

Board of Directors' Meeting Board Room, The Royal Marsden, Chelsea

Wednesday 26th March 2014, 2-4pm

Agenda

1. Apologies for Absence
2. Minutes of the Board Meeting held on 25th September 2013
(*Chairman*) Enclosed
3. Corporate Governance
3.1. NED Re/appointment
(*Chairman*) Enclosed
4. Board Assurance Framework
(*Nancy Hallett, Non-Executive Director*) Enclosed
5. Report from Medical Director
(*Medical Director*) Enclosed
6. Operational Plan 2014-16 and Board Declarations
(*Director of Finance*) Enclosed
7. Sutton for Life Business Case and Funding Strategy
(*Chief operating Officer*) Enclosed
8. MR Linac Business Case
(*Chief Operating Officer*) Enclosed
9. Performance and Quality
9.1. Key Performance Indicators Q3
(*Chief Operating Officer*) Enclosed
9.2. Quality Accounts – January / February 2014
(*Chief Nurse*) Enclosed
10. Board Committee Reports
10.1. Quality, Assurance and Risk Committee – report from meeting
held on 11th February 2014
(*Nancy Hallett, Non-Executive Director and Chair of Committee*) Enclosed
10.2. Audit and Finance Committee – report from meeting held on 29th
January 2014
(*Greg Andrews, Non-Executive Director and Chair of Committee*) Enclosed
11. Any other business

Date of next meeting:

Wednesday 2nd July 2014, 2pm – 4pm
Board Room, The Royal Marsden, Chelsea

Please note: There will be a short meeting for the Non-Executive Directors at the end of the Board Meeting

Minutes of The Royal Marsden Board of Directors (Public Session)

Wednesday 25th September 2013

Board Room, Chelsea.

Present:

R. Ian Molson
Cally Palmer
Greg Andrews
Alan Ashworth
Sir John Craven
Nancy Hallett
Richard Turnor
Colin Clark
Dr. Shelley Dolan
Alan Goldsman
Professor Martin Gore
Dr. Liz Bishop

Chairman
Chief Executive
Non-Executive Director
Non-Executive Director
Non-Executive Director
Non-Executive Director
Non-Executive Director
Non-Executive Director
Chief Nurse
Director of Finance
Medical Director
Chief Operating Officer

In Attendance:

Syma Dawson (minutes)

Head of Corporate Governance

The meeting was quorate.

1/13 Apologies for Absence
No apologies were noted.

2/13 Minutes of the Public Board meeting held on 20th March 2013
The minutes were approved.



3/13 Report from the Medical Director and Chief Nurse

3.1. Medical Director's update

The Medical Director recommended the appointment of Alistair Ring as Medical Oncologist for the Breast Unit. The Board approved the appointment and requested the distribution of Alistair Ring's CV to Board Members. The Board were also informed of the appointment of a new Chief of Surgery, Professor David Nicol, who has replaced Professor Meirion Thomas. This role will combine operational and strategic responsibility and provide leadership for surgical development.

The Board approved the appointments of Dr Alistair Ring as Consultant Medical Oncologist and Professor David Nicol as Chief of Surgery.

3.2. Chief Nurse's update

The Chief Nurse was delighted to report that Nurse Consultant Anna- Marie Stevens received a national award from MacMillan for Excellence in Cancer Practice. The Chairman extended congratulations to Anna-Marie Stevens on behalf of the Board.

4/13 NED appointment

The Chairman explained that the NED terms for Greg Andrews and Colin Clark were due to end on March 2014 and therefore, there is a need to reconstitute the Nominations Committee to seek their replacements.

The Chairman proposed the following:

- For Greg Andrew's replacement, to find a chair of the Audit and Finance Committee with relevant financial experience
- For Colin Clark's replacement, to seek candidates with a clinical/academic background

The Chairman further noted the end of his first three year term and expressed his interest in appointment for a second three year term. The appointment process will require the appointment of a Senior Independent Director to replace Dame Sarah Mullally, to carry out the Chairman's appraisal. The Nominations Committee and Council of Governors must then consider this evaluation in view of the Chairman's request for reappointment.

The Board noted the NED appointment process and endorsed the proposal to seek an NED with financial experience who can chair the Audit and Finance Committee, as well as another NED with clinical and / or an academic background.

5/13 The National Cancer Patient Experience Survey

The Chief Nurse provided the Board with background information regarding the survey and reported the Trust had received a rating of good / excellent at 91%. However, improvement areas had been identified (nine questions relating to hospital care) and an action plan produced as a result. The

following two areas were highlighted:

- The skill of informing patients sensitively on difficult matters – the Chief Nurse noted that a system of quality monitoring, known as the Schwarz Rounds is due to commence in January 2014 and will look at the way in which staff deal with difficult consultations.
- Clinical Nurse Specialists (CNS): the Chief Nurse noted that a review has been undertaken to assess the workload of CNSs and how administrative time can be reduced so they may have more free time to work directly with patients.

The Chairman noted that the Quality Assurance and Risk Committee had focused on the importance of communication between staff and patients.

In response to a query raised by Richard Turnor, the Chief Nurse noted that the Trust had scored the same as last year on the majority of questions but rate of improvement was greater in other Trusts.

Greg Andrews questioned whether the free form comments were the only way to qualitatively assess feedback. The Chief Nurse noted that the quantitative and qualitative analysis is undertaken by tumour type so the Trust can identify the areas where it is green or not.

The Chairman referred back to the CNS point and noted that an adjustment to CNS job descriptions is evidently required. The Chairman therefore asked when the Board could expect a report on this. The Chief Nurse confirmed this would be January 2014.

A report regarding the amendment of CNS job description to be brought back to the Board in January 2014.

6/13 Surgical Outcome Data

The Medical Director informed the Board of NHS England's plans to publish individual surgical outcome data, which gives rise to concerns about the quality and accuracy of the data as this was originally collected for a different purpose from the relevant professional organisations. While The Royal Marsden welcomes the initiative, it has established an internal system of audit to monitor the accuracy of the data submissions. The Medical Director explained that The Royal Marsden is a tertiary centre carrying out highly complex surgical work, the outcome of which is often dependent on the performance of primary and secondary organisations in the patients' pathway.

The Chairman asked that the Board, as a general principle, should be able to review data in a comparable and meaningful way going forward.

7/13 Finance Report

7.1. Financial Update

The Director of Finance provided an update on the Trust's financial performance for the first five months of the financial year, ending 31st August 2013.

It was reported that the Trust is on course with activity and has a low risk profile with Monitor. In relation to the efficiency programme, targets are being met and areas of improvement have been identified. Despite the

Trust's contract position, the Trust is able to operate under the current Heads of Terms however; this means the Trust's performance is not fully reflected in its cash position.

The Director of Finance noted how the capital working facility can sustain the Trust's business until contract negotiation has been finalised. The Director of Finance therefore explained that a key focus is to reach agreement on contracts for NHS services, and to ensure prompt payment by Clinical Commissioning Groups (CCGs).

7.2. Contracts

The Director of Finance reported that so far it has been a challenging year with commissioners as they are currently paying a proportion of activity under Heads of Terms. The hosting role of NHS England and their allocation of funding is yet to be clarified in conjunction with contract negotiation.

For those areas outstanding in payment, both the Director of Finance and Chief Operating Officer have made every effort to liaise with NHS England and reach agreement however, NHS England has failed to provide the Trust with any rationale or information to explain their decision to fail to pay the cost of critical care activity fully and to pay a paediatric supplement for specialist and high cost services to children. The Trust has therefore resorted to the Freedom of Information Act 2000 in an attempt to retrieve information about the decision taken by NHS England, which has been neither transparent nor in accordance with appropriate standards of business conduct.

The Director of Finance explained that the next step would be mediation by an independent arbitrator.

The Chief Executive noted how contract discussions are difficult in general however, the lack of response or explanation from NHSE (London), the failure to follow contract process and total lack of negotiation are notable this year. Their lack of engagement has left the Trust with no choice but to follow a formal process with the support of healthcare regulator Monitor.

Greg Andrews queried whether the specific areas identified on page 2 of the respective paper apply to the same commissioners. In response, the Director of Finance confirmed that Paediatric Top-Up was NHS England, outpatients and diagnostics is the CCG and for critical care, it is both. The Director of Finance believes there is a statutory requirement under the Health and Social Care Act 2012 for NHS England to pay the paediatric top-up.

In response to a query raised by Richard Turnor, the Director of Finance noted that UCLH were in a similar position and the Trust has therefore had discussions with them. The Chairman questioned how long the Trust can expect to be in this position. The Chief Executive said that she did not expect any reconciliation in the short to medium term.

The Director of Finance stated that he would continue to keep the Board informed on this important matter.

8/13 NHS England (London) Proposals on a review of Paediatric Services

The Chief Operating Officer explained that NHS England (London) has established a Strategic Clinical Network (SCN) which will review paediatric services across the capital and make recommendations for change and reconfiguration to improve quality and safety. It was noted that the London Cancer Alliance will lead the paediatric oncology workstream, and feed back to the SCN. In the meantime the Trust will develop its own proposals for strengthening the care pathway between St George's and The Royal Marsden and between the Centre and paediatric shared care units which are too numerous across the whole capital to manage communication and patient pathways in the best way possible. This is a problem for both The Royal Marsden and Great Ormond Street, and has been raised repeatedly with commissioners.

9/13 Performance and Quality

9.1. Key Performance Indicators: Quarter 1 2013/14

The Chief Operating Officer presented the Balance Scorecard to the Board and made reference to the following red areas:

- Theatre Utilisation: this will be addressed via the surgical strategy which is due to be presented to the Board in January 2014.
- No. of inpatients discharged with a long stay: this issue is being tracked and monitored through various work streams
- Research, 70 day target: this KPI is now reported nationally via National Institute of Health Research (NIHR) and the position is improving. The Trust hopes to increase the pace of study set up.
- Staff continue to remind those staff with outstanding training.

9.2. Quality Account

The Chief Nurse provided the numbers of Healthcare Associated Infections (MRSA and C. Difficile) and that these are currently below the trajectory. However, it was noted that there is a new multi-resistant organisms Carbapenemase producing Organism (CPO) that is causing operational challenges for Trusts across London because of the requirements for isolation. These CPOs are very difficult to treat as they are resistant to anti-microbials. It was reported that there was 1 case every 3-4 weeks in adults and once detected, those individuals must be isolated every time they are on site in addition to those suffering from other associated infections such as Flu and C. Difficile. The Chief Nurse raised this as a potential risk because should the organism become more prevalent, the Trust will not have sufficient capacity to isolate each patient affected. The Chief Nurse has been in discussion with the Health Protection Agency and is now including numbers affected by CPO in the quality account to the Board.

Information relating to medication errors will be improved so that a distinction is made between significant errors and incidents where there has been no risk to patients to improve QAR and Board monitoring of medication errors.

The Chief Nurse reported good results overall in Community Services.

In response to a query raised by Greg Andrews about chemotherapy waiting times, the Chief Nurse confirmed the systematic plans regarding a two stop service are in place. There are still however “long waiters” Liz Bishop COO agreed to take this away and explore the reasons.

Date of Next Meeting

Board Meeting, Wednesday 26th March 2014, 2:00pm – 4:00pm. Board Room, Chelsea.

Signed as a true and accurate record

Chaired by:.....

Date:.....

BOARD MEETING SUMMARY SHEET

<p>Date of Meeting:</p> <p>26th March 2014</p>	<p>Agenda item</p> <p>Item 3.1.</p>	
<p>Title of Document:</p> <p>NED Re/Appointments</p>	<p>To be presented by</p> <p>Chairman</p>	
<p>Background</p> <p>In September 2013 the Council of Governors agreed that the NED terms of appointment of Greg Andrews and Colin Clark would end on 31st March 2014, and that the incoming NEDS will specialise in the following areas:</p> <ul style="list-style-type: none"> • Audit and Finance; and • Clinical / Academic <p>The Nominations Committee reconvened in November 2013 to facilitate and review the selection of suitable candidates in accordance with its Terms of Reference.</p>		
<p>Recommendations</p> <p>The Board is asked to note the:</p> <p>Appointment of Ian Farmer to NED position and Chair of the Audit and Finance Committee for a period of three years, commencing on the 1st April 2014</p> <p>Reappointment of Sir John Craven for one year which will be reviewed thereafter</p> <p>On-going search for suitable candidates to fill the second clinical / academic NED position</p>		
<p>Author:</p> <p>Syma Dawson, Head of Corporate Governance</p>	<p>Contact Number or E-mail:</p> <p>8856</p>	<p>Date:</p> <p>11th March 2014</p>

THE ROYAL MARSDEN NHS FOUNDATION TRUST

Non-Executive Director re/appointments

1. Purpose

- 1.1. To inform the Board of the Council of Governors decision to approve the re/appointments of two Non-Executive Directors (NEDs).

2. Background

- 2.1. In September 2013 the Council of Governors agreed that the NED terms of appointment of Greg Andrews and Colin Clark would end on 31st March 2014, and that the incoming NEDS will specialise in the following areas:
 - Audit and Finance; and
 - Clinical / Academic
- 2.2. The Nominations Committee reconvened in November 2013 to facilitate and review the selection of suitable candidates in accordance with its Terms of Reference.

3. Non-Executive Director and Chair of the Audit and Finance Committee

- 3.1. On the 5th March 2014, the Council of Governors unanimously approved the appointment of Ian Farmer to a Non-Executive Director position and Chair of the Audit and Finance Committee, for a three year term which will commence on the 1st April 2014.
- 3.2. Ian Farmer brings a wealth of knowledge and experience as a Chartered Accountant and the former Chief Executive of Lonmin PLC, the world's third largest Platinum Group Metals mining company. As well as being a Chartered Accountant, Ian's various senior roles have given him an excellent commercial understanding which will be of great importance to the Board of Directors, particularly due to the loss of commercial expertise through the imminent departure of Colin Clark.
- 3.3. Holding various Executive and Non-Executive roles on a number of high profile Boards and Committees, Ian Farmer has an excellent working knowledge of Board practice and the role of the Non-Executive Director.

4. Clinical / Academic NED appointment

- 4.1. With reference to the second NED position, the Board is asked to note that the Trust is continuing in its search for suitable candidates and will provide an update at the next Board meeting.

5. Reappointment of Sir John Craven

- 5.1. Sir John Craven joined the Board as a Non-Executive Director on 1 April 2008 and was reappointed by the Council for a further three years in 2011. His current term of office is due to expire on 31st March 2014.
- 5.2. Sir John has chaired the Trust's Remuneration Committee, is a member of the Nominations Committee, and has provided invaluable and expert advice to the Trust's Board. He has expressed his willingness to continue as a Non-Executive Director, on the basis of an annual review by Sir John, the Chairman and the Council of Governors.
- 5.3. On the 5th March 2014, the Council of Governors unanimously approved the reappointment of Sir John Craven to undertake a further term of office for one year.

6. Conclusion

- 6.1. The Board is asked to note the:
 - Appointment of Ian Farmer to NED position and Chair of the Audit and Finance Committee for a period of three years, commencing on the 1st April 2014
 - Reappointment of Sir John Craven for one year which will be reviewed thereafter
 - On-going search for suitable candidates to fill the second clinical / academic NED position

BOARD MEETING SUMMARY SHEET

Date of Meeting: 26 th March 2014		Agenda item Item 4
Title of Document: Board Assurance Framework		To be presented by Nancy Hallett, Non-Executive Director
Executive Summary The purpose of the Board Assurance Framework (BAF) is to provide the Board with assurances when considered alongside the Trust's risk management processes, the statement of internal control and the programme of internal audit (NHS 2013).		
Recommendations The Board is asked to: <ul style="list-style-type: none"> • Adopt and endorse the current position of the Board Assurance Framework for 2013/14 whilst recognising that further information to support the Framework and provide assurance is submitted during the year. • Consider gaps reported against the Board Assurance Framework where there is a risk that the Trust might not achieve one or part of its key objectives. • Ensure identified assurances within the framework are being explicitly reported to and monitored by the Board. 		
Author: Shelley Dolan, Chief Nurse	Contact Number or E-mail: x2121	Date: 12 th March 2014

The Royal Marsden NHS Foundation Trust

Board Assurance Framework, February 2014

1.0. Introduction

The purpose of the Board Assurance Framework (BAF) is to provide the Board with assurances when considered alongside the Trust's risk management processes, the statement of internal control and the programme of internal audit (NHS 2013). Oversight of effective risk management by the board is underpinned by four interlocking systems of control:

- The BAF
- Organisational Risk Management
- Audit
- The Annual Governance statement.

2.0. The Board Assurance Framework (BAF)

This is a document that sets out strategic objectives, identifies risks in relation to each strategic objective along with controls in place and assurances available on their operation. Formats vary but the framework generally includes:

- Objective
- Principal risk and risk owner
- Key controls
- Sources of assurance
- Gaps in control/assurance
- Action plans for addressing gaps (NHS 2013)

3.0. The BAF at The Royal Marsden

The RM BAF in Appendix 1 presents the key strategic objectives for The Trust that have been identified from the four key themes identified in the Business Strategy for 2010/2015 which has involved wide consultation. Detailed operational and corporate risks can be found in The RM Risk Register which is presented to QAR quarterly.

Through an on-going consultation process with Directors, Divisional Directors and some Heads of Service, the organisation is in a position to:

- Ascertain key risks associated with the strategic objectives and identify the controls in place to manage the risks;
- Continuously review the Board Assurance Framework for 2013/14 and assess the risks that have either resolved or reduced significantly.

4.0. Development of The BAF at The RM

In May 2013 the existing design of the BAF was discussed by the Non Executive Director Chairs for the Audit and Finance Committee (AFC), Quality Assurance and Risk Committee (QAR), the Director of Finance and Chief Nurse. Although the format was fit for purpose it was felt that its length and breadth might dilute focus on key strategic risks. The Trust therefore consulted with internal and external audit and with other NHS Foundation Trusts (The Christie NHS FT, Guys and St. Thomas NHS FT, University College NHS FT) and a clearer more concise format was chosen. This new format was presented to the QAR committee in July 2013, the format was welcomed but the content needed further refinement. The BAF was further refined and brought back to the December QAR. Following further comments from QAR and KPMG further amendments have been made for the current version February 2014.

5.0. Recommendation

The Trust Board is asked to:

- Adopt and endorse the current position of the Board Assurance Framework for 2013/14 whilst recognising that further information to support the Framework and provide assurance is submitted during the year.
- Consider gaps reported against the Board Assurance Framework where there is a risk that the Trust might not achieve one or part of its key objectives.
- Ensure identified assurances within the framework are being explicitly reported to and monitored by the Board.

References

NHS Leadership Academy (2013) The Healthy NHS Board: Principles for Good Governance

Assurance Score: 1 – 5 with 1-2 (Red) being minimal assurance of objective being delivered / 3-4 (Amber) Medium value assurance / 5-6 (Green) high value assurance of objective being delivered. Grey not possible to make an assessment.

Appendix 1: The Royal Marsden Board Assurance Framework, February 2014

Strategic objectives	Annual objectives 2013-14 and Lead Director	Assurance score	Key Controls (what controls/systems are in place to assist in securing delivery of the objective)	Gaps in control (where is there failure to put controls into place. Where are they not effective)	Assurance (there is evidence that shows we are reasonably managing risks and objectives are being delivered)	Gaps in assurance (where are we failing to gain evidence that our controls/systems on which we place reliance are effective)	Actions and timescales/progress	Outcomes of discussion by relevant committee (QAR, Audit, Board)
1. Leadership of personalised medicine	1.1. In partnership with The ICR achieve national leadership of molecular diagnostics, cancer genetics and phase 1 trials in targeted therapies The RM and ICR CEOs.	4 Amber	The new Research Strategy and Research Governance Boards shared between The RM and ICR. The new RM Research Directorate led for the Trust by Director of Clinical Research and Research Executive.	New system to be commenced early 2014 will need evaluation over 2014/15. The Research Executive report through to IGRM 6 monthly and to QAR annually.	Research assurance documents presented to QAR July / Sept 2013.	None locally at the RM however achieving national leadership not totally within RM control as other centres develop specialised commissioning service specifications are implemented for regional genetics centres	All Trust wide / ICR Research governance systems in place by March 2014. Renewal of Cancer Research UK Centre status tbc but early feedback v positive.	
	1.2. Construction of a new clinical research facility at Sutton- COO	5 Green	Operational policy and plans for West Wing Unit complete; refurbishment work commenced. Overseen by the Director of Clinical Research and Research Executive.	None	Monthly West Wing Unit Steering Board overseeing work and implementation plan; Sutton and Chelsea Project Steering Board overseeing building work timelines	None	Due for completion February 2014 and commissioned for use in March 2014 (delay due to additional works required for Robert Tiffany decant).	Phased opening through Clinical Executive approval

2. Developing partnerships in service and research

Working in partnership with The ICR	5 Green	The joint Strategy Board chaired by the two CEOs	New structures to be implemented in January 2014 therefore controls too early to be assessed.	Only commenced in February 2014 therefore evidence will be accrued during first quarter 2014-15	None	Terms of Reference and Membership of new joint structures discussed and agreed by the Trust and ICR Boards in November 2013.	Agreed at Trust / ICR Boards November 2013.
2.1. Working with the London Cancer Alliance (LCA) to improve outcomes and the experience of care for patients, CEO, CN	5 Green	The LCA governance structure: Members Board, Clinical Board, pathway groups. CEO on Members Board, CN Clinical Director CO-Chairs the LCA Clinical Board.	Governance structure of the LCA currently being refreshed since its original inception in 2011.	Delivery against corporate and clinical objectives evaluated quarterly by the LCA MB and CB. All key informatics in liaison with The National Director for Cancer Registration.		The LCA has been formally in existence for a year, quarterly clinical metrics are presented to the Clinical Board and through to the Members Board. Presentations to The RM Board and CoG.	
2.2. Working in partnership with Kingston NHS Trust: Chemotherapy Medical Day Unit	6 Green	Kingston Partnership Board attended by The RM COO and Joint appointment clinicians.	None	Key metrics of quality and safety presented in QA. Financial metrics included in Annual accounts. Both in quality and financial accounts the partnership is delivering good outcomes.	None	Regular reporting schedule through Kingston Partnership Board	QAR and Board members noted the quality outcomes and positive experience of patients attending the MDU at Kingston.
2.3 Maximising opportunities for increasing cancer flows and leveraging RM influence for improved cancer care through sustained or new partnerships during	3. Amber	Director level attendance at both sector Reconfiguration Programme Boards. CEO led approach with possible models discussed at RM Trust Board.	Major design in this area outside RM control, therefore relationship development and innovative models being refreshed regularly.	Programme Board minutes and briefings by Director leads to EDs, Board and CoG when required	There are gaps in external assurance currently, whilst there are gaps in CEO leadership in neighbouring Trusts with whom the RM would like to develop relationships.	Update paper for NWL presented to the RM Board in November 2013. Neighboroughing Trust Executives presented to Trust Board January 2013. Update paper to be	RM Board support for timescales and process for exploring various RM models.

