The Christie NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Good
Are services safe?	Requires Improvement
Are services effective?	Outstanding
Are services caring?	Outstanding
Are services responsive?	Outstanding
Are services well-led?	Requires Improvement

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

The Christie NHS Foundation trust provides specialist oncology services. There are around 3,400 staff employed at the trust. It is the largest single site cancer centre in Europe, treating more than 60,000 patients a year. Around 95% of patients receive ambulatory care on an outpatient basis.

Based in Manchester, the trust serves a population of 3.2 million people across Greater Manchester and Cheshire; more than a quarter of the patients are referred from elsewhere across the UK.

From the main hospital site, the trust provides radiotherapy, chemotherapy, outpatient and acute oncology, complex surgical care, research and education, specialty diagnostics and other regional and national services. The UK's largest brachytherapy (internal radiation) service is on the main site. The trust holds numerous speciality international accreditations and was the first NHS organisation in the UK to deliver high energy proton beam therapy.

Other sites, closer to some patients' homes, are known as the 'Christie@Salford' and the 'Christie@Oldham'; these provide radiotherapy, chemotherapy and acute and outpatient oncology. The 'Christie@Macclesfield' provides radiotherapy, chemotherapy, haematology and outpatient services in addition to acute oncology services". The trust also gives chemotherapy care in ten community locations and offers outpatient appointments and blood tests closer to people's homes. There is a 24 hour, 365 days a year telephone 'hotline' for patients, families and professionals to use; there are around 35,000 hotline contacts each year.

We carried out an unannounced inspection of the acute medical services on 11 and 12 October 2022, as part of our continual checks on the safety and quality of healthcare services. We also carried out an announced well led inspection from 15 to 17 November 2022 as part of our continual checks and because we had concerns raised with us around culture and senior leadership of the trust.

At our last inspection we rated the trust overall as outstanding. We also inspected the well-led key question for the trust overall.

Our findings

We did not inspect surgical services during this inspection, (which was previously rated as requires improvement) because the service had made the improvements necessary to meet legal requirements as set out in the action plan the trust sent us after the last inspection. We did not inspect other core services of critical care, end of life, outpatients or diagnostics which were previously rated as overall good or outstanding.

Our rating of the trust went down. We rated it as good because:

In medicine we rated safe as requires improvement. Effective, caring, responsive and well led as good.

We took into account the current ratings of the 5 services not inspected this time.

The trust ratings for safe went down, we rated it as requires improvement. Effective, caring and responsive remained outstanding.

The rating for well led went down, we rated it as requires improvement.

At this inspection we found that;

- Staff told us that some senior leaders were not always visible or approachable. There were gaps in assurance for requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).
- Very senior executives were heavily invested in the promotion and protection of the trust's reputation. This impacted negatively on some staff; staff did not always feel supported and valued. A minority of staff expressed reservations about raising concerns and others did not always feel listened to. Although, staff remained focused on the needs of patients receiving care.
- Equality, diversity and inclusion had not been effectively prioritised within the trust in the previous 3 years. Staff, particularly those with particular equality characteristics, did not always feel engaged or supported.
- There were some fundamental strategies which were waiting final ratification.
- Some essential policies had passed their review date.
- The trust reported and investigated complaints, incidents and mortality but these were not always completed in a timely manner. Learning was not always shared with relevant staff across the trust**.**

However:

- Leaders had the skills, abilities and experience to run the trust. Most leaders understood the priorities and issues the trust faced.
- The trust had a vision for what it wanted to achieve, and a strategy developed with relevant stakeholders. The vision and strategy were focused on aiming to provide the best care for local people and those in wider areas.
- The trust had a culture where patients and their families could raise concerns without fear. Leaders and staff actively and openly engaged with patients. The trust engaged with external stakeholders and local partners to help improve services for patients.
- Leaders mostly operated consistent, effective governance processes and were clear about their roles.

Our findings

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- The trust collected data and information and analysed it. Staff could find the data they needed, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

How we carried out the inspection

During our inspections we spoke with a variety of staff, including allied health professionals, nurses, doctors, research staff, health care support staff, and consultants. We also spoke with patients and relatives. We visited clinical areas and non-clinical areas across the hospital site. We reviewed patient records, regional and national data and other information. We also reviewed other information sent to us from external sources.

