The ROYAL MARSDEN
NHS Foundation Trust

Board of Directors Public Meeting

Chelsea Boardroom

25 March 2026, 12.30pm – 2.30pm

Agenda

1.	**Welcome, Apologies and Declaration of Interest** *Chairman*	Verbal
2.	**Minutes of the Public Board Meeting held on 19 November 2025** *Chairman*	Enclosed
3.	**Matters Arising** *Chairman*	Verbal
4.	**Strategic**	
	4.1 NHS Oversight Framework Rating Q3 *Deputy Chief Executive*	Enclosed
	4.2 Chelsea Development *Deputy Chief Executive*	Enclosed
	4.3 Financial Plan 2026/27 *Chief Finance Officer*	Enclosed
	4.4 Staff Survey Results *Chief People Officer*	Enclosed
5.	**Quality & Performance**	
	5.1 Quality Account Q3 *Interim Chief Nurse*	Enclosed
	5.2 Infection Prevention Control Board Assurance Framework and Antimicrobial Resistance and Stewardship *Interim Chief Nurse*	Enclosed
	5.3 Emergency Preparedness, Resilience and Response *Chief Operating Officer*	Enclosed
	5.4 Mortality Review Q3 *Interim Chief Medical Officer*	Enclosed
	5.5 Financial Performance Report – February 2026 *Chief Finance Officer*	Enclosed
	5.6 Performance Report Q3 *Chief Operating Officer*	Enclosed
6.	**Regulatory**	
	6.1 Risk Appetite Statement 2026/27 *Company Secretary*	Enclosed
	6.2 Board Assurance Framework – end of year position and principal risks *Company Secretary*	Enclosed

NHS

6.3 Review of Board Standing Orders Enclosed
Company Secretary

6.4 Ratification of Board Sub-Committee Terms of Reference (AFC & QAR) Enclosed
Chair AFC/Chair QAR

Date of next Public Board Meeting: 21 July 2026

The ROYAL MARSDEN
NHS Foundation Trust

Minutes of The Royal Marsden Board of Directors Public Meeting

19 November 2025, 12.30-2.30 pm Chelsea Boardroom

Present	
Sir Douglas Flint	Chairman
Liz Adekunle	Non-Executive Director
Professor Ted Baker	Non-Executive Director
Katie Bickerstaffe	Non-Executive Director
Jane Bentall	Non-Executive Director
Alison Dickinson	Non-Executive Director
William Jackson	Non-Executive Director & Senior Independent Director
Dame Cally Palmer	Chief Executive
Karl Munslow-Ong	Deputy Chief Executive
Professor Nick Van As	Chief Medical Officer
Jen Watson	Interim Chief Nurse
Sofia Colas	Chief Operating Officer
Adedoyin Ogunbiyi	Chief Finance Officer

In Attendance	
Krystyna Ruszkiewicz	Chief People Officer for items 4.3 & 4.4
Brinda Sittapah	Company Secretary
Rebecca Kingdom-Kruszewski	Associate Director, PR and Communications
Vernon Bailey	Governor
Laura Collantes	Governor
Ella Devereux	Correspondent for Health Service Journal
Ian Frankcom	Health Solutions Partner, Chugai Pharma UK Ltd
Louann Heal	Governor
Philippa Leslie	Governor

Clinical presentation: Leading the Next Phase of Cancer Care: De-escalation of treatment and Delivery at Scale

Dr Emma Kipps, Medical Director for Clinical Services, delivered a presentation to the Board on the next phase of cancer care: de-escalation of treatment and delivery at scale.

She highlighted that while drug discovery continues to drive oncology, innovations such as antibody-drug conjugates (ADCs) are transforming outcomes in HER2-positive breast cancer, with long-term remission now possible even in Stage IV disease. The Royal Marsden's leadership extends beyond developing new therapies to optimising care delivery, using AI-supported imaging to detect toxicity early, ctDNA to guide treatment duration, and digital tools for remote monitoring and personalised care. By precisely determining who needs treatment, at what intensity, and when to safely stop, RM leads both escalation where cure requires intensity and de-escalation when cure is achieved, ensuring treatments are safe, effective, and sustainable. This integrated approach positions RM to set internationally recognised standards in precision oncology, demonstrating leadership in both therapeutic innovation and delivery at scale.

The Board thanked Dr Kipps for her presentation and for her ongoing leadership in advancing precision oncology.

1. Welcome, Apologies for Absence and Declarations of Interest

Sir Douglas Flint, Chairman, welcomed everyone to the meeting.

Apologies were noted from, Non-Executive Directors Baroness Rona Fairhead and Professor Kristian Helin.

No additional interests were declared beyond those already on record.

2. Minutes of Public Board meeting held on 26 March 2025

The minutes of the Public Board meeting held on 26 March 2025 were approved as an accurate record of that meeting.

3. Matters Arising

There were no matters arising. All updates had been covered on the agenda.

4. Strategic

4.1 Quality and Safety

The Interim Chief Nurse presented a patient story to the Board, highlighting the complex clinical and social challenges faced by a young woman with advanced ovarian cancer. Far from home with limited family support, the patient experienced recurrent bowel obstructions, complex nutritional needs, multiple admissions, and homelessness following loss of income. Her situation required extensive multidisciplinary collaboration across oncology, palliative care, surgery, welfare support services, and external partners. The Interim Chief Nurse described how teams managed her highly complex medical needs but also advocated for her dignity and personal wishes, illustrating how acts of kindness, collaboration, creativity, and unwavering commitment from multiple teams transformed a profoundly difficult journey into one characterised by humanity and grace. The Board noted that the case exemplified the Trust's values of kindness, collaboration, and excellence through consistent, patient-centred care.

Pursuing excellence every day is embedded in the work of our staff, through both routine actions and major care or research interventions. To support this, the Trust has developed an **"**Excellence Every Day" programme, which articulates and demonstrates our ongoing commitment to high-quality, patient-focused care.

The Chief Operating Officer (COO) and Interim Chief Nurse provided an overview of the programme to the Board, emphasising that excellence is a collective responsibility. It underpins the Trust's commitment to being consistently safe, caring, effective, responsive, and well-led, and is a daily endeavour benefiting colleagues, patients, and families.

The Board discussed the importance of celebrating achievements and noted that ward accreditation could serve as a positive means of recognising performance. It was agreed that the Excellence Everyday programme should be integrated into the Quality Assurance and Risk Committee agenda.

4.2 Chelsea Development – Public Consultation

The Deputy Chief Executive provided an update on stakeholder engagement for the Chelsea development, which began in September 2024 and has progressed through three phases of consultation to date.

Extensive engagement has taken place with residents, stakeholders, the wider public, patients, and staff. Key events included meetings with local residents' associations (Dovehouse Street, Sydney Street & District), The Chelsea Society, Royal Borough of Kensington and Chelsea (RBKC) councillors and Leader, a public webinar, and a Development Forum hosted by RBKC. Engagement statistics included 301 webinar/event attendees, 285 survey respondents, 122,825 reached via social media, 4,973 visitors to the online consultation hub, 6,855 flyers delivered, and 179 neighbours updated by letter.

Feedback and core themes were noted. There was overwhelming support for the rationale behind the development. Positive feedback included the addition of greenery, the change of façade colour

from red to London stock yellow, retention of a protected tree, and a more traditional frontage. Concerns were raised regarding building size and height, impact on daylight and sunlight for neighbouring properties, traffic management on Dovehouse Street and site deliveries, servicing and traffic issues, and requests for community access to greenspace. The clinical rationale for the building's height was explained, and all possible measures have been taken to manage the building's scale and massing.

Submission of the planning application is expected November/early December 2025, followed by statutory consultation by RBKC and further opportunities for stakeholder input. The planning committee meeting is expected in late spring/early summer 2026, after the local elections in May, with the outcome followed by review and negotiations with the Greater London Authority (GLA).

The Board commended the approach to stakeholder engagement, the transparent handling of feedback, and ongoing communication with the council and stakeholders. The Board noted the completion of extensive public consultation events, the commitment to address feedback in the final design and planning submission and thanked the Communications Team for their work in running the third phase of consultation.

4.3 Annual Equality, Diversity and Inclusion Report 2024/25

The Chief People Officer presented the Annual Equality, Diversity and Inclusion Report 2024/25 to the Board.

The Report demonstrates the Trust's compliance with the Public Sector Equality Duty of the Equality Act 2010 and provides analysis for key regulatory standards, including the Workforce Race Equality Standard, Workforce Disability Equality Standard, and Gender Pay Regulations. It also details progress against the NHS EDI Improvement Plan and highlights achievements and ongoing challenges in advancing equality, diversity and inclusion for both patients and staff.

During the year, the Trust delivered a range of initiatives, including a tailored anti-racist leadership programme for over 150 nurses, the launch of the Accelerate Programme to develop diverse middle management, and the introduction of reverse mentoring and a sexual safety charter. The Trust also piloted diverse interview panels for Band 7+ nursing posts, which improved the likelihood of appointing candidates from Black, Asian or Minority Ethnic backgrounds. A new 'Fair and Inclusive' recruitment training course was introduced for line managers, and the Trust continued to celebrate religious and cultural events, foster staff networks, and support staff with disabilities through a dedicated advice line.

The mean gender pay gap increased slightly to 11.9% in 2025 (from 11.29% in 2024), with the median pay gap rising to 5.7%. This is partly attributable to the nationally controlled Clinical Excellence Award scheme. There has been a significant increase in female staff receiving awards, which is not yet reflected in the figures, and the Trust is considering reviewing the award process to ensure fairness.

Staff experience and culture change remain central priorities. The Trust is committed to ensuring improvements are felt by staff, embedding EDI across all levels through the new People Strategy (2025), qualitative and quantitative feedback, flagship EDI events, and a transformative work programme.

The Board commended the work to move from compliance to transformational EDI, recognised that staff experience and culture are central to this progress, and acknowledged the importance of continued Board engagement and accountability.

4.4 Annual Education and Training Report 2024/25

The Chief People Officer presented the Annual Education and Training Report 2024/25, providing an overview of progress against the Trust's five strategic education priorities, as set out in the Education Strategy.

She was pleased to report that The Royal Marsden School had a successful year, with notable achievements in continuing professional development (CPD) and strong performance in the nurse apprenticeship programme. Research activities also remained robust throughout the year.

The Board acknowledged the importance of strong educational partnerships and recognised the significant contribution of the Royal Marsden Cancer Charity in enabling these initiatives.

Looking ahead, priorities include expanding commercial and internal education offerings, developing the next generation of healthcare professionals, enhancing learning systems, formalising strategic partnerships, and sustaining multi-professional learning and research excellence. The Board also noted the positive impact of nursing advocates in supporting staff, career development, and quality improvement.

The Board commended the excellent work of educators across all professions and endorsed the six strategic education goals for 2025/26.

5. Operational

5.1 Quality Account – September 2025 (August data)

The Interim Chief Nurse presented the Quality Account for September 2025, providing an overview of performance and key quality indicators for August.

SACT/MDU infusion waiting times were 85.4%, with patients starting treatment within one hour of their appointment, meeting the target. The Olayan Day Care Unit remains a focus for reducing waiting times.

Infection Prevention and Control (IPC) performance remained within thresholds. Notable points included four E. coli bloodstream infections, two post-transplant C. difficile cases, and VRE and CPE cases prompting enhanced IPC measures. No MRSA or MSSA cases were reported, and hand hygiene compliance remained high at 95.7%.

No calls for concern were reported; however, delays in observations, training, and education were identified as areas needing improvement. A task and finish group will review pathways for unwell ambulatory and outpatient patients to enhance staff confidence and escalation processes.

The nursing vacancy rate increased slightly to 4%, remaining below the Trust target of 7%, with turnover rates stable. Estates showed the highest vacancy rate at 14.4%. Sickness rates were higher in some units, requiring staff redeployment to maintain safe staffing levels. The Board noted the importance of maintaining a strong pipeline of nursing talent and continued engagement with education partners.

The Board discussed anticipated challenges during the winter period, including patient isolation, increased staff sickness, and lower vaccine uptake. Plans are in place to mitigate these risks, with ongoing vigilance and proactive management emphasised.

Friends and Family Test (FFT) results remained above the national average, with staff attitude highlighted as a key positive.

The Board noted overall IPC performance, recognised areas for improvement, and supported ongoing actions to maintain patient safety, effective care delivery, and workforce preparedness for the winter period.

5.2 Financial Performance Report – September 2025

The Chief Finance Officer presented the Financial Performance Report, providing an update on the Trust's position as at 30 September 2025.

The Trust reported a year-to-date deficit of £1.7m, in line with the financial plan. The statutory position, after adjusting for donated asset income and depreciation, showed a deficit of £0.9m, £2.1m adverse to plan due to the timing of capital equipment purchases via donated asset financing.

The cash balance at 30th September 2025 was £124.7m, £17.4m behind plan due to slower than planned recovery of NHS, non-NHS, and private patient debts and month-end payment timing. Despite this, the cash position remains strong and is expected to recover by November 2025 as payment timings normalise, and debt recovery improves. Private patient aged debt over six months has reduced to £16.1m, with non-private patient debt also trending downwards.

Total capital expenditure at Month 6 was £8.9m, £6.4m behind plan, mainly due to timing differences in Trust-funded and charity-funded schemes.

The full-year forecast remains on track to deliver the financial plan, with risks identified around private patient and commercial income, NHS contract offers and pay awards. Opportunities include commercial initiatives, asset valuation, and balance sheet management, which continue to be closely monitored.

The Board noted the Financial Performance Report for September 2025, recognising the stable overall position, the strong cash balance despite short-term timing issues, the improvement in private patient debt, and the ongoing management of risks and opportunities.

5.3 Performance Report Q2

The Chief Operating Officer presented the Q2 2025/26 Board Balanced Scorecard Report, highlighting a strong quarter with continued improvements across key performance metrics. The proportion of green-rated metrics increased, reflecting positive progress in several areas.

Bed occupancy remained high, with Chelsea at 91% and Sutton at 92%. Critical Care Unit occupancy was elevated at 77.4%, above the upper threshold, and is expected to remain high as winter approaches.

Overall theatre activity increased by 11% compared to the same quarter last year, despite a seasonal dip in session utilisation during summer leave. Session utilisation data continues to be monitored to ensure ongoing improvement.

Performance against the 18-week RTT standard and the 28-day Faster Diagnosis Standard remained strong, achieving 80.9% for the 28-day FDS and 96.4% for the 31-day cancer waiting time standard.

The 62-day cancer waiting time standard remains a challenge at 70.6%, primarily due to late referrals and capacity constraints. The Board requested a breakdown of the 62-day performance for all aspects including late referral information and breaches within the Trust's control. Internal action plans are in place to improve performance in these areas.

The Trust is in Segment 1 and ranked sixth nationally under the new NHS Oversight Framework, reflecting strong overall performance. NOF metrics have now been added to the scorecard and will be reported in retrospect.

Research performance remains robust, with 45.2% of commercial contract interventional trials led by the Trust and strong recruitment of first UK, European, and global patients.

The Board discussed the Q2 position, noting improvements in performance, the reduction in aged private patient debt, and areas requiring ongoing focus, particularly cancer waiting times and operational pressures ahead of winter, and acknowledged that these areas will continue to require attention.

6. For information

6.1 Communications Briefing

The Board noted the Communication briefing.

Date of next Public Board meeting: *25 March 2026*

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
25 March 2026	4.1
Title of Document:	**To be presented by:**
National Oversight Framework Rating Q3	Deputy Chief Executive

1. Status

2. Purpose:

Relates to:

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

3. Summary

On 17th March NHSE published the Q3 National Oversight Ratings for Trusts.

The results for Q1, Q2 and Q3 are shown below.

Period	Segment	Avg Metric Score	Rank
Q1 25/26	1	1.56	6th
Q2 25/26	1	1.58	5th
Q3 25/26	1	1.29	1st

There remain a relatively small number of applicable metrics for the Trust and as a consequence the quarter to quarter scores can be volatile. Improvement has been seen in the implied productivity metric and there has been a minor reduction in the IPC rating, with everything else remaining stable.

The framework is being reviewed with a final framework and metrics for 26/7 expected in the coming weeks.

4. Recommendations / Actions

The Board is asked to note the strong performance for the Trust year to date culminating in the top ranking for Q3.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 25 March 2026	**Agenda item:** 4.2
Title of Document: Chelsea Development	**To be presented by:** Deputy Chief Executive

1. Status **To note**

2. Purpose:

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

3. Summary

Background

The purpose of this paper is to provide an update on the planning application and key milestones for 2026.

Overview

- **Planning Application**

  The planning application was formally submitted to the Royal Borough of Kensington and Chelsea (RBKC) on 19 December 2025. The cyber-attack experienced by the Council has delayed the formal validation of the planning application (i.e. checking it is complete), and the commencement of the statutory consultation process.

  RBKC have recently confirmed that the Planning Portal has started to work and have advised that the Planning Application should "go live" on the portal w/c 16th March 2026. The statutory consultation process will commence at this stage. RBKC have advised that they are aiming for a June 2026 Planning Committee which will be dependent on the backlog caused by the cyber-attack although they have confirmed that we are a priority project. Subject to committee approval, the decision would then be formalised following Greater London Authority (GLA) review in October 2026, at which point formal consent would be granted.

- **Key Milestones for 2026**
  The programme is on track for 2031 completion, with the next 12 months being critical as a number of workstreams and approvals processes converge to enable construction to start. Key activities include RIBA Stage 4 design, development of a fixed price offer from Kier Construction, planning permission, Gateway 2 approval, Outline Business Case and the commencement of the Full Business Case and commence early enabling works.

4. Recommendations / Actions

The Board is asked to:

- Note that RBKC have confirmed that our planning application is due to "go live" on their portal w/c 16th March with a target Planning Committee meeting in June or July 2026.

- Note that the programme remains on track with a combination of different workstreams and approvals process all converging in the year ahead.

The ROYAL MARSDEN
NHS Foundation Trust

The Royal Marsden Chelsea Development

Public Trust Board

25th March 2026

Executive Summary

1 Background/ purpose

- The purpose of this paper is to provide an update on the planning application and key milestones for 2026.

2 Overview

- **Planning Application -** The planning application was formally submitted to the Royal Borough of Kensington and Chelsea (RBKC) on 19 December 2025. The cyber-attack experienced by the Council has delayed the formal validation of the planning application (i.e. checking it is complete), and the commencement of the statutory consultation process.
- RBKC have recently confirmed that the Planning Portal has started to work and have advised that the Planning Application should ”go live” on the portal w/c 16th March 2026. The statutory consultation process will commence at this stage. RBKC have advised that they are aiming for a June 2026 Planning Committee which will be dependent on the backlog caused by the cyber-attack although they have confirmed that we are a priority project. Subject to committee approval, the decision would then be formalised following Greater London Authority (GLA) review in October 2026, at which point formal consent would be granted.
- **Key Milestones for 2026 -** The programme is on track for 2031 completion, with the next 12 months being critical as a number of workstreams and approvals processes converge to enable construction to start. Key activities include RIBA Stage 4 design, development of a fixed price offer from Kier Construction, planning permission, Gateway 2 approval, Outline Business Case and the commencement of the Full Business Case and commence early enabling works.

3 Recommendations

The Public Board is asked to:

- Note that RBKC have confirmed that our planning application is due to "go live" on their portal w/c 16th March with a target Planning Committee meeting in June or July 2026.
- That the programme remains on track with a combination of different workstreams and approvals process all converging in the year ahead.

Planning Application Update

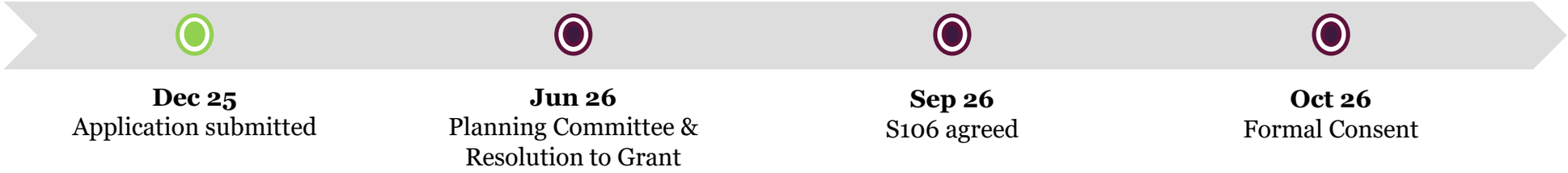
Planning Application Update

Despite the planning application being submitted on the 19th December 2025, the formal consultation process has been delayed due to the effects of the cyber-attack on RBKC.

RBKC have confirmed that the application is complete, have informally validated it (i.e. checked it is complete) and have commenced the procurement of independent reviews for key elements such as daylight/sunlight studies.

RBKC have recently noted that the Planning Portal is beginning to work sporadically and advised that the planning application is due to be formally validated and go live w/c 16th March 2026. The statutory consultation period will commence at this point.

RBKC have noted that they are aiming for a June 2026 (potentially July) planning committee. The Council has a large backlog to process as a result of the cyber-attack but have confirmed that RMCD is a priority project. Once a resolution to grant has been achieved, the process of final review with the GLA will commence along with negotiation of S106 conditions – with a target date for formal consent of October 2026 (potentially November depending on date of Planning Committee)



A senior leader meeting between Trust and RBKC Leader, Dep Leader and councillor responsible for Planning has been organised for 26th March 2026 (the week prior to Purdah commencing). The meeting is an opportunity to reinforce the importance of the project, our commitment to it, and the steps we are taking to be ready for commencing enabling/construction works at the end of 2026.

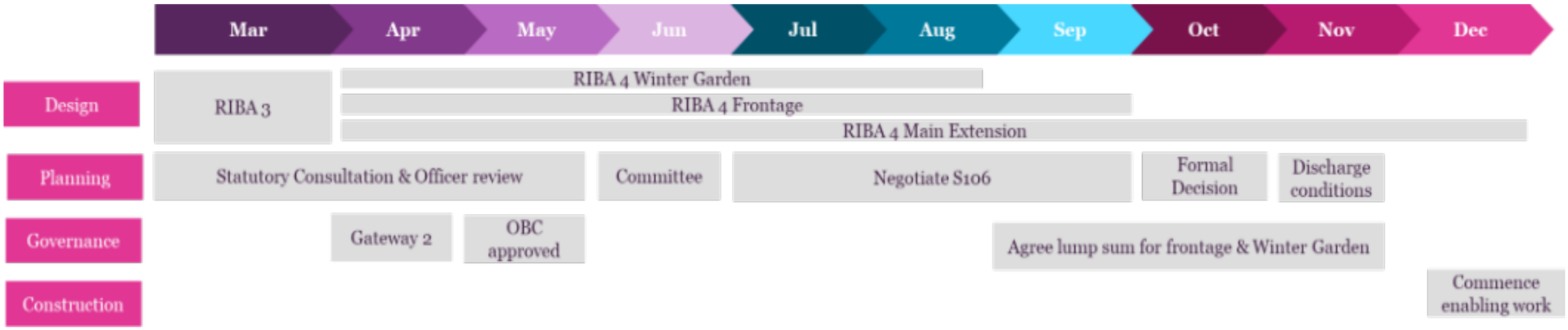
Recommendation – Public Board are asked to:

- **Note that the planning application is expected to go live on the RBKC portal in March which marks the start of the statutory consultation period.**
- **Note that RMCD is a priority project for RBKC.**
- **Note that a senior leader meeting between the Trust and RBKC is organised for 26th March.**

Key Milestones for 2026

The programme is on track for 2031 completion, with the next 12 months being critical.

During 2026 we will complete our technical design (RIBA 4), finalise the OBC, develop the FBC, secure planning approval, negotiate the fixed price for the Frontage and Winter Garden (Main Building is due February 2027) and commence early enabling works including some decant.



This will allow the programme to progress through to completion and approval of the Full Business Case, signing the contract and commencing construction in 2027.

Recommendation – Public Board are asked to:

- **Note that the programme is on track for 2031 completion with the next 12 months being critical as a number of different workstreams and approvals processes converge to enable construction to start.**

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 25 March 2026	**Agenda item:** 4.3
Title of Document: 2026/27 Plan Submission	**To be presented by:** Chief Finance Officer

1. Status For discussion and approval

2. Purpose:

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

3. Summary

The Trust submitted its rolling multi-year plan to NHSE on 12 February 2026. This plan included finance, activity, workforce and performance submissions as well as a triangulation template and a narrative document.

The Trust submitted performance trajectories in line with targets except for 62 days where the Trust modelled performance at c77%.

Workforce plans were set based on meeting all nationally required targets.

Although the Trust is forecasting achievement of a surplus of £7m for 2026/27, a breakeven plan was submitted to NHSE. There is significant uncertainty over the NHS income and the scale of efficiency required in year. The organisation will continue to work to understand and mitigate these risks to delivery with the aim of achieving a surplus plan for the year to support the future capital requirements of the organisation. Should these risks be mitigated, and a plan resubmission permitted, an updated plan will be made to NHSE. The Trust Board is asked to delegate approval of this return, if submitted in April, to the Audit and Finance Committee.

4. Recommendations / Actions

The Trust Board is asked:

- note the plan submission on the 12th of February 2026;
- delegate to the Chair and members of AFC the ability to submit a revised plan to NHSE if sufficient plan development occurs in line with a subsequent NHSE submission window in April or May.

2026/27 Plan Submission

1. Introduction

The Trust submitted a plan to NHS E on 12th February 2026.

This paper provides a summary of the February 2026 plan submission to NHSE and an update on the process for developing plan.

2. Background

The 10 Year Health Plan published in July 2025 set expectations for significant changes to the way that the NHS organises, funds and delivers services with three fundamental shifts outlined:

- Hospital to Community
- Analogue to Digital
- Sickness to Prevention

Historically NHS planning has been on a yearly basis, however following the publication of the 10 Year health plan, NHS organisations have been asked to take a longer-term view for planning. As such for February the Trust must submit.

- 3-year revenue and 4-year capital plan return
- 3-year workforce return
- 3-year operational performance and activity return
- integrated planning template showing triangulation and alignment of plans
- 5-year narrative plan
- Board assurance statements confirming oversight and endorsement of the totality of the plans

3. February Plan Submission

The February plan submission to NHSE encompassed:

- Finance
- Activity and performance
- Workforce

The key extracts from these submissions are summarised below.

The national team have invited Trusts to resubmit their plans on the 18th of March, if non-compliant. The Trust does not plan to participate in this submission for finance and workforce except for a small number of changes on capital following the confirmation of PDC allocations by NHSE. However, in relation to the activity submission, the Trust is meeting with NHSE regarding the 62-day target on the 16th of March. The CEO will assess whether this conversation enables a revised 62-day plan to be submitted.

The National team have said that a further plan submission may be available in April or May. At this point the work on mitigating the risks in the financial position may allow a revised financial position. The Trust Board is asked to delegate approval of a revised submission in April to the Audit and Finance Committee, if required.

Finance

Income and Expenditure

In the current financial year, the Trust has set a surplus plan of £5.5m and is forecasting to achieve a £7m surplus. There are significant non-recurrent benefits within this plan.

The Trust has an aspiration to achieve recurrent surpluses to support investment in the Chelsea development. The Trust is proposing to support the Chelsea New Build programme with £32.5m of capital, over the next five years, funded by surpluses utilising high-performing trust flexibility in the NHS financing regime.

However, there are two key risks influencing the current finance submission: NHS contracted income and efficiency plans. These risks are set out in detail below.

In light of these risks, the finance plan is currently set on assumptions that lead to a breakeven position.

	2026/27	2027/28	2028/29
Adjusted outturn position	(£14.4m)	(£10.0m)	(£10.0m)
Paediatric transfer	-	(£9.6m)	-
Deficit position including Paediatrics	**(£14.4m)**	**(£19.6m)**	**(£10.0m)**
NHS productivity, income and other movements	(£5.4m)	(£5.9m)	(£5.5m)
Investments	(£4.7m)	(£3.0m)	(£3.0m)
Deficit position before efficiencies	**(£24.5m)**	**(£28.5m)**	**(£18.5m)**
Baseline efficiency plan	£24.5m	£28.5m	£18.5m
Breakeven plan	**£0.0m**	**£0.0m**	**£0.0m**

Risk 1: NHS contracted income

NHS commissioned patient care income makes up approximately 50% of the Trust's total income. Although the Trust had been given the values proposed by commissioners for contracts in their December submission, it has not been provided with a breakdown of how these values were calculated. As such, the NHS income plan in the February submission was based on the Trust's understanding of commissioning rules, rather than the actual income proposals from NHS commissioners. Since the submission offers have been received from most organisations.