	major reconfigurations in West and South London. CEO, MD, CN, DPS						presented to the Board in March 2014.	
3. Development of more efficient clinical models and pathways	3.1. Increase growth and profitability of private patient business over next five years- MD	4 Amber	Agreed Private Care Strategy - Board approved Management restructure underway New income targets outlined	MD appointed to commence role in March 2014.	Income levels increased and ontarget	Capacity constraints on the Chelsea site and also at Sutton in 2014/15 whilst Robert Tiffany is being refurbished. 5 year income aspirations will be challenging without further dedicated PP beds in Chelsea or other Central London location	Recruitment of new senior leader MD confirmed for March 2014.	New strategy approved at Trust Board Jan 2013
	3.2 Increasing research income in line with new technological functionality on both trust sites- DoCR&D	4 Amber	Weekly Trial set up meet in place; Weekly performance management through the Research Management Team; New Clinical Research Leads in post	None	Improvement in trial set up times and 70 day target	Lack of research facility on Chelsea site and space constraints	Further negotiation with pharma and MOUs; Completion of West Wing Unit March 2014 to enable increase in research capacity. Old MDU conversion to research business space due to be complete May 2014	Ongoing monitoring through Performance Review Group
	3.3 Improvements in control and process redesign on areas such as pharmacy, pathology. Focus on treating patients for whom significant value can be added as specialist cancer centre. COO	4 Amber	Outsourcing and collaborative ventures in planning are being market tested	None	Market assessments positive. Agreed pathology partnerships Outline Business Case completed	None	Pharmacy model go live Q1 2014/15 Pathology venture - Decision to be made Q3 2013-14	Management Executive Approval

	3.4 Develop links with pilot provider sites (one in South West London and one in North West London) to enable safe and effective pathways of care especially around oncological emergencies COO	3 Amber	Developed as part of a service transformation plan Principle agreement at Croydon Unit Hospital (SWL) and Chelsea and Westminster FT (NWL)	Designs and implementation at an early stage and therefore there are gaps in control until full design completed.	Plans being developed and reporting to Management Executive	Further negotiation with Croydon required and review of the business case for chemotherapy delivery at CUH	Full planning underway	Management Executive approval to finalise plans and objectives Q1 2014-15
	3.5 Surgical strategy review to determine future portfolio of surgery across the trust. COO Chief of Surgery	3 Amber	Underway. Full engagement with all surgical teams	As yet not approved	Early plans and options discussed at Management Executive away day	None	Full surgical strategy presented to The RM Board January 2014 but requires further analysis and review, to be undertaken February 2014	Early plans and support to full plan at Management Executive
	3.6. Review of Paediatric Service Provision within SCN structure, CEO/CN	4 Amber	Project plan being designed to include DCS, Haed of Paeds, Matron Paeds, CN.	Early design phase	Key metrics will be designed and brought to Board /QAR	Early design phase	First report to Board in November 2013 next to Board in March 2014.	Board support for two options to be designed into a robust plan for The Board in 2014.
4. Completion of the extensive capital programme	4.1. Implement 10 year strategy which includes overview of medical equipment replacement, IT priorities and modernisation of buildings and infrastructure-FD	3 Amber	Underway. 10 year Capital Plan approved	10 year Capital Plan approved	Board approved Capital Plan	None	All underway – For medical equipment new post developed which will oversee new and replacement equipment purchase and maintenance - should be appointed to within next 3 months	Trust Board approved May 2013

4.2. Scheme of equipment replacement is underway including major diagnostic (e.g.MRI and CT) and treatment (Radiotherapy linacs)- DoF	5 Green	Underway. 10 year Capital Plan approved	10 year Capital Plan approved	Board approved Capital Plan	None	All underway - Chelsea MRI programme completed and Chelsea CT programme progressing well (see below). Programme of replacement for Linacs and Gamma Cameras is slightly behind schedule due to refinement of infrastructure works required.	Trust Board approved May 2013
4.3 Redevelopment of imaging centre on Chelsea site- DoF	5 Green	Underway. 10 year Capital Plan approved	10 year Capital Plan approved	Board approved Capital Plan	None	All underway. Chelsea MRI programme completed and scanners operational. Chelsea CT programme is likely to be slightly more expensive than originally predicted because of the requirement for increased floor strengthening. Survey conducted and additional requirement will be updated within the next 2 weeks.	Trust Board approved May 2013

4.4. Strategic development of comprehensive IT system to replace current system.

3 Amber

Strategic plan approved at ME and proposals for the development of an OBC approved at The Trust Board seminar September 2013.

10 year capital plan approved but may need adjusting in line with OBC.

Board approved process for approval

Early design phase

Design process underway and soft market testing of comprehensive IT systems underway

Trust Board approval early 2014.

BOARD MEETING SUMMARY SHEET

Date of Meeting: 26 th March 2014	Agenda item Item 5	
Title of Document: Report from Medical Director	To be presented by Professor Martin Gore, Medical Director	
Executive Summary The paper provides details of the new consultants who have joined the Trust since January 2014.		
Recommendations The Board is asked to note the new clinical appointments.		
Author: Professor Martin Gore, Medical Director	Contact Number or E-mail: 2198	Date: 12 th March 2014

Report from Medical Director: Clinical Appointments

Dr Robin Jones

Dr Jones qualified at Guy's and St. Thomas' and trained in Medical Oncology at St. George's, Guy's and The Royal Marsden hospitals. He wrote his MD on breast cancer with Professor Mitch Dowsett. It was while a trainee working with Professor Judson that he developed his interest in sarcoma.

In 2010 Dr Jones was appointed Associate Professor at the University of Washington/ Fred Hutchinson Cancer Center in 2010 with responsibility of building up their Sarcoma and Phase I Units. He has in a short time created a multidisciplinary sarcoma team of 25 people including 9 physicians and he has won two NIH grants. He is a member of the National Cancer Centre Network (US) committee on bone tumours and their risk management group. He is also a member of the Sarcoma Scientific Committee of the European Society of Medical Oncology.

His main interests include the predictive value of hypoxia, multidrug resistant PET markers in solid tumours and the role of immunotherapy in sarcoma, particularly adoptive T cell therapy. He is the PI on a number of sarcoma-specific Phase I trials as well as studies that are open to patients with other solid tumours. His group is consistently among the top enrollers in Phase 2 and 3 sarcoma trials in the US.

He has published 80 peer-reviewed papers and 14 non peer-reviewed chapters, reviews and editorials.

Dr Andrew Hodgkiss

Dr Hodgkiss qualified from Cambridge and Guy's and St. Thomas'. He is currently Guy's Consultant Liaison Psychiatrist at the Maudsley Hospital, Clinical Lead for Mental Health Liaison Services at King's Health Partners Academic Health Sciences Centre and Honorary Consultant at Guy's and St Thomas'/ Kings Health Partners Integrated Cancer Centre.

Dr Hodgkiss has nearly twenty years experience in full time liaison psychiatry working between the interface of psychiatry and other medical specialties. He has extensive teaching experience including teaching undergraduate and post graduate medical students and students from other disciplines. His special interests include psycho-oncology, chronic pain, self-harm and occupational psychiatry. He is the editor of *History of Psychiatry* and authored a book on chronic pain in the medical literature during the nineteenth century. He has published 20 chapters and 19 peer-reviewed publications, 9 as first author.

He wishes to join The Royal Marsden to help support and further develop our psycho-oncology service and research.

Dr Naureen Starling

Dr Starling qualified at UCL and trained in Medical Oncology at Guy's and St Thomas', Mount Vernon Cancer Centre and The Royal Marsden. She greatly impressed her supervisors here at The Royal Marsden when she was a trainee and they considered her to be one of the brightest and most motivated students in her generation of juniors.

She has been appointed to the new post of Associate Director of Clinical Research to support our research infrastructure and processes. The appointment includes her also taking on the role of Consultant Medical Oncologist. She has been working as the Associate Director in a locum capacity for the last year and she has already made a considerable contribution to our R&D team.

Dr Starling's research interest has been in clinical and translational research in GI cancer. She wrote her MD at the ICR on the application of genomics to therapy in patients with oesophageal cancer. She has published 17 original papers; she was first author in 6 of these. She has also published numerous review articles, book chapters, letters and editorials. Some of her publications are in high impact factor journals such as the New England Journal of Medicine and the Journal of Clinical Oncology. Her post as Associate Director will take up 50 per cent of her working week and in the other 50 per cent she will be expected to pursue her own research within the GI Unit.

Dr Charlotte Benson

Dr. Benson qualified in Liverpool and trained in Medical Oncology at The Royal Marsden. She has been a locum consultant on the Sarcoma Unit for over 3 years and has a large experience in sarcoma management and has developed a national reputation for her clinical judgement in this difficult area.

Dr Benson's research training was on the Drug Development Unit and one of her publications on the delivery of standard sarcoma chemotherapy has resulted in a change in practice. She is currently Principle Investigator on a number of therapy studies on the Sarcoma Unit but she also leads research into service delivery and assessment and control of toxicity. She is hugely respected for her work by all her colleagues in the multidisciplinary sarcoma team and has major contribution to the Unit.

Dr Lynley Marshall

Dr. Marshall qualified at the University of the Witwatersrand. She trained in paediatrics in South Africa and the UK and in paediatric oncology, at Bristol, Oxford and The Royal Marsden. She has been a locum consultant on our Paediatric Unit for the last 2 years with special responsibility for early phase studies and has successfully set up a number of trials.

Research for her PhD focussed on high grade glioma and was performed at the ICR. The work crossed over several areas of interest and included colleagues in Molecular Pathology, Cancer Therapeutics and Imaging. She had a unique 12-month secondment to the European Medicines Agency (EMA) which has given her an excellent working knowledge and understanding of European regulations that affect paediatric cancer and drug trials in this group of patients. She now has a rare insight for a clinician into the obligations, enticements and problems for industry in relation to Paediatric Investigation Plans.

BOARD MEETING SUMMARY SHEET

Date of Meeting: 26 th March 2014		Agenda item Item 6
Title of Document: Operational Plan 2014-16		To be presented by Alan Goldsman, Director of Finance
Executive Summary The Trust is required to submit its two-year operational plan to Monitor on 4 th April 2014. This paper summarises the two-year operational plan for 2014 – 16 using assumptions agreed by the Board in 2013.		
Recommendations The Board is asked to approve the operational plan and its declarations and to note the contract risk in the current position.		
Author: Alan Goldsman, Director of Finance	Contact Number or E-mail: 2151	Date: 12 th March 2014

ROYAL MARSDEN NHS FOUNDATION TRUST BOARD

Operational plan – 2014 – 16 and Board declarations

1) Introduction

The Trust is required to submit its two-year operational plan to Monitor on 4th April 2014. A strategic plan for 2014 – 19 must be submitted to Monitor by 30th June 2014.

This paper summarises the two-year operational plan for 2014 – 16 (attached) using assumptions agreed by the Board in 2013. It should be read in conjunction with the Board declarations (appendix 1); which were considered by the Audit and Finance and Quality, Assurance and Risk committees at their last meeting.

Board is asked to approve the operational plan and declarations (in section 4 below and in appendix 1); and to note the contract risk in the current position.

2) Operational plan

There are three key drivers of the operational plan;

2.1) Financial sustainability

The Board has previously functioned on its requirement to remain financially sustainable over a longer period of at least 10 years. This is set out in more detail in the Strategic Plan 2014 – 19 and requires annual operating revenue surplus (at current prices) of at least £20m to deliver its 10 year capital replacement programme and maintain sufficient cash headroom to meet its working capital needs (assumed to be at least £10m at current turnover). In this scenario new investment is funded either through loan or similar facilities based on revenue positive business cases; or where appropriate through charitable grants (for non-core NHS activities).

In the short term, and taking into account the risks outlined below, this 2-year operational plan provides sufficient cash and capital to meet the minimum requirements for sustaining operational performance and service quality; but does not provide the financial headroom required to commit to longer term investments such as new IT solutions and major building and site upgrades.

2.2) Clinical sustainability

This 2-year operational plan is built on delivering improvements across three key initiatives:

Service Portfolios

Services are managed by tumour type and differentiated according to whether they are provided to NHS patients, private patients or for research; creating portfolios of activity. The service line objective is to achieve a positive contribution across the portfolio. This task is

supported by service line reporting and patient level costing systems in order to understand the impact of cancer tariffs and clinical decision making on the underlying service.

Access policy

Revision to the access policy will involve realigning capacity and hospital resource allocation to achieve a more clinically sustainable level of service provision.

Surgery

In the first 2 years addressing utilisation and capacity issues and reversing financial deficits identified which will create the capacity for developing a specialty specific surgical portfolio to support the delivery of the private care strategy, the non-surgical portfolio, including research, presented through the financial assessment, market assessment and national trends

2.3) Quality of Service and patient experience

The Royal Marsden continues to provide an excellent service to its patients and their families by ensuring that cancer services are designed around their holistic needs. The Trust is continually assessing the quality of its service using all the nationally mandated cancer audits, the ISO 9001 framework for quality of its chemotherapy and radiotherapy services and the national patient excellence award (Craig M).

To monitor patient's satisfaction with the service and their overall patient experience the Trust uses the following methodologies to gain real time information about the patient experience: Picker hand held frequent feedback service; the meridien survey in the community, and the national inpatient and outpatient picker surveys. In addition the RM patients have placed the Trust in the top 10% of Trusts since the inception of the Friends and Family Test.

3) Risk

3.1) NHS Contracts

It is now very unlikely that NHS Contracts will have been agreed with NHS England and CCGs in time for the activity, income, CQUIN or QIPP values to be properly validated in the operational plan. In the short term the plan contains the following assumptions:

For NHSE and CCGs

- That a cost and volume based contract will continue to apply; with all activity being paid at the national tariff rate. This is consistent with the long standing arrangements in place and is considered low risk.
- CQUIN will be agreed at the full value; consistent with previous and considered lower risk.

- QIPP of 6% (approximately £6m) will not be successfully levied against the contract; other than for schemes mutually agreed as deliverable – this assumption is also consistent with previous experience but is considered higher risk. There is likely to be a (recoverable) cash deduction against contract sums in the first quarter pending contract signature.

For Sutton and Merton Community Services

The existing contract expires on 31st March 2014 and does not automatically roll-over to a new contract. Local commissioners have been engaged in this process and have offered to extend the contract for a further year; with some investment proposed in new services.

The Trust accepts that this one-year extension is the most that can be offered under European procurement rules pending full tender; however the Trust has made it clear that it will not accept any new financial risk over this timescale and additionally will require a new 'block' contract value to reflect activity changes over the first three years. Some new investment will also be required in IT upgrades.

4) Monitor

Monitor has divided its annual plan review into two distinct phases:

Phase 1 – operational plans for 2014 – 16 with supporting financial projections. Monitor will assess two year supporting financial projections and will seek to understand the degree to which Foundation Trusts have started planning for, and have already begun implementing, transformational initiatives.

In doing so Monitor will work with NHSE and the NHS TDA to reconcile key commissioner and provider planning assumptions and to highlight and local health economies where there are major planning 'divergences'.

Phase 2 – Strategic Plan for submission on 30th June 2014. Monitor will focus on the robustness of FT strategies to deliver high quality care on a sustainable basis. They will focus on the degree to which each FT has developed realistic transformational schemes and aligned its plans with those of other actors within the local health economy.

4.1) Operating Plan declarations

Foundation Trust Boards will be required to make the following declarations for the Operational Plan:

The Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- *The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;*
- *The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;*
- *The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and*
- *All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.*

5) Conclusion

Board is asked to approve the operational plan and declarations (in section 4 below and in appendix 1); and to note the contract risk in the current position.

APPENDIX 1 - Corporate Governance Statement

The Board is satisfied that The Royal Marsden NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time.

The Board is satisfied that The Royal Marsden NHS Foundation Trust implements:

- (a) effective Board and Committee structures;
- (b) clear responsibilities for its Board, for Committees reporting to the Board and for staff reporting to the Board and those Committees; and
- (c) clear reporting lines and accountabilities throughout its organisation.

The Board is satisfied that The Royal Marsden NHS Foundation Trust effectively implements systems and/or processes:

- (a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;
- (b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;
- (c) to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
- (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern);
- (e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
- (f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
- (g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
- (h) to ensure compliance with all applicable legal requirements.

The Board is satisfied:

- (a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

- (b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
- (c) the collection of accurate, comprehensive, timely and up to date information on quality of care;
- (d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
- (e) that The Royal Marsden NHS Foundation Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
- (f) that there is clear accountability for quality of care throughout The Royal Marsden NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

The Board of The Royal Marsden NHS Foundation Trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

OPERATIONAL PLAN 2014 - 16

1) Executive Summary

The operational plan is presented here using parameters agreed by Board (with advice from Governors) and designed to deliver long term financial and clinical sustainability with a low-risk profile.

There are four key drivers of the operational plan; financial, clinical (including Research) and workforce sustainability alongside quality of services and patient experience.

1.1) Financial sustainability

The Board has previously functioned on its requirement to remain financially sustainable over a longer period of at least 10 years. This is set out in more detail in the Strategic Plan 2014 – 19 and requires annual operating revenue surplus (at current prices) of at least £20m to deliver its 10 year capital replacement programme and maintain sufficient cash headroom to meet its working capital needs (assumed to be at least £10m at current turnover). In this scenario new investment is funded either through loan or similar facilities based on revenue positive business cases; or where appropriate through charitable grants (for non-core NHS activities).

1.1.1) Revenue

The proposed revenue plan is as follows:

2013/14 Plan £000s		2013/14 Outturn** £000s	2014/15 Plan £000s	2015/16 Plan £000s
183,824	NHS Income	189,600	187,800	185,500
24,565	Research and Development	25,300	17,900	17,300
67,404	Private Patients	69,000	82,400	94,200
42,466	Other Income	49,100	52,300	52,300
318,259	Total Income	333,000	340,400	349,300
297,657	Operating Expenditure	316,800	323,900	336,700
	Cost efficiency *	(4,400)	0	(6,200)
4,609	Dividend / Interest	4,600	4,900	5,200
15,993	Development Reserve	16,000	11,600	13,600

‘*’ Improvement to Q3 forecast out-turn represents surplus required during Q4; for 2015 – 16 this represents further cost reduction required.

‘**’ Forecast at Q3

In the short term, and taking into account the risks outlined below, this 2-year operational plan provides sufficient cash and capital to meet the minimum requirements for sustaining operational performance and service quality; but does not provide the financial headroom required to commit to longer term investments such as new IT solutions and major building and site upgrades.

OPERATIONAL PLAN 2014 - 16

1.1.2) Capital

The following capital expenditure is affordable within the revenue surplus; further details are contained in section 2.7:

2013/14 Plan £000s	Capital Programme	2013/14 Outturn £000s	2014/15 Plan £000s	2015/16 Plan £000s
10,200	Internal Finance	7,200	10,000	9,400
14,000	Equipment Loan	5,600	15,000	10,000
6,000	Charity Donations	3,100	3,000	0
30,200	Total Capital Expenditure	15,900	28,000	19,400
0	Loan Interest and Repayments	0	1,400	2,700
30,200		15,900	29,400	22,100
Financed By:				
14,000	Loan Finance	6,500	14,100	10,000
6,000	Charity Donations	3,100	3,000	0
16,000	Surplus	16,000	11,600	13,600
36,000	Total Financing	25,600	28,700	23,600

This shows £19.4m funds available (contingent on delivering the revenue surplus) and a likely loan requirement of £40m over 4-years; starting in 2015 – 16.

1.1.3) Cash

The cash plan set out in the table below; along with a committed working capital facility with Lloyds Bank will ensure a low risk profile is maintained over the period:

Cash Flow	2013/14 Outturn £000s	2014/15 Plan £000s	2015/16 Plan £000s
EBITDA	20,100	19,500	18,900
Movement in working capital	(10,000)	0	0
Cash from operations	10,100	19,500	18,900
Capital expenditure	(15,900)	(28,000)	(19,400)
Loan Finance (net)	6,500	12,700	7,300
PDC Dividend Paid	(4,400)	(4,700)	(4,800)
Movement in Cash	(3,700)	(500)	2,000
Closing Cash	10,600	10,100	12,100

Continuity of Service Risk Rating COSSR

Capital Servicing	4	4	4
Liquidity	3	3	3
Overall	4	4	4

1.1.4) Margin for transformation and development

This 2-year operational plan for financial sustainability is built on delivering improved margins through the following key objectives:

i. Service transformation and integration

The Trusts strategy covers a number of transformational initiatives being developed by and between providers. These are summarised in the next sections below and set out in more detail in the 5-year Strategic Plan.

ii. Fair prices for NHS activity

The Royal Marsden has been independently assessed in the highest quartile (best) of NHS providers for the costs of delivering specialist services. But its services to NHS commissioners are paid under tariff at 80% of the cost of providing these services; resulting in a loss of £27m per annum (roughly 20%). Positive margins from providing private care have been used to subsidise this shortfall; but this is no longer appropriate or sustainable other than in the very short term

The Trust will be submitting its case for Local Tariff Modification to Monitor in March; using the process already described and approved. Improvement is expected in services associated with cancer, outpatient services, paediatrics and Critical Care during the next two years but it is too soon to assess the likely impact during this period in advance of testing our case with Monitor.

iii. Improved productivity and expenditure cuts

The Trust is continuing to pursue a Cost Improvement Programme (CIP) based on procurement, outsourcing (such as for drug supply) and scale economies; however the scope for delivering benefits to commissioners (through tariff deflator and QIPP cuts) and to the bottom line through this route is becoming more difficult. Maximum 5% is deliverable over the two years through this route.

iv. Increase in NHS activity and income

Nationally a combination of a growing and ageing population with improved prospect of survival is resulting in increases in both cancer incidence and prevalence. The British Journal of Cancer cites a prevailing trend of +3% growth in cancer prevalence per annum. This data is further supported by the Trust's own referral and activity data which bears out the fact that hospital cancer populations have increased continuously over recent years. Furthermore treatment options for patients have also increased. All of this leads us to safely predict increases in the coming year across most treatment modalities, but most likely in outpatients attendances, chemotherapy, and imaging.

v. Increase in private activity

The Trust plans to increase its private income to at least £100m (from £70m) as quickly as possible. The key factor that drives an increase in PP income is increasing inpatient capacity. The Trust has identified additional PP inpatient capacity for 2014 - 15 and 2015 - 16; however, the £100m target is likely to require the Trust to identify capacity outside the existing hospital sites. The opportunities for this level of expansion will be explored in 2014 - 15.

Going forward surpluses made on this activity should be used to support developments in quality of cancer care, facilities and technology; and not to subsidise NHS tariff.

1.2) Clinical sustainability

This 2-year operational plan for clinical sustainability is built on delivering improvements across key initiatives:

1.2.1) Service Portfolios

Services are managed by tumour type and differentiated according to whether they are provided to NHS patients, private patients or for research; creating portfolios of activity. The service line objective is to achieve a positive contribution across the portfolio. This task is supported by service line reporting and patient level costing systems in order to understand the impact of cancer tariffs and clinical decision making on the underlying service sustainability.