We held several staff focus groups to enable staff to speak with inspectors. The focus groups included nursing staff, allied health professionals, research and innovation teams, junior doctors and consultants. We also held focus groups with the non-executive directors, governors and staff from networks for those with particular equality characteristics.

During the well led inspection we spoke with senior leaders, directors, executive directors and non-executive directors of the board.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- Senior pharmacists worked in partnership with NHS England and NICE (national institute for health and care excellence) to collate cancer guidelines, recommendations, commissioning policies and new medicines.
- The Manchester Academic Health Science Centre (MAHSC) had recently awarded 3 members of staff honorary clinical chairs for their contribution to cancer services, research and education. This included research into peritoneal cancers to improve outcomes for patients with these rare tumours and clinical trials that had improved outcomes for lung cancer patients with advanced disease.
- The trust opened the first high energy proton beam therapy (PBT) centre in the UK in 2018 and the first proton beam therapy clinical trial in the UK started in 2021. The trial was co-led by the trust and the Institute of Cancer Research to explore whether the use of proton beam therapy reduced long-term side effects and improved quality of life for patients treated with radiotherapy for throat cancer.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with legal requirements. This action related to medical care services.

Trust wide

- The trust must ensure staff complete mandatory training in accordance with the relevant schedule and receive relevant training, supervision and appraisal to perform their duties competently. (Regulation 18 (2)(a))
- The trust must ensure that policies are reviewed and ratified in a more timely manner. (Regulation 17 (1))
- The trust must ensure that serious incidents and mortality reviews are investigated in a timely manner and learning is shared across the organisation as required. (Regulation 12 (2)(b))
- The trust must ensure there is an effective process to manage complaints, in particular, ensuring the timeliness of responses. (Regulation 16 (2))
- The trust must ensure there is an effective process to manage the administration of the fit and proper persons checks. (Regulation 5)

Location/core service

Medical care

- The service must ensure staff complete mandatory training, including safeguarding training in accordance with the relevant schedule and receive relevant training to perform their duties competently. (Regulation 18 (1)(2)(a))
- The trust must ensure that patient risk assessments are consistently completed and reviewed in a timely manner for all patients. (Regulation 12 (1)(2)(a)(b))
- The service must ensure the proper and safe management of medicines, to include the completion of antimicrobial documentation for safe prescribing in line with trust policies. (Regulation 12(1)(2)(g))

Action the trust SHOULD take to improve:

Trust wide

- The trust should continue to make improvements in culture across the organisation, support staff when raising concerns and act on them in a timely way.
- The trust should continue to develop and promote fundamental strategies such as the equality, diversity and inclusion strategy and take appropriate actions to improve staff engagement, especially those with particular equality characteristics.

Our findings

- The trust should consider monitoring delayed discharges or transfers of care in regard to patient experience.
- The trust should ensure there is an effective process to provide information in an accessible format for service users with information or communication needs.

Is this organisation well-led?

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, abilities and experience to run the trust. Most leaders understood the priorities and issues the trust faced. However, staff told us that some senior leaders were not always visible or approachable. There were gaps in assurance for requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

The board of directors was a unitary board. This meant that within the board, the non-executive directors (NEDs) and executive directors made decisions as a single group and shared the same responsibility and liability. The board was led by the trust chairperson who was appointed in October 2014; they were nearing the end of their tenure. There were seven non-executive directors excluding the chairman. The chief executive officer (CEO) was appointed in December 2013, prior to this they had been the chief operating officer (COO) at the trust.

We found strong, visible clinical leadership from the chief nurse (CN) and medical director (MD). The MD had been a consultant at the trust from 2009. The CN was originally appointed to the trust as the inaugural joint professor in cancer nursing with the University of Manchester in 2015 and was appointed CN and director of quality in 2020. As CN they were developing a new leadership structure. They had appointed an associate CN for infection prevention and control (IPC) in January 2022. Their portfolio had expanded to include all aspects of patient safety. This had led to a recent change in job title to associate CN for quality and patient safety.