ICB Name	Status	
	Core ICB	Delegated ICB
NHS Thames Valles ICB	Contract offer received	Contract offer received
NHS Central East ICB	Contract offer received	Contract offer received
NHS Essex ICB	Contract offer received	Contract offer received
NHS Hampshire and Isle of Wight ICB	Contract offer received	Contract offer received
NHS Kent and Medway ICB	Not received	Contract offer received
NHS North Central and West London ICB	Contract offer received	Contract offer received
NHS North East London ICB	Contract offer received	Contract offer received
NHS South East London ICB	Contract offer received	Contract offer received
NHS Surrey and Sussex ICB	Contract offer received	Contract offer received
NHS South West London ICB	Contract offer received	Contract offer received
Spec comm - London Regional Office	Contract offer received	

For the Trust, the difference in offers is currently valued at £12m (commissioners lower than Trust expectations), creating a material difference in valuation. There is a further £2m gap from nationally commissioned work.

The Trust is in discussion with commissioners in order to align contract values, which would then provide a full understanding of the income position.

Detailed activity planning shows an associated risk about the level of activity purchased by commissioners. As the contract figures have not been agreed with commissioners, the planning assumptions for income may not reflect the funding in the contracts. Although this risk has been mitigated in the financial plan by offsetting growth income with growth costs, if growth is not funded the Trust may need to review the feasibility of activity plans.

Risk 2: Efficiencies

Historically a significant portion of the Trust's annual efficiency target has been met through growth of private patient income and significant non recurrent schemes.

Whilst there is an established record of identifying and delivering efficiency the nature of this year's plans mean that programmes need to have a greater balance of recurrent, cash-generating efficiencies to support the target I&E expectations.

Detailed bottom-up plans are in active development with key areas of focus being:

- Private Patients income growth
- Commercial opportunities
- Transformation programmes
- Procurement
- Benchmarking and productivity reviews

Capital

The Trust has developed a balanced capital plan based on the I&E assumptions above. This is summarised in the tables below.

Capital funding applications £m	2026/27	2027/28	2028/29	2029/30
Estates	25.5	49.6	22.1	14.5
Chelsea Development (RMCD)	31.5	16.8	26.9	50.8
Digital	4.6	2.2	1.6	3.1
Medical Equipment	17.7	23.2	13.9	9.7
Total	**79.3**	**91.8**	**64.5**	**78.1**

Capital funding sources £m	2026/27	2027/28	2028/29	2029/30
Operational CDEL allocation	24.5	28.5	24.9	25.4
Incentive CDEL allocation	5.3	7.0	-	-
Public Dividend Capital (PDC) CDEL	18.6	36.4	10.0	-
NHSE CDEL*	-	1.6	14.6	10.8
Donated Medical Equipment	13.2	7.2	3.0	3.0
Donated RMCD	17.7	11.1	12.0	38.9
Total	**79.3**	**91.8**	**64.5**	**78.1**

* Subject to confirmation with NHSE

The plan is based on the rolling five-year capital plan. However, there are assumptions that it is has been necessary in order to achieve compliant capital based on the information shown:

- RMCD expenditure over the next four years is assumed to be covered by funding from RMCC, NHSE CDEL and contributions from trust capital. However, work continues with NHSE to confirm how the NHS CDEL contribution will be made up.

- Donated RMCD funding is aligned to RMCC expectations for 2026/27. For subsequent years the level of funding is aligned to the assumptions agreed previously with RMCC about the timing of donations.
- Funding for donated medical equipment beyond 2027/28 has been assumed to be at £3m p.a., but this has not yet been agreed with RMCC.
- Several large schemes for which PDC funding is being sought, including Radiopharmacy and Genomics Superlab, have not been included in the plan as NHSE has not approved their inclusion.
- Capital scheme progress might be impacted if recurrent and cash-generating efficiencies across the Trust are not identified to compensate for the I&E impact of capital charges.

Performance Trajectories

The operational planning guidance set out required compliance thresholds for the access targets. The Trust submitted trajectories to meet most of these performance requirements, however, to achieve this, the 62-day RTT standard will require action from across the system to improve timely referrals to RM. Therefore, the Trust submitted a non-compliant plan for this target of 77%.

Performance Standard	Target	Submission
RTT	92% compliance	Maintain compliance
28-day Faster Diagnosis	80% compliance	Maintain compliance
62-day referral to treatment	80% compliance by March 2027 85% compliance by March 2029	Not achieved
31 Day treatment	96% compliance by March 2027	Maintain compliance
DM01 – diagnostic standard	95% compliance by March 2027 99% compliance by March 2029	Maintain compliance Achieve target

Activity

The activity plan baseline was curated utilising data from Months 1-6 2025/26. The internal activity plan is available by Point of Delivery (POD, i.e. activity type) and Clinical Business Unit and included comprehensive activity within the organisation. The requirements for the NHSE submission excluded some cohorts of activity based upon the national criteria such as chemotherapy. The final submission was broken down further by commissioner.

Seasonality has been apportioned by working days based upon the previous year's activity trends and further adjustment considered for summer months as required. Initial activity growth has been applied based upon a detailed planning exercise alongside the clinical units and agreement with each clinical unit to identify where a standard 2%, 2-year CAGR or 1-year prevailing growth is most appropriate. Activity growth for PP applied a standard 0.6% growth across all PODs with further application of approved business cases. Following discussions with SWL ICB no provision for growth within the system has been accounted for and therefore all growth assumptions are made at risk to the Trust.

Following the initial business planning workshop where growth projections were agreed with all clinical units, approved business cases and local knowledge of service developments have been applied to the activity plans across NHS and PP activity. This includes horizon scanning of treatment changes, efficiency programmes and updates to national guidance.

The following details the overall growth across each POD for the Trust, further split by NHS and PP activity for the internal plan including all activity:

Activity Type	Total Trust Growth	NHS Growth	PP Growth
Referrals	4.80%	6.00%	1.30%
Outpatient Firsts	1.70%	3.00%	4.40%
Outpatient Follow Ups	3.50%	3.00%	5.10%
Elective Overnight Inpatients	2.00%	2.00%	2.30%
Day cases	2.10%	2.30%	0.80%
Non-elective Overnight Inpatients	1.40%	2.00%	0.60%
Non-Elective 0-day LOS	1.80%	2.00%	0.60%
General bed nights activity	1.60%	1.90%	0.60%
CCU bed nights activity	1.50%	1.80%	0.60%
MDU activity	1.90%	2.00%	1.70%
Radiotherapy	2.90%	3.30%	0.70%
Imaging activity	2.90%	3.50%	0.60%

Workforce

The workforce plan was set based on:

- Consideration of any expected service redesigns, TUPE movements or expected structural changes to contribute to the business plan, this may include skill mix, extended working weeks or out of hours provision.
- Review of hard-to-fill posts, new roles, succession planning and training requirements.
- Review of embedding eRostering to identify efficiencies and any impact on establishments
- The current workforce plan assumes that the majority of the productivity gains are as a result of improving the efficiency of our activity rather than reducing headcount. This may change as the efficiency programme is further developed

In addition, the workforce plan was set to meet the requirements in the medium-term planning framework:

Area	Requirement	Submission
Agency and Bank	2026/27 – agency £1.949k; bank £16,661k 2027/28 – agency £1,253k; bank £15,412k 2028/29 – agency £557k; bank £14,256	Meet target
Resident doctor	Implementation of 10-point plan to improve resident doctors' working lives	Meet requirement
Sickness rate	Reduction to below the national average level of 4.1%	Meet requirement
Consultant job planning	Ensure that 95% of medical job plans are signed-off with the business cycle, underpinned by service level demand and capacity planning	Meet requirement
	by the end of 202026/27, ensure a system for monitoring and assurance is in place for tracking job planned activity	Meet requirement
	by the end of 2027/28, achieve tracking of job planned activity for the full year	Meet requirement
	by the end of 2028/29, ensure multiprofessional service level activity and job planning are in place	Meet requirement
Reformed statutory/mandatory training framework	Implementation of the framework due for publication in March 2026	Meet requirement

4. Board Assurance Statements and Narrative

The plan submission comprised:

- individual workforce, finance and activity and performance template.
- an integrated triangulation template, for workforce, activity and finance and board assurance statements.
- Plan delivery narrative.

These submissions, were prepared by the relevant directors and reviewed by the Executive, are covered by the Board assurance statements.

The plan assurance statement governing these submissions is set out in appendix 1.

5. Conclusion

The Trust submitted a breakeven plan in February, based on the key risks outstanding relating to income and efficiencies.

The Trust will work to gain greater clarity about the impact of these risks and to assess what this will mean for any future submission.

6. Recommendation

The Board is asked to:

- note the plan submission on the 12th of February 2026;
- delegate to the Chair and members of AFC the ability to submit a revised plan to NHSE if sufficient plan development occurs in line with a subsequent NHSE submission window in April or May.

Appendix 1: Board Assurance Statements

Updates since first submission	Assurance Statement	Maturity	Comment
No change	1. The board has reviewed the outputs from the foundational work undertaken as part of phase one of planning. This includes reviewing demand and capacity analysis.	1	Commenced capacity review of services with high levels of demand and growing waiting lists such as Gynaecology as a priority. Applied principles of NHSE Flow tool adopted, however due to complexities of cancer pathways and ongoing off-treatment care of patient pathways these have been adapted to suit the needs of the Trust.
Updated	2. The board can confirm strong clinical leadership has been involved in the development of plans.	1	The Trust has a 5-year clinical strategy that has been developed with clinical leaders. The strategy reflects organisational and national priorities.
Updated	3. The board can confirm that plans reflect the consideration of population needs, underserved communities and inequalities when developing plans.	1	The development of the Trust's plan is carried out in conjunction with the ICB. The CEO, CFO, COO and CPO are linked with their corresponding professional networks in the ICB to ensure plan alignment.
Updated	4. Robust quality and equality impact assessments (QEIA) have been underway or are planned to be undertaken and reviewed by the board to inform the sign off of the organisation's plan.	2	QEIA process is undertaken for CIPs, schemes were reviewed by CMO and CNO. Business cases approved during the year and in the business planning go through a QEIA process.
Updated	5. The board has played an active role in setting direction, reviewing drafts, and constructively challenging assumptions during the plan's development.	1	The development of the Trust's plan has been taken to the Board, Board away day, the Audit and Finance Board sub-committee and Executive Leadership Committee.
No change	6. The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability.	1	The Trust has a well-established and well-resourced Transformation team with a clear and transparent prioritisation process for resourcing change projects split between those that aim for organisational efficiency and those that aim for new service development/innovation. This is brought together at a 6 weekly transformation board but also accountable to our Finance and Performance Committee (FPC) and ultimately Executive Board. Priorities are based on multiple sources of information including top-down productivity analysis led by the finance team, strategic priorities set in the clinical and research strategies, performance concerns flagged by the Informatics team and bottom-up divisional concerns. We have demonstrable evidence of achieving significant, Trust wide change programmes with minimal disruption and demonstrated an ability to delivery on service level change.
No change	7. The board confirms that the organisation has established structures to work effectively with commissioners and system partners, ensuring that system working is constructive and efficient.	1	Refer to #3.
No change	8. The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across three years is realistic.	1	The development of the Trust's plan has been taken to the Board, Board away day, the Audit and Finance Board sub-committee and Executive Leadership Committee.
No change	9. The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent.	1	The development of the Trust's plan has been taken to the Board, Board away day, the Audit and Finance Board sub-committee and Executive Leadership Committee.
Updated	10. The Board can confirm that the organisation has fully considered and incorporated productivity opportunities into plans, and that any phasing is credible and realistic. The board can provide justification where any identified opportunities cannot be fully delivered during this planning round, especially in the context of decisions to submit non-compliant financial or performance plans or plans that do not deliver the 2% productivity improvement.	1	Refer to #6.
No change	11. The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.	1	As evidence by Board Assurance Framework, reviewed by the Board, and the risk register, reviewed by the Quality and Risk Committee.
Updated	12. The board can confirm that that the organisation has engaged with its ICB to ensure contract values used in planning submissions are agreed across (commissioner and provider) activity and financial plans.	1	Work is progressing to ensure that contract values used in planning submissions are consistent across commissioner and provider activity and financial plans. This alignment is essential to support accurate system-wide forecasting, reduce the risk of material variances between organisations, and provide assurance that both parties are planning on a unified financial baseline. Consistent contract values also strengthen the integrity of the overall submission by ensuring that activity assumptions, payment mechanisms and financial envelopes are aligned and reconcilable across the system.

Updates since first submission	Assurance Statement	Maturity	Comment
No change	13. The board can confirm that there is an effective process in place to manage the sign-off of contracts.	1	The organisation has a well-established process for the review and sign-off of contracts, supported by clear governance arrangements, defined delegated authority, and coordinated oversight from Finance, Contracting and Executive teams. This process ensures that all contractual changes are subject to appropriate scrutiny, align with organisational priorities, and comply with national requirements.
No change	14. The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the board.	1	The development of the Trust's plan has been taken to the Board, Board away day, the Audit and Finance Board sub-committee and Executive Leadership Committee.
Updated	15. The board can confirm the impact of the 10 Year Health Plan on the workforce has been considered in the development of plans. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention.	1	The development of the Trust's plan has been taken to the Board, Board away day, the Audit and Finance Board sub-committee and Executive Leadership Committee.
New	16. The board can confirm that the organisation has worked with its ICB to ensure their plans are fully aligned.	1	The Trust has been working closely with the ICB to understand plan alignment.
New	17. The board can confirm plans have been developed in line with the ambition to move care from hospital to community and this shift is evident in plan returns and the integrated delivery plan.	2/3	Through its engagement with the hosted cancer alliance, the Trust is prospecting for appropriate opportunities to deliver care closer to the community. However, the specialist nature of the Trust's patient cohort does not readily lend itself to community provision.
New	18. The board can confirm that the five-year integrated delivery plan is fully aligned with the numerical returns.	1	Evidenced in the plan submission paper.

Descriptors of the scoring used in the table above.

1. Embedded: The action is fully integrated into normal operations. It is standardised, sustainable, and reinforced by policy, leadership, systems, and culture. Continuous improvement is an established norm, and outcomes are consistently positive.
2. Maturing: The action is becoming routine. There are documented processes, growing staff awareness, and increasing consistency across teams. Evaluation and improvement mechanisms may be in place but are not yet fully optimised.
3. Developing: Steps have been taken to introduce and implement this action. There may be informal processes, or isolated examples of good practice, but they lack consistency, coordination, or broad awareness.
4. Not Embedded: There is little to no evidence that this action has started. If it has, it's ad hoc, inconsistent, or heavily reliant on individuals rather than being supported by systems or structures.

The ROYAL MARSDEN
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BOARD PAPER SUMMARY SHEET

Date of Meeting: 25 March 2026	**Agenda item:** 4.4
Title of Document: Staff Survey Results 2025	**To be presented by:** Chief People Officer

1. Status **To note**

2. Purpose:

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

3. Summary

- This report provides an overview of the Trust's performance, identifying year on year changes and highlighting priority areas requiring focused action.
- The 2025 National NHS Staff Survey took place between September and November 2025.
- A total of 2,443 responses were received, giving a response rate of 49.01% - an increase from 43.8% in 2024.
- The 2025 Staff Survey shows the Trust continues to perform strongly across the People Promise themes, with the majority of scores exceeding those of comparable organisations.
- Scores for the themes of *'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' and 'We are a team'* are significantly better than similar organisations.
- Trust, Diversity and Equality scores have improved since 2024 with an ongoing programme of work to improve staff experience further. Inclusion scores remain higher than the sector benchmark.

  Full report will follow.

4. Recommendations / Actions

The Board is asked to note the results and next steps.

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2025 NHS Staff Survey Results

The Royal Marsden NHS Foundation Trust
Results Summary

NHS

Context

- The National NHS Staff Survey was carried out from September to November 2025.
- Results are reported against the seven People Promise elements, plus two longstanding themes: Staff Engagement and Morale.
- Within each of the elements are subcategories, which the Trust are scored against (see table).
- The Trust is benchmarked against the 'Acute Specialist Hospitals'* sector.
- Comparison with London Trusts is underway and will be shared separately.

*Please see Appendix 1 for List of Acute Specialist Trusts

People Promise elements	Sub-scores
We are compassionate and inclusive	Compassionate culture
	Compassionate leadership
	Diversity and equality
	Inclusion
We are recognised and rewarded	No sub-score
We each have a voice that counts	Autonomy and control
	Raising concerns
We are safe and healthy	Health and safety climate
	Burnout
	Negative experiences
	Other questions [Not scored]
We are always learning	Development
	Appraisals
We work flexibly	Support for work-life balance
	Flexible working
We are a team	Team working
	Line management
Themes	**Sub-scores**
Staff Engagement	Motivation
	Involvement
	Advocacy
Morale	Thinking about leaving
	Work pressure
	Stressors

Performance Summary (1)

- The Trust Response rate for 2025 was 49% compared to 43.8% in 2024.
- Across all the seven People Promises, scores have either improved or there has been no significant change compared to 2024.
- We have not seen a decline against any of the overall People Promise elements scores compared to 2024.
- Overall, Staff Engagement and Morale also remain strong areas for the Trust.
- When comparing the results against Acute Specialist Trusts, we are above the average scores across all the People Promise elements and themes.
- Compared with our 2024 results, we have seen a significant improvement against the following People Promise elements and theme since 2024:
    - We are Compassionate and Inclusive
    - We are Safe and Healthy
    - We are a Team
    - Morale

Performance Summary (2)

Our strongest results for 2025 are:

- We are Compassionate and Inclusive
- Staff Engagement
- We have a voice that counts
- We are a team

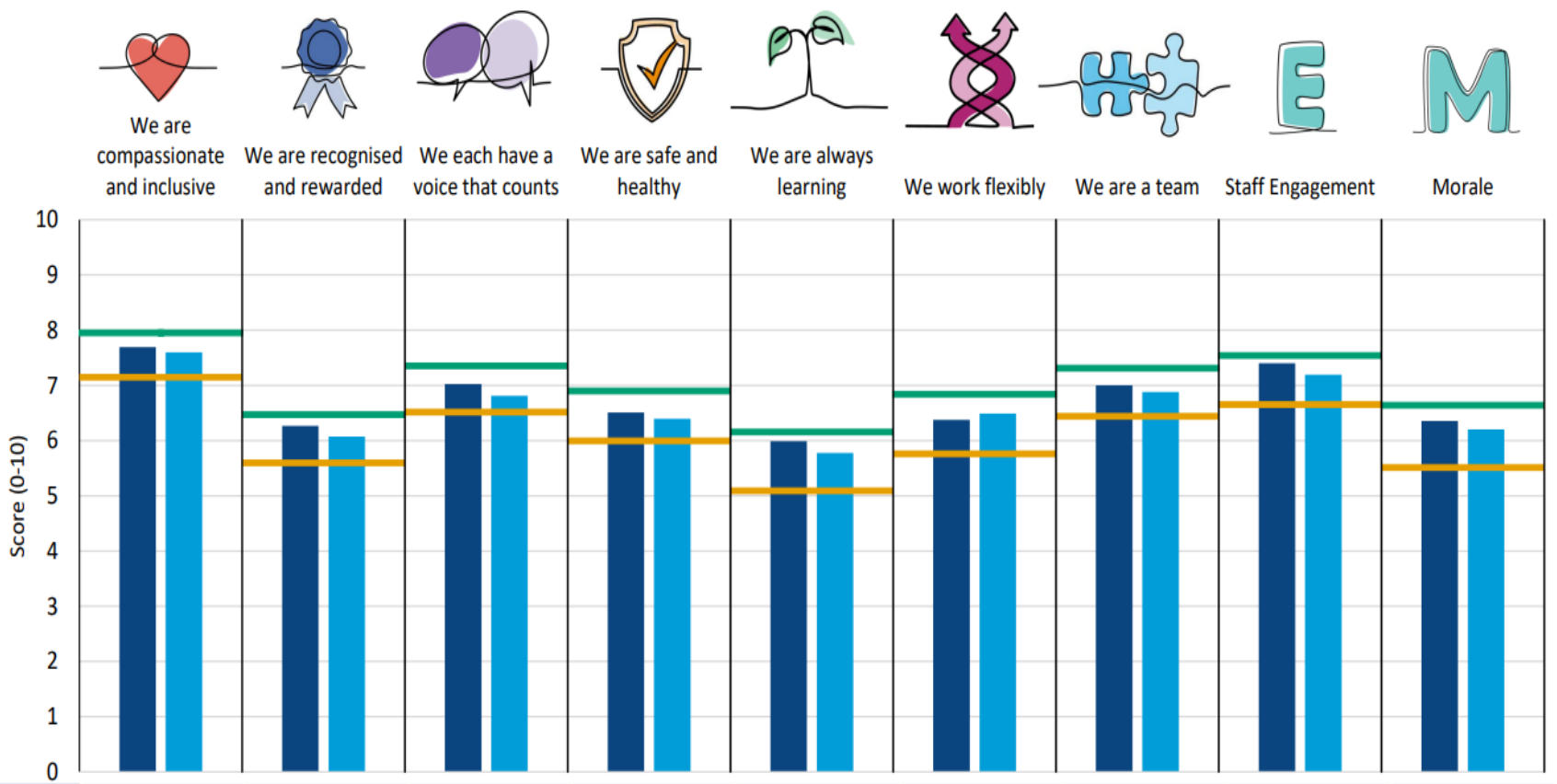
Other high scores include:

- 91% of our staff would recommend the Trust to their Family and/or Friends for Treatment
- 89.2% of staff said the care of patients / service users is the Trusts top priority
- 90.2% feel their role makes a difference to service users / patients

Comparison of Trust Scores against Specialist Acute sector

This table illustrates the Trusts performance against the best and worst scores within our benchmarking group.

We have used the average result as our comparator.



	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	7.69	6.27	7.03	6.51	5.99	6.37	7.00	7.40	6.35
Best result	7.95	6.47	7.35	6.90	6.16	6.84	7.31	7.54	6.64
Average result	7.60	6.07	6.81	6.39	5.77	6.49	6.88	7.19	6.20
Worst result	7.15	5.60	6.52	5.99	5.09	5.76	6.44	6.65	5.51
Responses	2439	2439	2418	2427	2376	2421	2436	2442	2442

Trust Performance Overview: 2024 v 2025 results

The People Promise elements, themes and sub-category scores are based on a 0-10 scale

People Promise/Theme	Trust 2024	RAG Rating comparison 2024 vs 2025	Trust 2025	Narrative
Theme – Staff Engagement	7.42		7.40	A steady result
Theme – Morale	6.28		6.35	One of our strongest areas for 2025
We are compassionate and inclusive	7.55		7.69	One of our strongest areas for 2025
We are recognised and rewarded	6.20		6.27	A positive increase
We each have a voice that counts	7.01		7.03	A steady increase
We are safe and healthy	6.43		6.51	One of our strongest areas for 2025
We are always learning	5.98		5.99	A steady increase
We work flexibly	6.33		6.37	A positive increase
We are a team	6.92		7.00	One of our strongest areas for 2025

Key Focus Areas for 2026

Whilst we have performed positively overall, we recognise there needs to a focus on some areas where we have scored lower within the subcategories.

Equality and Diversity (People Promise - We are Compassionate and Inclusive):

- Overall, we have seen an improvement on last year, which is positive. When reviewing the subcategory data, we recognise there is some room for improvement.

Sexual Safety (People Promise – We are Compassionate and Inclusive, Equality and Diversity)

- Although our score has improved since 2024 and remains above the sector average, we have seen an increase in staff receiving unwanted behaviour of a sexual nature from patients, relatives and/or members of the public.

Work life balance (People Promise - We work flexibly)

- We have performed well overall compared with 2024 and remain above the sector average. We recognise the importance of supporting staff to achieve a good balance between work and home life while continuing to deliver our operational and clinical priorities

Subcategory – Equality and Diversity

For these subcategories, the lower the score the better.

Discrimination from Patients/Relatives and or members of the Public

- When compared to our Trust score for 2024, we have **not** seen a change in this score. However, if we compare this to the Sector, we are above (7.6% and 5.3% respectively).
- It is important that we continue to monitor these issues and encourage staff to report any concerns arising from patient or relative interactions so appropriate support can be provided.

Discrimination from manager/team leader and or colleagues

- As a Trust we have seen an improvement compared to 2024, which is positive news for the Trust.
- When comparing with the Sector score, we are slightly above the sector average.
- Over the last 9 months, the Trust has embarked on an Inclusive Culture Programme which aims to accelerate the development of a fair, values-driven and high-performing culture by building on the Trust's existing strengths and the insights gathered through staff conversations, diagnostics, and the "everyone matters" conference. This work is now in development phase, and the plan will be presented to the People and Culture Board for approval and then a move to implementation stage.

Subcategory – Sexual Safety

The survey asked two questions about whether staff had experienced unwanted behaviours of a sexual nature from a) patients/public/relatives and b) staff/colleagues. In response to these questions:

a) Patients

- In 2025 we saw this score increase by 1.2% compared to 2024. We remain lower than the average sector score (3.8%).
- Nationally, this score has increased so we are not an outlier and indicates a better reporting culture at a local and national level.

b) Staff /colleagues

- This has increased by 0.7% compared to 2024 and we remain below the average sector score.
- The Trust signed up to the NHS Sexual Safety Charter in (2023) and continues to be committed to robust monitoring and reporting of all incidents of unwanted sexual conduct involving patients or staff. Through our participation in the London Sexual Safety Group, we continue to strengthen our learning, support systems and organisational response.

Subcategory – Work life balance

There are two subcategories under People Promise "**We Work Flexibly":**

Support for Work Life Balance

- Staff were asked the following questions under this subcategory:
  - Q6b "My organisation is committed to helping me balance my work and home life."
  - Q6c "I achieve a good balance between my work life and my home life."
  - Q6d "I can approach my immediate manager to talk openly about flexible working."

- Compared to 2024, we have performed better and this trend has continued since 2021. We are also above the sector average.

Flexible Working

- Staff were asked about "The opportunities for flexible working patterns."
- Our score has remained the same across 2024 and 2025.
- While we have improved or maintained performance for this element, our score remains just below the sector average, though the difference is small. Nevertheless, this remains a strategic priority. We are working closely with our clinical teams to enhance the effective use of our rostering system, recognising that robust rostering practices are fundamental to supporting staff in achieving a healthy work/life balance.

Subcategories – A glance

- The next slide gives an overall view of our performance for the subcategories compared to 2024 and the average sector score.
- Overall, our scores are consistent and do not show a significant decline in any of the subcategories.
- Divisions will review their local results and, alongside the three identified focus areas, will take a more targeted approach to developing action plans for improvement.

Subcategory Performance Overview

People Promise/ Theme	Sub Theme	Trust 2024	Trust 2025	Sector 2025
Theme – Staff Engagement	Motivation	7.09	7.02	6.91
	Involvement	7.12	7.12	6.92
	Advocacy	8.03	8.06	7.62
Theme – Morale	Thinking about leaving	6.16	6.33	6.0
	Work Pressure	6.06	6.07	5.63
	Stressors	6.64	6.66	6.50
We are compassionate and inclusive	Compassionate Culture	8.03	8.06	7.72
	Compassionate Leadership	7.10	7.20	7.13
	Diversity and Equality	8.06	8.45	8.54
	Inclusion	7.01	7.06	6.91
We are recognised and rewarded		6.20	6.27	6.05
We each have a voice that counts	Autonomy and Control	7.20	7.20	7.03
	Raising Concerns	6.82	6.86	6.69

People Promise/ Theme	Sub Theme	Trust 2024	Trust 2025	Sector 2025
We are safe and healthy	Health and Safety Climate	5.98	6.02	5.70
	Burnout	5.24	5.21	5.13
	Negative Experiences	8.06	8.28	8.21
We are always learning	Development	6.79	6.69	6.47
	Appraisals	5.16	5.28	5.04
We work flexibly	Support for work life balance	6.37	6.46	6.34
	Flexible Working	6.29	6.29	6.24
We are a team	Team Working	6.87	6.93	6.78
	Line Management	6.96	7.07	6.98

Staff Group Results

Scores by Staff Group are compared against the Trust's score and not sector average.

Significant improvements in several groups across themes:

- We are compassionate and inclusive - Additional Clinical Services (i.e. Healthcare Assistant, Trainee Pharmacist)
- We are safe and healthy – Allied Health Professionals (Dietitian, Radiographer – Diagnostic)
- We are a team – Medical and Dental

Staff Groups who performed consistently below Trust Scores across People Promises and Themes are:

- Add Prof Scientific and Technic (Psychologist, Technician)
- Estates and Ancillary
- Healthcare Scientists (Biomedical Scientist, Clinical Scientist)
- Additional Clinical Services

As part of Divisional Action plans, leads will focus on specific staff groups and departments to understand the variations and implement targeted actions to drive improvement.