Alongside this there are links to national service specifications will ensure that services continue to comply with the criteria laid down by Clinical Reference Groups (CRGs) on behalf of commissioners. A number of Trust experts are represented on these national bodies.

1.2.2) Access policy

Since the national tariff for cancer funds (on average) only 80% of the costs of all cancer care, and since the Trust as a specialist provider cannot subsidise these losses with surpluses from other NHS services, the Trust has advised its Commissioners that it may seek commissioner support for taking some services outside the NHS contract and tariff regime.

Revision to the access policy will involve realigning capacity and hospital resource allocation to achieve a more clinically sustainable level of service provision. The main areas of focus will be prioritising referrals based on agreed catchment areas for each tumour group, a clinical need which cannot be met at another centre or an opportunity to enter into a clinical trial that is only offered at the Royal Marsden. In addition triage of non-elective admissions to ensure priority is given to those patients requiring the specific and specialist services of the Royal Marsden

1.2.3) Surgery

Surgery accounts for c. £32.5m of Trust income and makes a net loss of £8.2m. Given current tariff pressures this position will worsen if not addressed through transformation in the surgical portfolio. In addition The Trust is facing significant capacity constraints which impact on the ability to deliver other approved strategies (e.g. Private patients and Research and Development)

In the first 2 years addressing utilisation and capacity issues and reversing financial deficits identified which will create the capacity for;

- i. Developing a specialty specific surgical portfolio to support the delivery of the private care strategy, the non-surgical portfolio, including research, presented through the financial assessment, market assessment and national trends
- ii. Delivery of elements of the surgical portfolio through robust partnership to protect the business against regulatory threat, strengthen surgical research links, address capacity concerns and support strategic growth,
- iii. Management of the surgical workforce to ensure a safe, sustainable and affordable portfolio, to support the delivery of the private care and NHS service strategy, including the development of academic surgery.
- iv. Investment in estate to expand the Chelsea footprint will enable delivery of private surgical activity and more efficient day surgery.

1.2.4) The London Cancer Alliance

The Royal Marsden was a core founder, and is host of the London Cancer Alliance (LCA). The LCA is the Integrated Cancer System (ICS) for West and South London and provides a quality and accreditation system across 16 provider Trusts; and works collaboratively with two Academic Health Science Networks, primary care and the voluntary sector. The LCA is led by two Clinical Directors one of which is the RM Chief Nurse. The LCA works across patient pathways to improve quality, to reduce unwanted variation, and to improve outcomes and the patient's experience of care. The LCA now has 2, 500 clinicians actively engaged driving clinical standards and innovation so that all Londoners can experience world class cancer care.

Since its inception the LCA has worked with all providers to ensure across South and West London that it has robust data to monitor for improvement. Across all tumour pathways and all treatment modalities, including survivorship and palliative care, the LCA is publishing exemplar pathways to ensure that patient journeys are seamless. For each tumour type clinicians are writing evidence based guidelines to ensure that wherever in London the person is treated they are receiving the best cancer care.

1.2.5) The Royal Marsden School

The Royal Marsden School offers comprehensive cancer and palliative care courses tailored to meet the needs of healthcare professionals from organisations across the UK (and worldwide) and is the UK's only dedicated provider of cancer education. The School provides academic programmes at both Degree and Masters level. In addition, the School offers a wide range of stand-alone modules at Degree and Masters level. A large number of individually planned projects and unaccredited study days are provided to a diverse stakeholder group to meet patient and service requirements in cancer and palliative care.

School activity has progressively increased with numbers of places rising from 373 in the academic year 2003/2004; to 1229 in the academic year 2012/2013. With the School now in its twelfth year and going from strength to strength, future developments will focus on increasing the multi-professional portfolio and providing a flexible cancer education pathway. The School is also working closely with local organisations and education commissioners in developing a range of activities that respond to the rapidly changing demands of clinical service delivery.

The overall aim of The School is to provide excellence in education that is both relevant to practice and enhances the lives of patients and their loved ones living with and after cancer. Through a sound strategy that promotes a dynamic and changing curriculum and that is increasingly accessible to cancer practitioners both in the UK and overseas, the School can justifiably be recognised as a leading provider of education in cancer and its associated long-term conditions.

In 2013/14 The RM School has diversified to embrace the “Out of Hospital” agenda and include the first course for Nurses new to the Community. This has been well evaluated by the first students and will be the first in a new portfolio of programmes for nurses and bands 1-4 in acute and in the out of hospital setting.

1.2.6) Community Services Integration

The community services division have been working with partners across both health and social care to transform services so that they are fit for purpose in supporting the out of hospital strategy and the Better Care Fund. Services will ensure that care is patient centred, meets their needs in a holistic way, and is available 7 days a week. Services will focus on supporting long term conditions and end of life care, and will provide intensive home support to those that need it; to prevent unnecessary admission to hospital and also to support timely discharge. Care teams in the community will realign themselves so that they relate more closely to primary care; enabling closer working and the ability to identify those most at risk and in need of services. These care teams will work in a more integrated way with social care; providing care that can wrap around the patient.

1.3) Quality of services and patient experience

The Royal Marsden continues to provide an excellent service to its patients and their families by ensuring that cancer services are designed around their holistic needs. The Trust is continually assessing the quality of its service using all the nationally mandated cancer audits, the ISO 9001 framework for quality of its chemotherapy and radiotherapy services and the national patient excellence award (Craig M). To monitor patient's satisfaction with the service and their overall patient experience the Trust uses the following methodologies to gain real time information about the patient experience: Picker hand held frequent feedback service; the meridian survey in the community, and the national inpatient and outpatient picker surveys. In addition the RM patients have placed the Trust in the top 10% of Trusts since the inception of the Friends and Family Test.

There is robust evidence that a necessary precursor for a positive patient experience is staff engagement and a good staff experience (Mabel et al 2012). The national staff survey illustrates that RM staff feel engaged, are proud of their Trust and would recommend it to friends and family.

Healthcare is a staff dependent industry with the major costs to the Trust being staff time. It is therefore essential that the Trust has effective, robust timely recruitment and people management policies. The following areas are those where quality of care and costs can be impacted and therefore the Trust is placing a major focus in these areas:

- Significant reduction in agency staffing – nursing, medical and all corporate areas. Some temporary staff use is inevitable where there are sudden gaps in service provision however it is key to the quality of the service that this is the exception. When agency staff are used to fill gaps in frontline services patients comment on lack of continuity and a reduction in the quality of their care.
- In February 2013 The Trust achieved NHSLA level 3 and with it the reduction in its insurance premium. The Trust Finance Director and Chief Nurse met with the NHSLA CEO and discussed the need to ensure that the Trust's insurance premium in the future appropriately reflects the low risk as compared to other multi-specialty Trusts. In February 2014 the Trust received its latest NHSLA assessment and scored green across all risk areas.

1.4) Clinical Research

The Royal Marsden clinical research strategy will prioritise the research that has been identified as having the most benefit to patients, and ensures that they benefit from the latest advances in cancer treatment. Research ultimately improves treatment options, and there is evidence to show that patients do better in hospitals that conduct research, even if they are not part of a study themselves. There are several elements within the research strategy:

1.4.1) Clinical Research Network (CRN)

The Royal Marsden is leading the South London CRN and is spearheading the rise of clinical research in the NHS, according to a league table from the National Institute

for Health Research (NIHR) Clinical Research Network. The Royal Marsden increased its studies from 159 in 2011/12 to 187 in 2012/13, and it is the top trust in England in the acute specialist trust category for the number of studies it conducted last year.

1.4.2) Biomedical Research Centre for Cancer

The Royal Marsden, together with its academic partner, The Institute of Cancer Research (ICR), is designated as the UK's only Specialist Biomedical Research Centre for Cancer. The specific remit of the BRC is to facilitate rapid and effective translation of scientific findings regarding the genetic and molecular basis of cancer into improved therapeutic strategies that are ultimately tested in large-scale national trials. The award of BRC status is made by the National Institute for Health Research (NIHR) and is done on a five year basis. We have to bid for this funding every five years – the next renewal is due in 2016 (for commencement, if approved, on 1st April 2017).

1.4.3) Investment in Clinical research

i. West Wing Unit

The Royal Marsden's new £2.6 million West Wing clinical research facility at Sutton opened to its first patients in March this year. The facility is a dedicated space for patients participating in clinical trials. The unit will increase the opportunities for translating early-phase studies conducted in the Drug Development Unit into late-phase research.

ii. Centre for Molecular Pathology (CMP)

The NIHR/BRC CMP is a shared building between the Royal Marsden and the opened in 2012 and is now fully functional with both a service and discovery function.

iii. RM Clinical Trials Unit

The Royal Marsden Clinical Trials Unit was formed in early 2014 as a specialist unit with a specific remit to design, conduct, analyse and publish clinical trials and other well-designed studies. Based in Sutton, it will operate cross-site, acting as a co-ordination hub for all Biomedical Research Centre funded activity. The CTU team will work with clinicians and researchers to conduct the highest quality clinical research.

1.4.4) Commercial Research Income

The Royal Marsden has a strong track record of delivering commercial studies with long standing relationships with pharma and technology; in 2012-13 commercial income was £10.8m and in 2013-14 is forecast to be £7.3m. The investment in research capability described above will ensure the Royal Marsden continues to grow income from commercial research.

1.5) Workforce

The Royal Marsden's workforce is the Trust's most valuable asset and is essential to support us in continuing to achieve our vision of providing excellent care delivered by expert and caring staff and enable our achievements in cancer research, treatment and education. The Trust attracts and retains a high concentration of clinical academics in conjunction with our academic partner the Institute of Cancer Research; as a result Royal Marsden / ICR are the fourth most cited cancer institutions internationally

The Royal Marsden is committed to developing and sharing knowledge of cancer both for existing staff and in the wider NHS and beyond. For example, the Royal Marsden School offers comprehensive cancer and palliative care courses tailored to meet the needs of healthcare professionals from organisations across the UK as well as internationally. The Trust is the UK's only dedicated provider of cancer education. In the last academic year it offered 756 module places, 193 study days, 280 other types of activity. This unique facility, with lecturers who are also regularly engaged in clinical practice, enables us to develop our workforce to rapidly respond to changing requirements through high quality education bespoke programmes.

The Royal Marsden's medical education is highly rated by our trainees and in Speciality School visits. In a joint initiative with The Royal Brompton NHS Foundation Trust, we have developed a state-of-the-art Education and Clinical Skills and Simulation Centre dedicated to deliver a range of high fidelity full immersion, clinical situational awareness and clinical skills based teaching activities for the benefit of staff in both Trusts and geographically in the wider NHS, particularly on medical education programmes.

Levels of staff engagement are consistently rated highly through the annual NHS staff survey. The support given by Royal Marsden line managers is rated particularly well and there is a clear commitment of staff to deliver high quality and safe care to patients.

In delivering the operational plan over the next two years, there is a need to maintain and build on these strengths and ensure the Royal Marsden is in a position to respond to the levels of transformational change that are needed and the focus is on the following key initiatives:

1.5.1) Strengthening clinical leadership

The Royal Marsden is further strengthening clinical leadership at all levels in the organisation to support service line management and ensure that clinical intelligence informs business decisions. This will be enabled by creating Clinical Business Units to ensure that this is achieved within the Divisions and multi-professional leadership development will maintain a focus on delivering a high performance culture that delivers results through engendering staff accountability and engagement and developing service improvement skills and those to support transformational change.

1.5.2) Pay and Remuneration

There are a number of key initiatives around pay and remuneration over the next two years which will support a high performance culture; the national changes in terms

and conditions will be implemented and a review of consultant and junior doctor contracts to reward and incentivise good performance will be conducted. There is a commitment to reduce temporary staff spend (both bank and agency); bank pay rates will be reviewed so these are aligned to market conditions, can be flexed according to supply and demand and support the Trust's financial strategy.

1.5.3) Recruitment and retention

Recruitment and retention of high quality staff underpins excellence and will directly support the Trust's business strategy; the 'employee brand' will be promoted to continue to attract the highest quality staff. Hard to recruit areas will be targeted through a range of initiatives including developing new attraction strategies, recruitment pipelines and talent pools, assessment centres and international recruitment, where appropriate. Local solutions will be developed to respond to areas of high turnover.

1.5.4) Maximising potential through productivity and efficiency

There are a number of components of the operational plan for the next two years to support staff in working to their optimum and delivering on the quality and efficiency agenda. High quality workforce information and systems are critical to monitoring progress and focusing effort related to improving workforce productivity and efficiency. Workforce expenditure controls will be developed to appropriately control costs and drive efficiencies whilst maintaining quality. A particular focus will be the further reductions in temporary staff spend.

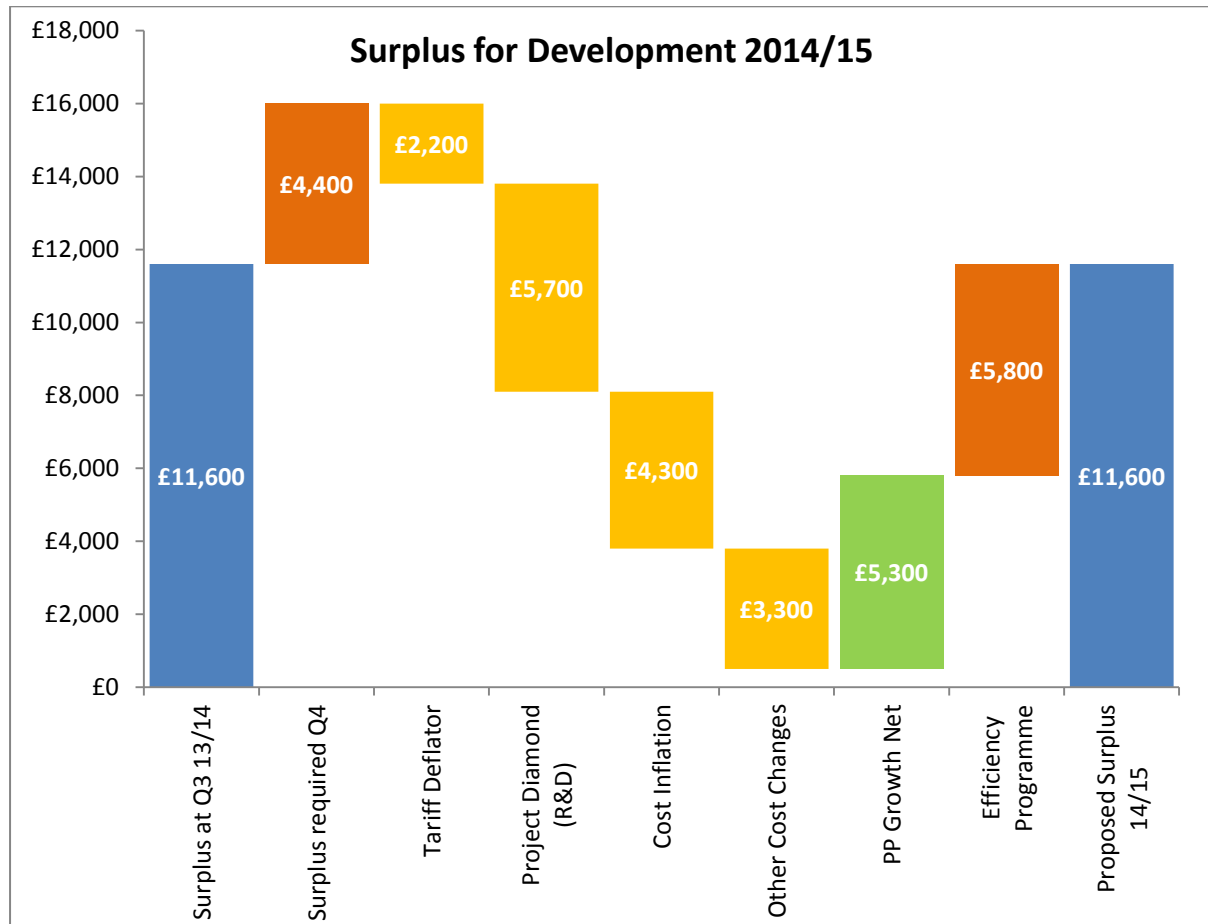
The aim is to ensure staff are working as efficiently and effectively as possible and performance is positively managed, reducing overall unit costs through workforce productivity and staff performance management improvements to optimise quality patient care and minimise the requirement for more formal action. Structures and ways of working will be reviewed to ensure that appropriate skill mix and working processes are in place and that staff are working at an appropriate level.

Internal communication strategies and mechanisms to support and engage with staff will be developed; in particular this will include implementing further ways to involve staff in the development of strategies and planning, for example, continuing with open meetings with senior staff.

2) Operational Plan

2.1) The short term challenge

The short term financial challenge is demonstrated, in headline terms, by the waterfall diagram below.



A combination of the tariff deflator, cost pressures within Divisions, inflation and loss of Project Diamond funding was factored into the efficiency assumptions agreed by the Board. Improvements for private care and efficiency are sufficient to meet the surplus required to fund the minimum cash and capital programme requirements set out elsewhere in this plan; with possible improvement to come from on-going negotiations over Project Diamond funding and over local tariff modification.

Key short term challenges have been identified as follows:

2.1.1) Commissioner Engagement

Meaningful engagement with NHSE has, to date, been very limited and it has not been possible to secure contract heads of terms at the time of writing; in particular for discussing service and financial strategies as part of the NHSE, Monitor and TDA joint initiative in strategic planning for the next two and the following three years.

Contract for Cancer Services

The Trust does not have any contract or contract heads in place with NHSE and the Trusts request for escalation in line with the national timetable has not been agreed by NHSE. In addition NHSE has not, so far, been prepared to discuss the Trusts 6-month notice letter (see Appendix 1). This letter contains important plans for activity management and tariff modification, among other things, which may potentially delay their implementation.

Contract for community services

The Trust does not have any contract or contract heads in place with CCGs, London Boroughs and NHSE. The Trust has already provided commissioners' with legal advice to the effect that the existing contract cannot be rolled over past 31st March.

The Trust has notified commissioners that it is not prepared to take any financial risk on this one-year only contract and that, potentially, a new arrangement will be required from 1st April. The operational plan has been prepared on this basis for 2014 - 15.

2.1.2) Fair pricing

Local tariff modification and 2015 tariff

The Trust has been working with commissioners for some years to address problems with cancer tariff, paediatric top-ups and specialist service provision. A very thorough case for modification to the tariff will be presented to Monitor; covering the entire period 2014 – 16. This is not yet included in the income assumptions for either year.

In addition the Trust has been informed that Project Diamond funding will not be provided from NHS Research and Development resources in future. PD Trusts have been directed to NHSE (as part of contract negotiations) and Monitor (as part of local price modifications) to recover these funds. Continuation of this funding for at least a further year until tariffs can be addressed remains possible.

Cancer tariff working group

This group is led by the Royal Marsden NHSFT and University College London Hospital NHSFT; with support from Ernst and Young. These two Foundation Trusts have extensive knowledge of cancer care and have highly developed patient level costing and benchmarking systems. They are actively involved in leading roles within the two London Integrated Cancer Systems, three London AHSNs and in Project Diamond and the Shelford Group (UCLH only).

EY has led the recent work, among other things, with Project Diamond Trusts and has evaluated comparative cost and PBR data. The Christie Hospital and Guys and St. Thomas' NHS Foundation Trusts have also lent their support to this work. Appendix 2 provides a more detailed summary of this work.

2.1.3) Cash Management

NHS commissioners have been particularly poor payers in 2013 – 14; with more than £10m outstanding for long periods. Significant cash pressures are expected in at least Q1 of 2014 and a fully committed working capital facility is in place.

2.2) Quality Plans

The quality framework uses key national and international metrics to assess and monitor patient safety, the effectiveness of patient care and patient and staff experience these include the following (although this should not be regarded as an exclusive list):

2.2.1) Patient Safety

- i. The prevention and control of Health Care Associated Infections (HCAI). People with cancer are vulnerable to infection because they are immuno – compromised, receive complex multi-modality treatment and inpatient care and require multiple courses of anti-microbials. The Trust therefore takes concerted positive action to prevent and control infection utilising the best international evidence to guide its infection prevention and control programme.
- ii. The use of the WHO Surgical Safety Checklist to ensure the safety of patients and staff in theatre. The use of the checklist is prospectively audited to ensure compliance and that any lessons learnt are shared.
- iii. The use of the Patient Safety First initiatives for high risk drugs, patient vital signs monitoring and leadership for safety.
- iv. Procurement and maintenance of medical equipment throughout the Trust that is coordinated and maintained centrally and through medical device passports in each clinical area.
- v. ISO 9001 for chemotherapy and radiotherapy attained again in 2013/14.
- vi. JACIE accreditation for the quality and safety of Blood and Marrow transplant attained again in 2013/14.
- vii. The use of the National Modified Early Warning Score (MEWS) and Situation Background Assessment Recommendation (SBAR) throughout all clinical areas to ensure that any clinical deterioration is monitored and acted upon rapidly.
- viii. Modern and well maintained resuscitation equipment in all areas of the Trust including non-ward areas.
- ix. A comprehensive and well-designed mandatory training programme for all clinical staff on patient safety. The Royal Marsden leads an excellent simulation programme for multi-professional teams in the acute or emergency scenario in patient care. This facilitates clinical staff to be experienced at working together in a time critical emergency setting.
- x. The Executive Medications group that is multi-professional and works to continuously improve medicines safety at all points of care.

- xi. Falls monitoring and audits to constantly improve the environment and care of people who are at risk of falls.

2.2.2) Effectiveness of care

In cancer care the key issues that are essential are:

- i. Early and effective access to definitive treatment: The Royal Marsden has strategies in place to ensure that all referrals are managed effectively through the system in a timely and effective way. One of the most difficult issues for a tertiary cancer centre is when referrals arrive late from another Trust this is being proactively addressed at CEO level locally and centrally. The Trust is a core member of The London Cancer Alliance and is working with all other providers in West and South London to improve clinical pathways and best practice patient navigation at provider Trusts that feed into the RM.
- ii. The right treatment given by the right person in the right place: The Royal Marsden meets all the essential Peer Review components of the core members of the MDT. The cancer patient experience survey (CPES) also revealed that patients thought there were the right number and skill mix of nurses on duty. The 2013 CQC unannounced inspection also assessed staffing levels and skill mix and found no concerns.
- iii. Reducing length of stay whilst ensuring that there are no avoidable readmissions: The RM has been actively working on reducing length of stay and has an active Enhanced Recovery Programme (ERP) and 23 hour Breast surgery programme. There is however more work to do around a small group of patients who have a prolonged length of stay. Various initiatives are currently being designed and will be instituted and evaluated this year. These initiatives include reducing non elective admissions by ensuring Consultant evaluation prior to admission, developing the out of hospital transitions into the community, ensuring that all inpatients are evaluated daily and have active care plans.
- iv. Therapeutic cancer care that is evidence based and continuously evaluated: The Royal Marsden is a research rich organisation and at any one time is leading over 500 clinical trials. This means that the patient has access to key cancer therapeutics. The Royal Marsden also has an excellent Health Services Research structure which ensures that all clinical professionals are enabled to be involved in research that examines systems and care as well as therapeutics.
- v. Cancer Education and Training: The Royal Marsden has the only dedicated training School for Cancer Nursing and Allied Health professionals and provides most of the postgraduate cancer training for nurses in England. In 2013 / 14 for the third consecutive year the School was awarded the highest quality indicator in London by the NHS Health Education England.
- vi. Clinical Audit: The RM completes all mandatory national cancer audits and then has a comprehensive programme of clinical audit responsive to patient and strategic requirements.

