in HPB and emergency general surgery. During COVID-19, he demonstrated leadership and pioneered service innovations, including the UK's first robotic day-case liver resection pathway. Committed to research, teaching, and advancing robotic surgery, he strives to improve patient outcomes.

Mr Pranav Patel
Consultant Oesophageal & Gastric Cancer Surgeon

Mr Pranav Patel was appointed by an interview panel to the post of Consultant Oesophageal & Gastric Cancer Surgeon on 19th November 2024. Mr Patal began his role on 1st January 2025.

Trained at The Royal Marsden, UCL, and The Royal Surrey, he specialises in oesophago-gastric cancer surgery, therapeutic endoscopy, and minimally invasive techniques. His PhD focused on cancer diagnostics and lipid metabolism. Mr Patel aims to establish a high-volume cancer centre and drive research collaborations.

Dr Krishanu Ray
Consultant Liaison Psychiatrist with an interest in Psycho-Oncology

Dr Krishanu Ray was appointed by an AAC interview panel to the post of Consultant Liaison Psychiatrist with an interest in Psycho-Oncology on 06th December 2024**.** Dr Ray commenced his role on 6th February 2025.

Dr Ray has over seven years of experience in NHS liaison psychiatry, specializing in oncology and pain services during his training at St Bartholomew's Hospital. He further honed his skills in end-of-life care at St Raphael's Hospice, where he led initiatives for carer support and suicide risk management.

Dr Praveena Idaikkadar
Renal Melanoma Consultant

Dr Praveena Idaikkadar was appointed by an AAC interview panel to the post of Renal Melanoma Consultant on 07th January 2025, she transitioned into her role on 13th January 2025.

In addition to her clinical work, Dr Idaikkadar serves as the Education and Training Lead for Medical Oncology at the Royal Marsden, where she mentors and trains oncology residents. She also leads quality improvement initiatives, including projects on acute oncology and virtual wards, and is dedicated to advancing cancer care through teaching, research, and management.

Dr Chen Sheng Low
Consultant Radiologist and Nuclear Medicine Physician

Dr Chen Sheng Low was appointed by an AAC interview panel to the post of Consultant Radiologist and Nuclear Medicine Physician on 16th January 2025, he will commence his role on 1st July 2025.

Dr Low has played a key role in advancing nuclear medicine, developing services such as FDG PET-CT for cardiac sarcoidosis, DPD imaging, PSMA PET-CT, and peptide receptor radionuclide therapy (PRRT) in collaboration with Neuroendocrine Tumour and Oncology teams. He also established the SIRT service and contributed to molecular radiotherapy trials.

Dr Aislinn Macklin-Doherty
Consultant Medical Oncologist/ Late Cancer Treatment Effects Lead

Dr. Aislinn Macklin-Doherty was appointed to the position of Consultant Medical Oncologist /Late Cancer Treatment Effects Lead following an AAC interview on 3rd February 2025. Her start date is to be confirmed.

Dr Macklin-Doherty brings extensive clinical expertise, underpinned by a diverse medical career. She has been actively engaged in cancer survivorship research, with a particular focus on the late effects of cancer treatments and has successfully secured multiple research grants to support her work.

Dr Hazel Lote
Consultant - Bowel Babe Research

Dr Hazel Lote was appointed to the position of Consultant – Bowel Babe Research following an AAC interview panel on 3rd February 2025.

Dr Lote is a highly qualified medical professional with extensive experience in clinical research, audit, service evaluation, and quality improvement. She is a lead auditor overseeing multiple audits across key oncology specialties, including advanced oesophageal and gastric cancers, melanoma, and breast cancer. She has also played a pivotal role in service evaluations and pathway enhancements, contributing to improved oncology care delivery.

Dr Thomas Charlton
Clinical Oncology Urology Consultant Chelsea / Kingston.

Dr Charlton was appointed by an AAC interview panel to the post of Clinical Oncology Urology Consultant Chelsea / Kingston on 10th Feb 2025. He commenced his role on 3rd March 2025.

In addition to his clinical expertise, Dr Charlton has demonstrated leadership in various roles, led on strategic initiatives, such as the development of a clinical roadmap for robotic surgery at Guy's and St Thomas' NHS Foundation Trust and has played a role in expanding national chemotherapy capacity through his work with the NHS Cancer Programme. His leadership experience extends to his role as Clinical Lead for the West London Cancer Alliance.

Mr Shengyang Qiu
Consultant Colorectal Surgeon

Mr Qiu was appointed by an AAC interview panel to the post of Consultant Colorectal Surgeon on 13th Feb 2025. He will start in his new role in May 2025.

Mr Qiu has a strong clinical and academic background. He specialises in the treatment of advanced colorectal cancers, including locally advanced and metastatic cases, and has experience in procedures such as pelvic exenteration and cytoreductive surgery with HIPEC. Mr Qiu has contributed to the development of digital infrastructure, improvement of perioperative care pathways, and involvement in national and international surgical registries.

Dr Shaista Hafeez
Urology Clinical Oncology Consultant

Dr Shaista Hafeez was appointed by an AAC interview panel to the post of Urology Clinical Oncology Consultant on 25th Feb 2025.

Dr Hafeez has successfully led and contributed to high-impact studies, including CRUK-funded randomised trials and international research protocols. Her work in adapting radiotherapy techniques to individual patient anatomy has led to improved cancer treatment outcomes, and her contributions have been recognised with awards, such as the Royal College of Radiologists Ross Award and the NCRI Prize. Her development of training programs for radiographer-led adaptive radiotherapy has been widely adopted.

Dr Sarah Allen
Consultant in Clinical Oncology - Breast

Dr Allen was appointed by an AAC interview panel to the post of Consultant in Clinical Oncology - Breast on 26th Feb 2025.

She played an integral role in the PARABLE trial, from its planning stages through to active recruitment, demonstrating her leadership in research and commitment to improving patient outcomes through innovative treatments. In addition to her clinical expertise, she has substantial experience in teaching and mentoring, frequently guiding registrars and contributing to educational programs. She also brings valuable management experience, having supported the development of departmental roles and helped optimise clinical workflows.

Dr Samantha Nimalasena
Consultant in Clinical Oncology – Breast

Dr Nimalasena was appointed by an AAC interview panel to the post of Consultant in Clinical Oncology – Breast on 26th Feb 2025.