Conclusion

- The Trust has delivered a strong and stable set of results, with improvements across multiple People Promise themes and continued performance above sector averages.
- No overall theme declined compared with 2024, and staff advocacy and engagement remain notable strengths.
- Response rates improved, and several staff groups demonstrated meaningful progress across key areas.
- ·Subcategory results show positive trends.
- We will Focus on 3 key areas include:
  - Equality and Diversity
  - Sexual Safety
  - Work Life Balance
- These areas will be prioritised alongside Divisional plans, ensuring targeted actions are implemented at department level to deliver meaningful improvement.

The ROYAL MARSDEN
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Link to Trust full survey results:

Local results for every organisation | NHS Staff Survey

NHS

Appendix 1 – List of Acute Specialist Trusts

1. Great Ormond Street Hospital for Children NHS Foundation Trust
2. Liverpool Heart and Chest Hospital NHS Foundation Trust
3. Liverpool Women's NHS Foundation Trust
4. Moorfields Eye Hospital NHS Foundation Trust
5. Queen Victoria Hospital NHS Foundation Trust
6. Royal National Orthopaedic Hospital NHS Trust
7. Royal Papworth Hospital NHS Foundation Trust
8. The Christie NHS Foundation Trust
9. The Clatterbridge Cancer Centre NHS Foundation Trust
10. The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
11. The Royal Orthopaedic Hospital NHS Foundation Trust
12. The Walton Centre NHS Foundation Trust

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BOARD PAPER SUMMARY SHEET

Date of Meeting: 25 March 2026	**Agenda item:** 5.1
Title of Document: Quality Account Q3	**To be presented by:** Interim Chief Nurse

1. Status

2. Purpose: For Information and review

Relates to:

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

3. Summary

Effective Care:

Patient % SACT/MDU infusion patients starting <1hr of appointment: Performance this quarter was 83-83.9%. Consistently three of the four branches continue to be above 85%. Ongoing focus on Sutton performance, in Olayan and Children's Day Unit/TYA. Breach analysis planned next quarter to inform forecast.

Safe Care:

Healthcare Associated Infections (hospital and community onset): Both Clostridioides difficile and Pseudomonas aeruginosa BSI, assuming a straight line forecast the Trust will be within the NHSE-set threshold at end of the year. However, E.Coli and Klebsiella BSIs, are likely to breach. The IPCT reviewed each E.Coli BSI over a period of seven months, gut translocation in neutropenic patients was identified as a key mechanism. No infection was linked to urinary catheter/CVADs.

Patient Falls: 67 actual falls this quarter, 4.5 falls/1000 bed days. One moderate harm (L1 vertebrae fracture). Poor patient compliance with falls prevention strategies being seen across the Trust- ongoing work with therapies to examine the cause of this, interventions to support patient compliance will feed into the quality improvement project planned in Q4.

Medication incidents: No moderate medication harms this quarter.

Venous thromboembolism (VTE): Compliance across the Trust continues to be above the national KPI of 95%. Education and training for both patients and staff continue to be a key goal of the VTE committee. The VTE policy has been reviewed and split into two separate policies, for ease. A focus on VTE in Trusts Big 4 published this quarter.

Hospital Acquired Pressure Ulcers (HAPU): 23 acquired pressure injuries this quarter, 13 device-related, all injuries low harm and healed. Level 1 Tissue Viability Course- 439 staff have completed this training.

Deteriorating Patient: Two calls for concern, one met the criteria, the patient had had recent review by their clinical team, CCOT reviewed, no concerns. Ongoing pilot of the patient wellbeing questionnaire, the third component of Martha's Rule, which is now with Epic analyst team for build, trust wide launch April 2026.

Caring and Responsive:

Patient experience and Complaints: Inpatient FFT 99%, and Outpatient FFT 93% (below the national average). The volume of respondents was significantly lower because of a provider change and a temporary interruption to service during the implementation of the new system. Percentage of complaints responded to in the required timescale increased to 83.3%. The rate of written complaints per 1000-day cases and IP discharges has increased to > 2.0 in the last couple of months.

Well Led:

Nursing Recruitment, Turnover and Retention: All divisions continue to perform strongly with turnover rates at or below the 7% target.

Multi-professional vacancy rates and recruitment: The Recruitment Services have been brought back in house, allowing greater control, flexibility, and oversight of the end-end recruitment process, in Q4 there is a dual running process in place.

4. Recommendations / Actions

The Board is asked to note the Quality Account.

The Royal Marsden
NHS Foundation Trust

Quality Account
JANUARY 2026 (December data) & Q3 Summary

NHS

Executive Summary- Quarter 3 (Oct/Nov/Dec 2025)

Key headlines:

Effective Care:

Patient % SACT/MDU infusion patients starting <1hr of appointment: Performance this quarter was 83-83.9%. Consistently three of the four branches continue to be above 85%. Ongoing focus on Sutton performance, in Olayan and Children's Day Unit/TYA. Breach analysis planned next quarter to inform forecast.

Safe Care:

Healthcare Associated Infections (hospital and community onset): Both Clostridioides difficile and Pseudomonas aeruginosa BSI, assuming a straight line forecast the Trust will be within the NHSE-set threshold at end of the year. However, E.Coli and Klebsiella BSIs, are likely to breach. The IPCT reviewed each E.Coli BSI over a period of seven months, gut translocation in neutropenic patients was identified as a key mechanism. No infection was linked to urinary catheter/CVADs.

Patient Falls: 67 actual falls this quarter, 4.5 falls/1000 bed days. One moderate harm (L1 vertebrae fracture). Poor patient compliance with falls prevention strategies being seen across the Trust- ongoing work with therapies to examine the cause of this, interventions to support patient compliance will feed into the quality improvement project planned in Q4.

Medication incidents: No moderate medication harms this quarter.

Venous thromboembolism (VTE): Compliance across the Trust continues to be above the national KPI of 95%. Education and training for both patients and staff continue to be a key goal of the VTE committee. The VTE policy has been reviewed and split into two separate policies, for ease. A focus on VTE in Trusts Big 4 published this quarter.

Hospital Acquired Pressure Ulcers (HAPU): 23 acquired pressure injuries this quarter, 13 device-related, all injuries low harm and healed. Level 1 Tissue Viability Course- 439 staff have completed this training.

Deteriorating Patient: Two calls for concern, one met the criteria, the patient had had recent review by their clinical team, CCOT reviewed, no concerns. Ongoing pilot of the patient wellbeing questionnaire, the third component of Martha's Rule, which is now with Epic analyst team for build, trust wide launch April 2026.

Caring and Responsive:

Patient experience and Complaints: Inpatient FFT 99%, and Outpatient FFT 93% (below the national average). The volume of respondents was significantly lower because of a provider change and a temporary interruption to service during the implementation of the new system. Percentage of complaints responded to in the required timescale increased to 83.3%. The rate of written complaints per 1000-day cases and IP discharges has increased to > 2.0 in the last couple of months.

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Nursing Recruitment, Turnover and Retention: All divisions continue to perform strongly with turnover rates at or below the 7% target.

Multi-professional vacancy rates and recruitment: The Recruitment Services have been brought back in house, allowing greater control, flexibility, and oversight of the end-end recruitment process, in Q4 there is a dual running process in place.

Executive Summary

Key headlines:

Effective Care:

Patient % SACT/MDU infusion patients starting <1hr of appointment: Performance in December was 83.9% with the average waiting time of 34 minutes. Three of the four branches continue to be above 85%. Continued focus on Sutton performance, breach analysis planned in Sutton to inform forecast.

Safe Care:

Healthcare Associated Infections (hospital and community onset): Both Clostridioides difficile and pseudomonas aeruginosa BSI, assuming a straight line forecast the Trust, will be within the NHSE-set threshold at end of the year.

Patient Falls: 18 actual falls, none with moderate harm. Pre-assessment team are planning some patient education related to bowel preparation. And ongoing review of falls information leaflet.

Medication incidents: There were three critical medication incidents; a delay of prescribing antibiotics for a patient who had spiked in outpatients, a delay in supplying insulin from pharmacy and a patient's insulin was incorrectly withheld which resulted in hyperglycaemia.

Venous thromboembolism (VTE): Education and training for both patients and staff continues to be a key objective of the VTE committee. Harm Free Care Link Practitioners fully embedded within clinical areas; representatives will formally join the VTE committee as part of their role in January 2026.

Hospital Acquired Pressure Ulcers (HAPU): Nine acquired pressure injuries this month, 55% device related, all injuries low harm and healed. Level 1 Tissue Viability Course- 439 staff have completed this training.

Deteriorating Patient: No calls for concern, ongoing pilot of the patient wellbeing questionnaire, the third component of Martha's Rule, which is now with Epic analyst team for build, trust wide launch April 2026.

Caring and Responsive:

Patient experience and Complaints: Inpatient FFT 99%, and outpatient FFT 93% (below the national average). The volume of respondents was significantly lower because of a provider change and a temporary interruption to service during the implementation of the new system. Percentage of complaints responded to in the required timescale increased to 83.3%. The rate of written complaints per 1000-day cases and IP discharges has increased to > 2.0 in the last couple of months.

Well led

Nursing Recruitment, Turnover and Retention: All divisions continue to perform strongly with turnover rates at or below the 7% target.

Multi-professional vacancy rates and recruitment: The Recruitment Services have been brought back in house, allowing greater control, flexibility and oversight of the end-end recruitment process, in Q4 there is a dual running process in place.

Patient % SACT/MDU infusion patients starting treatment < 1 hour of appointment (1/2)

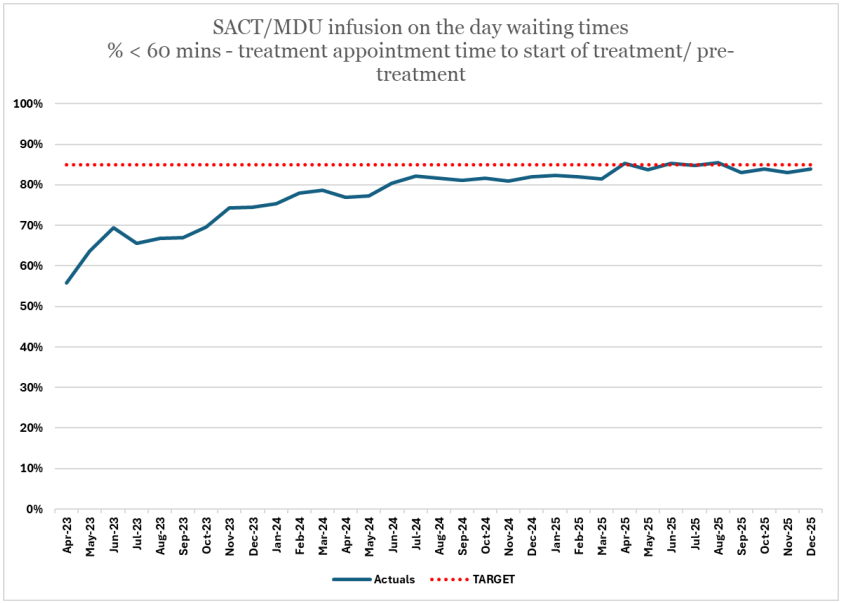
Update:

- Performance in December was 83.9% (slight improvement on November when it was 83.1%). The Trust met the standard in April, June, and August 2025.
- The average waiting time for December was 34 minutes (stable with November).
- Three of the four branches continue to be above 85%. The branch breakdown for December: Chelsea (93.1%); Cavendish Square (94.5%);Kingston (85.2%); Sutton (78.1%).
- All three private medical day units (Chelsea PP MDU, Sutton PP MDU and Cav Square) , Chelsea MDU and Kingston MDU all consistently meet the 85% standard.

Key issues & actions/next steps:

- Sutton position is driven by Olayan day care unit (77.1% in December, an improvement) and Children's Day Unit (69.5%)/TYA(67.4%) - continues to be the focus.
- Further analysis of OCC MDU and CDU/TYA on the day waiting time data (tumour group, one-stop vs two stop, drug). In addition rolling monthly breach review of units <85% (commenced in January 2026).
- Developing the presentation of pre-prescribing data to present to medical oncologists (Feb 2026).
- Working with The Christie to benchmark data (Q4 25/26).

Trends:

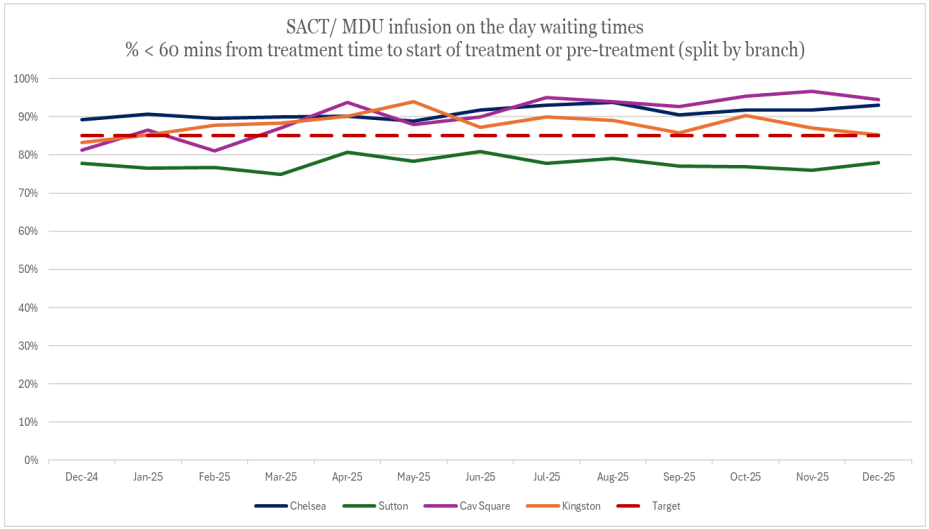


Forecast:

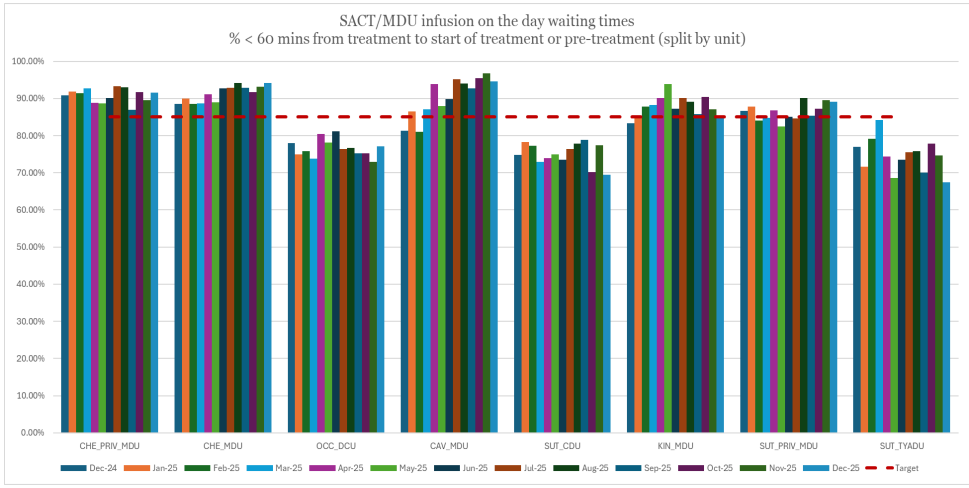
- Breach analysis at Sutton to inform forecast.

SACT % /MDU % infusion metric (2/2)

Branch level data:

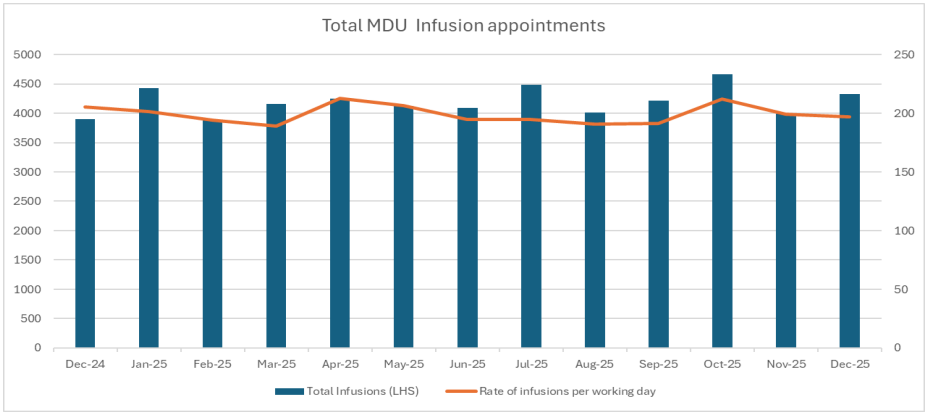


Unit level data:



Trial protocols –reported separately : 70.6% for December (69.3% in November 2025)

MDU infusion volumes (non –trial):



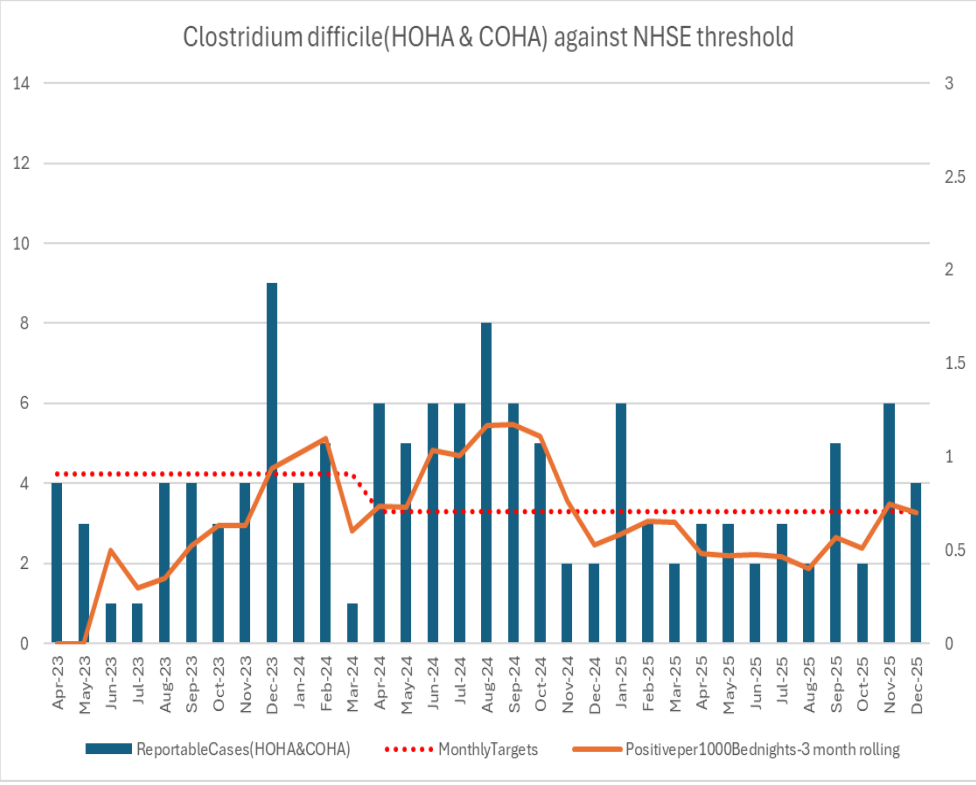
Healthcare associated Infections (hospital and community onset) (1/3)

MSSA and MRSA healthcare associated cases (HCAI) BSI:

- Zero cases of MRSA
- Zero cases of MSSA

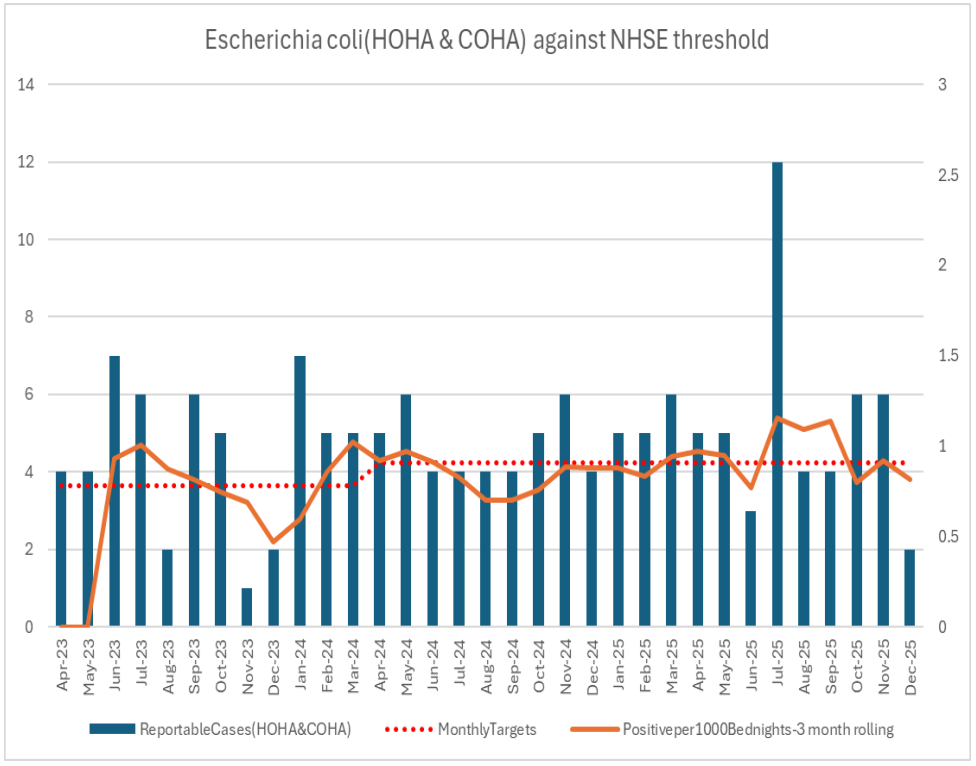
Clostridioides difficile healthcare associated infection:

- 4 HOHA/COHA cases in December
- The Trust has reported 30 HOHA/COHA April 2025 to end of December 2025. Based on current trends, the Trust expects to remain within the NHS England set threshold by year end.



E.coli healthcare associated BSI:

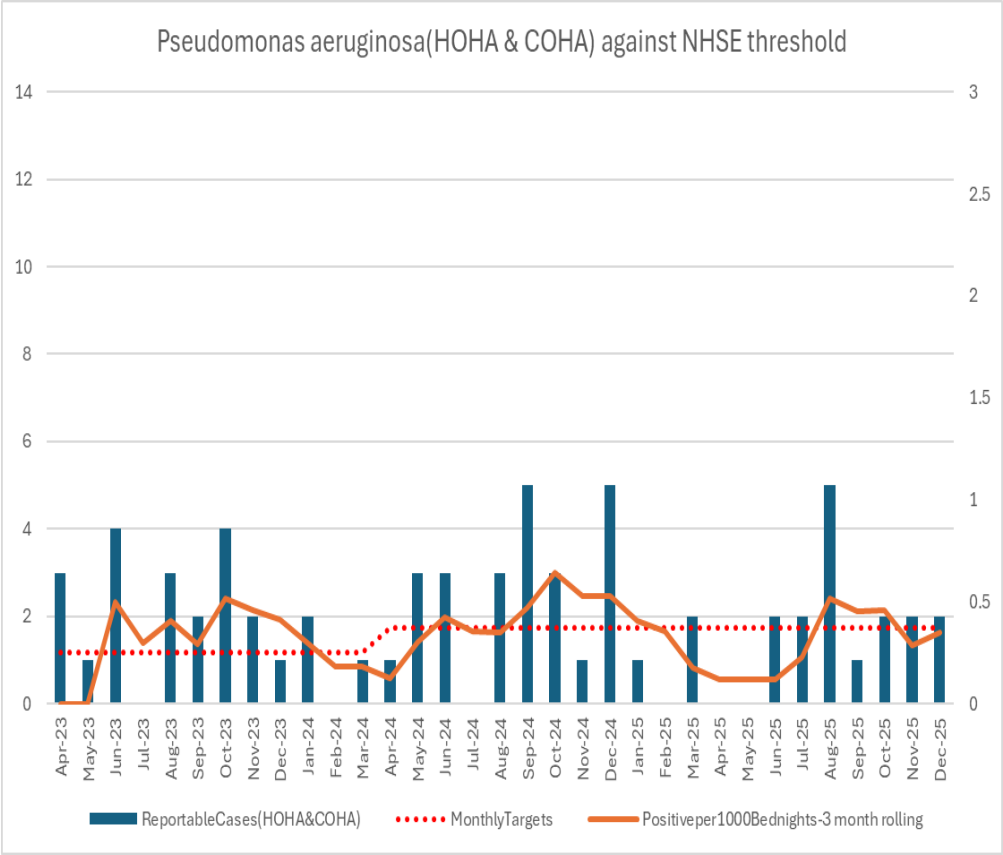
- 2 HOHA/COHA in December
- The Trust has reported 47 HOHA/COHA April 2025 to December 2025. The Trust is likely to exceed the NHSE-set annual threshold.



Healthcare associated Infections (hospital and community onset) (2/3)

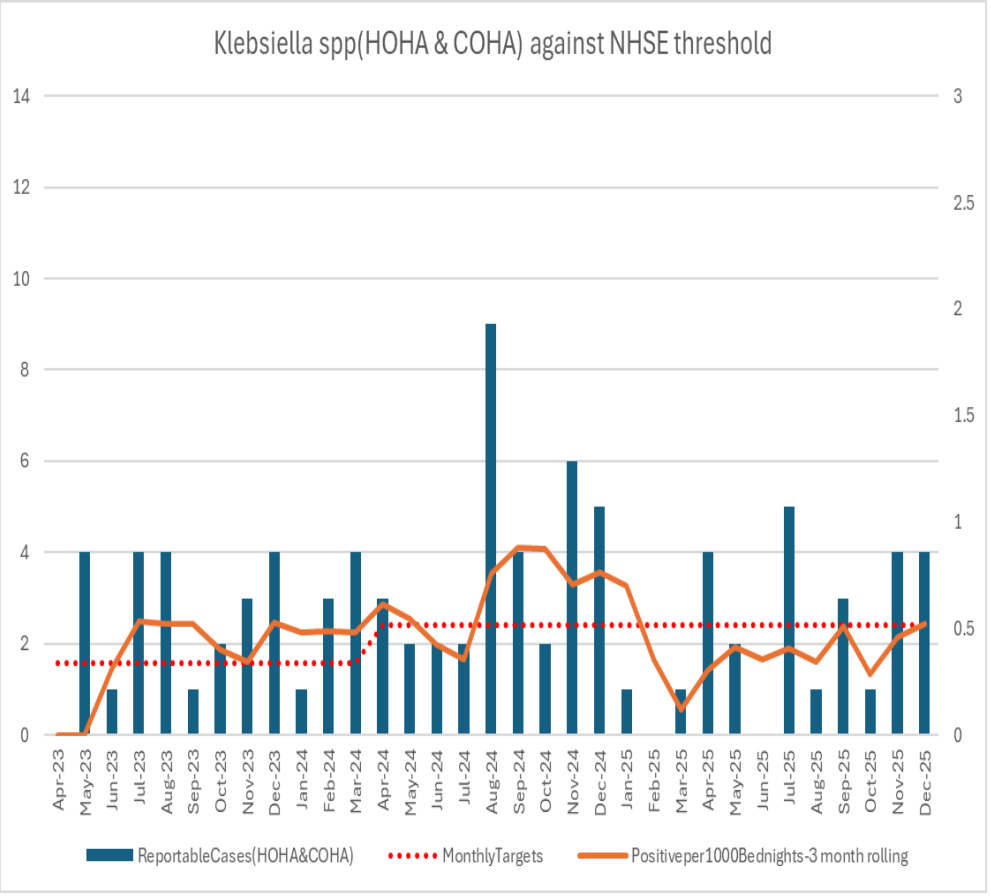
***Pseudomonas* aeruginosa healthcare associated BSI:**

- 2 HOHA/COHA cases in December
- The Trust has reported 16 HOHA/COHA April 2025 to end of December 2025. Assuming a straight line forecast, the Trust is at the NHSE-set threshold at end of year.



***Klebsiella spp*. healthcare associated BSI:**

- 4 HOHA/COHA cases in December
- The Trust has reported 24 HOHA/COHA April 2025 to end of December 2025. Assuming a straight line forecast, the Trust is at risk of exceeding the NHSE-set threshold.



Healthcare associated Infections (hospital and community onset) (3/3)

Outbreaks and incidences- Three incidences:

1 outbreak of Rotavirus on McElwain ward and 1 MRSA incident on CCU.