- vii. Access Policy: ensuring that those patients that require care at the Royal Marsden are able to access services when needed through matching demand to available capacity. Initiatives to reduce demand include reviewing each service to define the referral catchment area. Patient referrals should then only be accepted from the defined catchment area for each condition or where there is a clinical or research need to attend the Royal Marsden rather than the patient's local Trust. It is also essential that capacity is used as effectively as possible by only admitting non-elective patients who require specialist cancer care at the Royal Marsden and reducing length of stay.

2.2.3) Patient Experience

The patient experience is monitored through using Picker hand held devices in all clinical areas and outpatients to gain the individual patient experience, with these results fed directly back to Ward Sisters, Matrons and up through the Executive Directors to the Board. From 1st May 2013 all inpatient wards (except children's) also had the Friends and Family Test applied. The majority of comments have been extremely positive but where there have been suggestions for improvement these have been systematically fed back to clinical areas for action. Since the inception of the FFT the RM has constantly been in the top 10% of high performing Trusts.

All the national patient surveys are also conducted and where there is anything other than an excellent score an action plan with key deliverables is agreed. One of the important deliverables going forward is to ensure that the patient / and or their family are not overburdened with questionnaires. The Royal Marsden is a research rich environment which means that many of our patients are on clinical trials and therefore undertake associated quality of life questionnaire or patient diaries. It is essential therefore to monitor the volume of questionnaires that patients are subjected to and this will be closely monitored with the Patient Experience group in 2014 onwards.

All Matrons, through to Directors read complaints and praise letters and themes for learning and improvement from these are fed into improvement plans across the Trust. At the Board Quality Assurance and Risk (QAR) committee the Chairman and Non-Executive Directors all see complaints and discuss the response and any remedial actions with the Executive Directors. Following the Francis report and its recommendations the Trust has made some improvements to its complaints policy and practice. More complainant meetings are being provided at an early stage with positive feedback. The PALS team has also been conducting weekly ward rounds to ensure that inpatients have a route to raise concerns easily that can be actioned immediately.

Members of the senior Medical, nursing and AHP teams are leading or members of the new national Clinical Reference Groups, The Trust is also represented on the London Children's Strategic Clinical Network, The London Cancer Strategic Clinical Network and the London SCN Oversight group. Professional clinical leads continue to lead other cancer tumour specific national and international advisory boards for cancer or their profession and this knowledge is also therefore available to the Trust.

2.2.4) Quality priorities and targets for 2014-16

The following priorities and targets are updated for 2014 – 15.

Safe Care

- i. Reduction in Healthcare Associated Infections (MRSA bacteraemia and Clostridium Difficile infections). Applies to Acute beds @ RM and patients of Sutton and Merton Community Services (SMCS) Less than 1 MRSA bacteraemia
 - a. Less than 16 C Difficile infections (target for 14/15)
 - b. (Report in Quality Account the number of C. Difficile infections per 100,000 bed days)
- ii. Rate of patient safety incidents and percentage resulting in severe harm or death
 - a. (In 2012-13 the number of deaths from serious incidents per 100 admissions was 0; the number of severe harms from incidents per 100 admissions was 0.012) Acute beds and SMCS
 - b. Reduction in the rate of patient safety incidents per 100 admissions and the proportion that have resulted in severe harm or death
- iii. Percentage of admitted patients risk assessed for Venous Thrombo-embolism. Maintain above 95% the number of patients who have a completed VTE risk assessment

Effective Care

- iv. Reduction in community acquired grade 3 and 4 pressure ulcers: SMCS Reduce the incidence of severe community acquired pressure ulcers (Grade 3 & 4)
- v. Increase the number of patients that die in their preferred place of death (The National Primary Care Snapshot Audit in End of Life Care (2009) found that the number of patients achieving their preferred place of death is 42 %). Acute and SMCS achieve more than 42% of patients dying in their preferred place of death.
- vi. Increase the numbers of patients who have an Holistic Needs Assessment. Increase in the number of designated patients will be offered a Holistic Needs Assessment by the end of 2013-14
- vii. Emergency re-admissions to hospital within 28 days of discharge. Reduction in the number of avoidable re-admissions to hospital within 28 days of discharge
- viii. The RM acute service is on track to achieve 100% of its CQUIN payments in 2013/14 and the SMCS division is currently achieving

Patient Experience

- ix. Reduction in chemotherapy waiting times and improvement in patient experience related to waiting times. Reduction in chemotherapy waiting times at Sutton and Chelsea and improvement in the patient experience related to waiting times.

- x. Ensure that we are responding to in-patients' personal needs improvement in responses to 5 questions (in the CQC national survey described above) as monitored through the Inpatient Frequent Feedback Surveys
- xi. Percentage of staff who would recommend The Royal Marsden to friends or family needing care.
 - a. Patient Experience survey introduced into SMCS in December 2013. To achieve a baseline measurement and if possible benchmark with other community services.
- xii. Improve communication, particularly when patients arrive for first appointments. Increase or maintain the high percentage of positive comments in dedicated patient feedback.
- xiii. Reduce the length of time a patient waits for medicines or equipment at the point of discharge. Increase or maintain the high percentage of positive comments in dedicated patient feedback.

Children's services

- xiv. The uptake of immunisation working in partnership with primary care. Increase the percentage of children receiving pre-school immunisations in partnership with GPs.

2.3) Activity Plan

The following table shows the current projected activity volumes for 2013 - 14, with the anticipated values for 2014 - 17. These predictions are based on prevailing activity trends and include both NHS and Private Patient activity.

NHS & PP Activity	2013/14 Projected Outturn	2014/15	2015/16	2015/16
Inpatient admissions	10,124	10,209	10,296	10,383
BMTs	211	214	218	222
Day case admissions	11,942	12,025	12,108	12,192
Chemotherapy Attends	46,739	50,135	53,779	57,688
Consultant Outpatients	164,287	170,23	176,996	183,714
Ward Attends	24,448	25,671	26,954	28,302
Radiotherapy Attends	74,402	75,414	76,440	77,480

2.4) Operational requirements and capacity

Despite the pressure on NHS commissioner budgets there is no evidence of any reduction in demand for specialist cancer services and new referrals continue to increase. The table below shows the 1 year and 3 year growth in referrals between 2010/11 and 2013/14.

New Referrals

	2010/11	2011/12	2012/13	2013/14*	%age Growth over	
					1 year	3 years
NHS Patients	15,574	16,000	16,426	18,087	10.1%	16.1%
Private Patients	2,940	3,047	3,018	3,458	14.6%	17.6%
All Patients	18,514	19,047	19,444	21,545	10.8%	16.4%

**forecast from 11 months data*

There are no plans to cut the total number beds, theatres and other patient care facilities (in broad terms) in the next two years; however the operational plan has identified a number of services where no funding is provided by any commissioner; or where funding is significantly less than the 80% average seen across the NHS portfolio. Since it is unlikely that new tariffs will be agreed by commissioners these services will be reviewed against clinical and patient safety criteria for early decision; or alternative, non-NHS funding.

2.5) Productivity, efficiency and CIPs

The financial planning process is now nearly complete and Divisional budgets have been scrutinised by the Trusts Medical Director and Chief Nurse to assess any potential impact of these plans on the quality and experience of care provided by the Trust. This work has been carried out under a number of key themes:

OPERATIONAL PLAN 2014 - 16

- Firstly by ensuring that the Trust delivers the financial surplus in 2013 – 14 (£16m); an improvement of £4.4m in Q4 based around reducing agency premium costs and improving private income.
- Reducing new cost pressures (cost not being incurred today) in the first cut plan by at least 50%.
- Implementing the new access policy; coupled with key aspects of the surgery strategy.
- Assessing all unfunded services to NHS patients.
- Reviewing all charges received from, and charges to, 3rd parties.
- Increasing private patient activity.

In addition the management team is considering the implications for deferring all capital schemes not funded by loan or charity for 6 months in order to preserve cash.

2.6) Financial Assumptions

2.6.1) Financial planning assumptions

The Board agreed a set of high level planning assumptions for 2013 / 14 and the subsequent two financial years when it approved the Annual Plan in May. These have been updated for changes to the tariff deflator (£0.5m) and for the new pension arrangements (£1m) in the table below:

Year ended 31st March	2015	2016	2017
All figs in £'000's			
Efficiency required (2014 plan)	16,200	14,000	14,000
Additional efficiency for:			
Increase in tariff deflator	500		
Pension arrangements	1,000		
Revised target for 2015	17,700	14,000	14,000

This table shows that a programme of efficiency savings of between £14 - 18m per year is required to deliver a sustainable surplus available for development of between £18 – 20m; the level at which financial sustainability can be demonstrated. Annual improvements to liquidity (£18m over 10 years) will also be delivered.

2.6.2) Efficiency Requirement

The efficiency requirement comprises the following:

Year ended 31st March	2015	2016	2017
All figs in £'000's			
<u>Efficiency requirement</u>			
External factors (incl. tariff cut)	5,700	5,000	5,000
Cost inflation	5,000	5,000	5,000
Increase surplus	1,000	1,000	1,000
Other (<i>incl. possible loss of Project Diamond</i>)	<i>6,000</i>	3,000	3,000
Total Efficiency Required	17,700	14,000	14,000

The efficiency requirement represents a required improvement equivalent to approximately 5% of the current cost base and is in line with estimates elsewhere across the NHS.

OPERATIONAL PLAN 2014 - 16

2.7) Capital Programme

The first two years of capital programme has been revised to fit within a reduced surplus for development and ensures that existing schemes in progress (most notably for the PACS replacement in IT) can be completed. As in previous years a small allocation for essential minor works and backlog maintenance is allocated to the Director of Projects and Chief Operating Officer; with the remaining funds set aside for the schemes that will be required to deliver the capacity upgrades required for private care.

The equipment replacement loan will fund the remaining short term requirements for essential medical equipment.

2013/14 Plan £000s	Capital Programme	2013/14 Outturn £000s	2014/15 Plan £000s	2015/16 Plan £000s	2016/17 Plan £000s
Internally Financed					
500	Medical Equipment & Infrastructure	400	500	0	0
6,000	IT Schemes	3,500	5,000	5,000	5,000
3,000	Backlog & Minor Works	2,100	1,600	2,000	2,000
	Private Patients Chelsea & Sutton	200	2,400	0	0
700	Other	1,000	500	2,400	1,300
10,200	Total	7,200	10,000	9,400	8,300
Loan Financed					
14,000	Equipment Loan (Current)	5,600	15,000	0	0
	Equipment Loan (Proposed)	0	0	10,000	10,000
14,000	Total	5,600	15,000	10,000	10,000
Donated Assets					
2,500	West Wing	2,500	0	0	0
0	Gamma Camera (from legacy)	0	600	0	0
3,500	Other	600	300	0	0
0	Robot	0	2,100	0	0
6,000	Total	3,100	3,000	0	0
30,200	Total Capital Programme	15,900	28,000	19,400	18,300

Requirements for major investment in the following schemes will be addressed as part of business cases still to come to Board and will be addressed in more detail as part of the 5-year Strategic Plan.

- New build in Sutton; including land purchase and upgrade of accommodation.
- Replacement of the Trusts Electronic Patient record and associated IT schemes.
- Purchase of the Fulham Wing of the Royal Brompton Hospital

Appendix 1 – Trusts six-month notice letter to NHSE

30 September 2013

Dear Commissioner

The Royal Marsden NHS Foundation Trust (“the Trust”) 2014/15 6 Months’ Notice Letter

This letter sets out the following:

- 1 the conclusion of the Trust’s 2013/14 activity and the starting point for contractual negotiations and activity planning for 2014/15;
- 2 current work and future developments being carried out by the Trust as part of the Trust’s active drive to achieve transformation of the delivery of cancer services;
- 3 details of potential changes occurring at individual service level within the Trust (as listed in the Appendix to this letter),

and constitutes formal six month notice to Commissioners of the Trust’s proposed service changes, as required under the NHS contract.

1) Contract Variations and 2014/15 Contract Negotiations:

Contract variation to out-turn

The Trust expects that forecast out-turn performance will form the basis of contract negotiations for 2014 / 15. The NHS contract requires us to agree and document all agreed changes (both to the 2013/14 and 2014/15 contracts) for in-year performance by way of formal signed contract variations.

2014 / 15 Contract timetable

Commissioners have recently clarified the position on contract negotiations that run beyond 31st March. In addition they have confirmed the requirement for 6 months’ notice of any changes by the contracting parties.

Therefore, the Trust proposes that the Trust and Commissioners aim to conclude contract negotiations by 14 February 2014 – in the (hopefully unlikely) event that the parties have been unable to reach final agreement by this date this will allow sufficient time (in accordance with the current contractual dispute resolution procedure) for any escalation required and still achieve signature by 1 April 2014.

The Trust accepts the 6-months requirement and will expect to function on requests from commissioners received before 1st October 2013; provided these are clearly submitted in this form.

Outstanding items for 2013 / 14 contract

The following items are outstanding from the 2013 / 14 contract:

- SBRT/IMRT implementation and funding – the Trust has experienced difficulties this year in obtaining funding approval for SBRT. The Trust welcomes Commissioners current engagement on this issue and would like to continue

discussions on ways to improve patient access to these treatments (as set out in further detail in the Appendix).

- Paediatric top-up – the Trust provides specialist paediatric cancer services from its Sutton site and believes that Commissioners should exercise their discretion in awarding the Trust the specialist paediatric top-up (as has been awarded to other NHS Trusts).
- Critical Care review and pricing - the Trust currently provides critical care services at a 30% discount to its actual costs. The Trust can no longer afford to provide these services at such a discount and will therefore require an increase in the local price for critical care under the 2014/15 contract. The Trust welcomes the clinically led research programme into cancer critical care that the Trust and Commissioners have agreed to carry out this year.

2) Improvements in cancer care and value

The Trust would like to discuss with Commissioners the opportunities for working together more closely going forward. The Trust strongly believes that a collaborative relationship between the Trust and Commissioners will assist innovative commissioning and improve delivery mechanisms, with the ultimate aim of achieving strategic transformation in the delivery of cancer services.

Fair national tariff for cancer

As a provider of specialised cancer services, the Trust is continuously working to identify ways to improve efficiency and effectiveness while sustaining, and improving, the excellent standard of care provided to our patients.

The Trust has been independently assessed as the most efficient provider of specialist services in the UK. However, as Commissioners are aware, the Trust loses £20 to £25 million per year on the provision of NHS cancer services, a loss which is currently subsidised by the Trust's non-NHS private activity. Without action to improve the tariff for cancer, this loss will increase by £5 million year on year; a position which is unsustainable.

Monitor expects to publish its forward guidance on tariff setting on 3rd October 2013 and it is therefore not possible to fully anticipate how cancer tariffs can be addressed in advance of publication. This 6-months' notice letter therefore sets out the Trusts request to work with specialist and CCG commissioners, and Monitor, in agreeing new and fairer tariffs for cancer care; in line with the published guidance. In addition local price modifications based on a cancer diagnosis for all national tariffs, for use in the 2014 / 15 contracts may also be required.

New hospital development in Sutton

In the past 4 years the Trust has invested £170m in capital development for advancement of cancer care and translational research. Over the next 10 years the Trust has prepared plans to invest a further £280m. In line with these plans the Trust is preparing an outline business case for a new hospital development on its site in Sutton. This will be shared at an early stage with Commissioners in the next few weeks.

This £80m capital development will be funded from the Trusts own capital replacement funds, long term borrowing and charitable sources. The Trust would like to discuss and agree with its Commissioners potential options for acquiring land and buildings on the Sutton Hospital site as part of the capital build programme.

The Trust expects to fund the revenue costs of the new capital development and services provided in it mostly from its current NHS revenue streams and from new commercial and research activity. However early analysis indicates that local commissioner support for approximately £21m over the first 7 years would be required. Discussion on this investment could be aligned with the work on delivering fairer cancer tariffs already noted.

Molecular Diagnostics

Expanded use of molecular diagnostics provides a significant opportunity to improve treatment and outcomes for cancer patients whilst reducing wastage and improving value for taxpayers. The Trust already carries out a significant volume of mainstream tests for which it is unable to recover costs, since there is no tariff in place for such tests. Current funding from pharmaceutical companies is finite and the Trust therefore requests Commissioners support in order to continue to provide these critical services to patients.

Service design and reconfiguration

The Trust fully recognises the finite amount of resources available and the pressures faced by Commissioners in funding a nationally increasing level of activity across the NHS. In light of this, the Trust believes that innovative ways of working are required and would like to discuss these with Commissioners.

Specifically:

- The London Cancer Alliance - following the creation of the London Cancer Alliance in 2012, RMH has played a key role in developing clinically led pathway redesign groups. This will impact across the entire patient pathway.
- Coordinate My Care (“CMC”) - CMC is a clinical service developed by the Trust to encourage patient choice, preserving dignity and autonomy at the end of life and provides a care service that enables health professionals from primary, secondary and community care to put the patient at the centre of health care delivery. Where patients have a CMC record, 79% of them die in their preferred place of death and over 80% of deaths occur outside of the acute setting. The Trust’s CMC team is currently working with each CCG across London to implement QIPP plans, which rollup to a potential £46m saving across London if 50% of End of Life Care patients have a CMC record across London.
- Surgical Strategy review – the Trust is currently undertaking a full scale review of its surgical portfolio to identify and implement short and long term changes to improve efficiency and quality of care, including the consideration of a new model of care moving patients away from CCU where it is right and appropriate to do so.
- Sutton and Merton Community Services – the Trust has provided community services in Sutton and Merton since April 2011 (as commissioned by Sutton and Merton CCGs, the London Boroughs of Sutton and Merton and NHS England) under a block contract arrangement. The Trust will be notifying Commissioners of its intentions relating to these services under a separate notice letter.
- Outsourcing of Pharmacy services - the Trust has carried out extensive research and project planning into the potential outsourcing of pharmacy services (and the benefits of such in terms of patient experience and efficiencies for Commissioners) and would now welcome Commissioner involvement in the development of a joint homecare strategy for cancer patients.

- Improvements in diagnostic imaging – the dramatic improvements in imaging available have led to an increase in diagnostic activity within the Trust (and therefore an associated increase in cost). However, the increased use of diagnostic imaging and its ability to assist with early cancer diagnosis, define disease extent, provide a roadmap for therapy planning and guide intervention enables much more efficient treatment overall.

Decommissioning

The Trust is fully aware that NHS funding is increasing only very slowly in real terms and that commissioners are required to operate with finite funding allocations. The Trusts extensive engagement in service redesign and transformation is evidence of our commitment to supporting commissioners in this task.

The Trust has also been developing its service line reporting and patient level costing systems in order to understand the impact of cancer tariffs and clinical decision making on its underlying service and financial sustainability. A clearer picture is emerging for where risk is greatest; but it is not yet clear how much progress can be made in reforming the cancer tariff for 2014 / 15.

Since the national tariff for cancer funds (on average) only 80% of the costs of all cancer care, and since the Trust as a specialist provider cannot subsidise these losses with surpluses from other NHS services, this letter provides notice that the Trust may seek commissioner support for taking some services outside the NHS contract and tariff regime [For the purposes of the 6-months' notice letter only this applies to all NHS Services provided at the Trust]. This might also involve realigning capacity and hospital resource allocation to achieve a more sustainable outcome.

Please be assured that patients, their care, and their experience of care continue to be our highest priority.

The Appendix to this letter sets out potential changes occurring at individual service levels within the Trust which will be supported by detailed activity and financial data where required.

We look forward to working with Commissioners going forward. Please do not hesitate to contact me if you require any additional information or clarification.

Yours sincerely

Appendix 2 – fair tariffs for Cancer activity

Problem definition

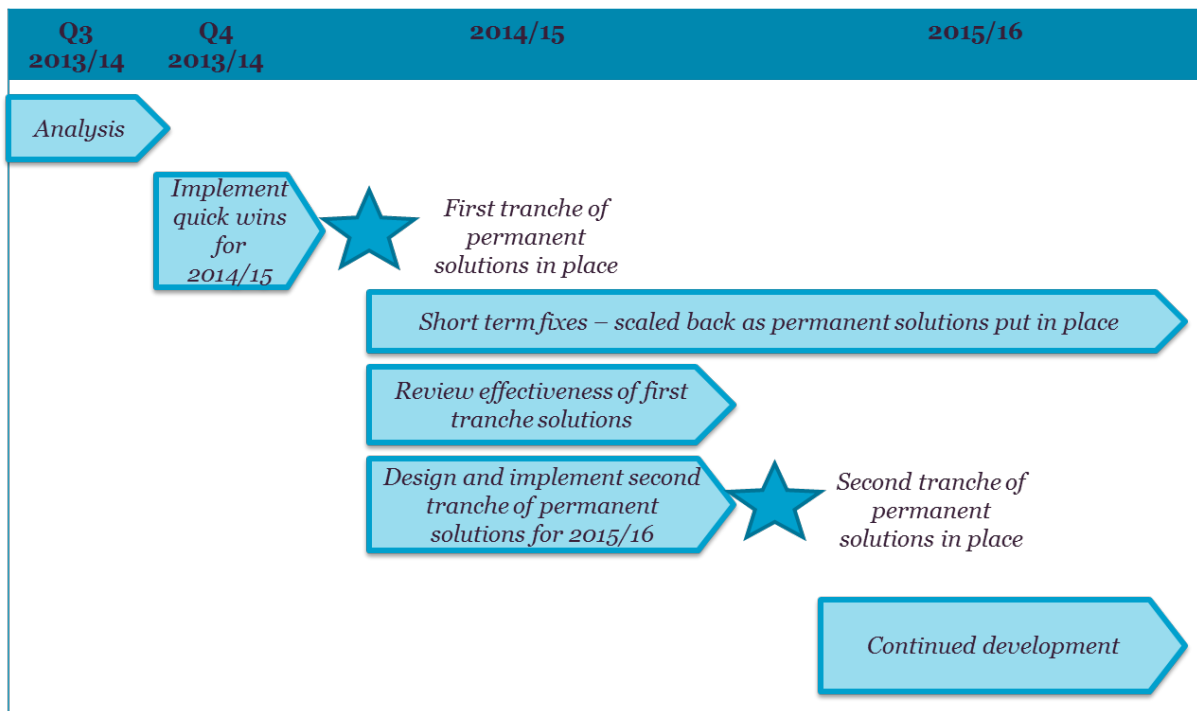
The working group has been developing a number of tariff themes:

- i. Tariff currency - National average tariffs (using HRCs) are largely based upon procedures undertaken rather than on the diagnosis of the patient - cancer is, of course, a diagnosis, not a procedure. This often means that procedures will cost considerably more to deliver when the patient has cancer. This problem is fundamental because many services (particularly surgery) provided to cancer patients as part of PBR can also be provided to patients without a cancer diagnosis. In the past this has resulted in top-up arrangements being implemented; such as for children's services; but there is no such top-up currently in place for cancer.
- ii. Tariff coverage - Most patients with cancer are receiving treatment and care for long periods; but this care is not always associated with procedures. Tariff does not adequately cover inpatient spells associated with only limited, or even no, procedures.
- iii. Care complexity – cancer services provision is likely to be more complex with multiple co-morbidities a factor in treatment planning and delivery. Cancer is not necessarily the most complex or expensive activity; but given its prevalence and the diversity of provision the impact of poor tariffs is much greater.
- iv. Outpatient follow-up tariffs – tariffs applied to outpatient follow up appointments are discounted, compared to their underlying reference cost, in part to incentivise providers to discharge patients more quickly. This mechanism is often inappropriate for cancer care where services are provided using protocols requiring longer follow up care pathways and where costs of follow up during active treatment are at least as much as the first appointment. This problem could potentially be solved quite quickly within PBR tariff rules.
- v. Impact of private patient income netted off from NHS tariff – we recognise and welcome the change in approach to collection of private patient costs as part of the 2013 / 13 reference costs return. This will help Monitor to understand the gross cost of providing NHS cancer care. Given that this issue has been identified and acknowledged, it is important that its impact is adjusted quicker than the 3-year delay between reference costs collection and tariff implementation.