There was a business case for a “chief of allied health professionals” together with more senior leadership for dietetics.

The COO provided clear strategic leadership over day to day functions at the trust and staff commented positively on their leadership and support. The COO had joined the trust in 2009 as a service manager. We had variable feedback about the visibility of other senior leaders.

However, the CEO attended a range of various staff engagement events and activities. These included induction sessions for new staff, monthly staff awards presentations and team briefs, ward accreditation panels, and individual staff drop in sessions.

There was a deputy CEO, who was also the medical director for strategy, their role was described as externally facing, they were not involved in the core clinical operations of the trust nor the delivery of frontline services. There was a director of education and a director of research who both reported to the deputy CEO.

The trust had an associate MD for quality and patient safety and a divisional MD in each clinical division who all reported to the MD.

Our findings

There were 2 interim board directors; the director of finance (DOF) had been appointed on an interim basis in August 2021 (their substantive role was the deputy DOF) and there was an interim director of strategy who was covering for long term sickness. The CEO was about to start recruitment for a permanent DOF. The director of HR was not a voting board member.

Most executive directors had been internal appointments. This could indicate effective succession planning and investment in existing employees. Although, an overreliance on internal hiring could lead to a stagnant culture, reduced talent pool and less diversity.

During our inspection we found that most leaders understood the challenges to quality and sustainability, and they could identify actions needed to address them. However, not all board members we spoke with understood the priorities and issues the trust faced. The executives met twice a week, once formally and once on an informal basis to manage the business of the organisation.

Executive leaders were involved or led on regional system work around cancer services. For example, the CEO chaired the Greater Manchester cancer alliance and the Greater Manchester clinical research network. The CEO was also a member of the Manchester cancer research centre steering board. The CN had developed the Christie clinical academic group and was deputy chair of supportive and palliative care at the University of Manchester.

There was a board development programme, the main agenda items for 2022- 2023 were;

- Freedom to speak up training for the board (this was an action from the NHS England review)
- Board development on equality, diversity and inclusion (EDI), specifically to focus on race, allyship and civility
- Work on planning & strategy, corporate governance, new models of care including NHS changes and regional integrated care system (ICS) development
- A board service review day with clinical leaders from across the trust
- A joint board and council of governors' session to look at strategy and major capital developments
- Mandatory training for board members to include information governance, Cyber security, risk management, EDI training, 'Prevent' training (Prevent covers all forms of terrorism and extremism and some aspects of non-violent extremism), and anti-fraud training.

There were plans in place for an open appointment process to recruit a new chair when the time came.

There was a board of governors which had the role of holding the trust publicly accountable for the services it provided.

Fit and proper person regulation 5 (FPPR)

This regulation is about ensuring that registered providers have individuals who are fit and proper to carry out the important role of director to make sure that providers meet the existing requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed 10 FPPR files for board members and found a lack of a robust process;

- Evidence of competency-based interviews were not consistently recorded in files. Five executive director files showed evidence that a competency-based interview process had been followed. However, only one file had their interview

forms saved. One file had a blank interview template saved and others had no interview forms saved at all. We were told 1 of the records was held in human resources. Similarly, five non-executive director files showed evidence that a competency-based interview process had been followed. However, no files had their interview forms saved and two had blank interview templates saved.

- One non-executive director file had no evidence of a robust recruitment process. There was no evidence of ID, proof of address or qualifications saved in the file to show they had been checked.
- One executive director's file had no evidence of DBS (Disclosure and Barring Service) checks.

This meant there were gaps in the trust's own assurance around FPPR processes.

Medicines leadership

The chief pharmacist and their senior leadership team were able to provide sustainable leadership for medicines optimisation in the trust. There was good engagement with the trust executives and awareness of medicines optimisation challenges.

Vision and Strategy

The trust had a vision for what it wanted to achieve, and a strategy developed with relevant stakeholders. The vision and strategy were focused on aiming to provide the best care for local people and those in wider areas. There were some fundamental strategies which were waiting final ratification.

The vision of the trust was to be a leader in cancer care, to provide the best experience for patients, relatives, carers and staff, and to lead research into cancer care on a national and international basis. Not all NEDS or executives spoke specifically about the trust values. However, the chair spoke with us about the vision being delivered through a strategic approach and annual objectives and that values and behaviours underpinned those.