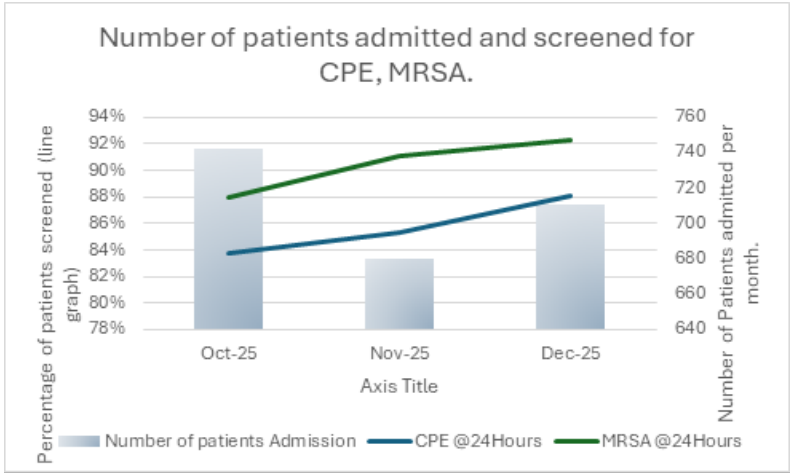
Rotavirus – There were two cases of Rotavirus on McElwain ward within a seven-day period.
Key learnings highlighed the importance of promptly isolating patients presenting with diarrhoea and ensuring that samples are sent to the microbiology laboratory following the first episode of loose stool.
Enhanced cleaning measures were implemented across the affected areas, and nursing leadership for the ward initiating an action plan to reduce the risk of further cases. No further cases were recorded.

MRSA colonisation
It was identified that a patient on GH3 was colonised with MRSA on day 18 of admission. Review of the case confirmed that the colonisation was not due to cross-transmission on the ward; the patient had been known to be colonised with MSSA on admission, indicating that the MRSA was more likely related to their own endogenous flora rather than due to cross contamination.

Innovations and training.
Gloves off - The "Gloves Off" campaign eLearning package is now live on the RM intranet and a patient information leaflet has gone live on the patient information library. The IPC team are working with marketing and communication regarding campaign resources and plan to formally launch the campaign in January 2026.

Personal Care QIP- The IPC team have commenced planning for a quality improvement project around personal care, with regards to the use of water versus the use of wipes and ensuring evidence-based practice. The IPC team are supporting ward accreditation and working through preparedness assessment of all inpatient services. This piece of work will support the writing of a 'Caring for a patient with neutropenia' SOP.

Admission Screening Compliance:.
Patient admissions increased in December compared with November.



Hand hygiene compliance

Actions / next steps:
Ongoing support to McElwain in education focusing on mitigations aimed at reducing the risk of cross-contamination.
Water-safety education package to be developed, covering the correct use of water for patient washing.

Patient Falls

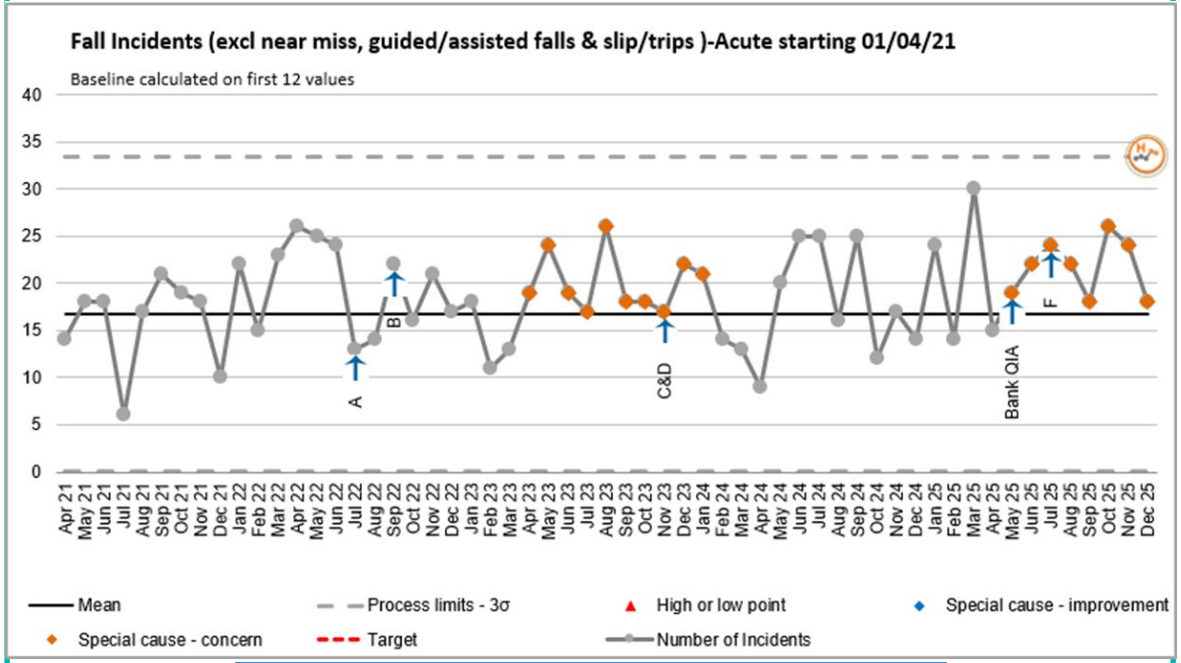
Update since previous quality account:

- Decrease in fall related incidents compared to the previous month.
- 24 incidents reported, of which 18 were classified as an actual fall (excluding near misses, slips/trips and guided falls).
- 6 low harm and 18 no harm incidents.
- Majority of fall incidents occurred in the 'fall from standing or walking' category.
- Cancer Services (13), Clinical Services (5), Private Care (6), Corporate Services (0).
- 11 falls occurred on the Chelsea site and 13 on the Sutton site.
- Increase (19.9%) in all fall incidents compared to the previous 12-month period.
- Increase (19.6%) in actual fall incidents compared to the previous 12-month period.
- 4.5 falls per 1000 bed days.

Key issues:

- Ongoing review of clinical areas MEG data at falls steering group, positive results regarding staffs' knowledge and ability to identify patients at falls risk, improvements required in completing admission risk assessments within the required timeframe.
- Importance of clear documentation to any delays to assessments, ie critically unwell patients.
- Ongoing engagements by nurses to utilize ward manager dashboards at safety huddles to identify missing actions.
- APU falls education for patients receiving bowel preparation.

Trends:



Key Interventions	
A	Adjustable height chairs trial on Smithers Ward
B	The Eat Drink Move project on Smithers utilising Volunteers
C	Introducing Twilight Volunteers on the Bud Flannagan wards
D	Fall prevention equipment trial in Sutton
E	Bank and agency booking QIA
F	Combined Pharmacy Risk Assessment on EPIC

Actions / next steps:

- Bed rail policy under review.
- To review compliance levels of bedrail assessments and see if this can be added into the ward manager dashboard.
- Ongoing review of falls patient information leaflet.
- National audit for inpatient falls SWARM template agreed to be used within the trust.
- Falls policy to be reviewed at Januarys NAHPC meeting.

Medication incidents

Update since previous quality account:

157 incidents in December, 29% (45) were due to adverse reactions when used as intended. 132 no harm and 25 low harm incidents.

Key issues and Themes:

Controlled Drug incidents(21)

- There were 15 patient involved incidents: A delayed administration of a CSCI, 2 x pump issues, 4 x wrong doses, 1 x wrong formulation and 1x wrong route (s/c given instead of IV). A complex discharge TTO incident in community which requires process review. There were 4 prescribing incidents. A patient had two of his CD TTOs omitted on discharge resulting in pain escalation.
- There were 3 accounted for loss incidents; 2 x breakages and one recording error on the CD register.
- There were 3 governance incidents; 2 x CDs not stored in safe custody and a dose of oral morphine not labelled.

Actions/next steps:

- To review INC15770 of midazolam supply for CSCI delay and insulin supply from pharmacy stores (INC15220)
- Review incident (INC 15692) where CD TTOs not given at discharge (this links into the wider review into POCDs which is in progress).

- **Omitted and delayed medicines (13)**
- There were 7 SACT delayed administration incidents; 3 x aseptic preparation delays, missed administration of a cytarabine dose and supply of oral SACT TTO, one prescribing omission of SACT infusion time and a multifactorial delay of a SACT trial.
- There were 3 critical medication incidents; Delay of prescribing antibiotics for a patient who had spiked in outpatients, and a delay in supplying insulin from pharmacy. A patient's insulin was incorrectly withheld and resulted in hyperglycaemia.
- There were 3 supportive medication incidents; Delayed administration of pre-medications for a SACT mobilisation regimen, steroid eye drops (take home meds) not prescribed until day 3 and pharmacy resupply of steroid eye drops not supplied (3 doses missed).

Venous Thromboembolism

Key issues and Themes:

- Compliance across trust continues to remain above the national KPI of 95%.
- Excellence Every Day is supporting there is a culture of routine monitoring of inpatient VTE risk assessments.
- The Venous Thrombo-embolism (VTE) risk assessment, prevention and management policy and guidelines document is out of date (expired 06/24).
- The VTE committee with Anaesthetics and Pre-assessment have standardising assessments for all patients. The focus for 2026 is to explore patient education strategies in different mediums such as videos.
- Education & training for both patients & staff continues to be a key objective of the VTE Committee.

Actions:

- Harm Free Care Link Practitioner roles are now fully embedded within clinical areas. They will formally join the VTE committee as part of their role in January 2026.
- VTE ward accreditation continues to focus on KPIs .The fitting and assessing of Anti Embolic Stocking (AES), AES prescriptions and daily checking of AES and skin integrity is part of the VTE ward accreditation. Ongoing work with the TVN team to ensure criteria is met for patients who cannot have AES.
- The VTE policy has been de-constructed into two smaller policies. 1. Line Thrombosis; 2. Managing anticoagulation for clotting disorders. Presented at CGPC. Will need to go through DTC.
- Patient education initiatives have been developed for inpatients as part of the HFC imitative.

VTE risk assessment figures

	Dec-25
% of all adult inpatients have had a VTE risk assessment within 14 hours of admission to hospital	97.26%
Low risk admissions	7142
VTE assessed admissions	444
Total admissions	7800

Actions / next steps:

- Updated VTE Guidelines to be presented to DTC (March ‘26) and CGPC (March '26) for final sign off. Objective 2026
- VTE patient information opportunities to improve awareness of VTE and standardise with key workers as well as enhanced communication. Objective 2026
- Identify Datix Incidents relevant to the VTE committee, analyse them using the PSIRF framework to determine Trust-wide themes and report findings back to the divisions. Via priSM and then to VTE committee
- Ensure all inpatients receive a leaflet 'Making your stay with us safe' outlining ways they can reduce risk of VTE, PU and falls as part of their admission process. Part of the Harm Free Care initiative.
- Ward Accreditation team are now part of the VTE committee and will feed back on when Wards and clinical areas have been accredited.
- Focus within pre assessment and prehabilitation initiatives to identify which SACT pathways are delivered over 6 hours and essential VTE assessment.

Key Achievements achieved in 2025

1. Established a VTE committee with multiprofessional and diverse representation
2. Big 4 focus on VTE prevention and an introduction to the VTE specialist consultant to be disseminated Trust wide.
3. MEG data altered to reflect nursing assessment for Anti-embolic stockings and skin assessment now integral part of HFC for VTE and PU.

Hospital Acquired Pressure Ulcers (HAPU) – excluding category 1

Update since previous quality account:

In December, there was nine acquired pressure injuries:

N=4 Category 2, n=3 Mucosal, n=2 SDTI

N=2 suspected deep tissue injuries and two category 2, patients RIP. Element of skin changes at end of life

55% of all acquired pressure ulcers this month from medical devices

N=3 mucosal pressure injuries all from ryles tubes, one sutured and two taped. All injuries low harm and healed

Two category 2 injuries from oxygen nasal cannula medical device – both low harm injuries and healed

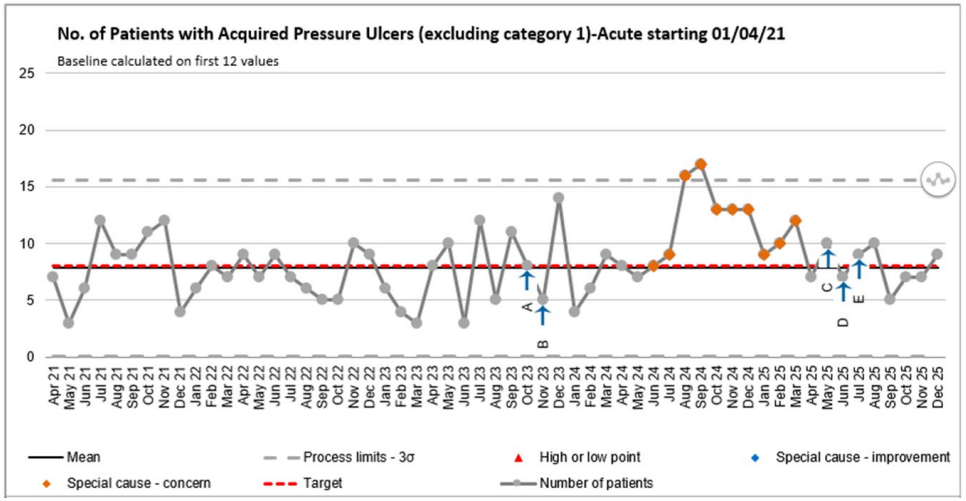
TVS Activities:

- TVN team to continue to attend monthly ward sister meetings
- TVN team to continue with monthly TV Link Practitioner Meetings- all dates for 2026 published on the intranet, next meeting 18th February. Theme: medical device pressure injury prevention
- Ad Hoc training for local trends/themes
- Creating resources for Level 2 Tissue Viability Study Day
- Reviewing and updating PU Policy

Update:

- PICC line related Pressure Injury training to be concluded this year and can request more training from Solventum clinical advisors if ongoing issue. Await documentation on all staff and areas trained
- Device related PUs an ongoing issue and different themes/trends every month
- TVS working with clinical services DND, clinical engineering and RMH IT to get Arjo express ordering system onto Trust computers

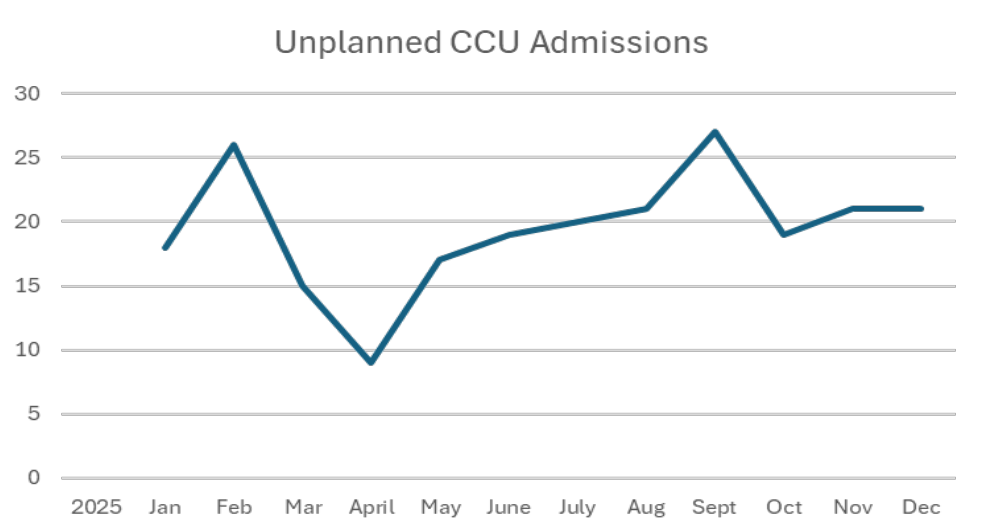
Trends:

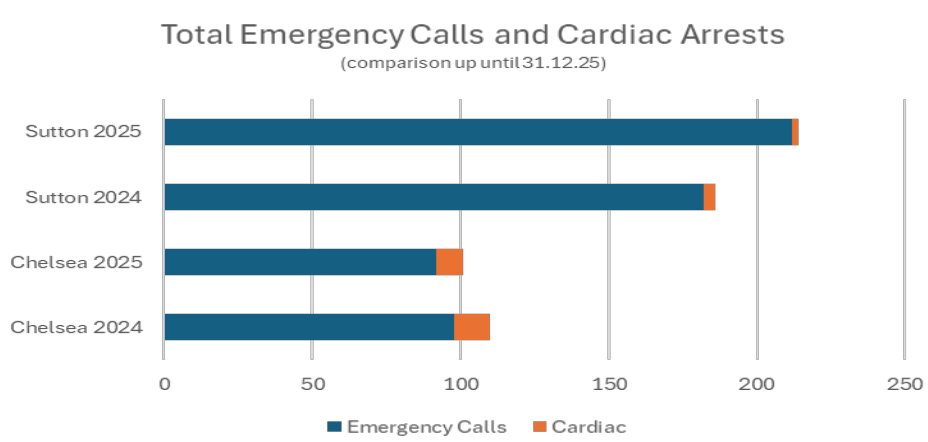


Actions/next steps:

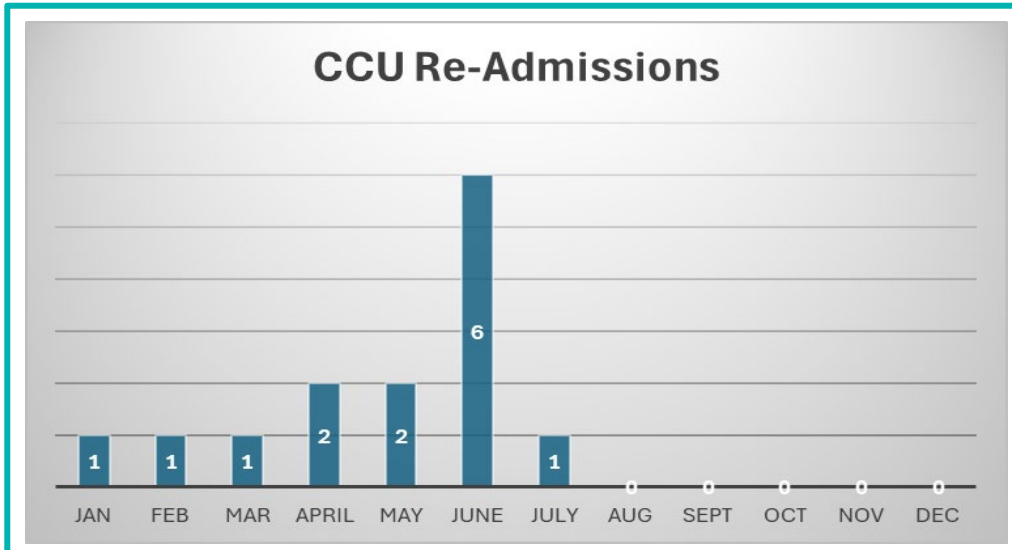
- PU Policy to send to stakeholders – to be presented to Harm Free Care Committee 24/3/26
- Level 1 Tissue Viability Course – 439 staff completed (as of Jan 26)
- Tissue Viability and Wound Care Documentation improvements due Q1 with EPIC team and Claire Westray

Deteriorating Patient





Martha's Rule update: 0 Calls for concern. Pilot of patient wellness questionnaire underway, Trust wide implementation Q1



Key updates:

Sepsis policy: Under peer review.

- Sepsis bundle audit: Strong compliance (aligned with NICE).
- Push notifications: Revalidation underway following Epic update.
- Martha's Rule questionnaire: With analyst team for build; will review timeline at next POG.
- Deteriorating Patient Navigator: Build progressing with stakeholder group.
- Clinical observation order: In development to support enhanced monitoring in the nursing hub workflow.
- Transfer risk assessment: Task & finish group standardising transfer forms.
- AKI nurse build: Complete; renal toxic drug build now in progress.

Next steps

- Finalise Sepsis policy and prepare committee submission.
- Monitor push notification performance and confirm readiness for May 26.
- Review timeline and progress of Martha's Rule patient wellness questionnaire at next POG.
- Testing of Deteriorating Patient Navigator.
- Review and update AKI policy.

Patient experience and Complaints

Update since previous quality account:

- **Complaints:** 14 new complaints were opened throughout December 2025: Cancer Services (5), Clinical Services (3), Corporate Services (1), Private Care (5).
- **Outpatient Friends and Family Test (FFT):** November 2025 is the latest published national data - 93% of respondents rated their overall experience positively, compared with the national average of 94%. OP data is based on a very small respondent sample.
- **Inpatient Friends and Family Test (FFT)** November 2025 is the latest published national data - 99% of respondents rated their overall experience positively, this is above the national average of 95%.

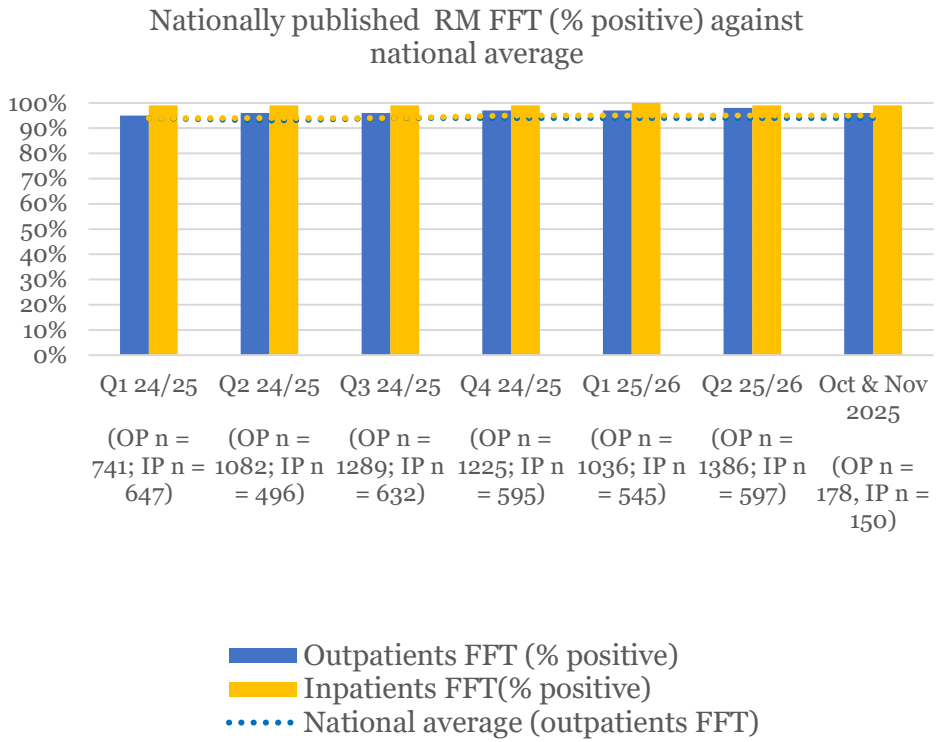
Key issues and themes:

- **Complaints:** Current theme is surrounding clinical treatment of patients
- **Friends and Family test:** No themes were identified

Actions/next steps:

- **Complaints:** No Actions for December 2025
- **Friends and Family Test:** Response rates are expected to increase significantly in Q4 following the implementation of the new feedback portal. Service leads have been trained to use the new portal, providing real-time access to feedback, and revised performance monitoring arrangements are now being implemented.

Trends:



The volume of respondents was significantly lower as a result of a provider change and a temporary interruption to service during the implementation of the new system.

Nursing Recruitment and Turnover & Retention

Update since previous quality account:

The overall nursing vacancy rate remained the same as the previous month at 2.5% and remains well below the Trust target of 7.0%. All divisions continue to perform strongly, with vacancy rates at or below the 7% target. The nursing Turnover rate is 6.6% and is below the Trust target of 12%

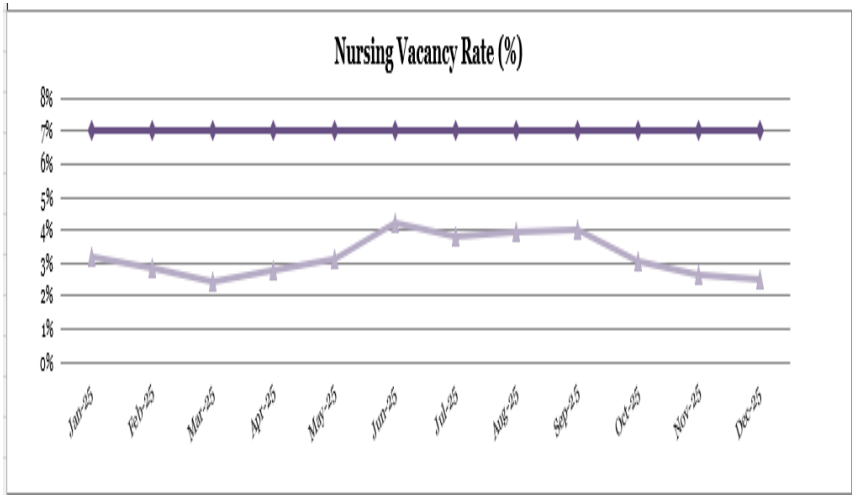
Key issues and Themes:

The Trust is reviewing all nursing job descriptions (Band 4 to Band 9) in line with national expectations now that the new profiles have been released. A team is meeting fortnightly to work this through

Actions/next steps:

The Trust is supporting newly qualified nurses into employment, with planned commencement dates in September and October, as part of its longer-term workforce sustainability approach. Engagement with local universities is ongoing to provide early employment opportunities for graduates as they complete training and registration.

Trends:



The nursing vancyy rate continues to track well below the Trust target of 7%

Forecast:

- Stabilisation of voluntary nursing turnover rate.
- Ongoing sustainable reduction in nursing vacancy rate.

Multi-professional Vacancy rates and Recruitment

Update since previous quality account:
The Trust-wide vacancy rate for December is 6.0%, representing a marginal increase compared to the previous month.

Nursing and Midwifery Registered (2.5%), Healthcare Scientists (4.4%), and Allied Health Professionals (5.9%) continue to perform well, with only marginal month on month movement.

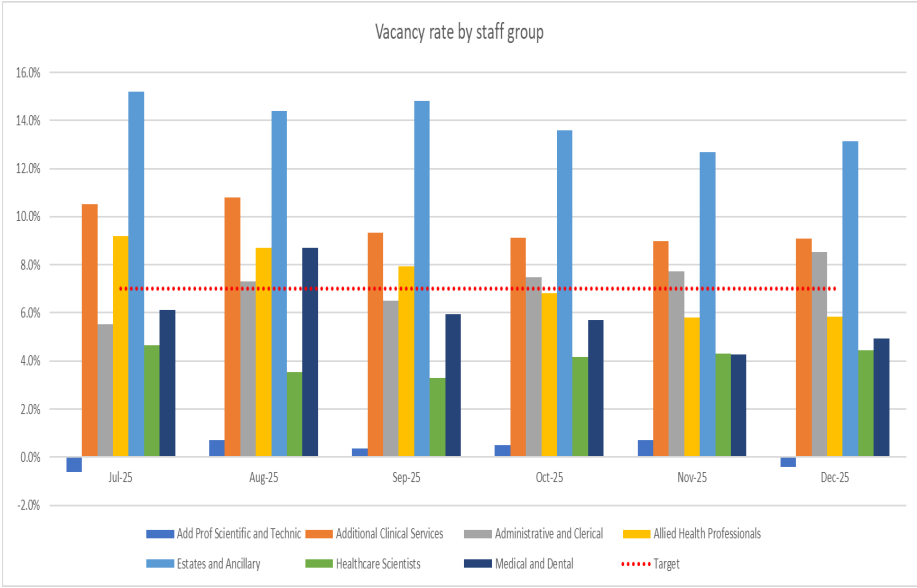
The highest vacancy rates remain within Estates and Ancillary (13.1%), Additional Clinical Services (9.1%), and Administrative and Clerical (8.5%).

Key Issues and Themes: •There are currently 77.1 WTE (whole time equivalent) candidates in the recruitment pipeline, of which 41.3 WTE candidates have a confirmed start date.