Dr Nimalasena research experience includes significant involvement in the KORTUC Phase I trial. Furthermore, her leadership role in the metastatic spinal cord compression (MSCC) service highlights her ability to improve patient pathways through effective collaboration and innovation.

Ms Michelle Wilkinson
Consultant Surgical Oncologist

Ms Wilkinson was appointed by an interview panel to the post of Consultant Surgical Oncologist on 03rd March 2025.

Ms Wilkinson has extensive clinical experience, having performed over 360 limb/trunk sarcoma resections. Her research contributions include establishing a clinical trial on oncolytic virotherapy via isolated limb perfusion, which earned international recognition and secured significant research funding. Ms Wilkinson is also leading two clinical trials and is an active member of the retroperitoneal sarcoma surgery database (RESAR).

Mrs Francesca Ruccia
Consultant Plastic and Reconstructive Surgery

Mrs Francesca Ruccia was appointed by an AAC interview panel to the post of Consultant Plastic and Reconstructive Surgery on 10th March 2025.

Mrs Ruccia is an experienced Consultant Plastic Surgeon specialising in microsurgery, breast reconstruction, skin cancer surgery, and gynaecological and perineal reconstruction. She has received several prestigious awards, including the Audit Prize and Poster Winner at Queen Victoria Hospital, and has made significant contributions to various research projects. Her clinical expertise includes breast reconstruction (including DIEP and TUG flaps), skin cancer surgery, and gynaecological reconstruction.

Dr Catherine Garnett
Consultant Haematologist

Dr Catherine Garnett was appointed by an interview panel to the post of Consultant Haematologist on 12th March 2025**.**

Dr Garnett has a strong research background, having conducted a Wellcome Trust-funded DPhil project on myeloid leukaemia in children with Down syndrome. Her work has been published in leading journals, and she has contributed to clinical trials and research in haematology. She has also led leadership and quality improvement projects aimed at optimising patient care and enhancing clinical governance.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 7.3
Title of Document: Board of Directors Standing Orders	**To be presented by:** For information

1. Status **For Noting**

2. Purpose:

Relates to:

Governance	*X*

3. Summary

In October 2024, Board members electronically approved changes to the Board of Directors' Standing Orders to reflect amendments made to the constitution of the board.

Section 12.3 of the Standing Orders requires that Standing Orders be reviewed annually by the Trust Board. The Standing Orders have been reviewed and remain fit for purpose.

4. Recommendations / Actions

The Board is asked to endorse the Standing Orders.

The ROYAL MARSDEN
NHS Foundation Trust

Board of Directors Standing Orders

March 2025

PRIVATE AND CONFIDENTIAL

NHS

Summary

NHS Foundation Trusts are required to adopt Standing Orders (SOs) for the regulation of their proceedings and business. Regulation 19 of the NHS Trusts (Membership and Procedure) Regulations 1990 (as amended) requires the meetings and proceedings of an NHS trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with Standing Orders made under regulation 19 (2). The Codes of Conduct and Accountability require Boards to adopt schedules of reservation of powers and delegation of powers.

As a public benefit corporation, the Trust has specific powers to take any action which appears to be necessary or desirable for the purposes of, or in connection with, its functions. It has the power to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

The documents, together with Standing Financial Instructions (SFIs), provide a comprehensive regulatory and business framework for the conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

These SOs are for the regulation of the Trust Board's proceedings and business.
All Directors and members of staff should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

Contents

1. Introduction

1.1 Purpose

1.1.1 The purpose of the Board SOs is to ensure that the highest standard of governance and conduct are achieved in the Board and throughout the Trust.

1.2 Statutory Framework

1.2.1 The NHS is governed by a regulatory framework that confers the functions of the Trust and comprises: Acts of Parliament and in particular the National Health Service Act 2006 and/or replaced by the Health and Social Care Act 2012; their constitutions and the provider licence, granted by the regulator.

1.2.2 The Royal Marsden NHS Foundation Trust is a public benefit corporation which was established on 1st July 2004 under the Health & Social Care (Community Health & Standards) Act 2003 (subsequently consolidated into Chapter 5 of the National Health Service Act 2006).

1.2.3 NHS Foundation Trusts are governed by a range of statutes, including the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) and the National Health Service Act 1977 (NHS Act 1977). The statutory functions conferred on the Trust are set out in the NHS & CC Act 1990 (Schedule 2), Chapter 5 of the National Health Service Act 2006 and the Trust's constitution.

1.2.4 No Statutory Instrument is required to establish an NHS Foundation Trust. Under section 7(1) of the Health and Social Care (Community Health and Standings) Act 2003, when the Regulator gives an Authorisation to an NHS Trust, then that body ceases to be an NHS Trust and becomes an NHS Foundation Trust. The Establishment Order of Royal Marsden NHS Trust was also revoked when the Authorisation was issued, by virtue of section 7(2) of the 2003 Act.

1.2.5 The statutory functions conferred on the Trust are set out in the NHS & CC Act 1990 (Schedule 2), Chapter 5 of the National Health Service Act 2006, Health Act 2009, in the Trust's Constitution and in its authorisation from the Independent Regulator.

1.2.6 The Membership and Procedure Regulations 1990 (SI (1990) 2024) requires the Trust to adopt SOs for the regulation of its proceedings and business.

1.2.7 Board Members will also be asked to confirm that they remain a fit and proper person in accordance with Regulation 5 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

1.3 NHS Framework

1.3.1 In addition to the statutory requirements the Secretary of State through the Department of Health issues further requirements and guidance. These are normally issued via circular or letter.

1.3.2 The Code of Accountability for NHS Boards requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a Scheme of Delegation). The code also requires the establishment of Audit and Remuneration Committees with formally agreed Terms of Reference. The Code of Conduct also outlines requirements concerning possible conflicts of interest of Board Directors.

1.3.3 The Code of Practice on Openness in the NHS and the Freedom of Information Act 2000 sets out the requirements for public access to information about the NHS.

1.4 NHS Constitution

1.4.1 The NHS Constitution sets out the rights and responsibilities of patients and staff. The Health Act 2009 places a duty on all providers of NHS services to have regard to the NHS Constitution in performing its NHS functions.

2. Interpretation

As permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of SOs (on which he/she shall be advised by the Chief Executive and/or Director of Workforce).

Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

ACCOUNTABLE OFFICER	shall be the Officer responsible and accountable for funds entrusted to the Trust. He shall be responsible for ensuring the proper stewardship of public funds and assets. For The Royal Marsden, this shall be the Chief Executive.
AUTHORISATION	shall mean the approval given to the Trust by the Independent Regulator to operate as a Foundation Trust.
BOARD OF DIRECTORS	shall mean the Chair and Non-Executive Directors, appointed by the Council of Governors, and the Executive Directors appointed by the remuneration committee of the Trust, as constituted in accordance with the Constitution.
BUDGET	shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
CHAIR	is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The Chair also presides at the meetings of the Council of Governors. The expression "the Chair of the Trust" shall be deemed to include the Non-Executive Director appointed as the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.
CHIEF EXECUTIVE	shall mean the chief officer of the Trust who is to be appointed (and removed) by the Non-Executive Directors, and whose appointment is subject to the approval of a majority of the Members of the Council of Governors present and voting at a General Meeting.
COMMITTEE OF THE BOARD	shall mean a committee appointed by the Trust Board, with specific Terms of Reference, Chair and membership approved by the Board.
COMMITTEE OF THE COUNCIL	shall mean a committee appointed by the Council of Governors, with specific Terms of Reference, Chair and membership approved by the Council.

COMMITTEE MEMBERS	shall be persons formally appointed by the Trust to sit on or to Chair specific committees.
CONSTITUTION	shall mean the established form of operations for the Council of Governors and Board of Directors as authorised by the Independent Regulator.
COUNCIL OF GOVERNORS	shall mean the persons, elected and appointed, to fulfil the functions as laid out in the Constitution.
DIRECTOR	shall mean a person appointed to the Board of Directors in terms of the Constitution.
GOVERNOR	means a person elected or appointed to the Council of Governors in terms of the Constitution.
INDEPENDENT REGULATOR	means the Regulator for the purpose of Part 1 of the 2003 Act.
MEMBERS	means any member of staff, public or patient who has signed to become a member of the Foundation Trust.
MEMBERSHIP AND PROCEDURE REGULATIONS	shall mean the National Health Service Trust (Membership and Procedure) Regulations 1990 (SI(1990) 2024).
NHSE	means the corporate regulatory body known as NHSI, as provided by section 61 of the Health and Social Care Act 2012.
MOTION	means a formal proposition to be discussed and voted on during the course of a meeting.
NOMINATED OFFICER	means an officer charged with the responsibility for discharging specific tasks within Sos.
OFFICER	means an employee of the Trust.
COMPANY SECRETARY	means the Company Secretary or other person appointed to perform the duties of a Company Secretary.
SFIs	means Standing Financial Instructions.
SOs	means Standing Orders.
TRUST	Means The Royal Marsden NHS Foundation Trust.
SENIOR INDEPENDENT DIRECTOR	means the Non-Executive Director appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

3. The Trust

3.1 All business shall be conducted in the name of the Trust.

3.2 The powers of the Trust shall be exercised by the Board of Directors.

3.3 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

3.4 The Council of Governors has certain powers conferred on it in accordance with the Constitution.

3.5 Composition of the Board - In accordance with the Constitution, the Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

The Board of Directors is to comprise:

- a non-executive Chair;
- up to seven other Non-Executive Directors;
- the Chief Executive of the Institute of Cancer Research (ICR) as an ex-officio member;
- the following Executive Directors:
    - a Chief Executive (and Accounting Officer);
    - a Deputy Chief Executive (if one has been appointed);
    - a Chief Finance Officer;
    - a Chief Medical Officer (who shall be a registered medical practitioner);
    - a Chief Nurse (who shall be a registered nurse or midwife);
    - a Chief Operating Officer;
    - such other Directors as shall be determined from time to time;

In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of Executive Directors, the Chair (and in his/her absence the Senior Independent Director) shall have the casting vote at meetings of the Board of Directors.

3.6 Appointment of the Chair and Directors - The Chair and Non-Executive Directors are appointed (and removed) by the Council of Governors.

The Chief Executive is appointed (and removed) by the Non-Executive Directors, subject to the approval of a majority of members of the Council of Governors present.

The Executive Directors are appointed (and removed) by a committee consisting of the Chair, the Chief Executive and Non-Executive Directors.

3.7 Nominations Committee - The Trust shall appoint a Nominations Committee whose Members shall comprise the Chair and selected Governors, to advise the Council of Governors on the appointment of Non-Executive Directors. The Nominations Committee may be advised by the Chief Executive, Non-Executive or Executive Directors and external advisors when appropriate.

3.8 Terms of Office of the Chair and Directors - The Chair and Non-Executive Directors are to be appointed for a period of office in accordance with the terms of the Constitution.

3.8.1 The Chair and the Non-Executive Directors:

- Shall serve terms of office of no longer than 3 years and shall be eligible for re-appointment at the end of the three years.
- Should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term

beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should be agreed with NHS England. Non-Executive Director becoming chair after a three-year term as a Non-Executive Director would not trigger a review after three years in post as chair.

- Should be subject to a review regarding their independence having served for a period of six years;

3.8.2 The Chief Executive and Executive Directors will normally hold non time limited contracts of employment.

3.9 Appointment of Senior Independent Director - The Board of Directors shall nominate one of the Non- Executive Directors to be a Senior Independent Director of the Board. If the Chair is unable to discharge his/her office as Chair of the Trust, the Senior Independent Director of the Board of Directors shall be the acting Chair of the Trust.

3.10 Powers of Senior Independent Director - Where the Chair of the Trust has died or has otherwise ceased to hold office or where he/she has been unable to perform his/her duties as Chair owing to illness, absence from the country or any other cause, references to the Chair in the Schedule to these Regulations shall, so long as there is no Chair able to perform his/her duties, be taken to include references to the Senior Independent Director.

3.11 Resignation - The appointed Senior Independent Director may at any time resign from the office by giving notice in writing to the Chair and the Directors of the Trust may thereupon appoint another Non-Executive Director as Senior Independent Director

3.12 Joint Directors - Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for Executive Directorship or in relation to which an Executive Director is to be appointed, those persons shall become appointed as an Executive Director jointly and shall count as one person.