Next steps

These issues are sometimes complex and often poorly understood. The working group will shortly be publishing a range of audience relevant briefings in advance of an engagement event for key stakeholders. This is being planned, in association with UCL Partners, to develop a consensus for the changes required.

In addition to an open invitation to join the engagement event, the working group has invited Monitor and DH to share the more detailed findings of the work we have undertaken to date and to discuss how we might work together going forwards to improve the national tariff for patients and the health economy.



BOARD PAPER SUMMARY SHEET

<p>Date of Meeting:</p> <p>26th March 2014</p>	<p>Agenda item</p> <p>Item 7</p>	
<p>Title of Document:</p> <p>Proposed development of the Sutton site: Sutton for Life</p>	<p>To be presented by</p> <p>Liz Bishop, Chief Operating Officer</p>	
<p>Background</p> <p>This paper sets out the initial vision of the Sutton Council, and their health partners, for developing a life science cluster by developing the Sutton Hospital site, providing there is investment.</p> <p>The health partners include:</p> <ul style="list-style-type: none"> • The Institute of Cancer Research • The Royal Marsden Hospital • Epsom and St Helier Hospitals (as current owners of the Sutton Hospital site) 		
<p>Executive Summary</p> <p>Sutton council and the partners are presenting the case for investment to the London Enterprise Panel (LEP); given that RM will want space/buildings on the Sutton Hospital site may mean that RM enters into some kind of partnership or negotiates purchase for part of the available site. The level of investment required by RM is unknown at this time, but the Board will be informed as required.</p>		
<p>Recommendations</p> <p>The board is asked to review/comment the early vision for the Sutton Hospital site and Sutton Life Science Cluster.</p>		
<p>Author:</p> <p>Liz Bishop, Chief Operating Officer</p>	<p>Contact Number or E-mail:</p> <p>8127</p>	<p>Date:</p> <p>10th March 2014</p>

Proposed Development of the Sutton Site: “Sutton for Life”

For information

Background

The Office of Life Sciences estimates that UK Life Science Industries generate turnover of over £50 billion and employ 167,500 people in over 4,500 companies. London is a world leading centre for life sciences with high quality of research and the London Enterprise Panel is actively seeking to build on existing strengths. This paper sets out the initial vision of the Sutton Council, and their health partners, for developing a life science cluster, with the development opportunity that exists within the borough, providing there is investment.

The health partners include:

- The Institute of Cancer Research (ICR)
- The Royal Marsden Hospital (RM)
- Epsom and St Helier Hospitals (ESHT as current owners of the Sutton Hospital site)

Sutton is uniquely placed to deliver a cluster which builds on world leading organisations (ICR and RMH) and collaborative research; it is well positioned for transport in and out of London and for international travel. The emerging concept for the site is to align the configuration of existing facilities with redevelopment on the new space, some of which has already been allocated by the Sutton Sites Development Plan (e.g. ICR already have permission to develop R&D space). A series of options have been developed which include residential, commercial and school accommodation, with the possible extension of the tram link.

In summary, the cluster provides:

- A 20 hectare development site (Sutton Hospital site) that can support future phased development, currently valued at c£28m
- Potential to generate jobs on site (c3675) and “*spin off*” jobs (c750) to the local community
- Additional annual economic output equivalent of £130m Gross Value Added in the local economy
- Current analysis indicates the at the capital investment value of developing the entire site would be in the order of £321m. The cost of development will be dependent on a number of factors, including mix, density and specification.

Next steps

Sutton Council and the partners are presenting the case for investment to the London Enterprise Panel (LEP) on 12 March 2014. The LEP will primarily provide cash to address cash flow issues for the upfront purchase of a site and the necessary investment in infrastructure. Whether or not they are positively involved, given that RM will want space of buildings on the site may mean that RM enters into some kind of partnership or negotiates purchase for part of the available site.

The partnership options are variable and should be shaped to suit RM needs; the options will depend on preferences and potential partners (including commercial partners). The discussions with potential biotechnical partners are at a very early stage and the Board will be kept informed of developments.

Implications for the Royal Marsden

It is unclear at this stage what the level of investment by RM will be required or what form a partnership may take; the potential positive impact of the Sutton Life Science Centre could include:

- Clinical research expansion; potential opportunities for pharma and technology partners
- Enhancement of the site; replacement of 1960's estate
- Increased private care business, particularly for overseas patients
- Enhancement of the site; local workforce; attractive popular place to live and improved and close transport links to central London

The full implications for RM will depend on partner(s) and the model; the Board will be kept informed of any major developments and will be consulted prior to making any major decisions/investment.



SUTTON FOR LIFE

Growing London's Global Life Science Cluster

theGROWTHagenda



ICR The Institute of Cancer Research

The ROYAL MARSDEN

Epsom and St Helier University Hospitals NHS Trust

“Life Demands Excellence” (The Royal Marsden)

Sutton for Life demands no less...

Sutton For Life will be the world-leading, life-science campus specialising in cancer diagnosis, treatment, research, education and biotech production. The Royal Marsden and ICR will maintain and enhance their global reputation for excellence and be joined on site by a multitude of world leading enterprises, creating a network of 10,000 additional researchers, clinical staff and support staff operating from the site.

The revamped and expanded campus will provide a truly exceptional healing environment, placing patient health and professional practitioners’ needs at its heart. The transformational design leading to 192,000 sq m of modern facilities, will make the most of the campus’ unique location at the transition between London - a global city - and the outstanding Surrey countryside.

The site will form a significant component of the London, Cambridge, Oxford life-science cluster, linked by exceptional communications technology and modern public transport.

The campus will create a powerful economic driver, fueling local regeneration and integrating the borough into a high-tech, high-value supply chain with employment, economic and lifestyle benefits for every resident.

Opportunity: Site Acquisition



Epsom and St Helier/
Sutton Hospital

The Institute for
Cancer Research

The Royal
Marsden

The Institute of Cancer Research, London

- World leading cancer research organisation
- The UK's no 1
- Discovers more new cancer drugs than any other academic centre in the world
- Generates more invention income per capita than any other UK higher education institution

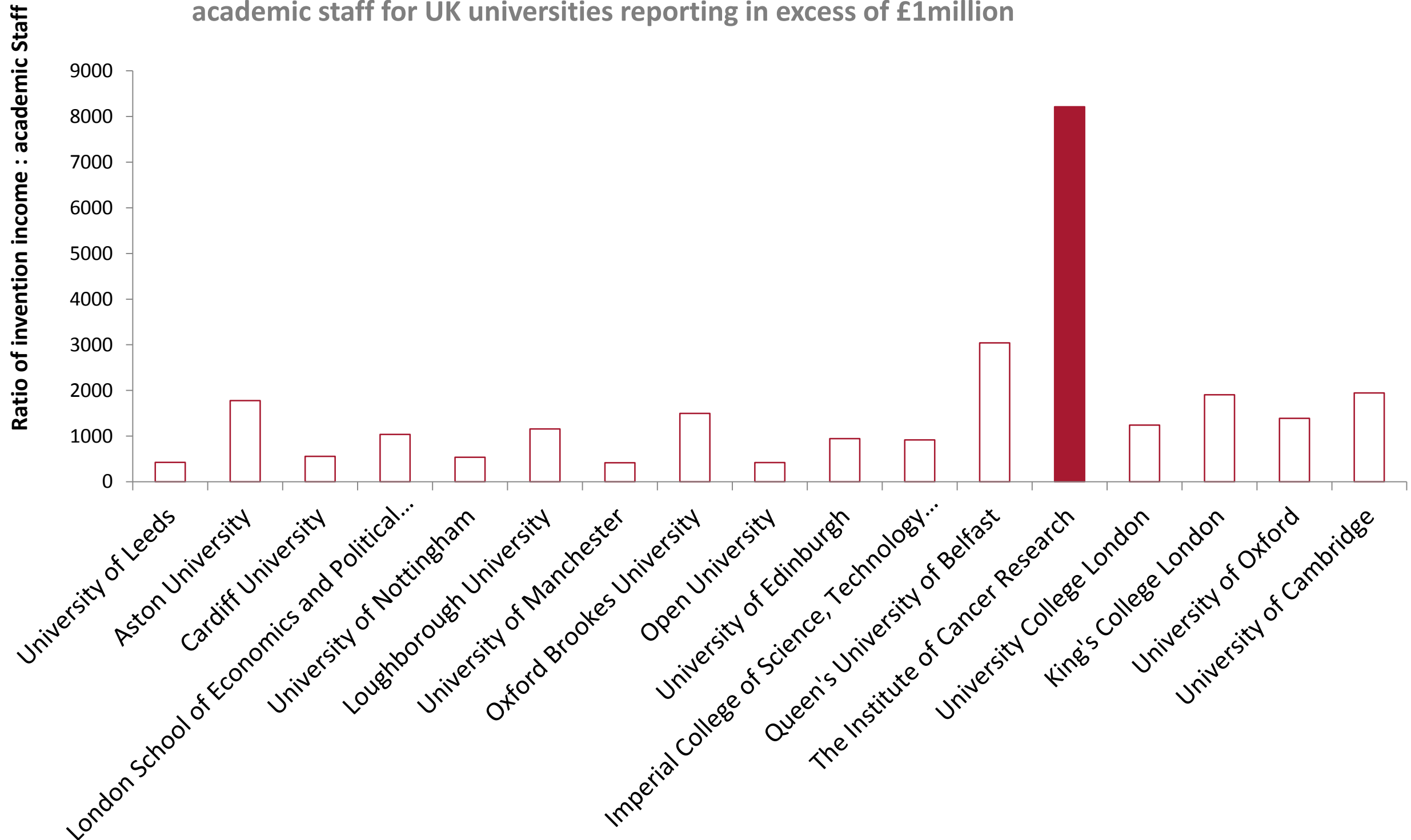
The Royal Marsden

- World-class cancer hospital treating 50,000 patients every year
- With the ICR, ranks among the top four cancer centres in the world
- Generates an operating surplus (much of this is used to cross-subsidise NHS care)
- 2% annual growth in cancer
- 10% growth in demand for private care
- Both partners have invested heavily in Sutton and have a proven track record of delivering capital projects

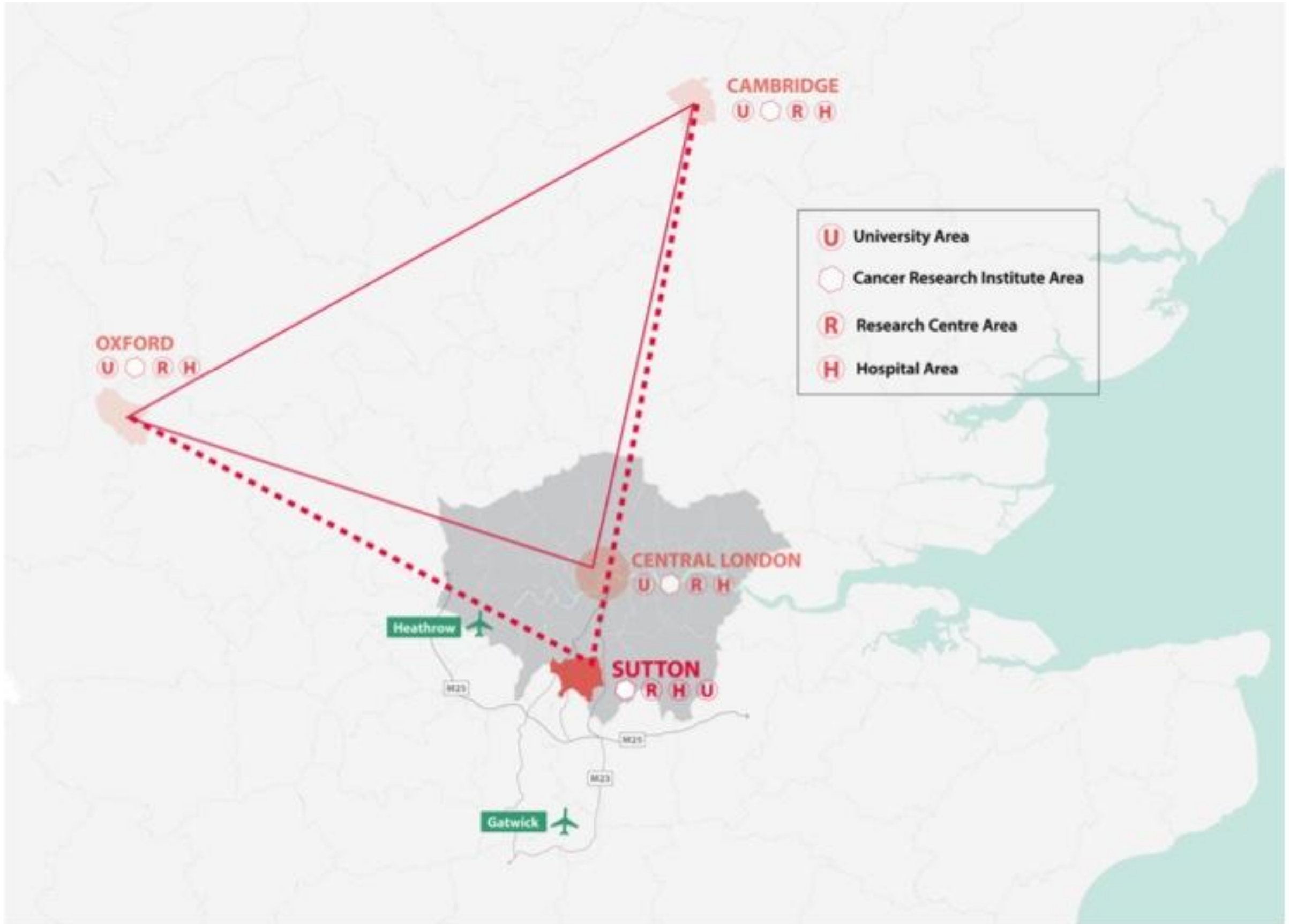


Leading HE Sector Invention Income

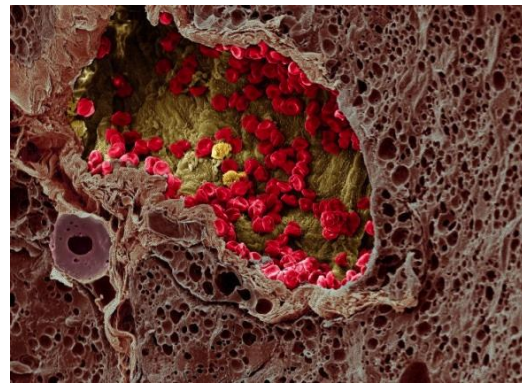
Ratio of 2011/12 invention income:
academic staff for UK universities reporting in excess of £1million



Sutton Life Science Cluster: a Hidden Gem



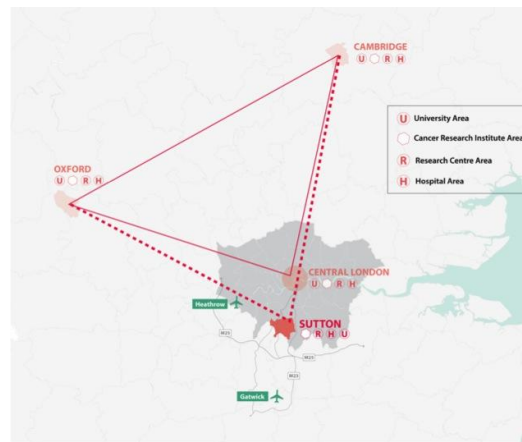
Sutton's Attraction as a Life Sciences Campus



- ICR & the Marsden act as the anchor
- Access to high-quality research facilities
- Clinical trial beds and clinical expertise allow excellent translational research
- A pool of world-class talent already on site
- Proximity to the venture capital markets
- Room to grow
- A strong, supportive public partnership

These attributes mean:

1. The site should be recognised as part of London-Cambridge-Oxford golden triangle of research
2. There is already a substantial pipeline of occupiers willing to co-locate on the site
3. Potential for 10,000+ jobs



What is limiting us?

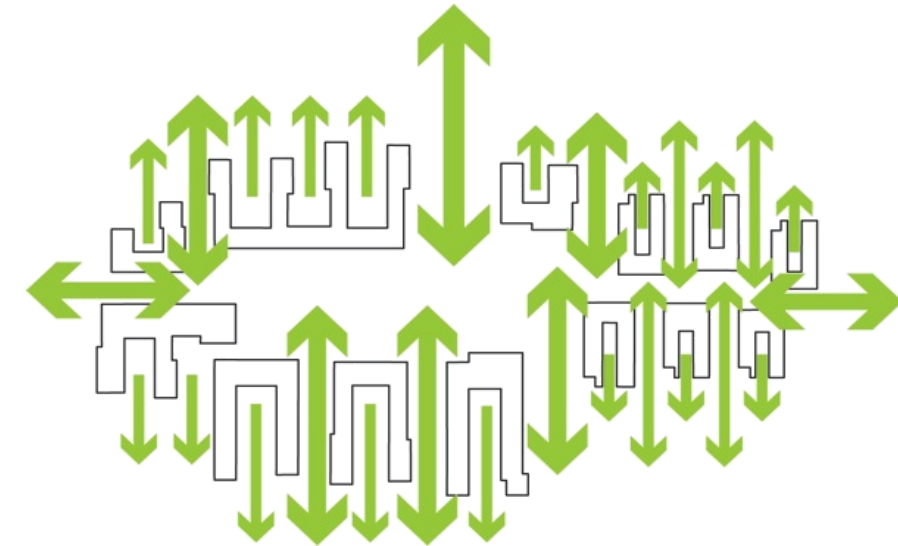
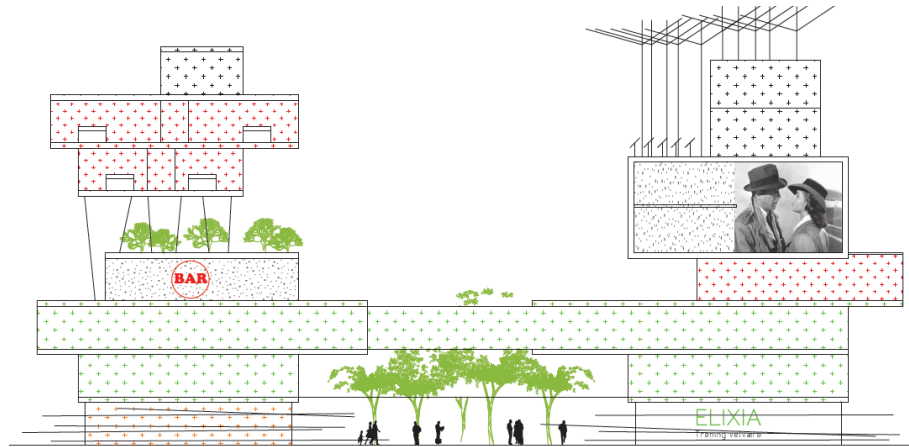
1. Need for unencumbered land to grow
2. Undersupply of modern research space
3. Connectivity of the site



Creating a world-class environment

“By entering partnerships, we can reach our research goals more quickly, speeding breakthroughs on big problems. Partnering with industry ultimately helps cancer patients.”

- The Institute of Cancer Research, 2014



	SENGER			
	SENGER			
	SENGER		TAKTERRASSE	
BRO	NTNU		TEKNIKK	BRO
BRO	OPERASJON/BILLEDIAGNOSTIKK			BRO
GATE/PASS	VESTIBYLE			GÅRDSROM
KULVERT	TEKNIKK			KULVERT

“Drug discovery is a complex ecosystem, involving not just big pharmaceutical companies, but also smaller biotechnology firms, and academic institutions such as The Institute of Cancer Research (ICR), as well as charity funders, private investors and the research councils.”

- Financial Times Global Pharmaceuticals and Biotechnology Conference, 2013

London has a world class life science cluster in Sutton.

The site presents a once-in-a-lifetime opportunity to expand and diversify that cluster

192,000+
Sqm

10,000
Direct
jobs

£350m
direct
GVA pa

Increased
research
income

We will work with the LEP and GLA to:

1. seed fund ICR expansion (inc. enterprise growth space)
2. facilitate land assembly to enable comprehensive development
3. support Enterprise Zone status
4. enhance transport capacity
5. adopt a delivery framework to de-risk planning for investors
6. realise London's full potential as a world-leading life sciences hub

BOARD MEETING SUMMARY SHEET

Date of Meeting: 26 th March 2014		Agenda item Item 9.1
Title of Document: Key Performance Indicators Q3		To be presented by Liz Bishop, Chief Operating Officer
Executive Summary This paper provides a report on the Trust's performance for quarter 3 2013/14 including the balanced scorecard for the Trust and a commentary on the red rated indicators and actions underway to improve performance.		
Recommendations The Board is asked to note the Trust's performance against the balanced scorecard indicators for quarter 3 2013-14.		
Author: Nicky Browne, Director of Performance and Strategy Implementation	Contact Number or E-mail: 8024	Date: 12 th March 2014

THE ROYAL MARSDEN NHS FOUNDATION TRUST BOARD

KEY PERFORMANCE INDICATORS

QUARTER 3 2013/14

1. PURPOSE

This paper is intended to provide the Trust Board with an update on the Trust's performance for quarter 3 2013/14.

The report includes the balanced scorecard for the Trust and a commentary on the red-rated indicators in the quarter 3 report and actions underway to improve performance.

The paper also provides the position on quarter 3 performance and the self certification to Monitor.

2. CHANGES TO INDICATORS

There has been one change to the indicators. The Monitor Financial Risk Rating has been removed in line with the new Monitor Risk Assessment Framework. This has now been replaced with the Monitor Continuity of Services Risk Rating.