There were 8 corporate objectives for 2022 to 2023:

- To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer
- To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey
- To be an international leader in professional and public education for cancer care
- To integrate the clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre
- To provide leadership within the local network of cancer care
- To maintain excellent operational, quality and financial performance

To be an excellent place to work and attract the best staff

To play a part in the local health care economy and community

Our findings

The corporate objectives were reviewed at board meetings and were 'on plan', in progress, or ahead of schedule to be completed by the end of March 2023.

In early 2018 the trust had refreshed its 5-year strategy to reflect where it wanted to be as an organisation in the future. There were 4 main themes in the strategy, 'leading cancer care, The Christie experience, local and specialist care and best outcomes.' The strategy was developed by the board following consultation with patients, staff, and governors. The current strategy was in its final year.

There were 2 enabling strategies which underpinned the overall strategy, these were the quality strategy (2022 to 2025) and the estates strategy (2014 to 2024). The quality strategy set out ambitions to improve quality of care over the next 3 years. The quality strategy described itself as a 'golden thread' that ran through all trust strategies, however some of these were waiting final ratification and would not be published until 2023. These included;

- the clinical outcomes strategy,
- the workforce strategy (people and culture plan),
- the digital strategy.

The trust had an equality, diversity and inclusion (EDI) plan (2019-2023) with an underpinning one year delivery plan of objectives (June 2022- June 2023).

There was no patient experience strategy.

Medicines strategy

There was a pharmacy service strategy in place until 2023 which included operational sustainability, education and training, research and innovation, regional working, partnerships and workforce. Pharmacy staff had good access to training, ensuring that they were aware of organisational aims and objectives. The chief pharmacist told us that the new overall trust strategy would be published at the end of this financial year to cover 2023 to 2028. There was a plan for the new pharmacy strategy to be aligned with the corporate strategy from 2023 onwards.

The key priorities for the medicine's optimisation team was to ensure patients received chemotherapy medicines safely, whilst maintaining a good patient experience.

Culture

Staff did not always feel supported and valued. However, they remained focused on the needs of patients receiving care. A minority of staff expressed reservations about raising concerns and others did not always feel listened to. Equality, diversity and inclusion had not been effectively prioritised within the trust in the previous 3 years. The trust had a culture where patients and their families could raise concerns without fear.

Very senior executives were heavily invested in the promotion and protection of the trust's reputation. This impacted negatively on some staff and was clearly evidenced from feedback by some staff, staff interviews and focus groups we conducted.

Our findings

There had been previous concerns about culture and freedom to speak up processes at the trust. The trust's audit committee commissioned a review into freedom to speak up processes. The report, dated January 2021, drew attention to deficiencies into the trust policy and processes. An investigation was also commissioned by NHS England/ Improvement about the same concerns. This report was published in December 2021.

The trust had launched a 'Respect Campaign' prior to the review which aimed to reduce the occurrence of bullying and harassment. However only around 150 people had signed up to the campaign in the first 10 months.

We were told by a range of staff that there was a lack of visibility of some senior and executive leaders. The relationship with staff side (trade unions) required development; there had been very limited engagement from the CEO for around 18 months. Staff side described an 'us versus them' situation and said they didn't feel recognised or listened to by executives. The terms of reference for the staff side committee were being reviewed.

There was a positive culture of putting patients first within the trust. Patient stories can help boards to get a better understanding of individuals' experiences and perspectives on a specific issue or service. The trust had recently held a patient experience day with patients, board members and clinicians. Patient stories were shared in annual reports and patient quotes were shared with the board in monthly reports. However, we looked at board papers for the previous six months and only positive feedback was quoted in the patient experience section. There was no additional section for any negative feedback to be shared with the board.

Staff stories were heard at trust board meetings. This included live videos of ward visits involving consultants, nurses and domestic staff. Staff experiences in their work areas have a direct bearing on their own wellbeing and on the quality of care they offer patients. Staff stories are valuable for improving the experiences and outcomes of patients.