Actions/next steps:

- The Recruitment Services has been bought back in house, allowing greater control, flexibility, and oversight of the end to end recruitment process. In Q4 there is a dual running period in place, during which the outsourced provider is concluding any remaining activity while in house arrangements are embedded.
- A number of initiatives are currently underway to further digitise and automate the recruitment and onboarding processes. We are currently in testing phase of some automated shortlisting, alongside the digitisation of new starter and onboarding documentation and the automation of key HR workflows

Trends:



The Trust vacancy rate increased from 5.7% to 6.0% in December

Appendix 1 – Quality Account Scorecard (1/2)

The Royal Marsden NHS Foundation Trust
Quality Account 25/26
December 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 25/26 Apr-25	May-25	Jun-25	Q2 25/26 Jul-25	Aug-25	Sep-25	Q3 25/26 Oct-25	Nov-25	Dec-25	Q4 25/26 Jan-26	Feb-26	Mar-26	Trend	YTD	24/25
	CCU SMR (1 qtr. in arrears) - 12 month rolling	≤1	0.87			0.97			0.95							0.93	N/A
	Hospital Standardised Mortality Rate 100 (rolling 12 months, NHS and PP) (1 Qtr. in arrears)	≤80	77.91			73.68			TBC							N/A	75.80	N/A
	Mortality audit	Green	G			G			TBC							N/A	N/A	N/A
	30 day mortality post surgery	≤0.4%	0.52%			0.44%			TBC							N/A	0.48%	0.37%
	30 day mortality post chemotherapy	≤1.4%	1.32%			1.46%			TBC							N/A	1.39%	1.43%
	90 day mortality post radical radiotherapy	≤1%	1.00%			0.00%			TBC							N/A	0.50%	N/A
	100 day SCT mortality (Deaths related to SCT)	≤5%	1.96%			4.17%			TBC							N/A	3.06%	1.94%
	% screened positive for sepsis who received IV abx in line with NICE guidance - all IP and emergency patients	≥90%	98.4%			99.1%			98.4%							N/A	98.8%	87.6%
Ψ	% screened positive for sepsis who received IV abx in line with NICE guidance - high risk	No Target	95.2%			96.7%			98.8%							N/A	96.9%	N/A
	Number of Incidents reported on Datix (Reported Date)	No Target	1245			1438			1325							N/A	4008	5201
	Never Events	0	0	0	0	0	0	0	0	0	0					0	0
	Number of PSII investigations	No Target	0	0	1	0	0	0	0	1	1					3	N/A
	DoLS applications	No Target	3	0	2	1	1	0	1	1	0					9	N/A
	Failure to recognise deterioration in a patient leading to death	0	0	0	0	0	0	0	0	0	0					0	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
Ψ	Number of diagnoses of Methicillin-sensitive Staphylococcus aureus (MSSA) (HOHA/ COHA)	TBC	0	1	0	0	0	1	2	1	0					5	5
Ψ*	Clostridium difficile (C. Diff)- Number of COHA and HOHA (at YTD)*	≤40	3 *	6 *	8 *	11 *	13 *	18 *	20 *	26 *	30 *					30	0
	Clostridium difficile (C. Diff)- Number of COHA and HOHA (monthly)	N/A	3	3	2	3	2	5	2	6	4					30	7
Ψ*	Number of (COHA/HOHA) E. Coli Bacterium (at YTD)*	≤51	5 *	10 *	13 *	25 *	29 *	33 *	39 *	45 *	47 *					47	57
	Number of (COHA/HOHA) E. Coli Bacterium (monthly)	N/A	5	5	3	12	4	4	6	6	2					47	57
Ψ*	Number of (COHA/HOHA) P. aeruginosa cases (at YTD)*	≤21	0 *	0 *	2 *	4 *	9 *	10 *	12 *	14 *	16 *					16	58
	Number of (COHA/HOHA) P. aeruginosa cases (monthly)	N/A	0	0	2	2	5	1	2	2	2					16	58
Ψ*	Number of (COHA/HOHA) Klebsiella spp. Cases (at YTD)*	≤29	4 *	6 *	6 *	11 *	12 *	15 *	16 *	20 *	24 *					24	27
	Number of (COHA/HOHA) Klebsiella spp. Cases (monthly)	N/A	4	2	0	5	1	3	1	4	4					24	27
	Falls- Attributable Moderate Harm Incidents while patient under RMH care	0	0	0	0	0	0	2	1	0	0					3	8
	Falls- Attributable Major Harm Incidents while patient under RMH care	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
	Number of patients with attributable pressure ulcers- Number of Patients	No Target	8	14	12	13	16	6	13	12	10					104	163
	Number of patients with attributable pressure ulcers: Medical Device Related	No Target	1	3	3	2	6	1	4	6	6					32	33
	Number of patients with attributable pressure ulcers: Mucosal	No Target	1	1	1	0	3	0	1	2	3					12	17
	Number of patients with attributable pressure ulcers- Category 1	No Target	1	3	5	4	3	1	5	5	1					28	25
	Number of patients with attributable pressure ulcers-DTI	No Target	0	2	1	2	1	1	0	2	2					11	10
	Number of patients with attributable pressure ulcers- Category 2	No Target	4	5	2	5	7	2	6	3	4					38	79
	Number of patients with attributable pressure ulcers- Category 3	No Target	0	1	1	1	0	1	1	0	0					5	14
	Number of patients with attributable pressure ulcers- Unstageable	No Target	2	2	2	1	2	1	0	0	0					10	31
	Number of patients with attributable pressure ulcers- Category 4	0	0	0	0	0	0	0	0	0	0					0	1
*	Number of attributable medication incidents with moderate harm and above	≤1 per month	2	0	1	0	0	0	1	0	0					4	8
	VTE Risk Assesment (14 Hours)	≥95%	96.7%	96.4%	96.8%	97.0%	97.2%	97.3%	97.2%	97.4%	97.3%					97.0%	N/A

Appendix 1 – Quality Account Scorecard (2/2)

Key

* denotes Year To Date (YTD) figures

Blue-shaded KPI denotes metric linked to BAF stategic framework

Ψ denotes NHS England metric

The Royal Marsden NHS Foundation Trust

Quality Account 25/26

December 2025 Data

Effective Care	**Target**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Trend**	**YTD**	**24/25**
% SACT Infusion patients starting treatment within 1 hr of appointment time- Chelsea	≥85%	90.2%	88.8%	91.8%	93.0%	93.7%	90.5%	91.7%	91.9%	93.1%					91.6%	89.2%
% SACT Infusion patients starting treatment within 1 hr of appointment time- Sutton	≥85%	80.8%	78.4%	81.0%	77.8%	79.1%	77.1%	76.9%	76.0%	78.1%					78.4%	75.8%
% SACT Infusion patients starting treatment within 1 hr of appointment time- Kingston	≥85%	90.1%	93.9%	87.2%	90.0%	89.1%	85.8%	90.4%	87.1%	85.2%					88.8%	79.9%
% SACT Infusion patients starting treatment within 1 hr of appointment time- Cav Sq	≥85%	93.9%	87.9%	89.9%	95.1%	94.0%	92.7%	95.4%	96.7%	94.5%					93.3%	83.0%
Caring	**Target**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Trend**	**YTD**	**24/25**
RMH Inpatient Friends and Family Test: % overall experience	≥95%	97.9%	99.4%	100.0%	96.8%	99.6%	99.2%	N/A	99.3%	98.7%				N/A	98.9%	99.2%
Friends and Family Test (Inpatient and Day Care) Number of Reponses	No Target	189	178	176	126	232	241	N/A	150	149				N/A	1441	2330
RMH Outpatient Friends and Family Test: % overall experience	≥95%	98.8%	98.2%	98.3%	96.5%	97.6%	97.1%	100.0%	93.2%	100.0%					97.8%	95.5%
RMH Outpatient Friends and Family Test: Number of Responses	No Target	412	281	359	282	552	620	119	59	24					2708	4733
Responsive	**Target**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Trend**	**YTD**	**24/25**
% of complaints responded to in required timescale	≥90%	15.4%	57.1%	40.0%	33.3%	50.0%	53.8%	44.4%	40.0%	83.3%					46.4%	71.1%
Rate of written complaints per 1,000 Day Cases and IP Discharges	≤2.00	0.94	1.79	1.36	0.87	1.67	1.72	0.72	2.93	2.10					1.57	2.17
Well-Led	**Target**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Trend**	**YTD**	**24/25**
Relative likelihood of white staff being appointed from shortlisting across all posts (WRES 2 Indicator) - 12 months rolling (1 qtr. in arrears)	0.8-1.25	2.20			1.86			TBC						N/A	2.03	N/A
Number of Freedom to Speak Up (FTSU) Alerts	No Target	31			32			24							29	96
Trust vacancy rate	≤7%	6.3%	6.7%	6.3%	6.1%	6.9%	5.9%	6.0%	5.7%	6.0%					6.2%	6.9%
Trust Sickness Rate (1 month in arrears)	≤3%	4.2%	3.7%	3.3%	3.5%	3.7%	3.8%	3.8%	3.9%	4.2%					3.8%	3.5%
Trust Sickness rate (rolling 12 month average)	≤3%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%					3.9%	3.7%
Trust voluntary staff turnover rate	≤12%	7.8%	7.9%	7.8%	7.9%	7.7%	7.2%	7.2%	6.9%	6.6%					7.4%	9.0%
% Compliance with Phase 1 of Oliver McGowan training	≥90%	94.4%	94.9%	95.2%	95.7%	95.7%	95.5%	96.1%	96.5%	96.7%					95.6%	89.0%
Mandatory Training	≥90%	94.2%	94.3%	93.8%	93.7%	93.5%	94.0%	93.9%	94.3%	94.1%					94.0%	92.7%
Sexual Safety training compliance	≥90%	68.5%	74.7%	78.2%	81.0%	84.0%	86.1%	88.9%	91.0%	92.1%					82.7%	N/A
Adult Safeguarding: % of staff compliant with training 1	≥90%	96.5%	96.6%	96.3%	96.5%	96.0%	96.7%	97.4%	97.2%	97.3%					96.8%	96.0%
Adult Safeguarding: % of staff compliant with training 2	≥90%	95.2%	95.1%	94.5%	95.0%	94.0%	93.7%	94.1%	94.4%	94.6%					94.5%	95.1%
Adult Safeguarding: % of staff compliant with training 3	≥90%	82.4%	84.7%	85.4%	85.0%	83.0%	82.9%	84.5%	87.4%	85.3%					84.5%	42.3%
Child Safeguarding % of staff compliant with training – Level 1	≥90%	96.8%	96.6%	96.1%	96.0%	96.0%	96.4%	96.9%	96.9%	96.8%					96.5%	96.4%
Child Safeguarding: % of staff compliant with training – Level 2	≥90%	94.1%	93.7%	93.2%	93.6%	93.0%	93.2%	92.9%	93.5%	93.6%					93.5%	94.2%
Child Safeguarding: % of staff compliant with training – Level 3	≥90%	86.7%	87.6%	87.6%	88.0%	91.0%	92.3%	92.8%	92.0%	91.7%					90.0%	89.9%

*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 Friends and Family Test (FFT) comments cards in November 2025.
- 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:

Bud Flanagan East, Sutton - My stay in the Marsden exceeded all expectations. Every nurse, doctor and support staff member treated me and my wife with compassion and respect. They made what could have been a stressful time feel safe and manageable. The care, cleanliness, and attention to detail were exceptional.

Outpatient department, Sutton - Very polite reception staff, excellent communication. Welcoming which is so important.

Radiotherapy, Sutton - No matter how I felt or what the day brought, there was always a warm smile, a reassuring word, and a sense of calm that made this journey lighter. Their professionalism is exceptional.

Critical Care Unit, Chelsea - I am very grateful for the excellent care provided by the hardworking staff. The team is well-led. I have been treated with kindness, respect and dignity by the team.

Ellis ward, Chelsea - The environment was very welcoming and cleanliness exceptional. All members of staff were friendly and approachable. They had a most professional attitude - it was clear that their first priority was always the patient, and their needs were paramount. Excellent service in every respect

Wilson ward, Chelsea - I received the most amazing treatment by the surgeon and anaesthetist. I was then in CCU and again received the best treatment. I was then on Wilson Ward, I was always treated with the best care by everyone. Nothing was ever too much trouble for anyone, and I was always kept up to date with the treatment I was being given.

Patient Comments requiring Action:

Outpatient department, Sutton - Waiting nearly 2 hours for a blood test. You really need more staff or a different system. Maybe get a public announcement system so we can all hear any bulletins regarding the wait.

Ellis ward, Chelsea - Apart from sorting out the lock for one of the bathrooms I could not fault care. Thank you for looking after me! 10/10 Gold star!

Appendix 3b: Safe Staffing: (Inpatients)

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

Occupancy %: High occupancy levels across some units others lower reflecting activity over holiday period
Fill rate: Safely staffed across all units. Red Unit: CCU – staffing reflects activity requirements. Staff redeployed to support other units.
CHPPD: Remains consistent slightly higher reflecting lower occupancy on some wards.
Red flags: Linked to staff unavailabilities and missing key skills
Sickness: High levels of sickness across units particularly CCU (12%) and Kennaway (10%) DND and Matrons working with teams to manage sickness
Controllable headroom: High across some units some linked to additional leave been given over BH and number of study days occurring linked to expiring skills.
Nurse sensitive indicators : Overall Medications (14) Hospital acquired PU (9) Falls (14)

Quality account: Safe Staffing - Dashboard
Inpatients

	Staffing metrics					Census	Nurse sensitive Indicators			Workforce				Rostering KPI				FFT
Dec-25	Budgeted CHPPD	Actual CHPPD	Registered Fill %	HCSW Fill %	Red Flags (open)	Pt census at 2400	Medications omitted/delayed	Hospital Acquired pressure ulcer	All reported falls	Vacancy %	Turnover %	Sickness %	Maternity Registered %)	Roster approval (publication)	Net hours	Temp staff (WTE)	Controllable headroom (AL, SL, WD)	% Extremely likely or likely
Target			95%			86%				7%	12%	3%		100%	2/-2 %		15%	
Burdett Coutts	7.3	8.5	102%	116%		89%	0	0	0	6%	8%	4%	4%	50%	-1%	3.5	19%	100%
Ellis	7.9	8.9	101%	116%	1	91%	1	0	1	-1%	0%	7%	12%	50%	4%	2.6	13%	n/a
Horder	11	11.3	98%	100%	0	93%	1	0	0	5%	16%	6%	9%	100%	-1%	3.8	16%	n/a
Wilson	7.4	8.5	84%	82%	1	71%	0	0	2	15%	0%	8%	4%	50%	2%	2.4	12%	n/a
Kennaway	7.9	9.6	102%	121%	1	88%	1	3	1	9%	4%	10%	5%	50%	4%	5.1	12%	100%
Smithers	6.9	9.8	96%	119%	2	76%	1	2	1	8%	14%	9%	3%	50%	-2%	7.4	19%	n/a
Bud Flanagan East	10.7	11.7	94%	111%	2	90%	1	0	2	3%	0%	2%	0%	50%	0%	2.6	23%	n/a
Bud Flanagan West	8.7	8.5	96%	112%		92%	3	4	1	10%	6%	4%	0%	100%	0%	4.7	14%	100%
Mc Elwain	9.5	12.7	98%	88%		66%	2	0	0	-10%	10%	8%	7%	100%	0%	1.1	19%	100%
Teenage & Young Adult	9.4	12.3	100%	96%	1	78%	1	0	2	1%	3%	5%	0%	100%	-2%	2.4	20%	n/a
Oak Ward	10.7	32.9	95%	112%		25%	0	0	0	8%	7%	4%	5%	100%	-5%	0.2	21%	100%
CCU	26.3	30.6	83%	89%	0	69%	1	0	0	8%	9%	12%	4%	50%	1%	8.1	20%	100%
Granard House 1	9.69	13.6	98%	101%	0	80%	0	0	1	8%	0%	5%	5%	100%	-2%	1.7	14%	100%
Granard House 2	9.69	14.3	99%	97%	0	77%	0	0	0	6%	13%	4%	4%	50%	1%	1.5	18%	100%
Granard House 3	9.69	13.5	98%	94%	0	80%	1	0	0	7%	3%	4%	4%	100%	5%	0.9	12%	93%
Markus	10.23	13.3	94%	94%	0	72%	0	0	0	7%	11%	4%	4%	100%	3%	0.6	17%	100%
Robert Tiffany	9.69	11.5	98%	93%	0	87%	1	0	1	10%	12%	5%	5%	50%	-5%	4	20%	n/a
Wiltshaw	9.94	11.4	93%	87%	0	81%	2	0	2	-2%	2%	5%	5%	100%	4%	1.7	14%	100%

Appendix 3b: Safe Staffing: (Day Areas)

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

Fill%: Overall safely staffed on all units the low fill % reflecting activity changes over Christmas and New year weeks. Red Units: RDAC Oak and PPOPD Chelsea both safely staff supported by matron.
Sickness: High levels of sickness across all divisions on some units.
Red Flags: Low reporting of red flags for the month.
Controllable headroom: High levels this month due to unit closures over Bank holidays.

Quality account; Safe Staffing - Dashboard Day areas

	Establishment		Staffing metrics			Nurse Sensitive Indicators		Workforce				Rostering KPI			
December	Budgeted Establishment (WTE)	Establishment Actual (WTE)	Registered Fill rate %	HCSW Fill rate %	Red Flags (Open)	Medication resulting in harm	All reported falls	Vacancy %	Turnover %	Sickness %	Maternity (Registered %)	Roster Approval (Publication)	Temp staff total	Controllable Headroom (AL, SL, WD)	Friends % Family results
Target (If applicable)			>95%					7%	12%	<3%		100%		18%	
Cancer Services															
CDU	22.7	25.3	87%	61%	0	0	0	-11.60%	3.00%	5%	7%	50%	0.4	31%	
MDU C	36.81	35.1	99%	117%	0	0	0	4.60%	13.00%	4%	6%	100%	1.5	21%	100%
MDU K	17.01	14.5	94%	96%	0	0	0	15.00%	36.10%	8%	11%	0%	2	14%	50%
MPS	4	3.9	154%		0	0	0	1.10%	0.00%	0%	0%	50%	2	28%	100%
Olayan	50.6	48.7	85%	76%	0	0	0	3.60%	7.30%	0%	2%	50%	2.7	31%	50%
Oak DU	metrics combined with Oak ward		92%	60%	0	0	0			5%	0%	100%	0	29%	100%
West Wing	26.6	27.5	101%	76%	0	0	0	-3.20%	4.00%	13%	0%	100%	1.1	26%	50%
Clinical services															
APU C	13.9	14	87%	47%	0	0	0	-0.60%	7.10%	19.90%	0%	100%	0.3	28%	100%
APU S	5.3	5	86%	99%	0	0	0	4.90%	32.10%	2.10%	0%	100%		25%	100%
CUC L	24.8	22.5	100%	97%	0	0	0	9.30%	18.80%	9.70%	0%	50%	4.2	19%	100%
CUC Oak	10.3	8.4	89%	40%	0	0	0	18.20%	7.00%	13.40%	7%	50%	1.3	14%	100%
DSU	11.6	10.5	101%	79%	0	0	0	9.30%	0.00%	0.60%	0%	50%	0.5	25%	100%
Endoscopy chelsea	20.6	19	94%	98%	0	0	0	7.80%	26.30%	6.20%	0%	100%	0.9	21%	100%
EndoscopyOak	16.1	12	94%	100%	0	0	0	25.40%	8.70%	0.00%	8%	100%		17%	94%
OPD C	36.5	34.2	86%	100%	1	0	0	6.20%	11.90%	8.00%	5%	50%	2.29	21%	
OPD Oak	51.5	50.5	95%	100%	0	0	0	2.00%	4.10%	2.60%	0%	50%	0.7	13%	83%
RDAC C	16.9	16	85%	62%	0	0	0	5.20%	6.70%	3.30%	0%	100%		24%	100%
RDAC Oak	9.7	9.1	74%	78%	0	0	0	5.80%	0.00%	1.40%	0%	100%		31%	
Theatres C	97.1	22.8	90%	56%	0	0	0	2.30%	10.00%	8.50%	36%	0%	6.7	23%	
Theatres S	24.6	94.7	97%	85%	0	0	0	7.20%	0.00%	13.10%	0%	0%	1	19%	
Private Pts															
Cavendish Square	24	20.3	86%	79%	0	0	0	15.40%	12.80%	5%	0%	0%		26%	
PPMDU C	22	21.3	92%	73%	0	0	0	-1.30%	9.50%	9%	9%	0%		11%	50%
PPOPD C	24.6	22.8	88%	85%	0	0	0	7.20%	0.00%	7%	5%	0%	0.1	30%	93%
PPMDU S	18	18.3	105%	104%	0	0	0	3.70%	0.00%	13%	0%	100%	0.5	21%	100%
PPOPD S	7.4	7.3	97%	82%	0	0	0	1.40%	0.00%	1%	0%	50%	0.3	25%	93%
PPDSU	7.6	7.1	88%		0	0	0	6.70%	25.70%	8%	0%	100%	0.2	22%	100%

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 25 March 2026	**Agenda item:** 5.2
Title of Document: Infection Prevention Control Board Assurance Framework – 2025/26	**To be presented by:** **Interim Chief Nurse**

1. Status **To note**

2. Purpose:

Relates to:

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

3. Summary

- The IPC BAF provides strong assurance that IPC standards are being met, gaps are well understood, and the organisation continues to build resilience through sustained improvement and robust governance.
- Key strengths include governance and leadership, cleanliness standards, testing and laboratory support, occupational health safeguards, and estates collaboration
- Amber-rated risks include microbiology capacity, overseas patient screening, fit-testing coverage, and isolation capacity constraints.
- Red-rated risks include waste management, decontamination services, catering oversight, and antimicrobial stewardship data reporting.
- All improvement areas have clear ownership, defined timelines, and active action plans, with progress monitored through established committees.
- Quality improvement initiatives include enhanced environmental monitoring, strengthened cleaning oversight, improved use of decontamination systems, better patient flagging, and a fidaxomicin trial to support evidence-based treatment of *C. difficile*.
- Overall, the IPC BAF provides the Board with robust assurance that IPC standards are met, gaps are addressed and the organisation continues to build resilience through systematic improvements and strong oversight.

4. Recommendations / Actions

The Board is asked to note the report.

Infection Prevention & Control
Board Assurance Framework 2025/26

1.0 Executive Summary

The Infection Prevention and Control (IPC) Board Assurance Framework (BAF) for 2025/26 aligns with the ten national IPC requirements under the Health and Social Care Act 2008 and draws on current national standards (National IPC Manual, NHS Cleaning Standards (2025), and Health Technical Memorandum (HTM) requirements for water, ventilation, and decontamination).

- Overall position (March 2026): 36 Green, 14 Amber, 4 Red. This reflects strong overall compliance with focused action plans for remaining gaps.
- Strengths: Governance and leadership, cleanliness standards, microbiology laboratory/testing support, occupational health safeguards, and estates collaboration, all with clear oversight through established committees.
- Work in progress: Waste management and Catering management (linked to the new Facilities Management contract), Antimicrobial Stewardship (AMS) data collection (EPIC reporting), decontamination services (planning ahead of 2028 sterilisation contract cycle), plus noted areas in microbiology capacity, overseas patent screening, fit testing coverage, and isolation capacity.
- Overall, the BAF provides the Board with sufficient assurance that IPC standards are met, any gap is addressed, and the organisation continues to build resilience through systemic improvement and strong oversight.

2.0 Introduction

The Board Assurance Framework (BAF) highlights areas of positive performance, and areas which require improvement, which strengthens patient safety.
The IPC BAF was developed by NHS England during the COVID19 pandemic and has since evolved into a comprehensive assurance framework covering all infection risks. Since April 2023, it has been aligned to the ten national IPC criteria from the Health and Social Care Act (2008). The current IPC BAF uses 160 Key Lines of Enquiry (KLOEs) to identify where the Royal Marsden (RM) is fully compliant, where gaps exist, and what actions are in place. Although not nationally mandated, the BAF strengthens internal assurance and board reporting.

Table 1: RAG rating structure taken from the BAF

Colour	BAF terminology	Description
Green – Compliant	We meet the requirement	No gaps in assurance, with regular reporting on.
Amber – Partially compliant	We are partly meeting it	There are minimal gaps in assurance, and an action plan is in place.
Red – Non-compliant	We do not yet meet the requirement	Areas that require input to bring into alignment with national requirement. Gaps are risk managed with oversight at appropriate committee.

3.0 Overall Compliance review

The March 2026 IPC BAF provides a comprehensive overview of current performance against national IPC requirements, which demonstrates strong overall compliance and clear evidence of sustained progress throughout the year.

- 36 Green (compliant) demonstrating full compliance.
- 14 Amber (partially compliant) minor gaps and improvement plans exist.
- 4 Red (non-compliant) targeted areas of work in progress.

Comparison charts of completion from Q1 to Q3 (2025/26)

Chart 1: Quarter 1 (2025/26) IPC BAF RAG rated summary plot.

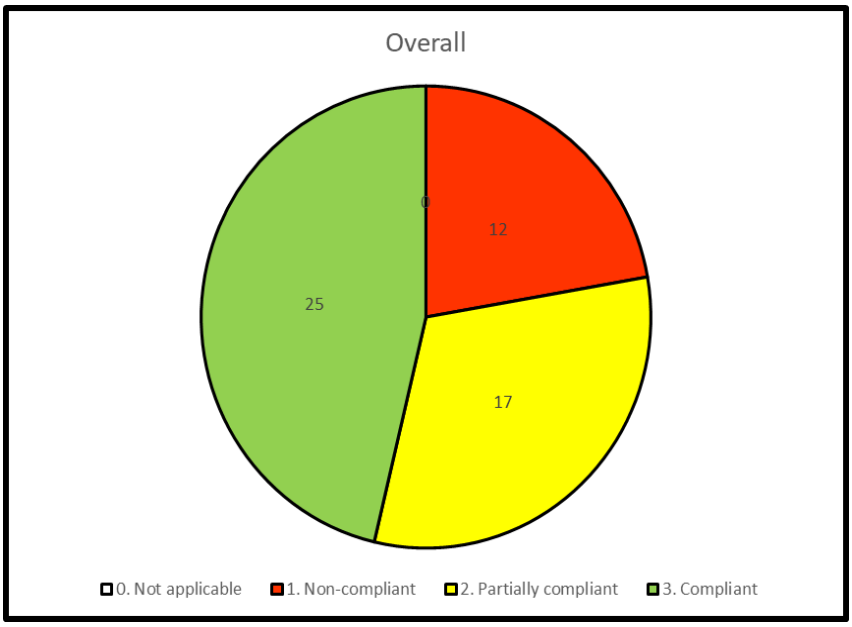
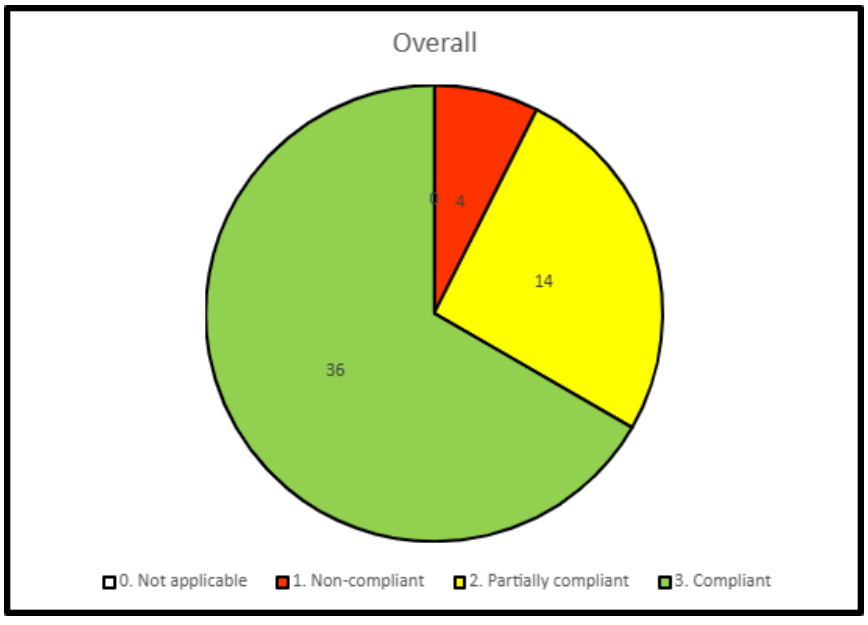


Chart 2: Quarter 3 (2025/26) IPC BAF RAG rated summary plot.



The comparison between Quarter 1 and Quarter 3 shows a clear improvement in IPC performance. Throughout this period, the organisation has continued to strengthen compliance with national requirements, and where gaps remain, there are well-defined improvement plans in place. This provides the Board with assurance that risks are being actively managed, and progress is both visible and sustained.

While the BAF demonstrates strong compliance across most criteria, it does highlight the areas that require additional focus. The BAF identifies gaps to help create focused work plans which allocate resources to priority areas.

Although there are still some operational and strategic challenges, the use of the BAF has significantly enhanced monitoring and oversight. It allows the Trust to track improvements more effectively, maintain momentum on key workstreams, and ensure any outstanding risks are identified early and acted upon. This structured approach supports continuous improvement and strengthens the organisation's overall infection prevention and control resilience.

3.1 Top 5 strengths: Green (compliant areas)

- Governance and leadership
- Cleanliness standards capability
- Testing and laboratory support
- Occupational health safeguards
- Estates collaboration

These areas benefit from strong and well-established oversight through formal governance groups, including the IPC committee, Environmental Action Group, Water Safety Group and Ventilation Safety Group. Together, these committees provide structured scrutiny, ensure risks are monitored and support timely action where improvements are required.