3. PERFORMANCE FOR QUARTER 3

The Trust met all of the Monitor indicators and targets for quarter 3 with the exception of the 62 day screening target where the Trust achieved 87.5% against a target of 90%.

The Trust met the 62 day wait from urgent GP referral cancer waiting times standard following the re-allocation of breaches where the referral was received by the Trust after day 42, in line with the London Cancer Alliance reallocation policy.

Attachment 1 shows the balanced scorecard report for quarter 3 for 2013/14.

As agreed a commentary is only provided for indicators where performance is 'red' rated.

(NB ▲ shows improvement from the previous quarter, ►◄ shows no change and ▼ shows deterioration).

4.1 Quality Account Indicators

The quality account indicator is rated amber in quarter 3 due to 1 case of MRSA for the year to date against a national standard of zero tolerance. This was the first case of MRSA at The Royal Marsden since October 2011 and a full root cause analysis has been carried out. Please note that this does not impact on the Monitor Governance Risk Rating score as Monitor has a de minimus of 6 for MRSA cases.

At the end of quarter 3 the number of cases of C diff was in line with the annual trajectory maximum set by the Department of Health (DoH) of 11 cases, and the Monitor de minimus target of 12. While this has not led to a change in the rating for the quality account indicators for quarter 3, it is a risk for quarter 4 as the number of attributable cases in the first two

months of quarter 4 has meant that both the DoH target and Monitor de minimus target have been exceeded.

The Trust is currently reporting one serious incident in quarter 3, however this may be de-escalated and RMH is awaiting confirmation.

4.2 Hospital Standardised Mortality Ratio

The Trust's HSMR figure has improved in quarter 3. However, following the increase over previous quarters of the Trust's rolling 12-month HSMR figure, RMH commissioned analysis from Dr Foster on the factors driving this increase.

The HSMR shows the Trust's in hospital mortality compares with expected mortality as calculated by Dr Foster. The analysis by Dr Foster indicates that crude mortality has not increased, however expected mortality has changed over time which has led to the slight increase in the HSMR figure. The reasons for the change in expected mortality are being investigated however initial analyses by Dr Foster indicate this may be related to a decline in the palliative care rate. This is being reviewed by the Head of Information.

Please note that while the HSMR figure increased it has remained below 100 (a standardised score of below 100 is rated 'better than expected' according to Dr Foster's methodology).

In addition, RMH's Chief Nurse has carried out a review of the mortality data of patients who have died between the period July 2012 to June 2013.

4.3 Waiting times targets

4.3.1 62 day screening service referral – Q3 performance 87.5% target = 90%

There were six screening breaches during quarter 3, of which 4 were unavoidable due to late referrals or patients being medically unfit. There were two cases which were potentially avoidable and issues have been addressed with the teams. Additional actions for quarter 4 are as follows:

- Daily reviews of screening with the service manager for performance and service manager for breast. This is in addition to bi weekly reviews and PTL.
- Monday screening update is copied to clinicians, which includes breach dates of patients

4.3.2 Zero tolerance on 52 week waiters – 2 breaches

There were two separate 52 week breaches (incomplete 18 week pathways) reported in quarter 3. In both cases comprehensive milestone reports were presented to the Trust's Clinical Quality Review Group (chaired by NHS England), which agreed the Trust should not be fined as the circumstances were out of the Trust's control.

- Mixture of patient fitness and patient choice (1 breach)
- 1 breach where the patient was referred to RMH's urology department on day 267. Treatment was booked at RMH for day 347, however was cancelled due to patient fitness.

4.4 Asset utilisation

4.4.1 Theatre utilisation Sutton – Q3 performance 52% , target 80%

There was a dip in surgical activity over Christmas and January 2014. There was also an increase in cancellations due to bed pressures, leading to a drop in activity. However, in the main the key reasons for the low levels of utilisation continue to be as follows:

Breast Surgery - Due to variations in screening referrals, surgical demand for the Breast Unit remains variable. The maternity cover locum consultant is not an onco-plastic surgeon which has resulted in some breast lists being under-utilised. Presently the practice of consolidated booking of surgical cases to the next available list has not been fully implemented.

- *Actions - Current analysis of workload among Sutton breast surgeons by breast service manager. Discussions around consolidated booking ongoing with team*

Sutton theatres accommodate a number of essential clinical support services including paediatrics, endoscopy and line placements but the utilisation of these sessions is dependent on both demand and the availability of the consultants. There is little cross cover / back-fill during holiday periods unlike Chelsea. This results in key periods of under utilisation.

Compared to Chelsea there is currently little demand for PP surgery

- *Actions – review of caseload and sessions within Sutton Theatres as part of wider surgical strategy*

The surgical patient pathway in Sutton remains inefficient and prone to delay. This impacts negatively on theatre start times.

- *Actions – Service manager & Matron for Sutton Theatres are meeting with the ward, admissions / pre-assessment and theatre leads on a weekly basis to plan surgical activity in advance in an attempt to reduce delays and improve the pathway*

Surgical strategy analysis is complete and was submitted to the Board in January for review. An implementation group will be set up to progress efficiency initiatives including theatre utilisation.

4.5 Number of inpatients discharged whose LOS >15 days – Q3 performance 258 target <200

The Trust actively manages all long-stay patients in the hospital ensuring that tests and treatment are carried out in a timely manner so patients are not kept in hospital any longer than they need to be. In addition there is a financial and patient satisfaction imperative in keeping patients' lengths of stay to a minimum.

There are a number of workstreams focused on reducing length of stay overseen by a Project Board which are detailed below. This Project Board is now being restructured to also look more proactively at patient journeys across the wider health economy to ensure, where appropriate, the repatriation of patients to hospitals and healthcare providers closer to their home.

- A daily tracking and alert system for all patients extending their estimated length of stay. This system requests the reasons for extending stay, the discharge plan and

consultant and senior team engagement in any problems with discharge or appropriate repatriation

- Tracking and performance managing extended length of stay with the introduction of a formal MDT review of all patients staying over 21 days by the consultant lead of the patient and the Divisional Medical Director for Clinical Services
- Efficient discharge & TTO process (take home drugs) with the development of a protocol for nurse-led discharge
- 'Enhanced Recovery Programme' for certain cohorts of patients undergoing surgery (now extended to Urology, GI and other surgical specialties)
- Shifting the standard model of care from the inpatient setting to ambulatory care particularly in the haemato-oncology practice
- Increasing admission on the day of surgery
- 23 hr breast surgery for patients undergoing breast surgery without reconstruction as an mandated plan unless appropriate clinical needs outlined
- The Trust is now set to refresh its benchmark of length of stay performance against national peers by procedure type to ensure performance levels are at least as good as the higher percentile providers.
- Surgical strategy includes initiatives to improve length of stay.

4.6 Research

RMH's performance against the 70 day target (% of studies recruiting first patient within 70 days) has improved and is now rated amber.

The Trust was recently asked by Dame Sally Davies, Chief Medical Officer for England (in a generic letter to over 50 Trusts) and the Association of UK University Hospitals for the Trust's contribution to a consultation on how the NIHR should apply financial penalties to Trusts that are poorly performing in clinical research as gauged by measurement of the performance metrics in clinical research. The Clinical Research Executive have responded to this consultation, taking the opportunity to highlight how the Trust has positively responded to the introduction of the metrics and suggesting how to define poor performance.

4.6.1 Actual recruitment vs. target recruitment (commercial interventional clinical trials) – Q3 performance 57% target >85%

The Trust's performance for quarter 3 2013/14 is 57%, which is a slight reduction on quarter 2 (58%).

Actions to improve performance:

- Performance Coordinator attends Senior Trial Coordinator meetings to provide updates on the Trust's performance. This allows research teams to see the impact of their continued work and provides a 'Q & A' forum to answer queries and consolidate the importance of the benchmarks.

4.7 Workforce

4.7.1 Statutory and Mandatory training – Q3 performance 76% target >90%

Compliance rates have remained stable at 70% or above for the majority of topics. A further increase is required in all areas to achieve compliance targets, with a particular focus being on Information Governance for quarter 4. E-learning continues to be promoted, with further measures in place to identify and address any technical issues raised. The reporting frequency for Information Governance training has increased to enable action to be targeted to particular hotspots.

5. UNQUALIFIED Q3 PERFORMANCE & MONITOR SELF CERTIFICATION

The Trust made an unqualified self certification to Monitor for quarter 3. The Trust did not meet the 62 day cancer waiting time (screening target) with the reasons for underperformance and actions put in place is outlined in section 4.3.1.

Monitor has recently confirmed the governance risk rating for quarter 3 as green.

ATTACHMENT 1 - Balanced Scorecard Report for Quarter 3 2013/14

BALANCED SCORECARD
end Q3

1. To achieve the highest possible quality standards for our patients, exceeding their expectations, in terms of outcome, safety and experience

Patient Safety, Quality & Experience	Q3 Actual	Trend from Q1	Q2 Actual
Monitor governance risk rating		▶▶	
Quality Account indicators		▶▶	
Serious incidents (excl pressure sores)	1	▼	0
Mortality			
Hospital Standardised Mortality Ratio (1 qtr in arrears)	78.34	▲	90.06
30 day mortality post surgery	0.5%	▲	0.80%
30 day mortality post chemotherapy	0.4%	▼	0.20%
100 day HSCT mortality in previous 6 months (Deaths related to SCT)	3.9%	▲	4.0%
100 day HSCT mortality in previous 6 months (All deaths)	7.7%	▼	5.0%
Cancer staging			
Staging data completeness sent to Thames Cancer Registry (1 qtr in arrears)	74%	▼	75%
Patient satisfaction			
Inpatient	88.6%	▶▶	88.6%
Outpatient	85.0%	▲	82.4%
Day Unit	89.7%	▲	89.3%
Waiting times for day chemotherapy (over 3 hrs)	12%	▶▶	12%
% of formal complaints reopened (indicator under review)			
Mixed sex accommodation breaches	0	▶▶	0
PP access to single rooms - Chelsea %	99.8%	▲	99.2%
PP access to single rooms - Sutton %	99.5%	▲	98.7%
Cancer waiting times targets			
2 wk wait from referral to date first seen: all cancers	97.8%	▲	95.2%
symptomatic breast patients	95.8%	▲	90%
31 day wait from diagnosis to first treatment	99.1%	▲	98.8%
31 day wait for subsequent treatment: surgery	97.0%	▲	96.6%
drug treatment	100.0%	▲	99.7%
radiotherapy	99.7%	▲	99.5%
62 day wait for first treatment: GP referral to treatment	89.7%	▲	85.2%
screening service referral	87.5%	▼	91.7%
Referral to treatment waiting times			
Maximum time of 18 wks from referral to treatment - admitted	94.9%	▼	96.1%
Maximum time of 18 wks from referral to treatment - nonadmitted	99.0%	▼	99.1%
Maximum time of 18 wks from referral to treatment - still waiting	97.7%	▼	97.8%
No of patients waiting > 52 wks	2	▼	0

2. To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework

Finance & Efficiency	Q3 Actual	Trend from Q2	Q2 Actual
Monitor Continuity of Services Risk Rating	4	▶▶	4
Capital Servicing Capacity (times)	5.1	▼	5.2
EBITDA Margin (%)	6.1%	▼	6.3%
Achievement of planned year to date operating surplus (%)	100.6%	▲	100.1%
NHS activity Income Variance (£000)	2,441	▼	2,679
PP activity Income Variance (£000)	767	▲	285
Liquidity (days)	26.0	▼	27.3
Achievement of Efficiency Programme (%)	90%	▲	83%
CQUINS % achievement	100%	▶▶	100%
Asset utilisation			
Bed occupancy - Chelsea	85%	▼	87%
Bed occupancy - Sutton	80%	▲	79%
Theatre utilisation - Chelsea	82%	▼	85%
Theatre utilisation - Sutton	52%	▶▶	52%
Utilisation of diagnostic radiology	27495	▼	27795

Delivering or exceeding Target	Improvement	▲
Underachieving Target	No change	▶▶
Failing Target	Deterioration	▼

3. To deliver the Trust's clinical and research strategy; redefining our market position to better meet the needs of patients and commissioners, and increasing market penetration

Clinical and Research Strategy	Q3 Actual	Trend from Q2	Q2 Actual
New referrals			
Total new referrals	5279	▲	5256
Total GP referrals	2272	▼	2287
GP referrals - urgent suspected cancers for diagnosis	1385	▲	1304
Referrals from Surrey	966	▲	881
RMH market share	annually measured		
	2011/12	▶▶	2011/12
RMH market share - England (planned cancer admissions)	2.30%	▶▶	2.30%
RMH market share - London (planned cancer admissions)	14.10%	▶▶	14.10%
Personalised care - building molecular diagnostics			
Internal referrals	770	▼	849
External referrals	780	▼	793
CRUK Stratified Medicine Programme (<i>awaiting phase 2</i>)	216		
Private care			
PP inpatient beddays and regular day attenders - Chelsea	4187	▲	4158
PP inpatient beddays and regular day attenders - Sutton	1668	▼	1873
Efficient clinical models			
No of inpatients discharged whose LOS > 15 days	258	▼	247
Research			
70 day target (for externally sponsored trials only)			
% studies recruiting 1st patient within 70 days	71%	▲	56%
Accrual to target			
% actual accrual vs target accrual	57%	▼	58%

4. To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust

Workforce	Q3 Actual	Trend from Q2	Q2 Actual
Human Capital - workforce establishment			
Bank & agency as % of total FTE	12.7%	▼	12.5%
Agency as % of total pay bill	5.3%	▲	5%
Workforce productivity			
Vacancy rate	8.0%	▲	8.1%
Staff turnover rate	11.1%	▼	11%
Sickness rate (<i>thresholds to be set</i>)	2.8%	▼	2.5%
Consultants job plans	92%	▶▶	92%
Junior doctor rota compliance	100%	▶▶	100%
Quality & development			
Consultant appraisal (number with current appraisal)	83%	▲	82%
Appraisal & PDP rate	81%	▶▶	81%
Statutory and Mandatory Staff Training	77%	▲	76%
Employee experience	annually measured		
Staff survey indicators (annual)	3.95	▶▶	3.95
Staff job satisfaction (annual)	3.71	▶▶	3.71
Staff who would recommend RMH as place to work	73.4%	▶▶	73.4%

Delivering or exceeding Target	Improvement	▲
Underachieving Target	No change	▶▶
Failing Target	Deterioration	▼

BOARD MEETING SUMMARY SHEET

Date of Meeting: 26 th March 2014		Agenda item Item 9.2
Title of Document: Quality Accounts – January / February 2014		To be presented by Shelley Dolan, Chief Nurse
Executive Summary The monthly Quality Account reports the current Trust performance against the targets for 2013/14 described in the Annual Quality Account (2012/13) under the following three nationally agreed categories: <ul style="list-style-type: none"> • Safe care • Effective care • Patient experience 		
Recommendations Board members are invited to note the performance of the Trust against the agreed national and local quality targets for January 2014, and the actions being taken.		
Author: Shelley Dolan, Chief Nurse	Contact Number or E-mail: 2121	Date: 12 th March 2014

The Royal Marsden NHS Foundation Trust
Quality Account for February 2014 presented to the March 2014 Board Meeting

Dr. Shelley Dolan, Chief Nurse

1.0. Introduction

The monthly Quality Account reports the current Trust performance against the targets for 2013/14 described in the Annual Quality Account (2012/13) under the following three nationally agreed categories:

- Safe care
- Effective care
- Patient experience

2.0. Safe Care

2.1. Reduction in Healthcare Associated Infections (MRSA bacteraemia and C Difficile infections)

Target: <11 C Difficile infections and <1 MRSA bacteraemia

Performance: Table 2.1 shows that the Trust had six attributable C Difficile (CDI) cases in February 2014. As shown in the table below the target this year for the Trust is 11 cases of CDI with a Monitor de Minimus of 12 and therefore the Trust has now breached its target and has briefed Monitor about this. The Chief Nurse has previously updated Monitor, NHS England (London region) and the Board on the challenge of achieving this target each year as the target number decreases. Cancer patients are particularly susceptible to CDI for the following reasons:

- Damage caused to the gut lining by radiotherapy and or chemotherapy
- The requirement for multiple antimicrobials due to the immunosuppression caused by the cancer and its treatment. Long periods of hospitalisation and acute care.

From April 2014 there is new more comprehensive and robust guidance from NHS England which clearly mandates that all CDI positive patients are reported. However in recognition of the concern across England with this particular target and monetary penalties imposed on Trusts where the CDI has been unavoidable, there is a new system whereby each CDI will be discussed with the relevant commissioners who will then decide whether it was avoidable or unavoidable and therefore whether a penalty should be levied. The CDI target for The RM for 2014/15 is 16 cases. It should be noted that a review of RM cases for 2013/14 reveals that all were unavoidable.

There have been no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) for February.

Table 2.1

No.	Organism	RMH attributable February 2014	Attributable to RMH YTD	RMH Annual Trajectory
1.	MRSA bacteraemia	0	0	*1

2.	C.Difficile	6	17	11 N.B. Monitor de minimus 12
3.	CPO Carbapenama se-producing organisms	0	8	n/a

*MRSA has a target of zero but Monitor has a de minimus of six cases.

2.2. Rate of patient safety incidents and percentage resulting in severe harm or death

To include:

- **Reduction of severe/moderate risk medication errors**
- **Reduction of harm from falls**

Target: Reduction in the rate of patient safety incidents per 100 admissions and the proportion that have resulted in severe harm or death

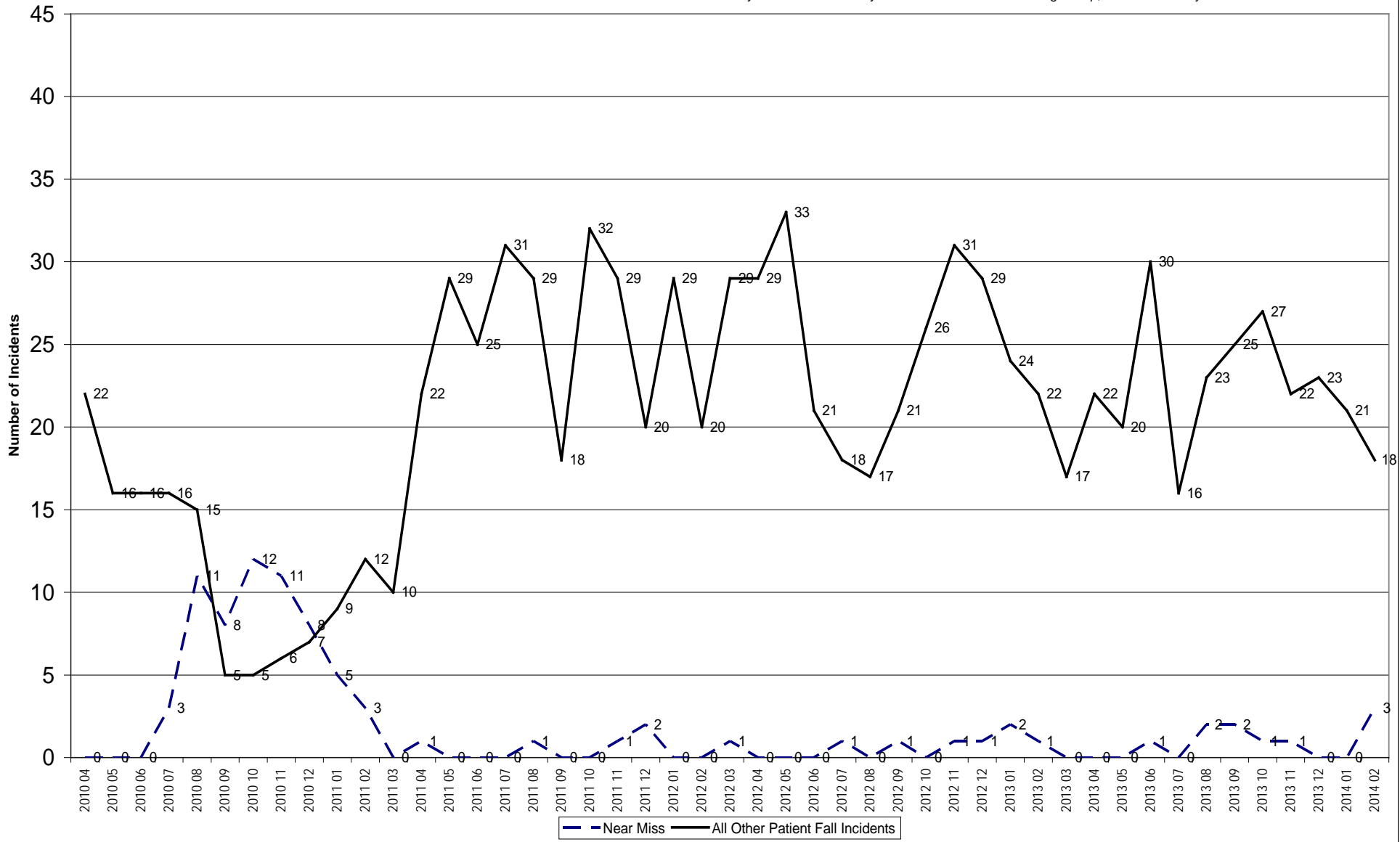
Performance:

2.2. (1) Reduction in Falls

Target: < 0.7 moderate risk (resulting in harm) falls per 1000 bed days
Year to date – April to February 2014 the Trust has met the target.