3.13 Relationship between the Board of Directors and the Council of Governors - It is the responsibility of the Board of Directors to manage the strategic business of the Trust (in accordance with the Constitution). The powers of the Council of Governors are detailed in the Constitution. The Governors will also represent the views of the Members of their constituency and ensure the needs of the local health community are taken into account when advising on the Trust's strategic direction.

3.14 Conflict Resolution -

In the event of a dispute between the Council of Governors and the Board of Directors:

- In the first instance, the Chair, on the advice of the Company Secretary and other such advice as the Chair may see fit to obtain, shall seek to resolve the dispute;
- If the Chair is unable to resolve the dispute, he shall convene and chair a special committee, comprising equal numbers of Directors and Governors, for the express purpose of considering the circumstances and to making recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute;
- In the case of the special committee passing a motion, the Chair shall have the casting vote in the event that the number of votes for and against the motion are equal;

- If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision;
- The dispute resolution procedures set out do not preclude the Governors from referring the matter to the panel of persons appointed by NHSE as set out in paragraph 22 of the constitution. In these circumstances, the dispute must relate to a question about the Trust failing or its failure to act in accordance with provision made by or under Chapter 5 of the 2006 Act and must otherwise satisfy the conditions set out in paragraph 22 of the Constitution.

4. Meeting of the Board of Directors

4.1. Admission of the Public and the Press - The public and representatives of the press shall be afforded facilities to attend public meetings of the Board but shall be required to withdraw:

4.1.1 upon the Board resolving as follows:

"A body may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings; and where such a resolution is passed, this Act shall not require the meeting to be open to the public during proceedings to which the resolution applies". *(Section 1(2) Public Bodies (Admission to Meetings) Act 1960).*

4.1.2 The Chair may exclude any member of the public from a meeting of the Board if they are interfering with or preventing the proper conduct of the meeting.

4.2 The Chair or Senior Independent Director shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public" (Section 1(8) Public Bodies (Admission to Meetings) Act 1960).

4.3 Nothing in these SOs shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board.

4.4 Calling Meetings - Ordinary meetings of the Board shall be held at such times and places as the Board may determine.

4.4.1 Meetings of the board shall be deemed closed for 'special reasons' in accordance with the Health and Social Care Act 2012 unless declared open to members of the public.

4.4.2 The Board may agree that its members can participate in its public meetings by telephone, or video link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

4.5 The Chair may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him/her, such one third or more Directors may forthwith call a meeting.

4.6 Notice of Meetings - Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, via email so as to be available to him/her at least three clear days before the meeting.

4.7 Lack of service of the notice on any Director shall not affect the validity of a meeting.

4.8 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

4.9 Agendas and supporting papers will be sent to members no later than three clear days before the meeting. Failure to serve such a notice on more than three members will invalidate the meeting. A notice shall be presumed to have been served one day after posting and may be issued electronically. Agendas and supporting papers will also be made available to members electronically.

4.10 Before each public meeting of the Board a public notice of the time and place of the meeting, shall be displayed on the Trust's website at least three clear days before the meeting. In accordance with the Health and Social Care Act 2012 (paragraph 152(4)); before holding a public meeting, a copy of the agenda will be sent to the Council of Governors, and approved Board minutes will be available to Governors.

4.11 Chair of Meeting - At any meeting of the Board, the Chair, if present, shall preside. If the Chair is absent from the meeting the Vice-Chair, if there is one and he/she is present, shall preside. If the Chair and Vice-Chair are absent such Non-Executive Director as the Directors present shall choose shall preside.

4.12 Declaration of Interests - At the start of a meeting of the Board of Directors, Directors shall declare any pecuniary, personal, family, financial or non-financial, interest whether that interest is direct or indirect, in any proposed contract or other matter that is under consideration or is to be considered by the Board. A family interest will include those of a Director's spouse or partner. Any Directors appointed subsequently shall declare such interests on appointment.

4.13 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Vice-Chair, if present, shall preside. If the Chair and Vice- Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

4.14 Annual General (Members') Meeting - The Chair will publicise and hold an Annual Members' Meeting in accordance with the terms of the Constitution. The meeting will be held within 9 months of the end of each financial year, at which the registers and documents referred to in paragraph 40 of the constitution.

4.15 Notices of Motion - A Director of the Trust desiring to move or amend a motion at meetings shall send a written notice thereof at least ten clear days before the Board meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the Board meeting, without notice on any business mentioned on the agenda.

4.16 Withdrawal of Motion or Amendments - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.17 Motion to Rescind a Resolution at Board meetings - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director(s) who gives it and also the signature of four other Directors. When any such motion has been disposed of by the Trust, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he/she considers it appropriate.

4.18 Motions - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.19 When a motion is under discussion or immediately prior to discussion at Board meetings, it shall be open to a Director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceeds to the next business. (*)
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put. (*)

** In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate.*

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

4.20 Chair's Ruling - Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

4.21 Voting - Decisions at Board meetings shall be determined by a majority of the votes of the Directors present and voting. In the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

4.22 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

4.23 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.24 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

4.25 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

4.26 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the

voting rights of the Executive Director. An officer's status when attending a Board meeting shall be recorded in the minutes.

4.27 Minutes - The Minutes of the proceedings of a Board meeting shall be drawn up and maintained as a permanent record. They will be submitted for agreement at the next ensuing meeting where they will be signed by the Chair.

4.28 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next Board meeting.

4.29 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by the Code of Practice on Openness in the NHS.

4.30 Joint Directors - Where the office of a member of the Board is shared jointly by more than one person:

a) each person may attend or take part in meetings of the Board

b) each of those persons shall be eligible to cast one vote if they agree

c) in the case of disagreements, no vote should be cast

d) the presence of those persons shall count as the presence of one person for the purposes of paragraph 4.37 (Quorum).

4.31 Suspension of Standing Orders - Except where this would contravene any statutory provision or any direction made by the Secretary of State (applicable to Foundation Trusts) or authorisation of the Independent Regulator, any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension.

4.32 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors.

4.33 No formal business may be transacted while SOs are suspended.

4.34 The Audit and Finance Committee shall review every decision to suspend Standing Orders.

4.35 Variation and Amendment of Standing Orders - These Standing Orders shall be amended only if:

- A notice of motion under Standing Order 4.16 has been given; and
- No fewer than half the total of the Trust's Non-Executive Directors vote in favour of amendment; and
- At least two-thirds of the Directors are present; and
- The variation proposed does not contravene a statutory provision or direction made by the Secretary of State.