4.0 Risk related areas (Amber and Red).

The priorities identified in March '26 represent the key areas where the organisation shows gaps in compliance against national IPC requirements and where additional focus is needed to strengthen overall assurance. These priorities reflect both operational pressures and strategic risks, and each has a clear set of actions, owners, and timelines. They are the areas where improvement work will have the greatest impact on patient safety, regulatory compliance, and the Trust's long-term- IPC resilience.

4.1 Amber-related risks.

- Microbiology capacity- Capacity of microbiologists with increasingly complex infections identified in patient populations.
- Overseas patient screening- Specialised infection risk to be built to include private patients and risk assessments for infections which are not broadly seen in the UK.
- Fit-testing programme- Supported with six monthly training sessions, there are pockets of training requirements noted throughout the Trust. Overall compliance is good, and trainers are available across sites.
- Isolation capacity- Ongoing shortage of side rooms, this is acknowledged on the risk register. There is daily IPC support with prioritisation and review of optimal patient

placement. Quality improvement initiatives are under development to further support decision making related to limited side room capacity, which includes measures designed to expedite turnaround times for respiratory and gastrointestinal infection testing.

4.2 Red related risks.

- Waste management– The improvement plan is paused and will be taken forward by the facilities management team once the new soft FM contract commences in April, with key priorities which includes training, appropriate bin placement, sustainability and recycling.
- Decontamination– Current contract with sterilisation service comes to end in 2028.
- Catering- Strengthening Trust-wide audits and training is required and will be taken forward by the facilities management team once the new soft FM contract commences in April.
- Antimicrobial stewardship data– Working with the EPIC team to align reporting to the RMs reporting requirements.

Each area has a clear owner, timescale and improvement actions already in progress with progress reported quarterly at the IPC committee and other committees.

Table 3: Quarterly Overview of IPC Progress and Assurance

Quarter	Notable Performance	Overall
Q1	Strong compliance across governance. NIPCM adherence. Cleaning standards, reviewed, training in place. Surveillance and flagging systems– good assurance with Epic team regarding nuances.	Stable governance. Strong adherence to core IPC standards. Early assurance across multiple risk-based areas.
Q2	Improved surveillance reporting strengthened estates–IPC links, multiple policy updates, and progress in AMR data quality and reporting.	Noticeable progress in surveillance reliability, upgrading policy frameworks, and estates–IPC alignment.
Q3	Consistent performance sustained. Daily AMS rounds maintained. Ventilation policy ratified (new). Isolation capacity challenges.	Good continuity and consolidation; several ongoing risks managed but not deteriorating.

5.0 Key IPC areas of focus and Quality Improvements.

- *Pseudomonas aeruginosa Quality Improvement* – strengthened environmental monitoring, rapid response to findings, and enhanced oversight of water safety controls. Reducing the risk of patients acquiring an environmental related *Pseudomonas aeruginosa* related infection.
- *Gloves Off Campaign* – promoting reduction of unnecessary glove use, supporting hand hygiene, and reinforcing best practice behaviours Trustwide.

- *Link Practitioner Programme* – introduction and growth of IPC link practitioners across clinical areas, improving local ownership, training reach, and rapid escalation of issues.
- *Cleaning Compliance Oversight* – strengthened monitoring of cleaning standards within clinical areas, with improved reporting and joint estates/IPC visibility of risks.
- Improved Use of Decontamination systems (e.g., Bioquell/UV light) – better prioritised and targeted deployment of room decontamination technologies, resulting in improved turnaround times and enhanced environmental safety.
- *Enhanced Patient Flagging* – better identification of patients with gastrointestinal or respiratory rule-out status, enabling earlier isolation decisions and improved flow management.
- *Fidaxomicin trial* - A clinical trial using fidaxomicin is in progress to support evidence-based treatment pathways for C. difficile and reduce the burden of recurrent infection.

6.0 Conclusion

The 2025/26 IPC Board Assurance Framework demonstrates that the organisation is performing strongly across the majority of national Infection Prevention and Control requirements with clear evidence of sustained improvement throughout the year. While several Red and Amber areas remain, these are well-understood, actively managed, and supported through targeted action plans with defined accountability and oversight.

The framework has strengthened the RMs ability to identify risks early, track progress, and focus effort where it will have the greatest impact on patient safety. It has also highlighted the effectiveness of our governance structures, the maturity of every workstreams, with the strong multidisciplinary collaboration across estates, clinical teams, private patients and corporate services.

Overall, the BAF provides the Board with robust assurance that IPC standards are being met, that gaps are addressed, and that the organisation continues to build resilience through systematic improvement, strong oversight, and a clear commitment to excellence.

GLOSSARY

Antimicrobial Stewardship (AMS) - A programme that ensures antibiotics and other infection-treating medicines are used safely and correctly to reduce resistance and protect patients.

Amber Rating -A middle rating in the Red/Amber/Green system. It means the Trust is *partly meeting* the requirement and has small gaps that are being worked on.

BAF (Board Assurance Framework) - A structured tool used by the Trust to check how well it meets national Infection Prevention and Control (IPC) requirements, showing strengths, gaps, and progress.

Bioquell - A specialist machine that deep-cleans rooms using vapour to remove harmful germs, used after infectious patients have been discharged.

Cleaning Standards (NHS Cleaning Standards 2025) -The national rules that set out how clean hospital environments must be, how this is measured, and who is accountable.

Decontamination - Processes used to clean, disinfect, or sterilise equipment and rooms to prevent infection.

EPIC (Electronic Patient Infection Control System) -The Trust's digital system used to track infections, monitor risks, and support decision-making.

Estate Constraints -Buildings-related issues (such as ventilation, plumbing, or room layout) that can affect infection control or patient safety.

Fit Testing - A procedure to check that staff respiratory masks fit properly so they are protected from airborne infections.

Green Rating - The highest rating in the RAG system. It means the Trust *fully meets* the requirement and has no gaps in assurance.

HTM (Health Technical Memorandum) - National technical guidance for hospital buildings, covering areas such as water safety, ventilation, and sterile services.

Isolation Capacity - The availability of single rooms where infectious patients can be safely separated to prevent spreading illness.

Link Practitioner Programme - A network of trained staff in each clinical area who support local infection control practice and act as a link to the IPC team.

Microbiology Capacity - The availability of specialist doctors and scientists who diagnose, advise on, and manage complex infections.

NIPCM (National Infection Prevention and Control Manual) -The standard set of rules the NHS uses to prevent and manage infection risks.

Pathogen Guidance (UKHSA) - Advice from the UK Health Security Agency on how to manage specific infectious diseases safely.

Pseudomonas aeruginosa - A type of bacteria that can cause infections, particularly in vulnerable patients. Monitoring water systems helps prevent risks.

RAG Rating (Red, Amber, Green) - A colour-coded system showing levels of compliance:

- Green – fully compliant
- Amber – partly compliant, small gaps
- Red – not yet compliant, improvement work required

Red Rating - Indicates the Trust does *not yet meet* a requirement and improvement actions are needed.

Side Room - A private, enclosed hospital room used to keep patients isolated to reduce the risk of infection spreading.

Surveillance (Digital Surveillance) - Monitoring infection patterns, risks, and patient status so that early action can be taken.

Ventilation Policy / Ventilation Safety Group - Policies and committees that ensure hospital air systems work safely and support infection prevention.

Water Safety Group - A multidisciplinary group that ensures hospital water systems are safe and do not pose infection risks.

Waste Management - How clinical and general waste is stored, handled, and disposed of safely, including recycling and sustainability requirements.

Appendices (available on request)

Appendix A: Full BAF entries by criterion (Sheet: *Board Assurance Framework*).
Appendix B: Risk Register extracts and action logs (Sheet: *Risks*).
Appendix C: Governance structure and committee terms of reference (Sheet: *C1*).
Appendix D: Compliance distribution charts (Sheet: *Data / Summary plots*).
Appendix E: Antimicrobial Stewardship QAR paper (Paper: *March 2026*)

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 25 March 2026	**Agenda item:** 5.2
Title of Document: Antimicrobial Resistance and stewardship	**To be presented by:** Interim Chief Nurse

1. Status To note

2. Purpose: This paper provides the Board with assurance on the Trust's current position in relation to national Antimicrobial Resistance (AMR) targets and the actions required in response to NHS England's *AMR Call to Action* (November 2025). The detailed report was considered in depth by the Quality Assurance and Risk Committee (QAR), and this summary highlights the key issues and assurances for Board oversight.

Relates to:

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

3. Summary

National Context and Drivers

Antimicrobial Resistance has been identified by the World Health Organisation as one of the most significant global public health threats and is included on the UK Government's National Risk Register. National surveillance shows that, while overall antibiotic prescribing is falling, prescribing in secondary care continues to rise and rates of Gram-negative bloodstream infections already exceed the 2028/29 national targets in most areas. AMR is associated with twice as many deaths annually in the UK as breast cancer.

In November 2025, NHS England issued a formal call to action requiring Trust Boards to provide executive oversight of antimicrobial stewardship, undertake risk and capability assessments, and agree priority improvement actions by Q1 2026, with further delivery expectations by April 2026.

Current Trust Position

The Royal Marsden has a higher level of antibiotic usage than many acute Trusts, reflecting the complexity of its patient population. A significant proportion of patients receive highly immunosuppressive chemotherapy and are therefore at increased risk of severe infection, sepsis, and bloodstream infections, necessitating early and sometimes prolonged antibiotic treatment.

Since 2019, total antibiotic usage has increased, and the Trust is unlikely to achieve the national target for 70% of antibiotic use to fall within the WHO "Access" category. This position is driven by clinical necessity, including the need to treat suspected sepsis promptly and to use antibiotics aligned to local and international resistance patterns.

Mandatory surveillance data indicates that the majority of the Trust's bloodstream infections are Gram-negative and occur predominantly in haematology and gastrointestinal medical patients. As a tertiary oncology centre with national and international referrals, the Trust also manages a higher risk of resistant organisms, requiring careful stewardship and infection prevention controls.

Stewardship and Controls
The Trust has established antimicrobial stewardship arrangements, including regular multidisciplinary ward rounds, daily stewardship meetings, senior specialist support through EPIC, and ongoing education for clinical teams. Antibiotic usage and resistance patterns are monitored closely by the microbiology and infection control teams and inform local prescribing guidance.

Further enhancements are planned, including increased frequency of antimicrobial ward rounds and the development of EPIC dashboards to support early review and de-escalation of treatment.

Oversight is provided through the Antimicrobial Stewardship Committee, Drugs and Therapeutics Committee, and Infection Control Committee, with assurance reporting through QAR.

Assurance from QAR Committee
The Quality Assurance and Risk Committee reviewed the detailed AMR report and was assured that:

- The Trust understands the national requirements and timelines set out in the NHS England call to action.
- Current antibiotic usage reflects clinical complexity rather than inappropriate prescribing.
- Robust stewardship arrangements are in place, with clear plans to strengthen oversight and reporting.
- AMR risks are recognised and managed through established governance structures.

The detailed report is accessible here.

4. Recommendations / Actions

The Board is asked to:

1. **Note the national AMR targets and requirements set out in the NHS England call to action.**
2. **Note the Trust's current performance and the clinical factors influencing antibiotic usage.**
3. **Note the stewardship arrangements and planned actions, as reviewed by the Quality Assurance and Risk Committee.**

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 25 March 2026	**Agenda item:** 5.3
Title of Document: **Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Annual Report**	**To be presented by:** Sofia Colas Chief Operating Officer Interim Accountable Emergency Officer

1. Status **For Information**

2. Purpose:

Relates to:

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

3. Summary

As a listed Category 1 Responder within the Civil Contingencies Act 2004, The Royal Marsden NHS Foundation Trust must demonstrate that it can effectively plan and respond to incidents / events while maintaining critical services to the community.

The Trust was rated substantially compliant with the EPRR Core Standards in the annual assurance process for 2024-2025 and was also noted for an impressive return and for its work within the wider EPRR Community in improving resilience within the healthcare sector.

The introduction of the Terrorism (Protection of Premises) Act 2025 (Martyns Law) brings new risks, challenges, and requirements for the NHS. This Act changes the mindset of physical and personal security within public places and introduces the need for preventive measures and training not previously considered necessary within a hospital setting. Security Risk Assessments and investigative work is ongoing to ensure the Trust achieves compliance with the legislation and provides assurance that it remains a safe place for our staff, patients, and visitors.

4. Recommendations / Actions

The Board is asked to note both the EPRR Annual report and work the Trust undertakes in providing assurance that the Royal Marsden remains resilient during disruptive events and compliant with legislation.

The ROYAL MARSDEN
NHS Foundation Trust

Title:	Emergency, Preparedness, Resilience and Response (EPRR) Annual Report Business Continuity Annual Report
Owner **Version:**	Dean Reece - Trust EPRR Manager

Annual Report (2025-2026)

Executive Summary

The Civil Contingencies Act 2004 (CCA) sets out the requirements for UK responder agencies to plan for and respond to emergencies while maintaining critical services. Within the NHS, this work is known as Emergency Preparedness, Resilience and Response (EPRR). NHS organisations must meet these obligations in line with the CCA, the NHS Act 2006, the Health and Care Act 2022, the NHS Standard Contract, the NHS Core Standards for EPRR, and the NHS England Business Continuity Management Framework (2022).

As a Category 1 Responder under the CCA, The Royal Marsden NHS Foundation Trust has a duty to plan for and respond to incidents, cooperate with partner agencies, and support the wider health and civil resilience system. Although the Trust is not normally designated as a casualty receiving hospital, it may be required to provide hospital accommodation and services during a major incident.

During 2025/26, the Trust undertook a range of EPRR activities including departmental testing and exercising. The Trust also planned and delivered a tabletop exercise simulating the loss of digital health records and participated for the first time as an active partner in London-wide major incident live exercises. Learning from these activities has informed improvements to policy, procedures and organisational resilience.

New and revised response tools and protocols supported the Trust's management of a range of incidents that had the potential to impact service delivery. Relevant incidents were investigated in line with the Trust's Patient Safety and Accident Incident Reporting Policy, with action plans developed to support organisational learning and strengthen resilience.

The Trust continues to audit EPRR arrangements and provide staff training to ensure capability in responding to incidents and unexpected events. In the 2024/25 EPRR annual assurance process, the Trust was rated Substantially Compliant, achieving 56 green ratings and 2 amber ratings, with no red ratings. Feedback highlighted improvements in the Trust's submission, with the remaining observations largely related to external factors. An action plan is in place to support further improvement ahead of the next assurance audit in late 2026.

Looking ahead, the Trust will be required to comply with the Terrorism (Protection of Premises) Act 2025 (Martyn's Law) from April 2027. The legislation places increased emphasis on organisational security and protection of premises. Initial risk assessments have been completed and a task group established to identify priorities and mitigation measures to support compliance.

Overall, the Trust's EPRR and Business Continuity Management arrangements continue to support a resilient and coordinated organisational response to incidents and disruptions, while aligning with national NHS guidance to ensure effective collaboration with partner organisations during major incidents.

1. Introduction

1.1 Purpose

This report outlines the Trust's EPRR activities during the period 1st April 2025 to 31st March 2026. The report is compiled from reports presented to the EPRR and IGRM Committees in line with the Trust EPRR policy.

1.2 Background

As the Trust is a CCA Category 1 responder, it therefore has a duty to:

- Assess the risk of incidents occurring and use this to inform contingency planning.
- Put in place incident plans.
- Put in place business continuity plans.
- Share information with other local responders to enhance co-ordination.
- Co-operate with other local responders to enhance co-ordination and efficiency.

1.3 EPRR Committee

There were three committee meetings within the reporting period; 22 Jun 2025, 14 Nov 2025, and 12 Feb 2026. An ongoing action log collates action points and monitors completion. The Committee receives relevant papers in advance of the meeting for review, allowing for discussion and approval. During the reporting period they reviewed the following policies and papers;

Trust Heatwave Contingency Plan, Trust Cold Weather Contingency Plan, Hospital Evacuation Plan, Fuel Oil Storage Policy, Introduction of the SBAR Form for incident reporting, 2222 caller operating scripts, and the introduction of OPEL (Operational Pressure Escalation Levels) monitoring framework.

After a period learning the operations of RM, the EPRR associated polices are under review and will be revised throughout 2026, ensuring that Trust policies and recovery actions remain effective by learning from internal and external events and implementing changes from updates and recommendations within legislation and guidance.

2. Risk Assessment and Trust Risk Register

The Trust is complying with its duty to undertake risk assessments for the purpose of informing contingency planning activities. EPRR risks are recorded on the Trust risk register and discussed as required at the EPRR Committee. Due to EPRR risks generally attracting a high score as a result of the nature of the topic i.e. Counter Terrorism Threat, Fuel Supply Network, and Power Failure within London, these risks have now been collated within a separate EPRR annex to reduce the high scores from dominating the Trust risk register whilst still being monitored and updated from current guidance and scoring from the Borough, London, and National Risk Registers.

2.1 The Terrorism (Protection of Premises) Act 2025

The 2017 Manchester Arena bombing and subsequent public enquiry highlighted gaps in security capability and resilience measures within public buildings. The Terrorism (Protection of Premises) Act 2025, effective from April 2027, places public buildings containing more than 200 people into two categories; Basic and Enhanced Tier, with each tier having differing requirements in maintaining the safety and monitoring of their visitors.

Due the number of staff and visitors within hospital buildings, NHS Trusts are classed as Enhanced Tier organisations and will be required to have conduct risk assessments, implement barrier methods and controls to deter hostile actors, have methods of public monitoring and communication during an event, and plan for, and exercise against, acts of aggression to the premises and its occupants.

The Act is making the NHS and its Trusts look at security provision within their buildings in a way that was never considered in the past. Engagement with Counter Terrorism Police and NHSE London is ongoing to fully understand our obligations and to ensure that the Trust will be compliant with the legislation. Risk assessments have been conducted of our departments and buildings, and a working group has been formed to identify our requirements and associated work and costs for completion.

3. Business Continuity Management Systems / Planning

In Q1 2025, it was concluded that ISO 22301:2019 (Business Continuity Management System) was not suitable for RM and the healthcare sector as the Standard did not fully align with hospital operations and was assessed by individuals looking at the Trust from a business lens and not incorporating the additional requirements of the Trust as listed within the Civil Contingencies Act and the Health and Care Act. It was therefore decided that RM would no longer be formally assessed by the ISO office for this Standard.

Whilst formally withdrawing from the ISO 22301 assessment programme, the Trust has maintained the framework foundations whilst incorporating the additional requirements expected within NHS operating documentation. This has allowed for the revision of the Business Continuity Plans (BCP) with a focus on maintaining patient safety during restricted service delivery, identifying and implementing departmental resilience, installing departmental command and control hierarchies, and promoting faster recovery. This brings the Trust closer alignment with other Trusts and allows for greater information sharing and understanding when formulating mitigation plans.

Departmental business continuity training sessions have allowed all members to discuss their concerns and personal impact during periods of disruption and become involved in the formulation of the BCPs. This approach has produced positive results in providing a renewed resilience vision and mindset from departmental management and satisfying visiting external assessors during accreditation visits of other departments and services.

4. NHSE Assurance Framework

Annually, all NHS funded organisations are requested to provide an assurance return against the NHS Core Standards for EPRR. The London NHSE Regional Office holds individual review meetings with each organisation to discuss and agree a level of compliance. In respect to this, the RAG ratings were agreed at the review meeting, and the report was received in November 2025. An action plan is in place and is monitored as part of the EPRR committee. See Appendix 1 for actions.

Year	Red Ratings	Amber Ratings	Green Ratings	NHSE Compliance Grading
2024	0	7	57	Substantially Compliant
2025	0	2	56	Substantially Compliant

5. Training and Exercising

Guidance set out by NHSE stipulates that exercises must be carried out and provides a time frame and frequency of exercise. The Committee receives debrief reports and actions from training events which are added to the Committee Action Log. The EPRR training and exercising plan was agreed by the Committee. The Committee also conduct and review post incident reports for learning and incorporation in future policy revisions.

The table below shows exercises undertaken in 2025/2026 and planned events:

Exercise Type	Minimum Frequency	Undertaken/Comments
Communications Cascade Exercise	6 monthly	Quarterly COMMEX (national)
Command Post Exercise (CPX)	3 Yearly	Command Post stood up for Wi-Fi outage in November 2023. Scheduled - Lockdown 2026 and 2027 Scheduled – IT Failure Part 2
Tabletop exercises	12 monthly	Exercise SOLARIS – Pandemic Influenza Exercise EPIC FAIL – Loss of EPIC Exercise CENTUM – Major Incident Departmental IT Downtime Exercises Departmental Fire Training Scheduled - Lockdown 2026 and 2027 Scheduled – IT Failure
Live exercises	3 Yearly	Exercise SOLARIS Exercise CENTUM (London Region) MDU Chelsea Fire Evacuation Scheduled – Lockdown 2026 and 2027

A robust departmental training programme is also delivering sessions covering IT downtime preparedness, business continuity and security. In the temporary absence of a Trust Fire Officer, additional fire awareness training is also being delivered to supplement the existing packages provided by the external provider and sharpen fire prevention focus.

The Clinical Site Practitioners (CSP) are also undertaking a new training programme focusing on Command and Control and initial incident actions, this will ensure that the CSPs set the correct tone in the early stages of the incident recovery phase, promoting a faster recovery, and ensuing an effective handover of the incident to hospital management.

6. Co-operation

In order to share information and cooperate with other local responders to enhance co-ordination and efficiency, RM attends EPRR planning groups hosted by NHSE London, London Resilience Direct, Borough Resilience Forums from all three council areas, Northwest and Southwest London NHSE EPRR network meetings, and attends associated working groups and learning sets. The Trust is recognised as a key member of several committees and is involved in work strands in improving healthcare provider resilience.

7. Recent Significant Events

The Trust has experienced the following incidents which were investigated in accordance with the Trust Patient Safety & Accident Incident Reporting Policy.

- Impacting Lift Failures
- On Site Gas Leak (External pipework failure)
- Localised Flooding in Ward
- Power Outage

The Trust continues to plan for disruptive events including strike action by resident doctors, disruption to supply chains, adverse weather events, and external public events and protests.

8. Conclusion

The Board is asked to note the findings and the Trust action plan to address the amber ratings from the NHS Assurance Framework. It is also asked to note the effectiveness of the controls put in place during the year to ensure that RM remains resilient and proactive when faced with incidents or business continuity events.

Appendix 1 – Core Compliance Domains which contribute to assurance assessment criteria / level of compliance

Core Standard Reference	Domain	Action	Target Action Date	Action Owner
CS22	Training and exercising	Required to formulate EPRR Training Needs Analysis	To be complete by Q3 2026 following introduction and greater understanding of new security legislation requirements	EPRR Manager
CS53	Business Continuity (Assurance of Commissioned Suppliers)	Known issue across NHSE. Work ongoing from NHSE London and ICB. RM to maintain engagement with NWL Procurement Services	Ongoing. Expected to be upgraded at next assurance assessment following additional 12 month demonstration of service provision	EPRR Manager

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 25 March 2026	**Agenda item:** 5.4
Title of Document: Quarterly Hospital mortality review audit, 1st October 2025 and 31st December 2025.	**To be presented by:** Interim Chief Medical Officer

1. Status **For information**

2. Purpose:

Relates to:

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

3. Summary

This report has been reviewed at the Quality Assurance and Risk Committee.

There were 76 inpatient deaths between 1st October 2025 and 31st December 2025, 100% of which were reasonably expected. 7 patients had a SJR of their care undertaken – no problems in care were identified. Overall, the Trust is RAG-rated Green for the period.

4. Recommendations / Actions

The Board is asked to note the report.

The Royal Marsden NHS Foundation Trust

Quarterly Hospital mortality review audit, 1st October 2025 and 31st December 2025.

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 a 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 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 10th February 2026.

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 76 inpatient deaths between 1st October 2025 and 31st December 2025.

Conclusion: Standard was achieved. 100% of inpatient deaths were reasonably expected. 76/76 deaths were indicated as definitely not avoidable, and 7 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**:** For all of the deaths there was an identifiable reason outside the control of RM as to why their preferred place of death was not achievable. Standard achieved

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 76 deaths, 71 patients were discussed and reviewed by the Symptom Control and Palliative Care team before their death, 93% - 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 7 patients reviewed, no problems in care were identified – standard achieved

4.0 The Learning Disabilities Mortality Review (LeDeR)
Conclusion: No patients were identified as having Learning Disabilities

5.0. Children's cases
Of the 76 deaths in this quarter, there was one paediatric death reported.

6.0 Incidents requiring a learning response
Of the 76 deaths in this quarter, One had a SWARM huddle, two MDT (Multi-disciplinary Team) and two After Action Reviews (AARs) carried out, and one PSII (Patient Safety Incident Investigation.

Reasons for SJRs
There were 7 deaths in this quarter that had a 'Structured Judgement Review' (SJR) conducted. The 7 deaths were selected for SJRs for the following reasons:

Reasons for SJR	October	November	December	Total No of Deaths
ME Request	2	0	0	2
Coroner Referral	3	0	0	3
Coroner and family concerns	0	0	0	0
Family Concern	0	1	1	2
Complaint	0	0	0	0

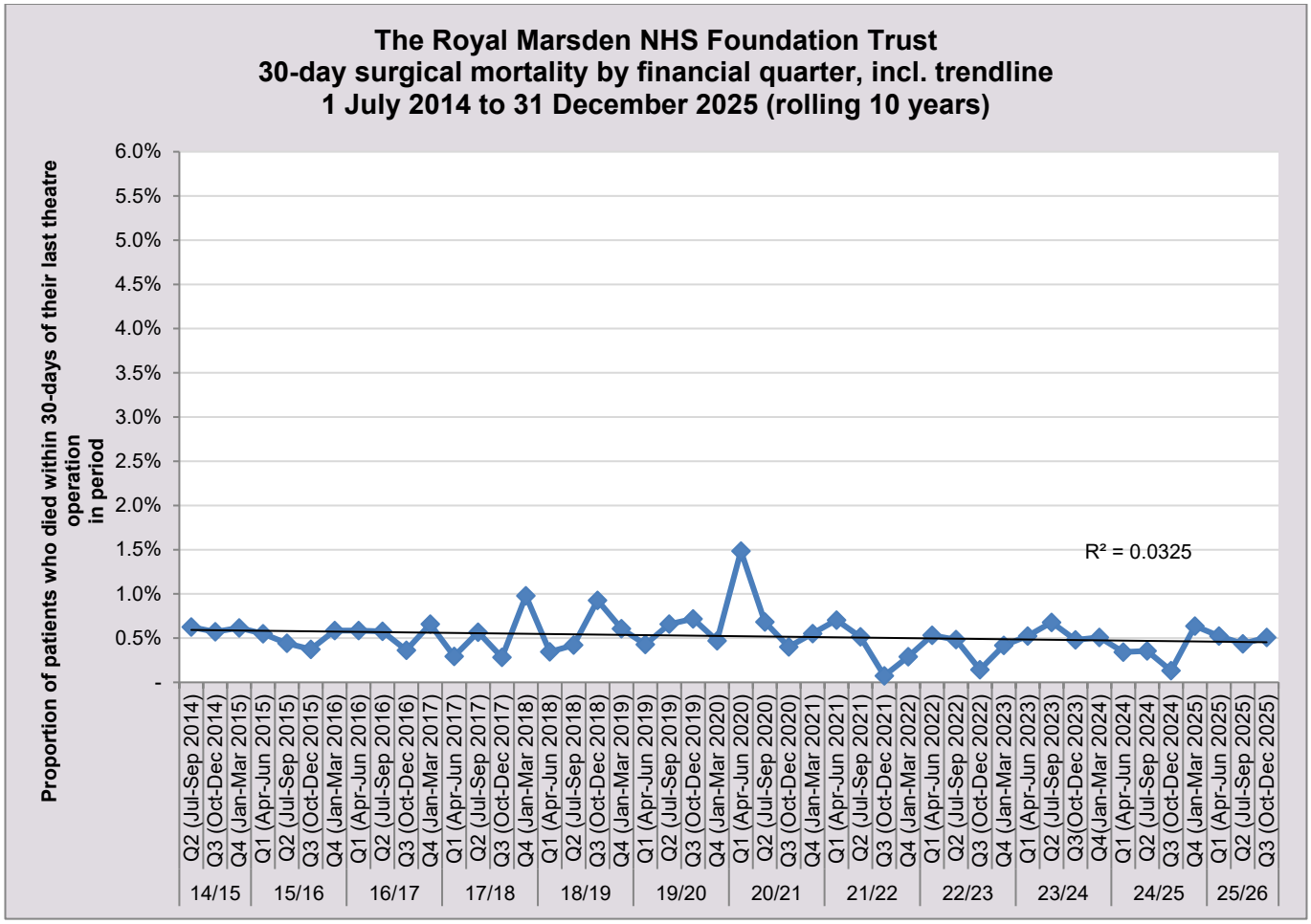
7.0. Numbers of deaths caused by problems in care
All of the deaths that had an SJR were indicated as definitely not avoidable.