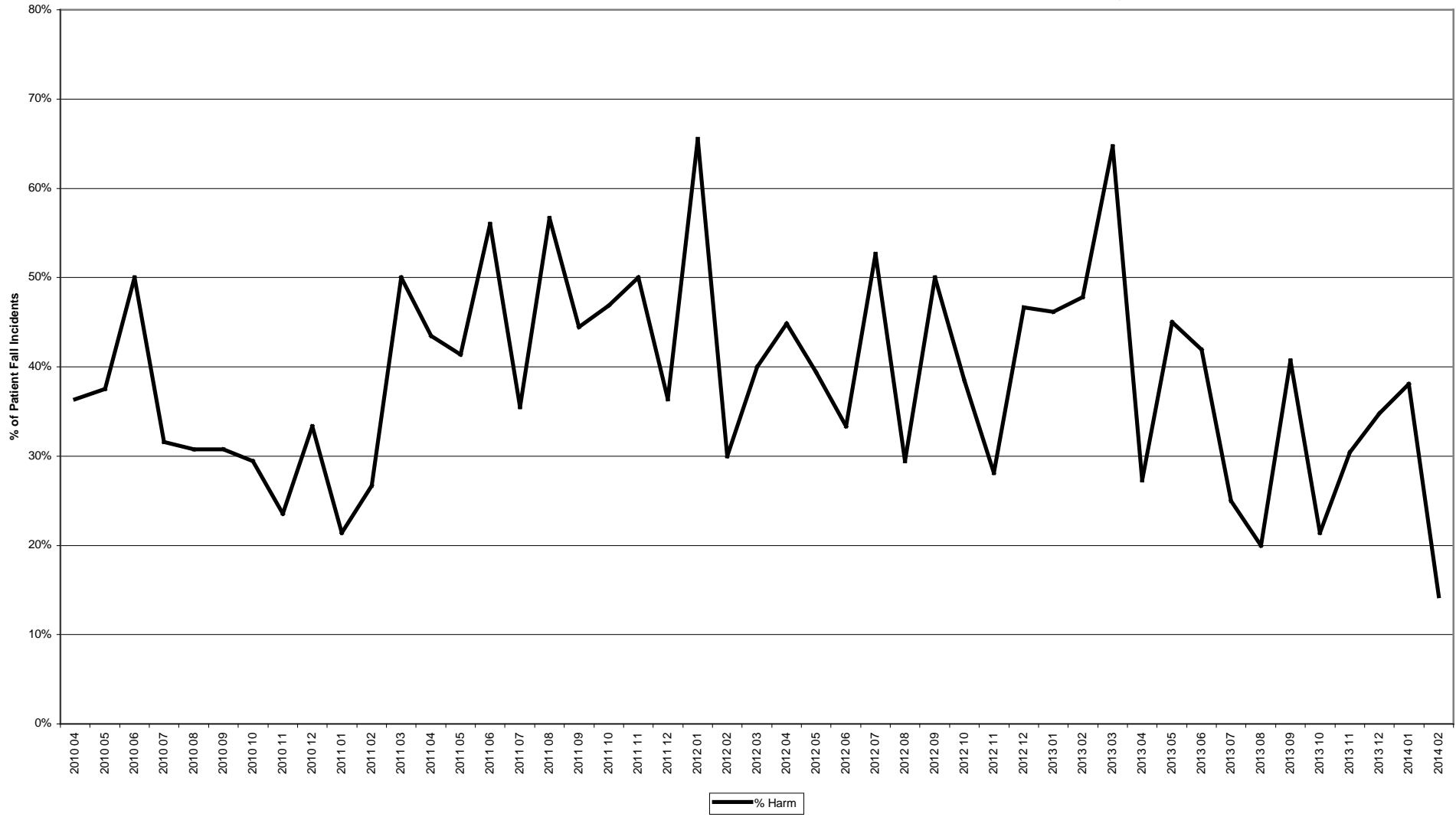
Patient Fall Incidents

Analysis of data between years reviewed at Falls Steering Group, conclusions may differ from data below



Severity: Harm as a % of all Patient Fall Incidents

Analysis of data between years reviewed at Falls Steering Group, conclusions may differ from data below



Severity of Patient Fall incidents:

Severity - Current Period	2013 03	2013 04	2013 05	2013 06	2013 07	2013 08	2013 09	2013 10	2013 11	2013 12	2014 01	2014 02	Tota l
None / Insignificant	6	16	11	18	12	20	16	22	16	15	13	18	183
Low / Minor (Minimal harm)	10	6	9	11	4	5	9	5	6	7	8	3	83
Moderate (Short term harm)	1	0	0	2	0	0	2	1	1	1	0	0	8
Severe / Major (Permanent or long term harm)	0	0	0	0	0	0	0	0	0	0	0	0	0
Death / Catastrophic (Caused by the incident)	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals:	17	22	20	31	16	25	27	28	23	23	21	21	274
% Harm	65%	27%	45%	42%	25%	20%	41%	21%	30%	35%	38%	14%	33%

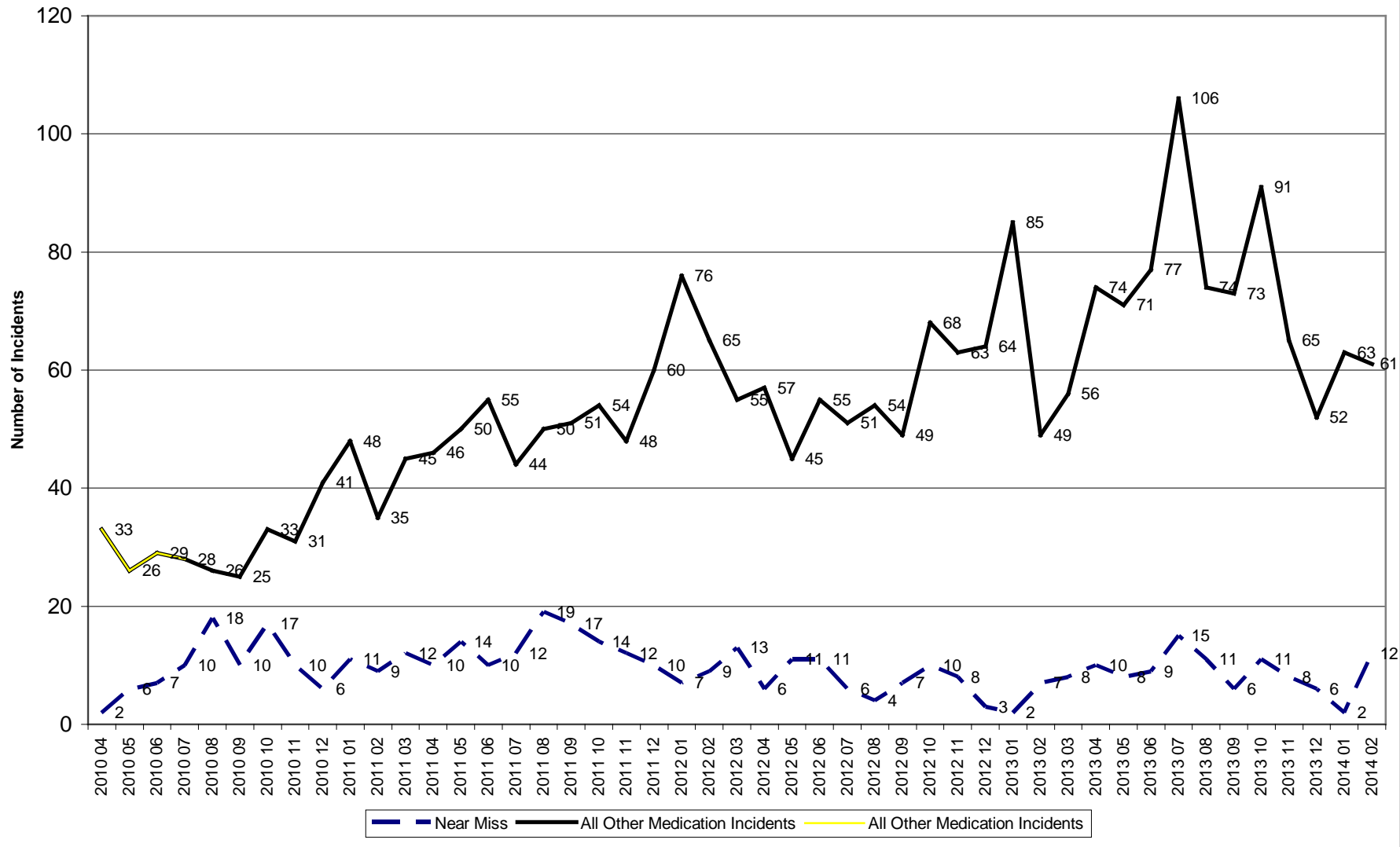
2.2. (2) Reduction in medication errors

Target: To increase the reporting of near misses and decrease the incidents that cause actual harm (low < 2 per 1000 bed days and moderate < 0.17 per 1000 bed days).

N.B. To place medication errors in perspective, annually 0.05% of all medicines administered result in a medication error. For February 2014, this is also 0.05%.

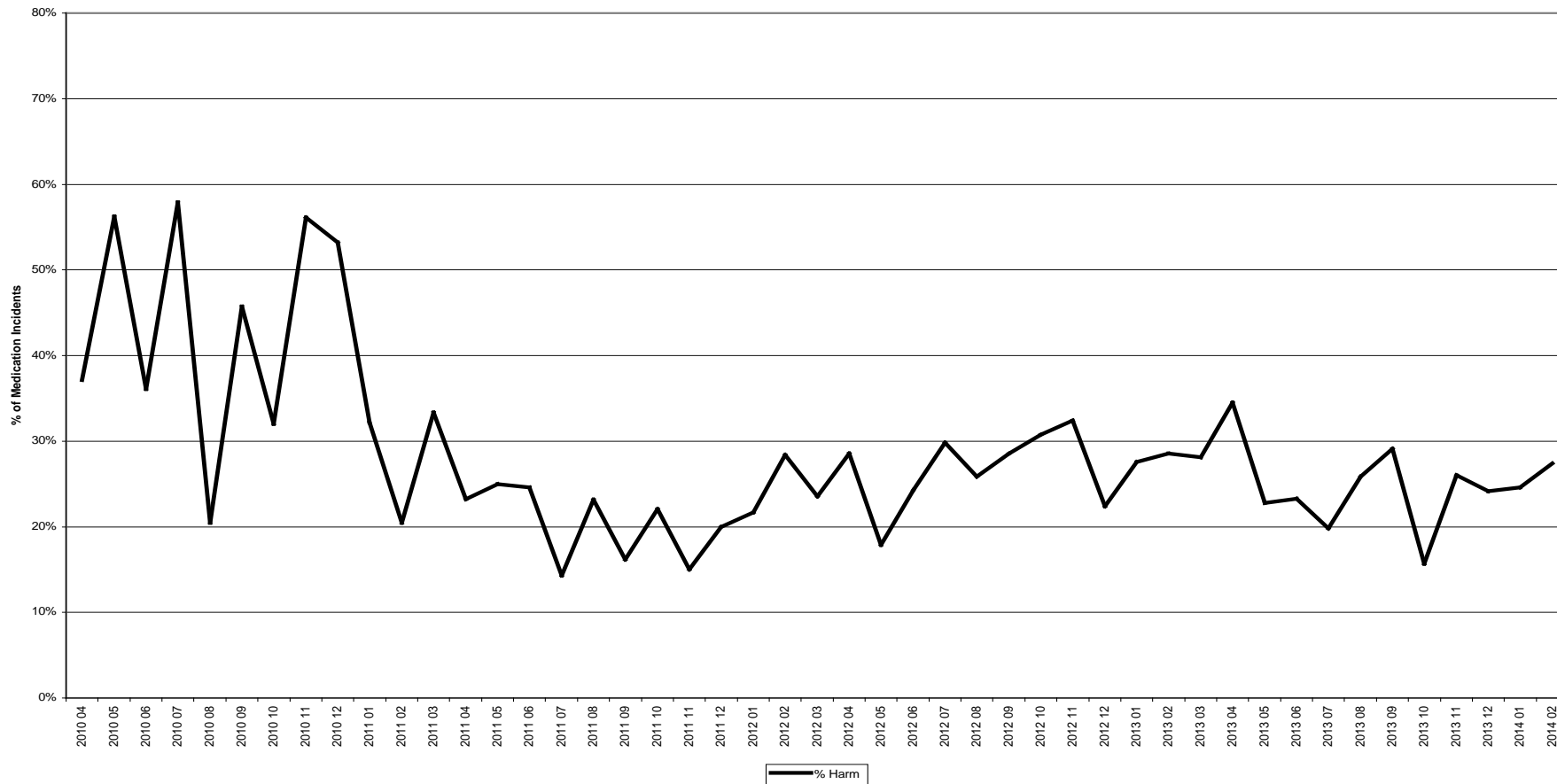
Medication Incidents

Analysis of data between years reviewed at Executive Medications Safety Group, conclusions may differ from data below



Severity: Harm as a % of all Medications Incidents

Analysis of data between years reviewed at Executive Medications Safety Group, conclusions may differ from data below



Severity of medication incidents:

Severity - Current Period

	2013 03	2013 04	2013 05	2013 06	2013 07	2013 08	2013 09	2013 10	2013 11	2013 12	2014 01	2014 02	Tota l
None / Insignificant	46	55	61	66	97	63	56	86	54	44	49	53	730
Low / Minor (Minimal harm)	16	27	18	20	22	20	19	16	16	12	13	19	218
Moderate (Short term harm)	2	2	0	0	2	2	4	0	3	2	3	1	21
Severe / Major (Permanent or long term harm)	0	0	0	0	0	0	0	0	0	0	0	0	0
Death / Catastrophic (Caused by the incident)	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals:	64	84	79	86	121	85	79	102	73	58	65	73	969
%Harm Medication Incidents	28%	35%	23%	23%	20%	26%	29%	16%	26%	24%	25%	27%	25%

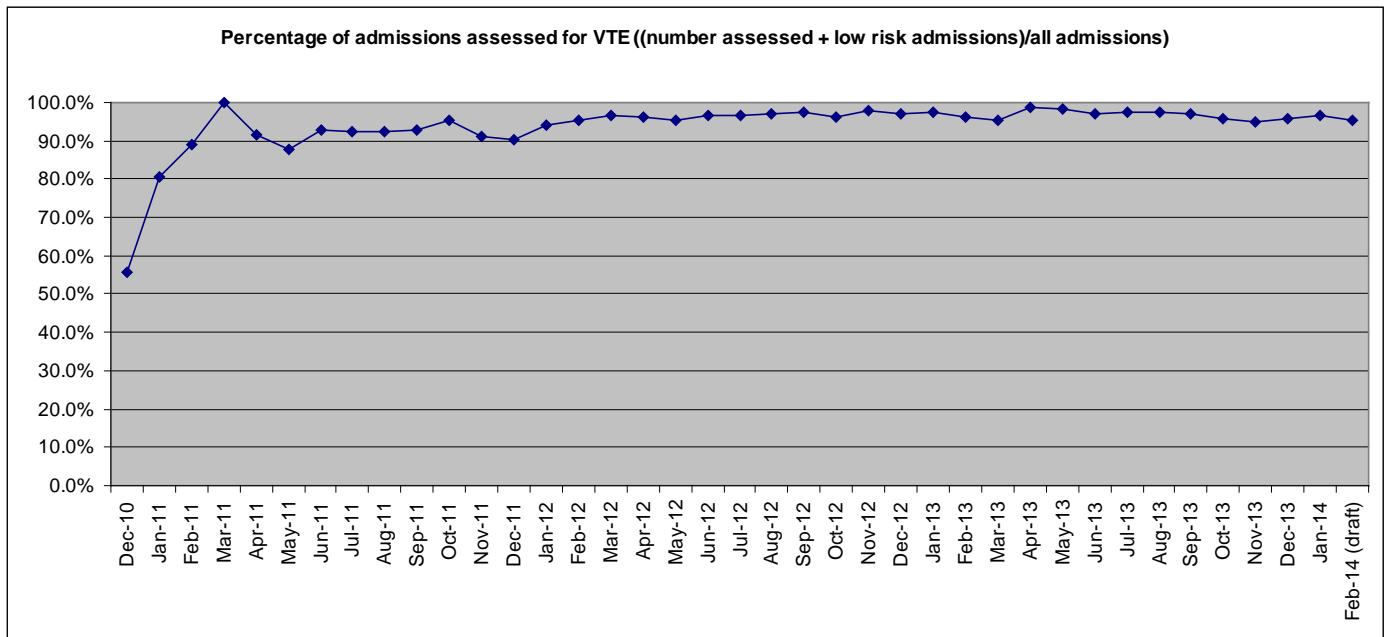
Medication errors notes and actions:

- Omitted drugs and missed visits have reduced in the community since September and further again since December when the last community locality started using the T card system
- A review of the ‘time and day of the week of medication incidents’ is currently being undertaken.
- Further work has been completed to improve the Controlled Drug section of the Medication chart to aid safe prescribing.

2.3. Percentage of admitted patients risk assessed for Venous Thrombo-embolism (VTE)

Target: 95% have completed VTE risk assessments

Performance: The Trust consistently achieves >90% compliance with risk assessment (CQUIN target is 90%). All patients with confirmed VTE as reported by radiology undergo a Root Cause Analysis (RCAs). 98% of patients are achieving appropriate prophylaxis therefore we have reached our CQUIN target of 98%. The VTE steering board monitor all confirmed VTE and scrutinise the RCAs.



3.0. Effective Care

3.1. Reduction in community acquired grade 3/4 pressure ulcers

3.2 Incidence of Trust acquired pressure ulcers

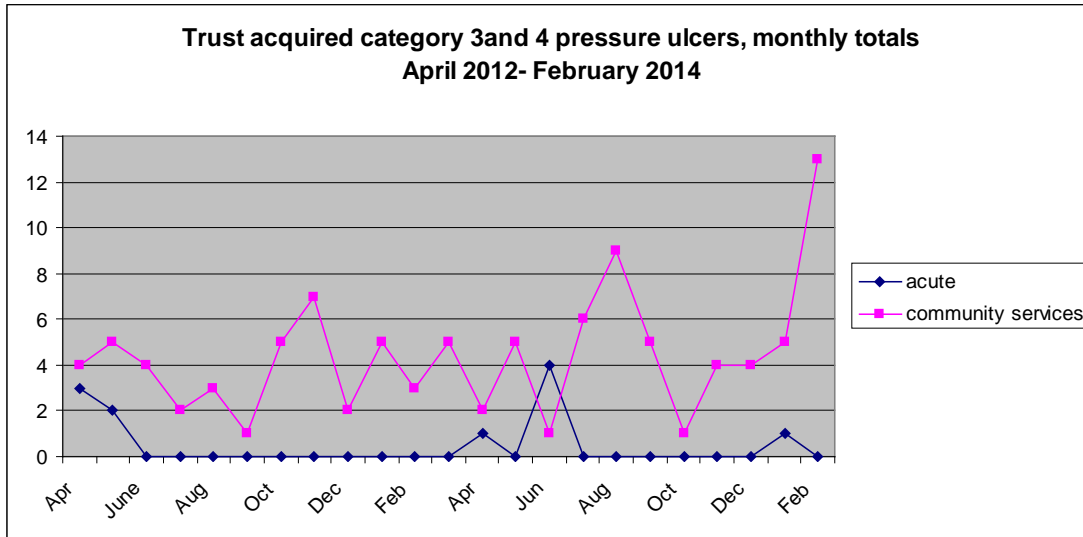
3.2.1 The number and severity of hospital acquired pressure ulcers are used internationally as a proxy for the effectiveness of care provision. Many people with cancer and or co-morbidity are more vulnerable to tissue damage for the following reasons; multiple hospital admissions, frailty, multiple drugs including high dose steroids (decreases skin elasticity), immobility, malnutrition or susceptibility to infection.

3.2.2 Data for this report was taken on **5 March** (acute) and **5 March** (community services) 2014 from DATIX. Data may have been updated since then.

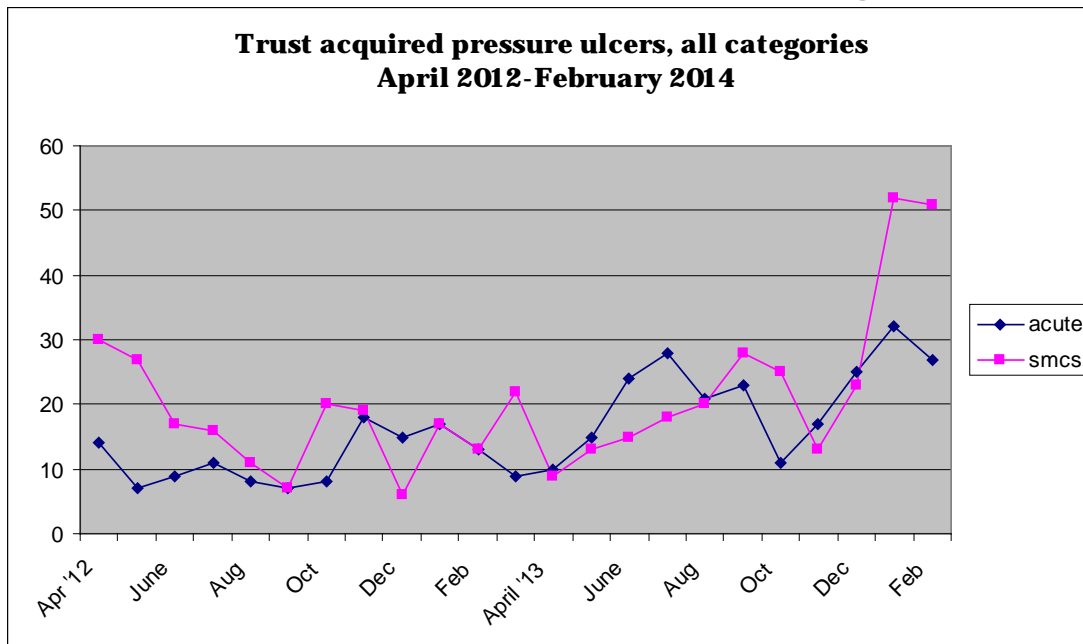
3.2.3 Total number of Trust acquired pressure ulcers for the month of **February: 78** [acute=27, community services=51]

4.2.4 For serious incident reporting to Steis [Strategic Executive Information System] as Acute/Community Services acquired at category 3 and 4 for the month of **February: 13** [acute=0, community services=13]

4.2.2 Number of Trust acquired category 3 and 4 pressure ulcers



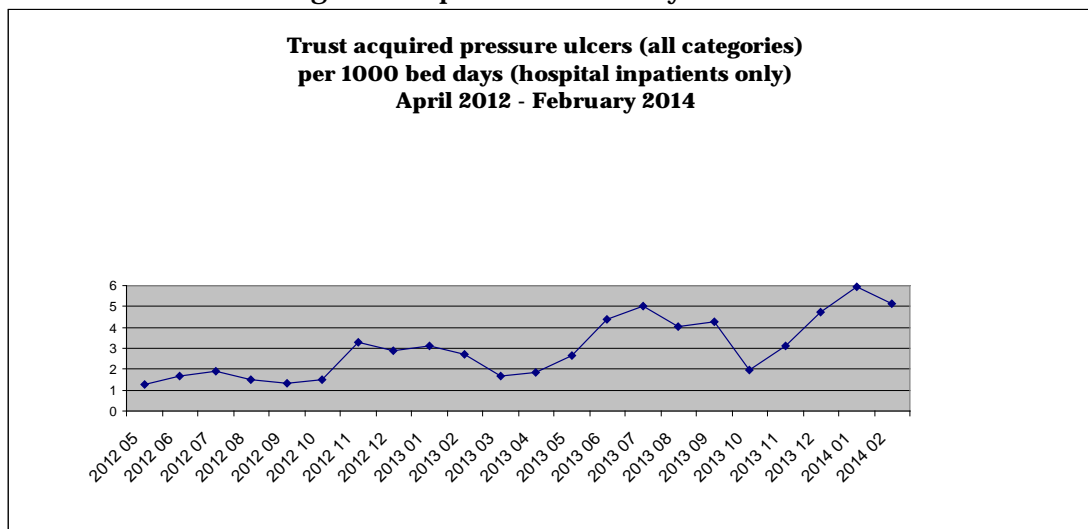
4.2.3 Number of Trust acquired pressure ulcers, all grades



4.2.4 Number of Trust acquired pressure ulcers per 1000 bed days (Royal Marsden hospital inpatients only)

The following table shows how many inpatients have acquired pressure ulcers per 1000 bed days. This does not include community services.