4.36 Record of Attendance - The names of the Directors present at the Board meeting shall be recorded in the minutes.

4.37 Quorum - No business shall be transacted at a meeting of the Trust unless at least one-third of the whole number of the Chair and Directors appointed (including at least one Executive Director and one Non-Executive Director) are present.

4.38 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

4.39 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (section 7 and 8) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.40 Frequency - The Trust shall hold meetings of the Board of Directors at least six times in each calendar year.

4.41 Petitions – Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda for the next meeting.

5. Arrangements for the exercise of functions by delegation

5.1 The Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by committee or sub-committee, appointed by virtue of SO 5.3 or 5.4 below or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

5.2 Emergency Powers - The powers which the Board has retained to itself within these SOs (may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors). The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

5.3 Delegation to Committees - The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The Constitution and Terms of Reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.

5.4 Delegation to Officers - Those functions of the Trust which have not been retained as reserved by the Board or delegated to an Executive Committee or Sub- Committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Board.

5.5 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendments agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board as indicated above.

5.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of any Executive Director to provide information and advise the Board in accordance with any statutory requirements.

5.7 The arrangements made by the Board as set out in the "Scheme of Delegation" shall have effect as if incorporated in these Standing Orders.

6. Committees

6.1 Appointment of Committees - The Trust may appoint committees of the Trust, consisting wholly or partly of Directors of the Trust or wholly of persons who are not Directors of the Trust.

6.2 A Committee appointed may appoint Sub-Committees consisting wholly or partly of members of the Committee (whether or not they include Directors of the Trust) or wholly of persons who are not members of the Trust Committee (whether or not they include Directors of the Trust).

6.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any Committees or Sub-Committee established by the Trust. There is no requirement for committees established under SO 5.1 and SO 5.2 above or sub-committees, to hold meetings in public.

6.4 Each such Committee or Sub-Committee shall have such Terms of Reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide. Such Terms of Reference shall have effect as if incorporated into the Standing Orders.

6.5 Committees may not delegate their Executive powers to a Sub-Committee unless expressly authorised by the Board.

6.6 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines that persons, who are neither Directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board.

6.7 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the Independent Regulator, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by the Independent Regulator and approved by the Board.

6.8 Confidentiality - A member of the Board or a Committee of the Board shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

6.9 A Director of the Trust or a member of a Committee shall not disclose any matter reported to the Board or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or Committee shall resolve that it is confidential.

7. Declaration of Interests

Pursuant to Section 20 of the Schedule 7 of the National Health Service Act 2006 and guidance on Managing Conflicts of Interest in the NHS issued by NHS England in June 2017, a register of Director's interests must be kept by each NHS Foundation Trust.

7.1 All Executive and Non-Executive Directors should declare financial, non-financial relevant and material interests in accordance with the Trust's Business Conduct Policy. Any Directors or Governors appointed or elected subsequently should do so on appointment or election, as soon as an interest arises no later than 28 days of the interest arising, on joining the Trust and on an annual basis to the Company Secretary.

Directors must also declare details of any significant transactions which their close families or entities controlled by any of these, have undertaken with the Trust or anyone associated with the Trust, such as management contracting, NHS mergers or acquisitions, and operating in competition with the Trust. The Trust is required to disclose in its annual report details of such transactions. Board members, Governors and the Leadership Team should notify the Company Secretary within 28 days of any changes to the declarations of interest.

7.2 Interests regarded as "relevant and material", financial and non-financial and which should be included in the register are: -

a) Any Directorship of a company, or any position of authority held in another NHS organisation or commercial, charity, voluntary or professional, statutory or other body which could be seen to influence decisions you take in your NHS role.

b) Any interest, including shareholdings and other ownership interests held by a Director or Governor in any publicly listed, private, not-for-profit company, business, partnership or consultancy which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust.

c) Any interest in an organisation providing health and social care services to the National Health Service.

d) A position of Authority in a charity or voluntary organisation in the field of health or social care.

e) Any affiliation to a special interest group campaigning on health or social care issues.

f) To the extent not covered above, any connection with an organisation, entity or Company considering entering into or having entered into financial arrangement with the Trust, including but not limited to, lenders or banks.

g) Any gifts valued over £50 accepted on behalf of an organisation, not in a personal capacity.

h) Any hospitality of a value between £25 and £75. Hospitality of a value of more than £75 should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the Trust's register of interests as to why it was permissible to accept.

i) Any patents and other intellectual property rights held where applications to protect have started or are on-going which are, or might be reasonably expected to be, related to items to be procured by the Trust.

7.3 If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair.

7.4 At the time Directors' interests are declared they should be recorded in the Board minutes. Any changes in interests should be officially declared at the next Board meeting. It is the obligation of the Director to inform the Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the Register upon receipt within three working days.

7.5 Directors' Directorships of companies in 6.2(a) or in companies likely or possibly seeking to do business with the NHS (6.2(b)) should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

7.6 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, a majority will resolve the issue with the Chair having the casting vote.

7.7 Registers of Interests - The Chief Executive and the Company Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Directors. In particular, the Registers will include details of all Directorships and other relevant and material interests which have been declared by Executive and Non-Executive Directors.

7.8 The details of Directors' interests recorded in the Register will be kept up to date by means of an annual review of the Registers in which any changes to interests declared within the preceding twelve months will be incorporated by the Company Secretary.

7.9 Subject to contrary regulations being passed, the Registers will be published on the Trust's website. The Chair will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

7.10 Board Members will also be asked to confirm that they remain a fit and proper person in accordance with Regulation 5 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The declaration will be made each year in conjunction with the declarations of interest.

8. Disability of Directors in proceedings on Account of pecuniary interest

The entire text of this section is based on the Membership and Procedure regulations.

8.1 Subject to the following provisions of this SO, if the Chair or a Director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

8.2 The Independent Regulator may, subject to such conditions as he may think fit to impose, remove any disability imposed by this SO in any case in which it appears to him in the interests of the NHS that the disability shall be removed.

8.3 The Trust may exclude a Director from a meeting of the Trust while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

8.4 Any remuneration, compensation or allowances payable to a Director by virtue of such appointment or employment shall not be treated as a pecuniary interest for the purpose of this SO.