8.0 The review found that of the 76 inpatient deaths there were 52 deaths from metastatic disease, 1 death with non metastatic disease and 23 from haematological malignancies

9.0 Number of COVID-19 related deaths reported
There were no hospital acquired COVID-related deaths reported between 1st October 2025 and 31st December 2025.

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 8 such deaths out of 1,575 patients (0.5%). 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

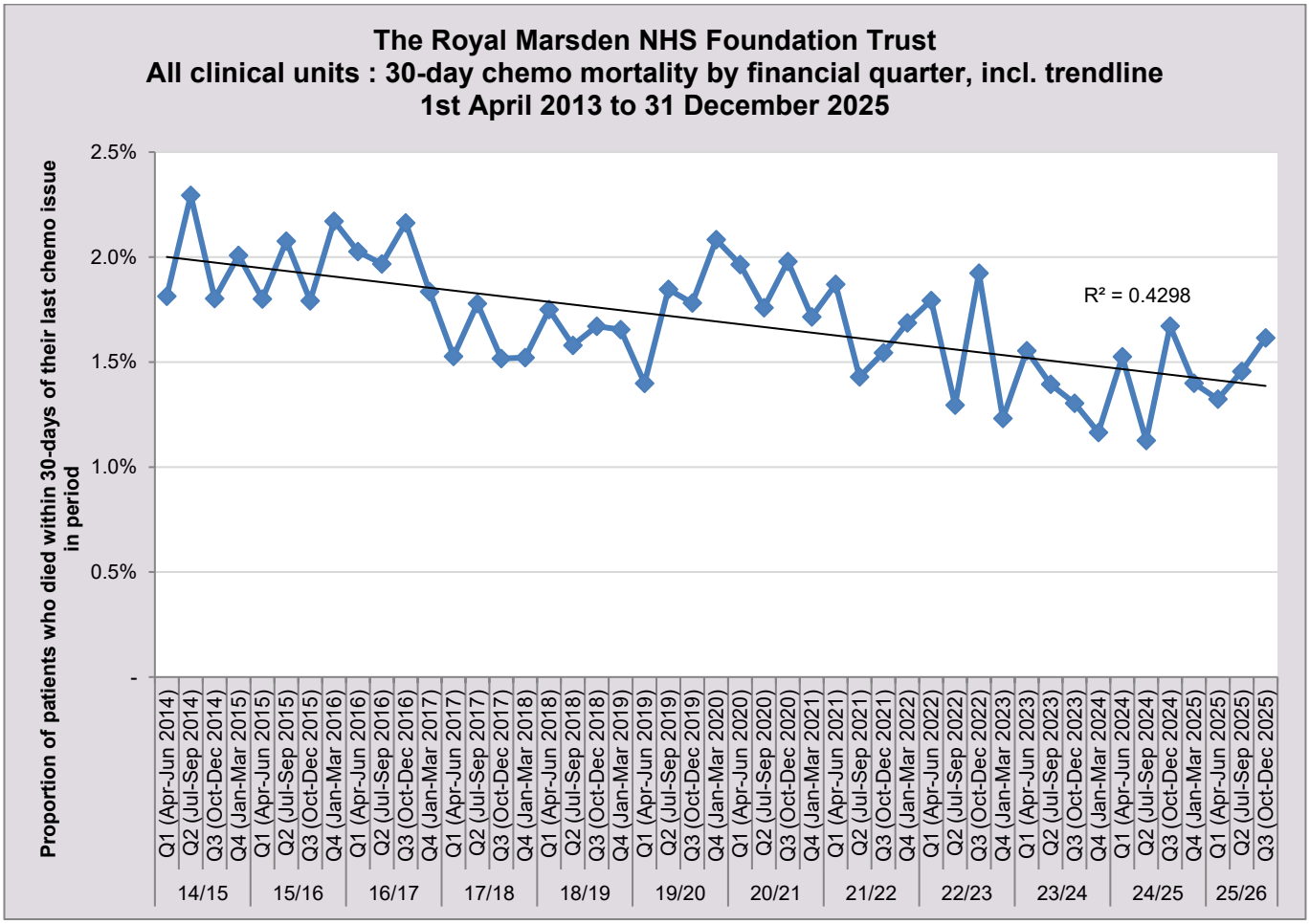
Deaths within 30 days following administration of chemotherapy are reviewed and monitored at the 30-day Mortality Group. The figure for Q3 was 1.6%, representing 88 deaths out of 5447 patients.

The ten-year data is shown in the chart overleaf.

12.0 Themes, trends and learning points

There is evidence of good practice identified:

- Evidence of high quality documentation
- Evidence of sound MDT working in the holistic management of patients
- Timely referrals to palliative care



Potential areas for development:

- A periodic EPIC summary for patients with prolonged lengths of stay

13. 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 2025 and 31st December 2025. The table below shows the RAG ratings from previous quarters:

Quarter	RAG rating
Q3 2025-2026	Green
Q2 2025-2026	Green
Q1 2025-2026	Green
Q4 2024-2025	Green
Q3 2024-2025	Green

Dr Angela Halley, Palliative Care Consultant
Dr Andrew Tweddle, Palliative Care Consultant
Tom Kirby, Deputy Director of Patient Safety and Clinical Assurance
February 2026

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 25th March 2026	**Agenda item:** 5.5
Title of Document: Month 11 Finance Report	**To be presented by:** Chief Financial Officer

1. Status **For noting**

2. Purpose:

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

3. Summary

The report presents the Trust financial performance as at 28th February 2026.

Key Headlines:

- The Trust reported a control total year to date of a £1.7m surplus, £1.7m ahead of plan due to additional funding received
- The Trust efficiency programme is head-of-plan by £4.0m for the year so far with overperformance on non-recurrent schemes offsetting underperformance on recurrent position
- As at 28th February 2026 the cash balance was £117.8m £26.8.0m behind plan YTD
- Total capital expenditure for the year so far is £28.1m, £1.2m behind plan YTD. Trust-funded schemes were £0.8m behind plan, and PDC spend £2.8m ahead of plan. Donated funded schemes was £3.1m behind plan.

4. Recommendations / Actions

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

Finance Report

1. Introduction

The paper provides a summary of the financial position as at 28th February 2026.

2. Background

The Trust Board has approved the following financial plan targets for 2025/26:

- A £5.5m surplus control total;
- A £41.8m capital plan, of which £23.8m was Trust-funded (CDEL), £5.3m additional Public Dividend Capital (PDC) funded, and £12.7m charitably funded;
- A planned cash balance of £140.3m at 31 March 2026.

3. Executive Summary of financial position

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

- The Trust position is on plan in-month with a £0.5m surplus. This brings the position to £1.7m surplus year to date, £1.7m favourable to the plan. The Trust is forecasting a £7m surplus at the end of the year, £1.5m favourable to the plan. The adjusted run rate for the month is £0.6m bringing in the year-to-date adjusted position to £10.9m. There are non-recurrent benefits of £12.5m in the position year to date.
- CIP delivery is £36.6m against a plan of £32.6, £4.0m better than plan. The forecast is to deliver £39.5m against a £36m plan. The position on efficiency is better than the plan due to additional non recurrent schemes, both overperformance on planned schemes and additional schemes identified in year. This offsets underperformance on private patients and commercial income.
- In-month income is above plan due to additional Royal Marsden Partners (RMP) income offset in costs. Private patients' income remains below plan and is £0.6m adverse in-month, £7m adverse year to date, the income target was increased significantly in this financial year. Pay costs are worse than plan by £0.4m, this is in line with the spend in December and January but has increased from the start of the year. Non pay costs are overspent by £2.5m, of which £1.8m is due to RMP spend and £0.8m is due to drugs costs which are mainly reimbursed in income.
- Total capital expenditure for the year so far is £28.1m, £1.2m behind plan YTD. Trust-funded schemes were £0.8m behind plan, and PDC spend £2.8m ahead of plan. Donated funded schemes was £3.1m behind plan. At 28th February, the full-year forecast was behind plan by £10.2m, of which £5.9m relates to trust-funded capital and £1.0m relates to PDC funded schemes. There is £16.4m to be spent in March to achieve the CDEL (Trust funded and PDC) spend of £38.2m spend for the year. This presents a significant challenge. However, the key projects yet to be fully delivered have been monitored closely over the last few months. Based on latest conversations with project owners and review by Finance of key orders already placed in the system, there is a high degree of confidence that the Trust can achieve the internal full-year forecast for these projects. Bi-weekly meetings remain in place to review spend and assure delivery.
- Cash at the end of the month was £117.8m, £26.8m behind plan. The key drivers are income to be received from GOSH, which is delayed due to delays in billing and agreed delays to income due from RMCC.

2. Income & Expenditure February 2026

Status	Jan-26	Feb-26

February				Year to Date			Annual Budget
Budget £'000	Actual £'000	Variance £'000		Budget £'000	Actual £'000	Variance £'000	£'000
(27,792)	(28,606)	814	NHS Acute Income	(314,108)	(324,312)	10,204	(341,900)
(16,157)	(15,530)	(627)	Private Patients Income	(183,047)	(175,900)	(7,147)	(200,929)
(43,949)	**(44,136)**	**187**	**Total Patient Care Income**	**(497,155)**	**(500,212)**	**3,057**	**(542,829)**
(853)	(781)	(72)	R&D income	(9,386)	(11,940)	2,554	(10,240)
(2,780)	(2,581)	(199)	Commercial clinical trials	(30,582)	(33,673)	3,091	(33,362)
(2,116)	(2,419)	302	Grants income (Charitable contributions to Income)	(23,643)	(25,354)	1,710	(25,760)
(859)	(1,005)	146	Education income	(7,555)	(8,981)	1,426	(8,339)
(1,648)	(1,364)	(284)	Commercial income	(18,132)	(16,326)	(1,806)	(19,781)
(1,884)	(2,793)	909	Other Operating Income	(21,129)	(25,775)	4,646	(23,050)
(1,726)	(3,583)	1,857	Other Operating Income - RMP	(21,278)	(20,433)	(846)	(22,967)
(11,867)	**(14,527)**	**2,660**	**Total Other Income**	**(131,706)**	**(142,481)**	**10,775**	**(143,499)**
(55,816)	**(58,663)**	**2,847**	**Total Operating Income**	**(628,861)**	**(642,693)**	**13,832**	**(686,328)**
29,755	30,201	(446)	Substantive	327,293	326,676	618	357,046
1,356	1,411	(54)	Bank	14,920	15,532	(613)	16,276
163	50	113	Agency	1,797	1,425	372	1,961
31,275	**31,662**	**(387)**	**Total Operating Pay**	**344,010**	**343,633**	**377**	**375,283**
10,015	10,713	(698)	Drugs	117,245	124,493	(7,248)	128,528
4,849	5,138	(289)	Clinical Supplies	53,763	54,630	(867)	58,651
1,046	1,202	(155)	Non Clinical Supplies	11,510	12,888	(1,377)	12,557
2,048	1,485	563	Premises	23,582	21,909	1,673	25,615
3,124	3,282	(158)	Other Non Pay	43,750	49,898	(6,148)	42,279
1,369	3,136	(1,767)	Other Non Pay - RMP	17,299	16,498	801	18,631
22,451	**24,954**	**(2,504)**	**Total Operating Non Pay**	**267,150**	**280,316**	**(13,166)**	**286,261**
53,726	**56,617**	**(2,891)**	**Total Operating Expenditure**	**611,160**	**623,949**	**(12,789)**	**661,543**
(2,090)	**(2,046)**	**(44)**	**Total Operating (Surplus)/Deficit**	**(17,701)**	**(18,744)**	**1,042**	**(24,784)**
407	407	(0)	PDC	4,473	4,473	(0)	4,879
(414)	(369)	(45)	Finance (Income)/Costs	(4,555)	(4,641)	86	(4,969)
(462)	(68)	(394)	Donated Asset Financing	(12,145)	(7,251)	(4,894)	(12,717)
2,398	2,331	66	Depreciation	26,402	25,950	452	28,799
0	(3)	3	(Profit)/Loss on Disposal of Fixed Assets	0	(12)	12	0
1,928	**2,298**	**(370)**	**Total Non operating Income and Expense**	**14,174**	**18,518**	**(4,344)**	**15,992**
(162)	**252**	**(414)**	**Total (Surplus)/Deficit**	**(3,527)**	**(226)**	**(3,301)**	**(8,792)**
462	68	394	Deduct: Donated Asset Financing	12,145	7,251	4,894	12,717
(785)	(805)	19	Add back: Depreciation on Donated Assets	(8,639)	(8,698)	59	(9,425)
(485)	**(485)**	**(0)**	**Control Total (Surplus)/Deficit**	**(21)**	**(1,672)**	**1,651**	**(5,500)**

4. Income and Expenditure

In-month: £0.5m surplus, on plan, YTD £1.7m surplus, £1.7m favourable variance to plan

Income

In-month: £58.7m, £2.8m favourable to plan, YTD £642.7, £13.9m favourable variance to plan.

NHS Income

The table adjacent shows NHS acute income reporting £10.2m favourable to plan year-to-date, an improvement of £0.8m in-month.

In-month the Trust recorded additional income for variable elective income relating to previous months of £0.6m. The work to improve the income reporting identified a coding change which improved the position. The Trust has also reduced the overperformance expected from the Genomics contract, as there is a cap on overperformance payments across the consortium.

NHS Income @ Month 11	Annual Plan £'000	Plan £'000	Actual £'000	Variance £'000
Fixed	113,796	103,733	103,738	5
Elective	55,638	50,915	50,448	(467)
Variable	28,029	25,693	29,167	3,474
Drugs	81,094	74,336	83,612	9,276
Devices	574	526	747	221
CAR-T	1,916	1,756	1,729	(28)
PET-CT	26,259	24,070	25,401	1,331
GLH	13,941	12,779	13,168	388
GLH Arbitration	-	-	-	-
OSV	8,679	7,956	5,855	(2,101)
Paediatrics	3,000	2,750	-	(2,750)
LVA	8,438	7,735	7,736	1
Other	536	1,857	2,712	855
Total	**341,900**	**314,108**	**324,313**	**10,205**

The year-to-date position is driven by overperformance of high-cost drugs of £9.3m of which £3.3m related to prior year payments from NHSE. Other variable activity (£3.5m YTD), and PET-CT (£1.3m YTD) have also overperformed. There has also been additional non recurrent income for pay awards and industrial action year to date of £1.9m.

This has been offset by underperformance of elective activity (£0.5m adverse YTD) due to a change in coding between elective activity and non-elective. Non elective overperformance is included in the fixed element of the contracts.

Income shortfalls relating to differences in the planned position for Paediatrics support (£2.8m year-to-date and £3m full year) and overseas visitors allocation (£2.1m year-to-date and £2.3m full year) have continued.

Private patients

February's private patient income was £0.6m worse than plan with income of £15.5m against a plan of £16.2m, this is an improvement on January performance. The income mix is at a higher margin than plan, driving Private Patients to be in line with plan at contribution level for February. The year-to-date position is £7.4m below the plan reflecting the stretching income target set in the year. The income plan in February is set at a lower level due to the lower number of working days in the month. There is an increase in the plan in March.

The PP Division continue to drive the initiatives planned for the year, but the forecast is expected to under deliver the planned contribution by c£4.1m. This is also noted in the risk to plan section below.

Other income

Other income is ahead of plan by £10.8m, £2.7m in-month. The key drivers for the favourable position are R&D (£2.6m YTD), Commercial trial income (£3m YTD) and Education income (£1.4m YTD).

Commercial income is £1.8m behind plan with delays to the consultancy advisory programme tendering process. This has been offset with over-performance on commercial genomics and radiopharmacy (£1m).

Other operating income continues to over-perform with £0.9m above plan in February with continued over-performance on clinical services P2P contracts and paediatric transition funding in cancer services leading to

£4.6m above plan YTD. This is offset by RM Partners programme which is behind plan for the year by £0.8m but over-performed budget in February by £1.9m.

Pay

In-month: £31.7m, £0.4m adverse to plan. YTD £343.6m, £0.4m favourable to plan

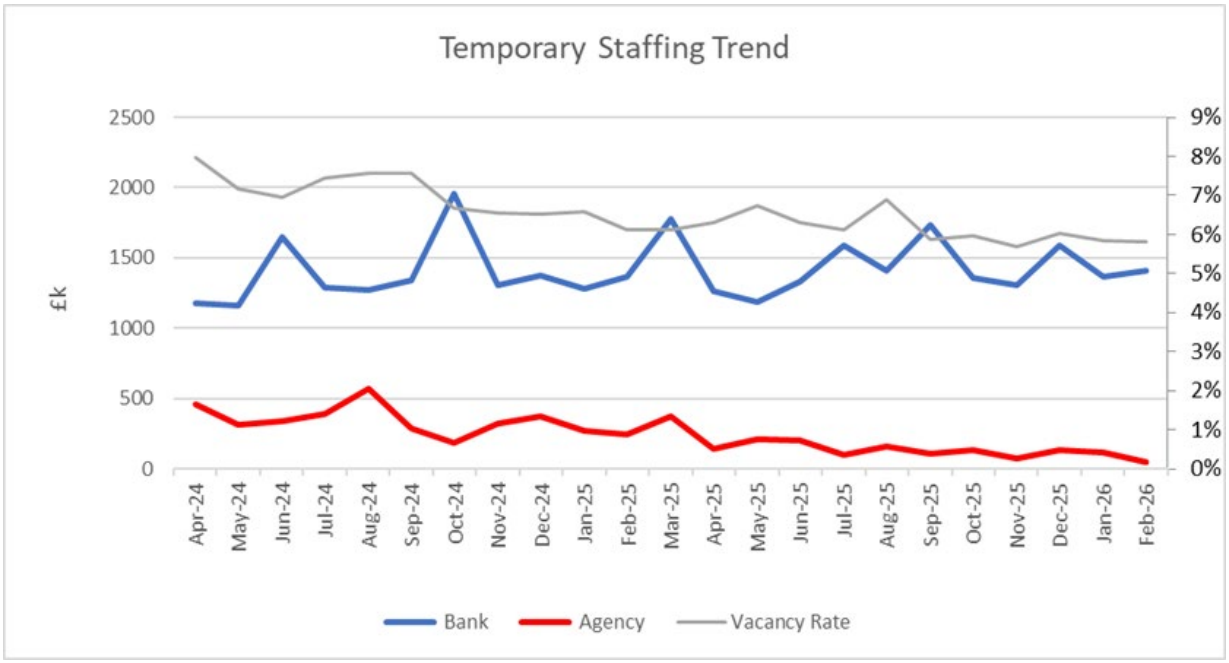
In-month substantive pay reduced by £0.1m, mainly in research. After adjusting for this there has been a £0.4m increase in February of substantive pay against the Q3 average, primarily driven by recruitment to open posts and staffing of approved business cases.

Pay costs are £343.6m YTD, £0.4m favourable to plan. This is driven by savings association with the delayed commencement of new commercial activity (£1.1m), reduced private patient activity (£1.4m) and holding of vacancies across other divisions delivering additional non recurrent savings.

Temporary Staffing

Bank and agency costs are £17m YTD, which remains below average run rate when compared to 2024/25, particularly driven by a reduction in Agency costs.

Bank usage in February was £1.4m in line with January, a £0.2m reduction seen from the high level seen in December. Agency costs at £1.4m YTD are 0.5% of pay spend and remains low when compared to 1.2% in 2024/25.



Non-pay expenditure

In-month: £25.0m, £2.5m adverse to plan. YTD £280.3m £13.2m adverse to plan

In-month drugs costs are overspent by £0.7m but have reduced from previous months. The drugs costs are mainly offset through payments for pass through activity. Premises costs are £0.6m below plan in-month, this is due to a non-recurrent benefit on property rates which we will not be charged.

The year-to-date position is driven by drugs cost overspend of £7.2m. NHS High-cost drugs are largely recovered through NHSE income. Non-clinical supplies are £1.4m overspent YTD from additional facilities costs on the cleaning contract and pharmacy aseptics costs associated with increased activity.

Other non-pay is £6.1m adverse YTD with cost pressures in Cancer services (£1.2m) related to tissue typing costs for BMT activity and costs above plan on Clinical research (£1.3m) primarily due to mix of funded projects and additional ICR recharges. The Chelsea development costs are above plan which is offset with grant income, driving a £1.4m overspend in Estates. The plan included an expectation of non-recurrent benefit in non-pay of £3.2m by M11. This has mainly been achieved through improvements in the income position driving an adverse pay variance year to date. There are continued savings in premises (£1.7m YTD), driven by savings on digital licenses and network costs via VAT recovery. RM Partners report a £0.8m underspend in line with reduced income.

Efficiency plans

In order to deliver the Trust's planned surplus in 2025/26, the Trust has set a £36m efficiency target (6.9% of influenceable costs).

Classification	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	Plan £'000	Forecast £'000	Variance £'000
In-Year Additional Non-Recurrent	0	3,919	3,919	0	3,919	3,919
Non-Recurrent	13,440	15,625	2,185	14,634	16,593	1,958
Recurrent	19,183	17,148	(2,035)	21,366	19,034	(2,331)
Total	**32,622**	**36,691**	**4,069**	**36,000**	**39,546**	**3,546**

The CIP program has delivered £36.7m efficiencies YTD, £4m ahead of plan YTD. The under-performance on recurrent schemes is offset by an additional £4m of non-recurrent prior year upsides recognised into the YTD position. This is in addition to other non-recurrent benefits in the position to cover under-performance outside of the efficiency program.

The program is behind plan on the recurrent schemes in the £36m plan by £2.0m YTD in February with Private Patients initiatives (£6.5m) and Consultancy program (£1.4m) partially offset by commercial genomics over-performance (£1.1m) and additional income from clinical research commercial trials (£2.7m).

The Trust will need to deliver recurrent savings going forward, to reduce reliance on one-off benefits to remain financially sustainable in the future and deliver its financial strategy objectives.

Adjusted financial performance

The adjusted run rate analysis describes the financial position when in-year, unplanned, one-off cost pressures or benefits are removed, showing an unadjusted view of the Trust's financial performance. The Month 11 adjusted run rate is £0.6m deficit. On average year-to-date the adjusted run rate has been a £1.0m deficit.

The Trust has £12.5m of non-recurrent benefits YTD in the position. The table below sets out a summary of these adjustments.

Area	£m
Prior year SPF adjustment	1.5
Prior year Drugs true-up payment	3.2
Additional non recurrent funding	1.9
Historic Private Patients WIP recognition	2.0
Other non-recurrent benefits	3.0
Adjustments to the run rate year-to-date	**12.5**

It is expected the Trust will deliver its forecast in 2025/26, but the adjusted run-rate analysis shows the way in which this is being delivered is not sustainable. As such measures need to be taken during planning to deliver recurrent improvements and to remove the reliance on non-recurrent one-off benefits to deliver the financial objectives.

Forecast

The full year forecast is to deliver a £7.0m surplus.

Changes in the risks and opportunities are not anticipated to affect the forecast outturn.

5. Capital Expenditure

The Trust Board approved a capital plan for year of £41.8m, consisting of:

- Trust-funded schemes of £23.9m
- PDC-funded schemes (cash-backed) of £5.3m
- Donation-funded schemes of £12.7m.

The Trust has subsequently received additional PDC funding (cash-backed) of £6.1m and additional Trust funded (non-cash-backed) of £9.8m, taking the authorised spend to £57.8m.

The detail below shows the performance of the overall program for the year so far, and an estimated year end forecast.

	Year to Date			Full Year		
	Budget £m	Spend £m	Variance £m	Plan £m	Forecast £m	Variance £m
Trust-funded	11.8	8.3	3.5	23.9	18.2	5.7
PDC	2.5	4.0	(1.5)	5.3	4.2	1.0
Donated	9.5	6.4	3.1	12.7	9.4	3.3
Capital Plan Approve	**23.8**	**18.7**	**5.0**	**41.8**	**31.8**	**10.0**
Additional Trust-fund	**5.3**	**8.0**	**(2.6)**	**9.8**	**9.6**	**0.2**
Additional PDC	**0.1**	**1.4**	**(1.3)**	**6.1**	**6.1**	**0.0**
Total Capital Spend	**29.3**	**28.1**	**1.2**	**57.8**	**47.6**	**10.2**

Year-to-date (YTD) expenditure

Total capital expenditure for the year to date is £28.1m, £1.2m behind plan. Of this: trust-funded schemes were £0.8m behind plan; PDC was £2.8m ahead of plan; and donated schemes were £3.1m behind plan.

The main drivers for the YTD **Trust-funded** underspend of £0.8m compared to plan are:

- £3.1m overspend on Cyberknife equipment which was not in the original plan but for which the Trust received CDEL allowance.
- £0.4m overspend on the Critical Clinical Messaging Digital project, which was originally phased throughout the year but has now been fully recognised.
- £2.4m underspend on Aseptics project. This was identified earlier in the year and the project is on track to meet the updated target of £6.2m by year-end.
- £1.5m underspend on Hardware Replacement, Firewall Replacement and other smaller Digital projects. These projects are expected to be delivered in March.

The main drivers for the **Donated** £3.1m YTD underspend compared to plan are:

- £4.8m underspend: Chelsea New Build project grant relating to RIBA stage 4 was planned to commence in June 25 and is now expected to commence after the end of this financial year.
- £0.7m underspend: Brachytherapy system was planned for £1m and only £0.4m has been spent to date.
- £1.8m overspend against the original plan due to the Beech linac delivered during this financial year rather than the previous one but, as this is donated, it is not a capital pressure.
- other small variances due to timing of delivery.

Full year forecast

At 28th February, the full-year forecast was behind plan by £10.2m, of which £5.9m relates to trust-funded capital and £1.0m relates to PDC funded schemes.

The Trust will defer the maximum available capital flexibility allowance of £5.3m into 2026/27. The Trust will also carry forward the £1m underspend on PDC projects, as agreed with NHSE. This means the Trust is on course to realise a small underspend of £0.6m against the CDEL allowance (Trust-funded + PDC). However, the Trust is exploring options to mitigate the underspend and has not therefore reported the forecast underspend against its CDEL allowance to NHSE.

There is £16.4m to be spent in March to achieve the CDEL spend for the year. This is a significant increase in spend. The key projects yet to be fully delivered have been monitored closely over the last few months and based on latest conversations with project owners and review by Finance there is a high degree of confidence that the Trust can achieve the internal full-year forecast for these projects.

6. Cash

Current position

As at 28th February 2026 the cash balance was £117.8m, £26.8m behind plan YTD.

The key drivers of the cash position are as follows;

- NHS Debtors are higher than plan driven by GOSH debt of £9.3m for 2025/26. There were delays in raising invoices for this income but payment is expected
- RMCC debt is higher than plan by £15.0m, this has been agreed with the charity

Other contributors

- Stock holding is higher than plan by £1.4m, due to clinical supplies and lab reagents increasing YTD, reflecting the increase in commercial Genomics activity.
- Prepayments have increased higher than planned by £0.5m

Cash Reporting Metrics

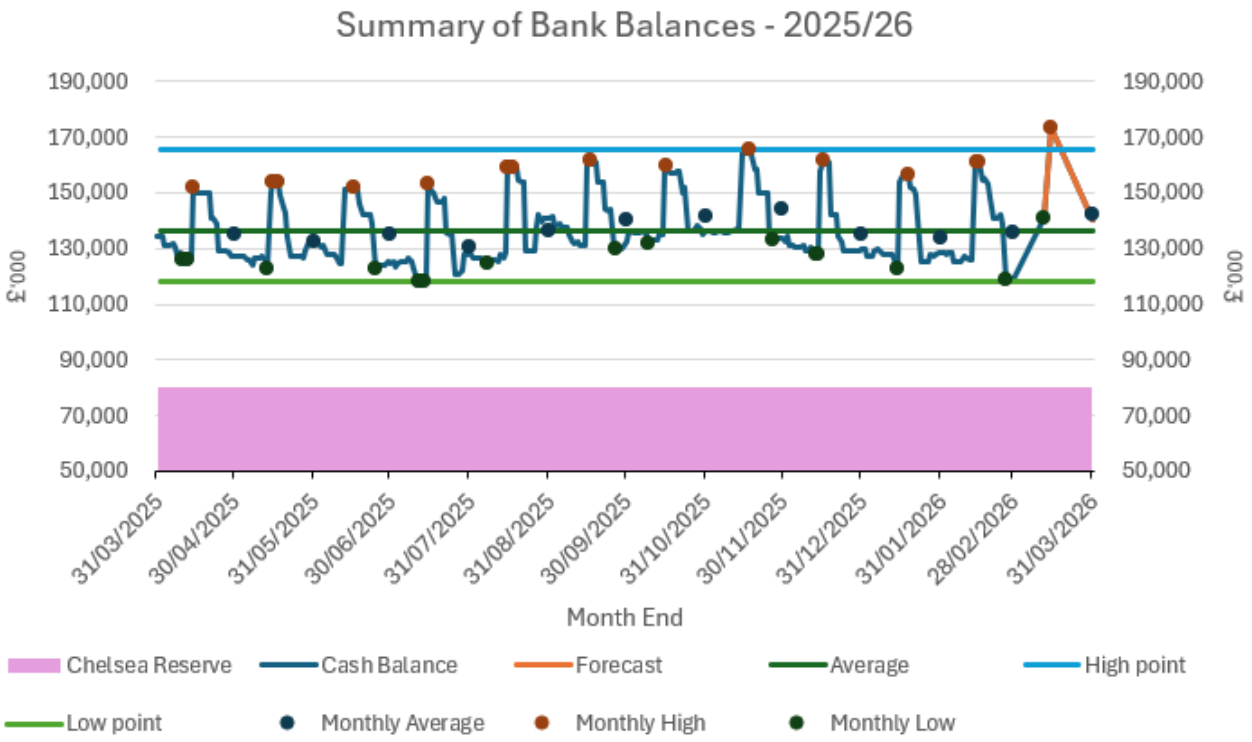
Below are key metrics used widely by organisations to monitor their cash position and liquidity. The Trust's figures are reported below, alongside commentary on how ratios are derived and whether within healthy ranges.