The Trust 2013/14 target is <4 per 1000 bed days.



Description of European Pressure Ulcer Advisory Panel (EPUAP) pressure ulcer classification system.

EPUAP	Description of Stage
1	Non blanching redness of intact skin
2	Partial thickness skin loss or blister
3	Full thickness skin loss (fat visible)
4	Full thickness tissue loss (muscle/bone visible)

Prevention of community acquired pressure ulcers actions

- Tissue viability nurses to clarify the category of pressure ulcers within 24 hours of reporting on datix and take the lead for the investigation of all categories 3 and 4 pressure ulcers in the community.
- Ensure that at each pressure ulcer panel there is clinical representation from the patients' localities to aid discussion and learning.
- Every month to use the first of the fortnightly pressure ulcer incident panels to review the ongoing category 3 and 4 pressure ulcers' action plan and update.
- Identify the person who will feedback recommendations from each panel to the local clinical team, as well as sharing cross cutting issues with the wider staff audience.
- Community nurse managers to be emailed weekly a collated list of category 1 and 2 pressure ulcers, to ensure that documented assessment and plans of care are in place and access to appropriate pressure relieving equipment, e.g. mattresses, offloading boots and cushions.
- In December 2013 at the SMCS Pressure Ulcer incident panel there was concern about the effective and timely identification of Pressure Ulcers. The Chair of the Panel therefore asked all District Nurses to review their caseloads. Over 2000 patients were reviewed, resulting in the rise illustrated above.

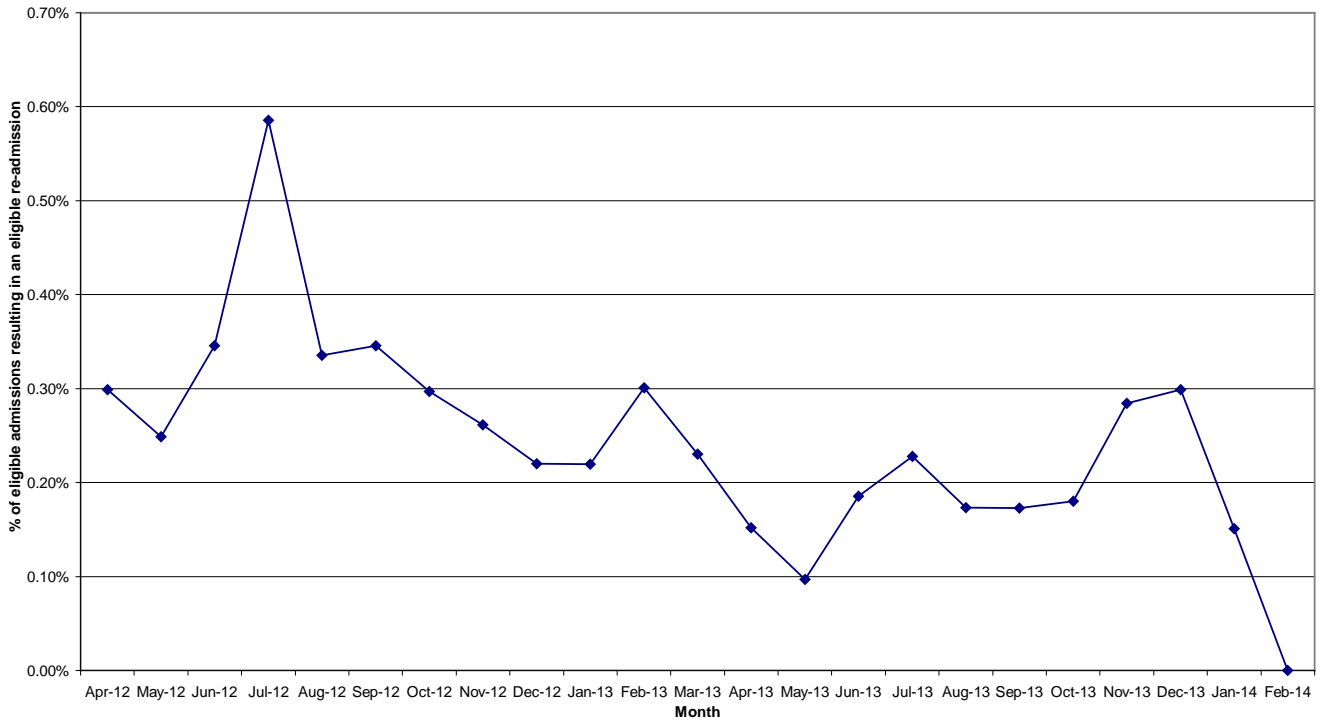
3.3. Emergency re-admissions to hospital within 28 days of discharge

Target: Reduction in the number of avoidable re-admissions to hospital within 28 days of discharge

Some emergency re-admissions following discharge from hospital are an unavoidable consequence of the original treatment, however some can be potentially avoided through ensuring the delivery of optimal treatment according to each patient’s needs, careful planning and support for self care. It is important to note that some readmissions will inevitably include patients who are admitted with side effects of treatment therefore it may be difficult to explain any differences between RMH with other acute Trusts.

Performance: Within 28 days of original admission there were the following emergency admissions:

Reported % of Emergency Readmissions



4.0 Patient Experience

4.1 Reduction in chemotherapy waiting times and improvement in patient experience related to waiting times

Target: Reduction in chemotherapy waiting times at Sutton/Chelsea and improvement in the patient experience related to waiting times

Performance:

Data in the following graphs are for all chemotherapy attendances, for NHS and Private Patients.

Table 1: Chelsea chemotherapy waiting times

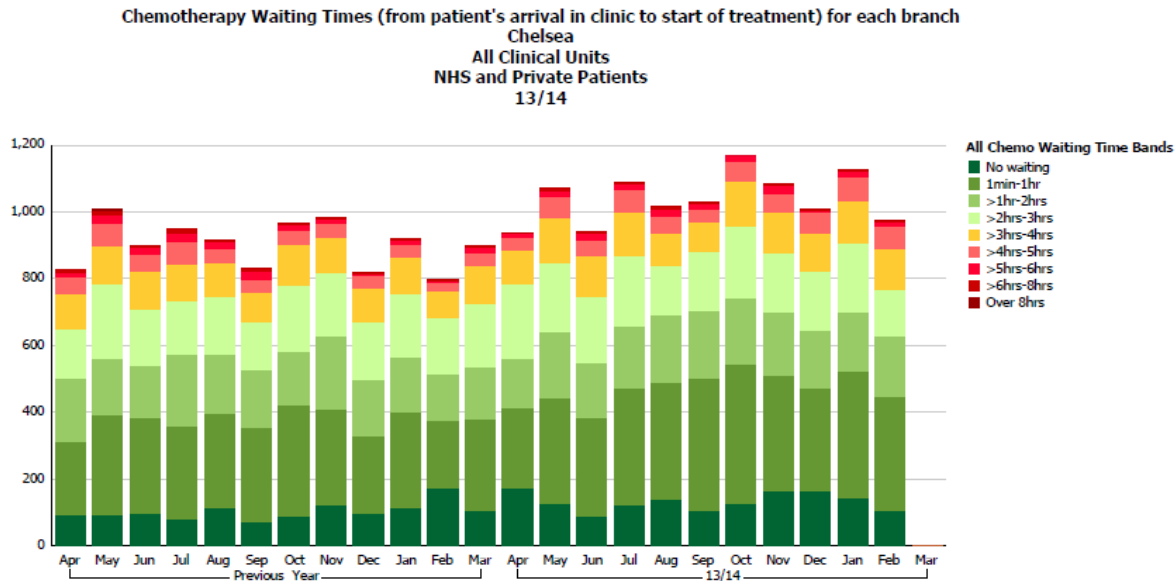


Table 2: Sutton chemotherapy waiting times

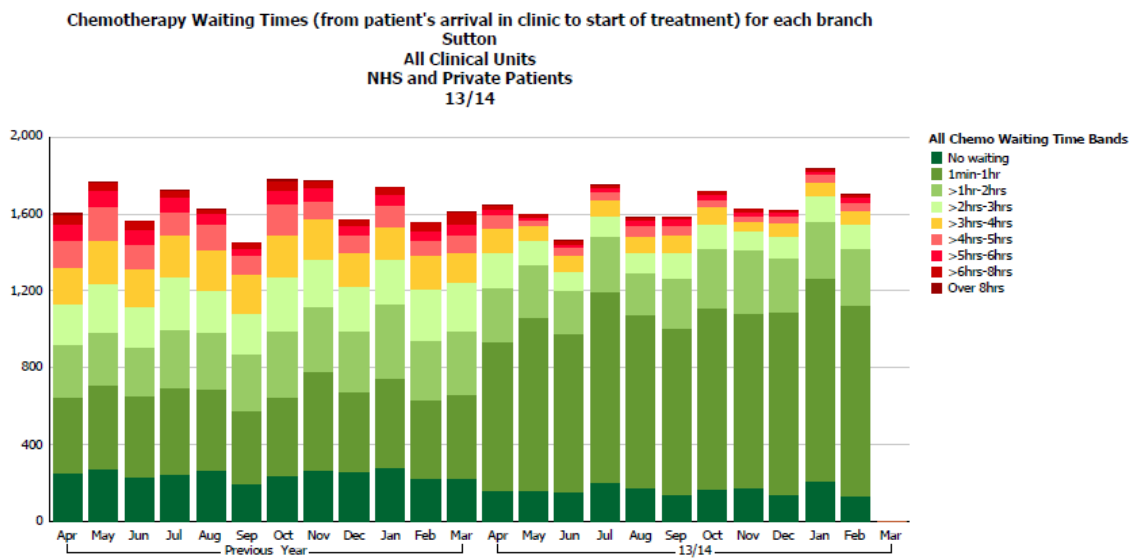
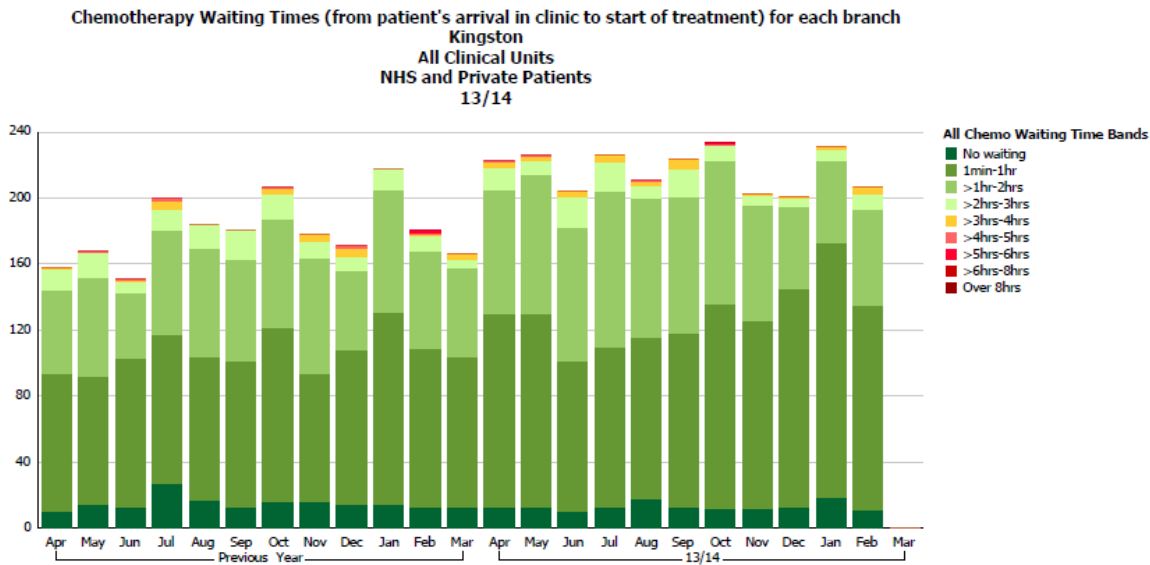


Table 3: Kingston chemotherapy waiting times



Scheduled Care for NHS Medical Day Units (MDU) – Chelsea and Kingston

Scheduled care has been in place in on the NHS MDU in Chelsea since December 2011 and NHS MDU in Sutton since March 2013. All patients attending the MDU are scheduled both for the outpatient and treatment parts of their attendance. Both MDUs aim to see patients within 30 minutes of their scheduled appointment time and within 1 hour of their scheduled treatment time.

Minimum waiting times

Sutton has approximately 44% more day unit activity (across all areas of research, private patients and NHS). In the table below there are differences at each site due to demand placed on the services

Minimum times for the various appointments are highlighted in the table below:

Type of Treatment	Drug not manufactured on the same day	Drug manufactured on the same day not clinical trial	Drug manufactured on the same day and clinical trial
Minimum time between appointments (Sutton)	120 minutes	180 minutes	240 minutes
Minimum time between appointments (Chelsea)	90 minutes	180 minutes	

It is standard practice that all patients are treated on the 2-stop pathway, including patients on clinical trials where the protocol allows. As part of trial setup all sponsors are being challenged if they insist on patients being treated on the same day and routinely now only for clinical safety reasons and for drugs with short expiries would the 1-stop process apply.

4.2 Ensure that we are responding to inpatient's personal needs

The Friends and Family Test

The NHS "Friends and Family Test" was announced by the Prime Minister on 25 May 2012. All Trusts are expected to be "live" by the 1st April 2013. Nationally all patients will be asked a simple question to identify if they would recommend a particular A&E department or ward to their friends and family. The results of the test will be used to improve the experience of patients by providing timely feedback alongside other sources of patient feedback. It will highlight priority areas for action.

The Royal Marsden elected to be an early implementer site and therefore started collecting the data in February 2013. Outside all wards across the Trust are a Poster and Collection Box. All adult patients who have been an inpatient for more than one night are asked to complete the Friends and Family Test form and then to put it straight into the collecting box. Once a week the forms are collected and an external company collates and presents the data.

The national mandated question asked is:

"How likely are you to recommend our ward to friends and family if they need similar care or treatment?"

The patients then select their answer from the following Likert Scale:

Extremely likely; Likely; Neither likely nor Unlikely; Unlikely; Extremely unlikely; Don't know.

The Royal Marsden has then chosen to add a second question:

What was good about your care and what could be improved?

Patients answer this question with free text comments.

January (290 responses)

Alongside positive comments 26 patients made suggestions for improvement. These were around food (poor, would like hot drink at night, breakfast too close to lunch), lack of communication (between wards and porters, waiting time for surgery), waiting for prescription, noise from mobile phones on wards, problems with showers and plumbing issues, lack of continuity at junior doctor level and preferring to go to RDAC in own clothes not hospital gowns.

Finally the Royal Marsden also asks the patient to complete two demographics: Age and Gender. All of the detailed comments are fed back to the individual wards and aggregated to Matrons and Divisional Nurse Directors for action.

February (119 responses)

Alongside positive comments 24 patients made suggestions for improvement. These were around food (needing to be improved, more vegetables), late night noise from other patients (from mobile phones), lack of continuity when nurses change over, agency staff not as same standard as permanent staff, parking on a daily basis is expensive, automatic flush on pipe work took place at 0300hrs and 0500hrs on consecutive morning (understand this is necessary but woke patient and disturbed sleep), when on a trolley going from theatre to ward very bumpy and uncomfortable ride.

National FFT results reporting:

Inpatient data was collected for 171 Acute NHS trusts and independent sector providers.

Nationally, for January the overall average inpatient score for NHS trusts and independent sector was 73 with specialist hospitals scoring higher than general acute trusts.

In January, The Royal Marsden was in the top ten of trusts nationally with a score of 93. The table below shows the results for the Trust over each quarter to date. At the time of reporting (10th March) national figures were available up to January 2014 only.

The Royal Marsden	Q1	Q2	Q3	Q4
Overall FFT score	95	94	92	
Response number	585	635	450	

5.0. Board members are invited to note the performance of the Trust against the agreed national and local quality targets for January 2014, and the actions being taken.

BOARD MEETING SUMMARY SHEET

Date of Meeting: 26 th March 2014		Agenda item Item 10.1
Title of Document: Quality, Assurance and Risk Committee – report from meeting held on 11 th February 2014		To be presented by Nancy Hallett, Chair of Quality, Assurance and Risk Committee
Executive Summary The Chairman of the Quality, Assurance and Risk Committee will provide the Board an update on the meeting held on 11 th February 2014.		
Recommendations For information.		
Author: Shelley Dolan, Chief Nurse and Nancy Hallett, NED	Contact Number or E-mail: 2121	Date: 12 th March 2014

Quality, Assurance & Risk Committee Highlight Report to Board

Meeting held on Wednesday 18 September, 2013, 0900–1100

	Issue	Actions/assurances in place	Key points
1.	The Trust has been asked by Monitor to support Colchester Hospital University NHS Foundation Trust with clinical leadership and organisation as it responds to a recent negative review of its cancer services by the Care Quality Commission.	Monitor will fund the backfilling of the roles of any Royal Marsden staff assigned to supporting Colchester Hospital University NHS Foundation Trust.	The CEO of the RM has agreed a robust action plan with the Colchester CEO against defined timelines until July 2014.
2.	Information Governance Toolkit: Level 3 is the highest level. The Trust's current overall score is 88%. The information-governance culture of the Trust is good. The Trust has many data flows, including the sharing of information with external agencies, which makes information management complex.	Mandatory training Trust wide on IG awareness and compliance. Submission of the IG Toolkit current prediction of 88% as in 2012/13.	Public awareness of data flow issues currently high.
3.	Risk register: The current high level risks remain bed capacity restraints and increasing demand; The IT systems infrastructure vulnerability. Aging stem cell storage tanks.	COO led work programme on capacity and demand including the design of an access policy. The IT systems infrastructure is undergoing an intensive programme of renewal and upgrade. Two replacement storage tanks have been purchased and a programme of ongoing replacement and maintenance in pathology is being designed.	Increased demand and constrained capacity to deliver inpatient and outpatient services. Need for robust IT infrastructure
4.	Robust clinical governance of radiotherapy services.	Leading Trust Radiotherapy Radiographers attended QAR to discuss the ISO 9001 standard for radiotherapy and their compliance with it. The Radiographers demonstrated with practical examples the quality systems	The RM awarded compliance for Radiotherapy ISO 9001 for another year in 2013/14.



		requirements that are embedded in their practice.	
5	Members of QAR were asked to agree that the evidence presented in the self-certification report against each of Monitor's statements is adequate. The Audit and Finance Committee has also been asked to review the evidence against relevant statements. With the suggestion of two additional examples of evidence, the meeting agreed it was assured by the level of evidence and recommended that the Board sign off the document. It was agreed that a reference be added about the role of the Governors in reviewing the quality accounts.	Self-certification report and evidence presented to QAR and previously Audit and Finance committee. Scrutiny by QAR, AFC and Council of Governors.	Self-certification against The Monitor Risk Assessment framework agreed.



BOARD MEETING SUMMARY SHEET

Date of Meeting: 26 th March 2014	Agenda item Item 10.2	
Title of Document: Audit and Finance Committee – report from meeting held on 29 th January 2014	To be presented by Greg Andrews, Chair of the Audit and Finance Committee	
Executive Summary The Chairman of the Audit and Finance Committee will provide the Board an update on the meeting held on 29 th January 2014.		
Recommendations For information.		
Author: Greg Andrews, Chair of the Audit and Finance Committee	Contact Number or E-mail:	Date: 12 th March 2014

Audit & Finance Committee Meeting Highlight Report to Board

Wednesday 29th January 2014

Key issues/papers/presentations received and discussed	Key decisions and actions agreed	Key points for Board to note
<p>Update to the NHS FT Code of Governance and the 2013/14 Annual Reporting Manual</p>	<p>Requirement for reporting on compliance with the revised Code in the 2013/14 Annual Report:</p> <ul style="list-style-type: none"> • setting out the significant issues considered and how they were addressed; • details on audit tenure and tendering policy; and • a detailed assessment of the effectiveness of the external audit process <p>AFC required to ensure processes for fair, balanced and understandable statement in accounts are supported and sufficiency of disclosures</p> <p>AFC will be required to ensure appropriate policies in place for Safeguarding of Whistle-blowers</p> <p>Losses and Special payments are subject to specific pre-approval regime by Monitor</p>	<p>Board to note these changes extensive new disclosures and expanded responsibilities for AFC. Checklist of new requirements and actions required including changes to Standing Financial instructions to be developed for next AFC meeting</p>
<p>Annual Planning Process for 2014/15</p>	<p>Monitor's Annual planning cycle has been revised with</p> <ul style="list-style-type: none"> • Introduction of five year period (vs. current three) • Deadlines brought forward • Central guidance from NHS England, Monitor, Local Government Association on planning assumptions • Self-Assessment tool published • Requirement to publish a summary of the Strategic Plan 	<p>Board to note extensive changes to planning process including requirement to liaise with other bodies and requirement to publish a summary of Strategic Plan</p>



Key issues/papers/presentations received and discussed	Key decisions and actions agreed	Key points for Board to note
Internal Audit Report – KPMG	<p><u>Revalidation</u></p> <p>Follow up review confirmed that the revalidation process was robust and the Trust had clear and thorough guidance in place. Three low priority recommendations made.</p> <p><u>Outstanding Recommendations</u></p> <p>Of the 22 outstanding recommendations after the last AFC meeting, there were now 12 outstanding, including new recommendations since added</p>	
Counter Fraud Progress Update	<p>NHS Protect had selected the Trust for a focused review – “Hold to account” undertaken on 12 December 2013. A report will be issued shortly. Advisory process only – no impact on license.</p>	
Finance Report for the 10 months to December 2013	<p>Key issues highlighted</p> <ul style="list-style-type: none"> - Spend on temporary staffing had increased and was now forecast to be £20m - Private Care was exceeding its income target, but had not delivered on its efficiency programme so could have been performing better - NHS income had been fluctuating in recent months - Cash position was at its lowest level for some time, partly as a result in delays in payment of commissioner debt - Reserve balances had been fully utilised 	
Board Self-Certification	<p>AFC Committee have been asked to review the Corporate Governance Statements and to comment on the level of evidence available. AFC reviewed the allocation of the evidence base to Board Committees and agreed that assignment of accountability and build-up of evidence over the course of the year was appropriate.</p>	<p>Board to note AFC have reviewed the statements and assignment of responsibility.</p>



Key issues/papers/presentations received and discussed	Key decisions and actions agreed	Key points for Board to note
Joint Procurement Service (presentation from new Joint appointed Head of Procurement)	Savings of £500k had been achieved against a target of £1m. With major strategic areas addressed, addressable spend is now relatively small, so opportunities for future savings may be limited. The next phase is on pharmacy outsourcing and achieving greater scale generally. Opportunity to outsource the procurement service being examined	Board to note achievements to date and potential for outsourcing of procurement.
Agency and Temporary Staffing	<p>A summary of temporary staffing expenditure and the actions currently being taken to manage its usage and associated costs and risks was presented.</p> <p>There have been some issues in relation to the management of temporary staffing and some potential financial risks had been identified.</p>	KPMG have been providing additional audit support to this process and a paper will be presented at the next AFC meeting.