8.5 For the purpose of this SO the Chair or a Director shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he/she, or a nominee of his/hers, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

(b) he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this SO to be also an interest of the other.

8.6 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of his membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he/she is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director or a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

8.7 Where the Chair or a Director:

a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this SO shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

8.8 This SO applies to a Committee or Sub-Committee of the Board as it applies to the Board and applies to any member of any such Committee or Sub-Committee (whether or not he/she is also a Director of the Trust) as it applies to a Director of the Trust.

8.9 Whilst this SO is aimed at the Board of Directors, because it exercises the powers of the Trust, it applies equally to Governors in circumstances in which Governors are in any way considering a contract with the Trust.

9. Standards of Business Conduct

9.1 Policy - Staff must comply with the national guidance contained in HSG (93)5 'Standards of Business Conduct for NHS staff'. The following provisions should be read in conjunction with this document and the Trust's SFI's and the Trust's Business Conduct Policy.

9.2 Interest of Officers in Contracts - If it comes to the knowledge of a Director, or an officer of the Trust that a contract in which he/she has any pecuniary interest not being a contract to which he/she is himself/herself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Chief Executive of the fact that he/she is interested therein as well as notify the Company Secretary of the interest as soon as possible and in any case within 28 days of the interest arising. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

9.3 An officer must also declare to the Chief Executive and the Company Secretary as soon as possible and in any case within 28 days of it arising any other employment or business or other relationship of his/hers, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust requires interests, employment or relationships so declared by staff to be entered in a register of interests of staff established and maintained by the Company Secretary, and in the case of Directors, made publicly available on the Trust website.

9.4 Canvassing of, and Recommendations by, Directors in Relation to Contractor / Business Supplier Appointments - Canvassing of Directors of the Trust, or Members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the contractor / business supplier for such appointment. The contents of this paragraph of the SO shall be included in application forms or otherwise brought to the attention of candidates.

9.5 A Director shall not solicit for any person any appointment under the Trust or recommend any contractor / business supplier for such appointment: but this paragraph of this SO shall not preclude a Director from giving written testimonial of a contractor's ability, experience or character for submission to the Trust's procurement department.

9.6 Informal discussions outside appointment panels or Committees, whether solicited or unsolicited, should be declared to the panel or Committee who is considering relevant candidates in the tender procedure.

9.7 Relatives of Directors or Officers - Candidates for any staff appointment shall, when making application, disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

9.8 The Directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

9.9 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Company Secretary whether they are related to any other Director or holder of any office under the Trust.

9.10 Where the relationship of an officer or another Director to a Director is disclosed, the Standing Order headed 'Disability of Directors in proceedings on account of pecuniary interest' (SO 8) shall apply.

10. Custody of Seal and Sealing Documents

10.1 Custody of Seal - The Common Seal of the Trust shall be kept by the Company Secretary on behalf of the Chief Executive in a secure place.

10.2 Sealing of Documents - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by the Chief Executive (or nominated deputy) and the Chief Financial Officer (or nominated deputy). The affixing of the Seal shall be attested and signed the Chief Executive (or nominated deputy) and the Chief Financial Officer (or nominated deputy).

10.3 Where a document is required to be executed as a deed (documents such as leases and transfers of land), or where the Trust determines that a contract or other document should be executed as a deed, the document must be executed under seal in accordance with the procedure in 10.2 above. For the avoidance of doubt, the requirements set out above in relation to the execution of deeds and the affixing of the seal do not affect, and operate in addition to, the delegated authorities set out in the Trust's Scheme of Reservation and Delegation.

10.4 Register of Sealing - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal.

A report of all sealing shall be made to the Trust at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

11. Signature of Documents

11.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive or any nominated executive director, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

11.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

12. Miscellaneous

12.1 Standing Orders to be given to Directors and Officers - It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs.

12.2 Documents having the standing of Standing Orders - Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers shall have the effect as if incorporated into SOs.

12.3 Review of Standing Orders - Standing Orders shall be reviewed annually by the Trust Board. The requirement for review extends to all documents having the effect as if incorporated in SOs.

Annex A

Reservation of Powers to the Board

1. Approval of Standing Orders, including Reservation of Powers to the Board.
2. Establishment, membership, terms of reference and reporting arrangements for all Committees acting on behalf of the Board.
3. Approval of strategic plans and policies.
4. Approval annually of a Business Plan, a Financial Plan, a "Budget Book" (for internal purposes), the Annual Accounts and accounting policies and the Annual Report. The Financial Plan will include authorised Reserves and Provisions against which expenditure can be committed.
5. Approval of business cases for capital schemes in excess of £3m.
6. Approval of the disposal of land and buildings
7. Approval of additional revenue or capital expenditure on approved schemes and of new expenditure proposals, where these exceed the Chief Executive's delegated authority.
8. Personnel policies determining the terms and conditions of staff. The application of these policies to Executive Directors will be determined by the Board upon receipt of recommendations from the Remuneration Committee.
9. Determination of the Board's information needs, both routine and ad hoc, to enable the financial and operational performance of the Trust to be monitored.
10. Receipt of reports from Board sub-Committee meetings such as Audit and Finance and Quality, Assurance and Risk Committee.
11. Approval of long term and short term borrowing facilities.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 26 March 2025	**Agenda item:** 7.4
Title of Document: **Board Sub-Committee Terms of Reference:** Audit & Finance Committee (AFC) Terms of Reference (ToR) Quality Assurance & Risk Committee (QAR) Terms of Reference (ToR)	**To be presented by:** For information

1. Status: **For approval**

2. Purpose:

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

3. Summary

The Terms of Reference (ToR) for the Audit & Finance Committee (AFC) and Quality Assurance & Risk Committee (QAR) were reviewed at their respective meetings in February.

The AFC ToR were deemed fit for purpose, and no changes were made.

Several changes were proposed to the QAR ToR which have now been incorporated.

4. Recommendations / Actions

The Board is asked to approve the Audit & Finance Committee and Quality Assurance & Risk Committee Terms of Reference as part of its annual review.