Below are some key metrics used to monitor the cash position:

Cash Metrics	Description	M9 2025/26	M10 2025/26	M11 2025/26
Cash Days	Number of days Trust can pay its operating expenses	68	68	63
Debtor Days	Average days taken to turn income into cash	77	83	77
Quick Ratio	Ability to meet current liabilities with easily liquid assets	1.86	1.79	1.79
Working Capital Ratio	Ability to meet current liabilities with current assets	1.96	1.87	1.88
Creditor Days	Average days taken to pay creditors	127	133	133
BPPC Value % paid in target (95%)		95%	96%	96%
BPPC Number % paid in target (95%)		93%	93%	93%

Forecast

Cash high points in the reflect the timing of NHS payments (received on 15th of the month), with the low points being substantive salary pay date, 25th of the Month-end.



7. Summary

The Trust reported a control total year to date of a £1.7m surplus, £1.7m ahead of plan due to additional funding received.

The Trust efficiency programme is head-of-plan by £4.0m for the year so far with overperformance on non-recurrent schemes offsetting underperformance on recurrent position.

There are significant non recurrent benefits supporting the in-year position and the adjusted run rate shows a £0.6m deficit in-month and a £10.9m deficit year to date. The Trust must identify recurrent improvements in future years to maintain financial sustainability.

As at 28th February 2026 the cash balance was £117.8m, £26.8.0m behind plan. This is due to billing delays for GOSH and RMCC.

Total capital expenditure for the year so far is £28.1m, £1.2m behind plan YTD. Trust-funded schemes were £0.8m behind plan, and PDC spend £2.8m ahead of plan. Donated funded schemes was £3.1m behind plan. Tight controls are being maintained on capital spend and the Trust expects to meet the current forecast.

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 2026	**Agenda item:** 5.6
Title of Document: • Q3 25/26 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

Provides an update on the Trust's performance for Q3 25/26.

Recommendations:

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

The Royal Marsden NHS Foundation Trust

25/26 Q3 Performance Report

1. Executive Summary
2. Key Areas of Improvement
3. 62 Days (Cancer Waiting Time Target)
4. Other red-rated metrics
5. Appendix A : Scorecard

NHS

Executive Summary

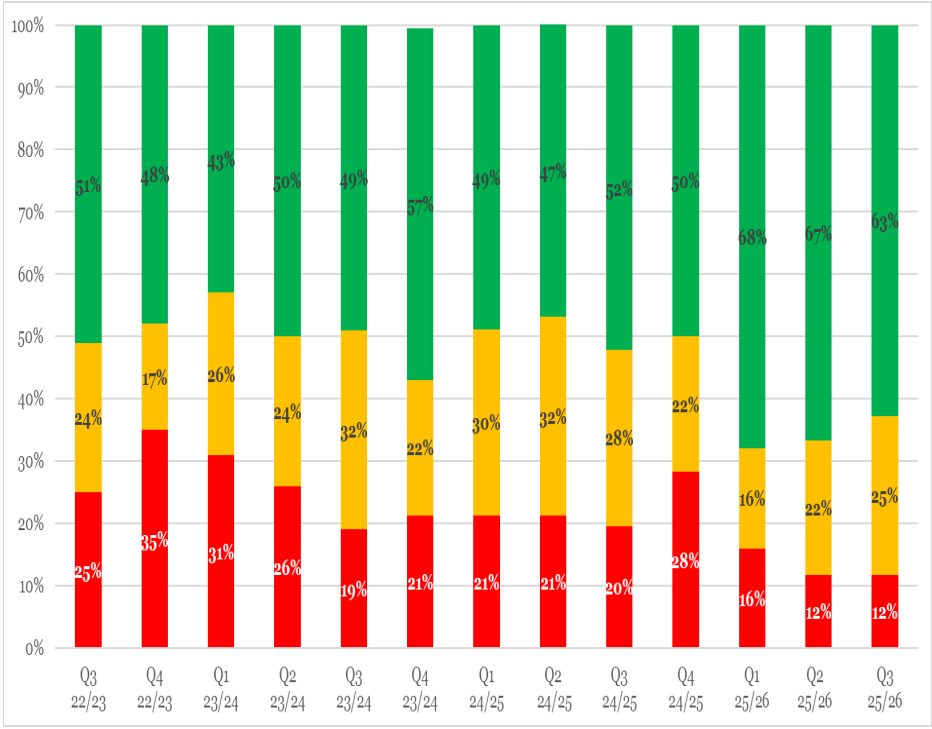
Key headlines:

- Q3 has seen continued strong performance across the Trust, with sustained improvements in key operational and quality metrics.
- Inpatient capacity remains tight across all sites. Chelsea, Sutton and CCU bed occupancy all amber rated in Q3, sitting above target range, reflecting increased referrals & activity compared to the previous year.
- Theatre Session Utilisation (Chelsea) has improved in Q3, reporting 86.9%. This is also an improvement on the same quarter in 24/25. Reviewing utilisation against a 9-hour day (KPI in development), also shows improvement at both sites between Q2 and Q3 and compared to the same quarter in the previous year.
- PP Aged Debt at > 6 months has improved to amber rated in Q3, reflecting continued improvement due to the debt recovery project.
- Improvement has been across a range of workforce metrics. Vacancy rates are reducing each quarter, with voluntary staff turnover also steadily falling and remains below the target. Consultant appraisal and appraisal/PDP rates have also been increasing since Q1.

Key areas of focus:

- Two of the four IPC metrics (CDIFF and P. aeruginosa) remain green-rated in Q3 2025/26, each showing a reduction in reported cases compared to the same period in the previous year. However, E.coli and Klebsiella are at risk of exceeding the NHSE annual target. A detailed narrative is provided in the Quality Account.
- Performance against the 62-day cancer standard in Q3 remained red-rated, reporting 69.2% **(Slide 3).**
- While the Friends and Family Test (FFT) scores remain very strong in Q3, the volume of respondents included is significantly lower. This is due to a change in provider and a temporary interruption to service during implementation of the new system. Response rates are expected to increase significantly in Q4.

Scorecard KPI Performance:

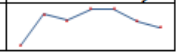


NHS Oversight Framework (NOF):

- The Q2 NHS Oversight Framework Segment ratings were published in early December 2025. Q3 is expected in late February.
- RM remained in segment 1, ranked in fifth place nationally.
- The key areas of risk for the Trust relates to the Implied Productivity metric (where the Trust is seeking greater understanding of the KPI methodology); discharge readiness data and IPC where performance is measured against NHSE set thresholds.

62 Days (Cancer Waiting Time Target)

	Target	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26
Ψ 62 Days (Cancer Waiting Time Target)	≥85%	65.7%	71.9%	70.6%	73.0%	73.1%	70.6%	69.2%

Latest data	Trend (exc. latest data)
N/A	

Update since previous quarter:

- Performance against the 62-day cancer standard in Q3 was 69.2% (Q2 was 70.6%).
- In Q3, The Trust met the 31-day cancer waiting time standard, the 28-day Faster Diagnosis standard and 18 weeks referral to treatment standard.

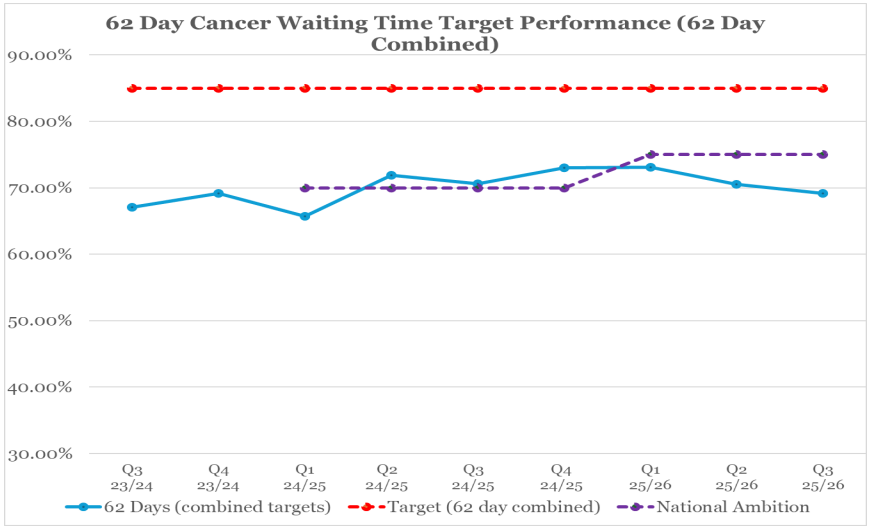
Key issues and causes:

- In addition to the previously reported challenges to achieving compliance with the 62-day standard, Q3 performance was impacted by a significant increase in demand to the breast service.
- YTD breast USC referrals are 8% higher than last year. Referrals have been particularly high since September, and while December saw a modest seasonal dip, demand remained well above December 2024 levels.
- The increased demand and resulting diagnostic capacity challenges have been seen across the sector. RM has provided mutual aid to Imperial (August - October) and Kingston (October to date) to support the wider system.
- Following the increased demand, the number of breast surgical treatments increased by 50% from Q2, putting additional pressure on the Trust's surgical capacity and resulting in a higher number of breast surgical breaches.

Actions/next steps:

- RMP funding has been secured to support extra weekend breast surgical lists throughout Q4 to manage the increased demand.
- Operational teams continue to work through the CBU action plan to address internal barriers to compliance.
- RMP has a programme of work to address diagnostic waits across the system.
- NHSE has committed to working with local providers to minimise late referrals.

Trends:

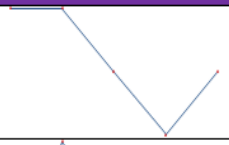
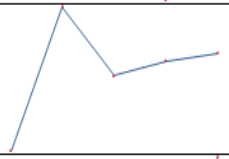
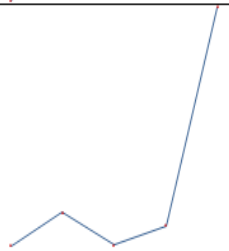
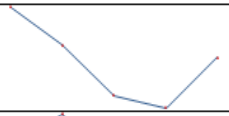
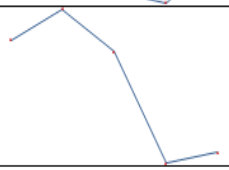


The Trust also monitors performance nationally via benchmarking. The Trust's 62 Day CWT figure was above the national average for Oct-25; however, it was just below national average in Nov-25 and Dec-25.

Forecast:

- The Trust remains focused on its improvement plan and is working hard to meet the national ambition of 75% compliance by March 2026.

Other red-rated metrics to note:

Metric	Target	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Trend	Forecast	Narrative
18 wks. pathways - patients waiting > 65 wks. (distinct patients across the quarter)	0	2	2	1	0	1		🔴	The trust reported one incomplete RTT pathway over 65 weeks at the end of Q3. This was a very late referral to the Trust (received week 54). Following referral to RM, the patient was seen and worked up quickly. The patient requested treatment took place after Christmas (treated in January).
Cash (£m)	YTD Plan	105.8	136.2	121.6	124.7	126.3		🔴	Cash shows an improved position over Q3 2025/26. Cash is behind plan year to date due to delays in debt recovery. There has been growth in NHS debt and this will be resolved by the end of the financial year. The RAG rating remains red due to the timing of expected cash inflows that have been delayed. These are being actively managed with the respective counterparties.
PP activity Income Variance YTD (£000)	YTD Plan	433	904	447	712	3748		🔴	PP income at Q3 YTD ran at 6.1%, significantly more than the annual growth rate of 2.5% in 24/25, but below the challenging plan set for 25/26. The key driver is continued declines in embassy income driven by Kuwait (-42%), with the strong growth in PMI (+14%) and self-pay (+8%) not able to fully compensate for this given the significant differences in profitability by payor group. The Trust has put a range of actions into place to address these challenges, including multiple service and billing improvements and a series of international visits to key referral institutions, all of which we expect to have an impact going forwards.
Non-PP Debtors >6 Months (£m) - absolute value at month end	<£3.0m	5.2	4.9	4.5	4.4	4.8		🔴	The Trust has set a challenging target to return to pre-Epic levels of debt. These debt levels are continuing to progress towards the target, and the trust continues to work with its credit control provider to reduce the levels of non-PP debtors.
Capital Expenditure (CDEL) Variance YTD (£000) - variance to plan in £m	YTD Plan	-0.9	0.5	-1.4	-6.4	-5.9		🟢	CDEL is behind plan due to the timing of some large projects which now fall into Q4 for completion. To ensure delivery, bi-weekly Executive led meetings are in place to ensure that the forecast for capital spend is met for the year. The Trust intends to use the flexibility over its surplus capital incentive to move capital budget to the next financial year and avoid the loss of capital resources. This will mean a year-end underspend (agreed with NHSE) irrespective of the level of projects completed in Q4.

Appendix A

The Royal Marsden NHS Foundation Trust

Balanced Scorecard Q3 25/26 Published 16th February 2026

Key

* Denotes Year To Date (YTD) figures

Blue-shaded KPI denotes metric linked to BAF stategic framework

Ψ Denotes NHS Oversight Framework metric

Denotes change in threshold or definition

	1. Safe Care	Target	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	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	42*	58 *	13*	33*	47*		
Ψ	C Diff - Number of Reportable Cases (COHA/HOHA) (at YTD)	40	46*	57 *	8*	18*	30*		
	Number of Hospital Associated (HOHA/COHA) P. aeruginosa cases (at YTD)	21	24*	27 *	2*	10*	16*		
	Number of Hospital Associated (HOHA/COHA) Klebsiella spp. Cases (at YTD)	29	35*	37 *	6*	15*	24*		
	% screened positive for sepsis who received IV abx in line with NICE guidance (inpatients & emergency	90%			98.4%	99.1%	98.4%		
	Never Events	0	0	0	0	0	0		
	Hospital Standardised Mortality Rate 100 (rolling 12 months, NHS and PP) (1 Qtr. in arrears)	≤80			77.91	73.68	70.15		
	Mortality audit	G	G	G	G	G	G	N/A	
	30 day mortality post surgery	≤0.4%	0.13%	0.64%	0.52%	0.44%	0.51%		
	30 day mortality post chemotherapy	≤1.4%	1.67%	1.40%	1.32%	1.46%	1.62%		
	100 day SCT mortality (Deaths related to SCT)	≤5%	1.45%	1.75%	1.96%	4.17%	3.23%		
	90 day mortality post radical radiotherapy	≤1.0%			1.00%	0.90%	0.82%		
	Staging data completeness (1 qtr in arrears)	≥80%	86.4%	87.8%	87.4%	84.1%	80.2%		
	2. Effective Care	**Target**	**Q3 24/25**	**Q4 24/25**	**Q1 25/26**	**Q2 25/26**	**Q3 25/26**	**Trend**	**Forecast**
Ψ	28 day Faster Diagnosis Standard (FDS): All Cancers	≥80%	89.4%	90.3%	89.9%	87.9%	88.7%		
Ψ	31 Days (Cancer Waiting Time Target)	≥96%	96.4%	95.8%	96.0%	96.4%	96.1%		
Ψ	62 Days (Cancer Waiting Time Target)	≥85%	70.6%	73.0%	73.1%	70.6%	69.2%		
Ψ	18 weeks. % RTT incomplete pathways < 18 weeks	≥92%			93.5%	94.8%	94.8%		
Ψ	18 wks. pathways - patients waiting > 52 wks. % of waiting list	<1%			0.3%	0.1%	0.1%		
	18 wks pathways - patients waiting > 65 wks. (distinct patients across the quarter)	0	2	2	1	0	1		
	6 week diagnostic waiting times (DM01)	95%	95.4%	97.2%	98.1%	99.1%	98.4%		
	Cash (£m)	YTD Plan	105.8	136.2	121.6	124.7	126.3		
	Delivery against planned control total YTD (£m) - variance to plan	YTD Plan	2.3	0.0	0.0	0.0	1.5		
	Achievement of Efficiency Programme YTD (%)	YTD Plan	109.3%	100.1%	83.6%	100.0%	120.2%		
	Agency Spend as a % of total pay bill	YTD Plan	1.32%	1.18%	0.60%	0.50%	0.45%		
	PP activity Income Variance YTD (£000)	YTD Plan	433	904	447	712	3748		
	PP Aged debt at >6months	<£8.0m	24.6	21.9	17.5	16.1	8.8		
	Non-PP Debtors >6 Months (£m) - absolute value at month end	<£3.0m	5.2	4.9	4.5	4.4	4.8		
	Capital Expenditure (CDEL) Variance YTD (£000) - variance to plan in £m	YTD Plan	-0.9	0.5	-1.4	-6.4	-5.9		
	Bed occupancy - Chelsea	≥82% ≤87%	90.1%	91.2%	91.1%	91.0%	89.8%		
	Bed occupancy - Sutton (excluding McElw+TCTU+Oak+RadNuc)	≥82% ≤87%	86.6%	86.5%	90.9%	93.2%	91.2%		
	Bed occupancy - Critical care Chelsea	≥67% ≤75%	71.4%	77.1%	75.4%	77.4%	76.3%		
	Session theatre utilisation - Chelsea	≥85%	84.2%	87.1%	90.6%	83.2%	86.9%		
	Session theatre utilisation - Sutton	≥70%	69.8%	67.6%	73.0%	67.8%	69.9%		
	Research: Confirmed No. of 1st UK pts recruited in last 12 months	12	28	21	23	20	19		
	Research: Confirmed No. of 1st European pts recruited in last 12 months	3	4	7	5	5	7		
	Research: Confirmed No. of 1st global pts recruited in last 12 months	1	2	2	2	2	2		
	% of commercial contract interventional trials where RM is lead NHS site	≥35%	54.6%	48.7%	43.0%	45.2%	45.2%		
	3.Caring	**Target**	**Q3 24/25**	**Q4 24/25**	**Q1 25/26**	**Q2 25/26**	**Q3 25/26**	**Trend**	**Forecast**
	Friends and Family Test (Inpatient and Day Care): % overall experience	≥95%	99.2%	98.9%	99.1%	98.8%	99.0%		
	Friends and Family Test (Outpatients) : % overall experience	≥95%	96.6%	97.3%	98.5%	97.2%	98.0%		
	Percentage SACT Infusion patients starting treatment < 1 hour of appointment time (Excluding Trials)	≥85%	81.5%	81.9%	84.8%	84.4%	83.6%		
	4. Responsive	**Target**	**Q3 24/25**	**Q4 24/25**	**Q1 25/26**	**Q2 25/26**	**Q3 25/26**	**Trend**	**Forecast**
	Number of patients moved to Patient Initiated Follow Up/Open Access against trajectory	Q3 ≥ 378	406	429	449	399	423		
	Rate of written complaints per 1,000- day cases and IP discharges	≤2.00			0.99	1.41	1.86		
	5. Well Led	**Target**	**Q3 24/25**	**Q4 24/25**	**Q1 25/26**	**Q2 25/26**	**Q3 25/26**	**Trend**	**Forecast**
Ψ	NHS Oversight Framework (1 Qtr. in arrears)	1				1	1	N/A	
	Vacancy rate	≤7%	6.6%	6.4%	6.4%	6.3%	5.9%		
	Voluntary staff turnover rate	≤12%	8.7%	8.3%	7.8%	7.6%	6.9%		
Ψ	Sickness rate	≤3%	4.3%	4.3%	3.5%	3.8%	4.1%		
	Consultant appraisal (number with current appraisal)	≥95%	94.0%	94.5%	85.0%	94.0%	94.4%		
	Appraisal & PDP rate	≥90%	83.8%	86.5%	79.9%	85.1%	89.3%		
	Completed induction	≥85%	83.2%	88.1%	93.6%	96.0%	89.8%		
	Statutory and Mandatory Staff Training	≥90%	92.9%	94.3%	94.1%	93.8%	94.2%		

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:	**Agenda item:**
25 March 2026	6.1
Title of Document:	**To be presented by:**
Risk Appetite Statement 2026/27	Company Secretary

1. Status **For Noting**

2. Purpose:

Relates to:

Governance	*X*

3. Summary

The Risk Appetite Statement sets out the level of residual risk the Trust is willing to accept, tolerate or justify in delivering its healthcare, education, training and research objectives. It is recognised that the delivery of healthcare involves inherent risks that cannot be entirely eliminated.

The Board is required to set specific limits for the levels of risk the Trust is prepared to tolerate in pursuit of its strategic objectives at least annually, and to review these limits during periods of increased uncertainty or significant change in the internal or external environment.

In May 2024, the Board approved the Risk Appetite for 2024/25 in line with the Trust's new clinical strategy. Each year, the Risk Appetite is also presented in summary form within the Trust's Annual Report. For 2025/26, the Risk Appetite was reviewed and approved with no major changes. For 2026/27, a small number of changes are proposed to reflect recent Board discussions on strategic risks and to ensure continued alignment with the Trust's evolving risk profile.

4. Recommendations / Actions

The Board is asked to review and approve the Risk Appetite Statement for 2026/27.

Risk Appetite 2026/27

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 strategic categories and is linked to the Board Assurance Framework (BAF):

- Reputation, Regulation and System Leadership
- Research and innovation
- Compassionate, Committed, Excellent Workforce .
- Innovative and Personalised Diagnostics Treatment & Care.
- Sustainable investment

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 2026

Objective / Risk Appetite	Risk Tolerance
Reputation, Regulation and System Leadership	
Risks that threaten safe, high-quality care or effective operational and governance management	Moderate – risks accepted within controlled parameters to maintain safe services and reputation.
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.)
Risks from failing to anticipate, influence, or adapt to NHS policy, regulatory changes, and funding frameworks.	Moderate tolerance - controlled engagement ensures alignment with national strategy.
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.	Low 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	Low tolerance (in respect of risks associated with

threaten the principles of maintaining Equality, Diversity and Inclusion and supporting staff wellbeing.	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)
Innovative 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. 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.	Moderate 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)
<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	
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).

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: 25 March 2026	**Agenda item:** 6.2
Title of Document: Board Assurance Framework	**To be presented by:** Company Secretary

1. Status: For review and approval

2. Purpose: This paper provides the Board with a revised Board Assurance Framework (BAF) following discussions at previous Board meetings regarding the Trust's top strategic risks.

Relates to:

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

3. Summary

The purpose of the Board Assurance Framework (BAF) is to set out the Trust's principal risk assurance framework in the context of the strategic objectives and the core and cross-cutting themes within the Strategic Plan. It enables the Board to maintain oversight of the most significant strategic risks and the effectiveness of the controls and assurances in place to manage them.

At previous Board meetings, members considered whether the BAF accurately reflected the Trust's most significant strategic risks. Board members were invited to identify both short-term and longer-term risks, which were subsequently mapped against the existing BAF. This exercise demonstrated that the Trust's risk management framework is effective in identifying and capturing strategic risks. It also confirmed that while some risks would benefit from inclusion within the BAF, others are more appropriately managed at an operational level through the Trust's risk register and associated governance processes. The BAF has been updated to reflect these discussions and the feedback received from Board members.

As part of the refresh, a new section has been introduced to strengthen coverage of reputational risk, regulatory risk and system leadership. In addition, a new strategic risk has been included in relation to the Trust's ambition to advance its Environmental, Social and Governance (ESG) agenda. Other existing strategic risks have been refined to incorporate Board feedback and to improve clarity and alignment with the Strategic Plan.

At the most recent Board meeting, members requested that cyber risk be made more prominent within the BAF and explicitly incorporated under reputational risk. The Board also asked that risks relating to private patient income be clearly reflected within the financial plan risk. These changes have now been made and are reflected in the updated BAF.

The updated BAF now comprises sixteen strategic risks. Of these, three risks exceed their agreed tolerance levels and are therefore identified as the Trust's top strategic risks under the proposed methodology. All other strategic risks remain within tolerance or are being closely monitored. Operational risks will continue to be reported and managed separately through the Trust's established risk management arrangements.

The three strategic risks currently exceeding tolerance are:

- 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.
- 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.
- 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 full BAF is available here.

4. Recommendations / Actions

The Board is asked to review and approve the Board Assurance Framework.

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NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting:	**Agenda item:**
25 March 2026	6.3
Title of Document:	**To be presented by:**
Review of Board Standing Orders	Company Secretary

1. Status **For approval**

2. Purpose:

Relates to:

Governance	*X*

3. Summary

In accordance with section 12.3 of the Standing Orders, the Board of Directors is required to review the Standing Orders annually.

A review has been undertaken, and the Standing Orders remain fit for purpose, current, and aligned with best practice and the Trust's Constitution.

The only proposed amendment relates to the delegation of authority for approval of the Annual Report and Accounts to the Audit and Finance Committee, reflecting the Standing Financial Instructions and established practice.

Full Board Standing Orders are accessible here.

4. Recommendations / Actions

The Board is asked to approve the updated Standing Orders.

The ROYAL MARSDEN
NHS Foundation Trust

BOARD PAPER SUMMARY SHEET

Date of Meeting: 25 March 2026	**Agenda item:** 6.4
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:** Chair AFC Chair QAR

1. Status: **For ratification**

2. Purpose:

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

3. Summary

The Terms of Reference for the Audit and Finance Committee and the Quality Assurance and Risk Committee were reviewed at their respective meetings in November and February, with updates agreed to clarify roles, responsibilities and interfaces.

For the Audit and Finance Committee, the reference to a joint meeting with QAR was removed, membership and attendance expectations were clarified, and the Committee's responsibilities were strengthened, including clearer oversight of digital and cyber risk, monitoring the timely implementation of internal audit recommendations, explicit coverage of the capital programme, tender waivers and annual review of accounting policies, and clearer reporting arrangements to the Board and Council of Governors.

For the Quality Assurance and Risk Committee, it was agreed that the reference to a joint meeting with AFC be removed and that not all policies need to be reviewed by QAR, with appropriate delegation of policy review to the Integrated Governance and Risk Management Committee to allow QAR to focus more effectively on quality, safety and risk oversight.

4. Recommendations / Actions

The Board is asked to ratify 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 Finance 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.
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	12 November 2025
Review Date	20 October 2026 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

Terms of Reference

Committee	**Quality, Assurance and Risk Committee (QAR)**
Membership	At least two Non-Executive Directors Chairman Chief Executive Deputy Chief Executive Chief Nurse Chief Medical Officer Chief Operating Officer Chief Finance Officer Chief People Officer Chief Information Officer Director of Operations - Cancer Services Director of Operations - Clinical Services Director of Operations - Private Care Chief Pharmacist Deputy Director of Patient Safety and Clinical Assurance Notify the Corporate Governance Manager if deputies will stand in for members.
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	Corporate Governance Manager
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 meetings a year.
Meeting Frequency	QAR will meet five times a year 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. 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: • 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) • Symptom Control and Palliative Care Team report 3. To oversee clinical governance and risk management arrangements within the Trust, including those for clinical audit, Complaints, Claims and Patient Safety Incident response 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 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 maintain an oversight and monitor the Trust's whistleblowing and Freedom to Speak Up function 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. 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 will ensure that the key business of QAR is reported to the Trust Board including any recommendations for action. 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 2026
Revision date	February 2027