The Royal Marsden NHS Foundation Trust (the Trust)
Terms of Reference

Committee	**Audit and Finance Committee**
Membership	Membership of the Audit and Finance Committee (the Committee) will be sought from amongst the Non-Executive Directors of the Trust Board (the Board) and shall consist of not less than three members.
Attendance	The Chief Financial Officer, one other Board level Executive Director (either the Chief Nurse or Chief Operating Officer), the Head of Internal Audit and a representative from the External Auditors shall normally attend meetings. However, at least once a year the Committee may wish to meet with the External and Internal Auditors without any Executive Board members present. The Chief Executive has an open invitation to attend the meetings, but particularly annually to discuss the process for assurance that supports the annual governance statement. Board members only would normally be present for discussion of matters covering the Financial Duties (6. Below).
Chair	A Non-Executive Director with the requisite financial experience and recognised accounting qualification (or on his/her absence another Non-Executive Director)
Secretary	Board Secretary or their designate
Quorum	Two members
Meeting Frequency	Not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. At least one private meeting without management present with the External Auditor and Head of Internal Audit is required each year. One additional joint meeting with the Quality Assurance & Risk Committee.
Authority	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
Relationships with other committees	The Committee has shared responsibility with the Quality Assurance & Risk Committee (QAR) to provide assurances to the Board that the Royal Marsden NHS Foundation Trust is properly governed and well managed across the full range of its activities. As such, both Committees need to work collaboratively to ensure that all aspects of governance are covered and that the Board receives comprehensive assurances on the Trust's business and activities. The Committee has specific responsibility for monitoring of financial risks.

Main Aims	The Committee is formally constituted as a subcommittee of the Trust Board and its main purpose is to contribute independently to the Board's overall process for ensuring that an effective internal control system is maintained for all Trust operations including any subsidiary entities. In particular the Committee will have the following key objectives: 1. Providing confidence in the objectivity and fairness of financial reporting; 2. Providing assurance about the adequacy of internal controls; 3. Safeguarding of assets; 4. Reducing the risk of illegal or improper acts; 5. Reinforcing the importance, independence and effectiveness of internal and external audit
Duties & Responsibilities	**1. Internal Control and Risk Management** The Committee shall review the establishment and maintenance of an effective system of internal control and risk management. In particular, the Committee will review the adequacy of: • All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board (including the annual governance statement and declarations to NHSEI); • The structures, processes and responsibilities for identifying and managing key risks facing the organisation; • The identification and management of key risks of the Trust through the Board Assurance Framework (BAF) which is assigned to the Committee; • The operational effectiveness of policies and procedures; • The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Counter Fraud Authority or any replacement organisation with similar national remit for fraud and security; • Standing Orders and Standing Financial Instructions and Codes of Conduct. • The Trust's digital programme, with particular focus on risk management, including cyber security. **2. Internal Audit** The Committee's responsibilities shall include: • To have overall responsibility for the provision of an effective internal audit function; • To consider the appointment of the internal audit service, the audit fee and any questions of resignation or dismissal; • To review the internal audit programme and ensure it is aligned to the key risks of the business; • Consider the major findings of internal audit investigations (and management's response) and ensure co-ordination between the Internal and External Auditors;

	• To monitor the implementation of all recommendations from Internal Audit and ensure they are completed in an appropriate timeframe; • To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; • To undertake an annual review of the effectiveness of internal audit, in conjunction with QAR. **3. Anti-Fraud and whistleblowing** The Committee's responsibilities shall include: • To consider the appointment of the Local Anti-Fraud Specialist, its fee and any questions of resignation or dismissal; • To review the anti-fraud programme, and consider the major findings of its investigations (and management's response); • To ensure that the Local Anti-Fraud Specialist has appropriate standing within the organisation; • Review arrangements by which employees and contractors may, in confidence, raise concerns about possible improprieties in financial reporting or other matters. These arrangements should allow proportionate and independent investigation of such matters and appropriate follow up action. **4. External Audit** The Committee's responsibilities shall include: • Consider the appointment of the External Auditor and make recommendations to the Council of Governors; • Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors and Internal Auditors in the local health economy; • Review and approve the annual audit plan and ensure that it is consistent with the scope of the audit engagement, having regard to the seniority, expertise and experience of the audit team • Review External Audit reports, including review any representation letter(s), management letter(s) and management's response to the auditor's findings and recommendations requested by the external auditor before they are signed by management; • Develop and implement policy on the supply of non-audit services by the external auditor to avoid any threat to auditor objectivity and independence, taking into account any relevant ethical guidance on the matter. **5. Financial Reporting** The Committee's responsibilities shall include: Monitoring the integrity, reviewing and approving the annual financial statements on behalf of the Board, focusing particularly on: • Changes in, and compliance with, accounting policies and practices;

	• The methods used to account for significant or unusual transactions where different approaches are possible; • All material information presented with the financial statements such as the annual governance statement, internal control, the going concern and value for money assessment as well as the quality report; • Major judgmental areas; and • Significant adjustments resulting from the audit. **6. Financial Review** On behalf of the Board, the Committee, meeting without external attendees, will have responsibility for the following financial aspects of the Trust's activities: • Review the annual financial plan and recommend to the Trust Board its adoption; • Monitor in-year performance and corrective action and consider further actions the Trust Board should take to ensure the financial plan is achieved; • Oversee the on-going development and review of the medium term financial plan; • Review strategic plans and major business cases and consider proposals for action/discussion at the Trust Board; • Oversight of the Capital programme – regular review of spending against plan, procurement, including tender waivers; • Review of Accounting Policies – at least annually.
Recording	The key issues discussed with decisions and outcomes will be recorded.
Reporting	The Chairman will ensure that the business of the Committee is reported to the Trust Board including any recommendations for action. A copy of the minutes of the Committee will be made available to the Trust Board after each meeting (together with a verbal or written report from the Chair of the Committee). An annual report of the work of the Committee will be presented to the Board and the Council of Governors, including how it has met its Terms of Reference and duties and responsibilities. This report should include: • a summary of the role and work of the audit committee; • the number of audit committee meetings; • an explanation of how the committee has assessed the effectiveness of the external audit process and of the approach taken to the appointment or reappointment of the external auditor; the length of tenure of the current audit firm; the current audit partner name, and for how long the partner has held the role; when a tender was last conducted; and advance notice of any retendering plans; • an explanation of how the committee has assessed the effectiveness of internal audit and satisfied itself that the quality, experience and expertise of the function is appropriate for the

	business; • the significant issues that it considered in relation to the financial statements and how these were addressed, having regard to matters communicated to it by the auditors; and • any other issues on which the Board has requested the committee's opinion.
Approved	11 November 2024
Review Date	12 November 2025 To be reviewed annually by the Committee
Forward Agenda Plan	A Forward Agenda Plan will be documented in line with the Committee's responsibilities.

The Royal Marsden NHS Foundation Trust

Terms of Reference

Committee	**Quality, Assurance and Risk Committee (QAR)**
Membership	Membership will be as follows: Chairman Chief Executive At least two Non-Executive Directors Deputy Chief Executive Chief Nurse Medical Director Chief Operating Officer Divisional Director, Cancer Services Divisional Director, Clinical Services Divisional Director for Private Care Managing Director, Private Care ~~or Director of Operations, Private Care~~ ~~Director of Transformation and Charity Liaison~~ Chief ~~Director of Performance and~~ Information Officer Director of Workforce Chief Financ~~ial~~ Officer Chief Pharmacist~~/Head of Quality Improvement~~ Deputy Director of Patient Safety and Clinical Assurance Notify the Corporate Governance Manager if d~~D~~eputies will ~~are not to~~ stand in for members~~. unless the approval of the Chair has been given.~~
Chair	A Non-Executive Director with sufficient experience of clinical and risk issues. In their absence, another Non-Executive Director can act as Chair.
Secretary	~~Quality Officer and~~ Corporate Governance Manager ~~(minute taker)~~
Quorum	Fifty per cent of members, to include at least two Non-Executive Directors (can include the Trust Chairman and the Non-Executive Director Chair of QAR) and one Executive Director. Members are expected to attend at least three~~two~~ meetings a year.
Meeting Frequency	QAR will meet five times a year, ~~including a joint meeting with Audit and Finance Committee~~, to monitor the implementation of clinical governance arrangements in the Trust and the work of the Integrated Governance and Risk Management Committee (IGRM).
Authority	The Committee is authorised by the Board to investigate any activity within its terms of reference and has overarching responsibility for non-financial risk. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of

	outsiders with relevant experience and expertise if it considers this necessary
Relationships with other committees	QAR is a sub-committee of the Trust Board. QAR has shared responsibility with the Audit and Finance Committee to provide assurances to the Board that the Royal Marsden NHS Foundation Trust is properly governed and well managed across the full range of its activities. As such, both committees need to work collaboratively to ensure that all aspects of governance are covered and that the Board receives comprehensive assurances about the Trust's business and activities. Once a year a joint meeting of QAR and the Audit and Finance Committee will be held. QAR will monitor the functioning of the Integrated Governance and Risk Management Committee (IGRM).
Main Aims	QAR is formally constituted as a subcommittee of the Trust Board and its main purpose is to support the Board in developing an integrated approach to risk, control and governance by ensuring robust systems, which enable achievement of its objectives. The Board Assurance Framework will be central to the committee achieving its purpose. A key focus of the Committee is patient safety, including infection control, and quality monitoring.
Duties & Responsibilities	1. To monitor the implementation of clinical and research governance and risk management arrangements within the Trust, including the development of local standards and performance monitoring mechanisms to supplement national standards. 2. To receive and review the following annual reports and plans on behalf of the Board of Directors:~~regular reports of relevant clinical outcomes from clinical teams to facilitate benchmarking~~ • Infection Prevention and Control (six-monthly update) • Safeguarding Children and Vulnerable Adults (plus six-monthly update) • Clinical Audit report (plus six-monthly update) • Medicines Optimisation • Safer staffing report – (plus six-monthly update) • Patient Experience report • Emergency preparedness and resilience report (EPRR) • End of Life Care. 3. To oversee clinical governance and risk management arrangements within the Trust, including those for clinical audit, Complaints, Claims and Patient Safety Incident response ~~Serious Incidents~~ and environmental risks and to ensure action plans are implemented and evaluated in a timely manner. 4. To review all appropriate policies relating to Clinical Governance, Risk Management (other than Financial) and Health & Safety. ~~5. To review an Integrated Governance Monitoring Report on a 6 monthly basis on behalf of the Board and to advise the Board of any issues arising from the Report on an exception basis.~~

	5. To be responsible for the monitoring and review of the Trust's risk register on a quarterly basis ensuring action is taken as appropriate in relation to identified risks. 6. To be advised on the progress of any major quality initiatives in the Trust, including JACIE, ISO 9001 for radiotherapy and chemotherapy and external accreditation arrangements. 7. Receive and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these. 8. To review the Trust's Quality Accounts and the processes by which they are produced. 9. To review and monitor the Care Quality Commission's Fundamental Standards (or successor standards). 10. To review compliance with corporate governance arrangements including but not limited to the Provider License, Board Assurance Framework and Corporate Risk Register 11. To ~~review the *Whistleblowing policy* annually; to~~ maintain an oversight and monitor the ~~function of the~~ Trust's whistleblowing ~~policy~~ and Freedom to Speak Up function ~~scheme~~ for assurance that concerns raised are listened to and acted on appropriately and to receive notice of any 'whistleblowing' concerns and freedom to speak up concerns raised on quality or safety matters. The committee will receive quarterly reports about the Freedom to Speak Up Guardian function. 12. To receive feedback on patient and staff experience within the Trust and how learning has been implemented from these findings. 13. To review policies about and controls over information governance and data quality. 14. To be advised of any research and development or research ethics issues which may impact on clinical governance in the Trust. 15. To develop a communication and reporting relationship with the Council of Governors, with particular reference to the development of patient, carer and public involvement at all levels. 16. ~~To u~~Undertake an annual review of the effectiveness of the Committee to inform the Committee's annual report to the Board of Directors and the following year's work programme.
Recording	The key issues discussed with decisions and outcomes will be recorded.
Reporting	The Chair~~man~~ will ensure that the key business of QAR is reported to the Trust Board including any recommendations for action.

	~~The minutes of the meetings of the Committee, together with a summary of the key issues, matters discussed and decisions taken will be made available to the Trust Board after each meeting through a report from the Chair of the Committee.~~ An annual report of the work of the Committee will be presented to the Board and Council of Governors, including how it has met its Terms of Reference and duties and responsibilities.
Date created	February 2023
Revision date	February 2025~~4~~