We were told that partnership working within the trust was improving, especially between medical and clinical oncology. We were told that some teams were managing this well, with others requiring some support. The split between the two areas was being removed; although still professionally line managed, they operationally delivered as one team to benefit patients, for example breast services. The trust was focused on ensuring successful partnership working between different departments, in particular medical and clinical oncology.

The NHS staff survey 2021 showed that the trust scored 7.6 out of 10 for compassion and inclusivity. This was better than the average score of 7.5 out of 10 when compared to other specialist trusts in England. The survey showed that 74.8% of staff felt that people they worked with treated them with respect. This was better than the average score of 72.4%.

However, before, during and after our inspection we received information of concern from staff about the workplace culture at the trust. We also received other mixed feedback; some staff told us culture had recently improved in their workplace, and others told us there was a supportive culture.

After our inspection, senior leaders sent us a revised values and behaviour framework which was presented to the workforce assurance committee in November 2022. The framework outlined the need for a clearer set of values, principles and/or behaviours to help shape their culture. The framework was due to be launched January 2023.

They also sent us a 'kinder culture' project presentation from December 2022 which was supported by the workforce committee. The aim of the project was to support anyone who may be involved in bullying or other disrespectful behaviour to find a better solution. This included training on awareness, reflection, discussion and de-escalation.

Appraisals

Our findings

A mechanism for staff to discuss professional or personal issues was in annual appraisals, known as performance development reviews (PDRs). PDR's are when managers appraise staff performance, identify strengths, areas for development and set goals for future performance. Board papers from October 2022 indicated there needed to be full compliance by the end of March 2023. Compliance was shown as red, amber or green (RAG) ratings with a percentage. The compliance target was 84%. Overall PDR compliance for the whole trust was 82.9% in September 2022. The medical director's office had attained 100% compliance throughout the year. Some areas had been rated as non-compliant (red) for the whole year from September 2021 to September 2022. These areas included the clinical support and specialist surgery division, where the compliance ranged from 71.2% to 84%. The estates team compliance ranged from 49.6% to 83% across the year. This meant the workforce in those areas might not always know where they were doing well, how they might improve, nor how their work aligned to the trust strategy.

After our inspection, senior leaders told us that they were working hard to improve compliance rates for PDR's.

There were mechanisms for staff to receive mandatory training appropriate to their role. The compliance target was 84%. Clinical support and specialist surgery teams had not been compliant with mandatory training for 11 of the 12 months from September 2021 onwards. Compliance rates had ranged from 79% to 84.9%. At overall trust level, compliance had fallen from 88% in September 2021 to 85.5% in September 2022, this was just above the 84% target.

Freedom to speak up (FTSU)

We received mixed feedback on the effectiveness of the FTSU processes. There was a FTSU guardian who had been in post since 2016; they worked 3 days a week in that role and 2 days a week in the patient experience team. The FTSU guardian reported to the director of workforce (DOW) who attended board meetings.

We were told there was a non-executive who was a FTSU champion. Having a board member to champion FTSU and support the FTSU guardian helps demonstrate a commitment to speaking up. The guardian's annual PDR was carried out by the patient experience and improvement lead with input from the DOW. The FTSU guardian told us they presented a report twice a year to the management board, the staff forum and the trust board. The FTSU guardian described the trust culture as strong, with hotspots which were related more to NHS issues than to issues at the trust. There were 4 FTSU champions who staff could speak with for their concerns to be escalated or signposted. The FTSU guardian told us champion roles had been advertised again to try to recruit others to the role.

After our inspection, senior leaders told us that the FTSU Guardian had regular meetings with the CEO and reported directly to the board twice a year.

The FTSU guardian told us their role was 2-fold, to support staff who raised concerns, and to work to improve culture at the trust. They had links with the trade unions, human resources business partners and the staff networks. During 2022, 13 concerns had been raised between April and June, and 9 concerns raised between July and September. Around 40% of the concerns in those 6 months were in relation to 'attitudes and behaviours', and another 40% were in relation to 'policies, procedures and processes.' The percentages of staff raising concerns through the FTSU guardian in the preceding year, 2021/2022, were lower that the England average. There was a FTSU plan for 2022 – 2023 which had been refreshed. The actions included;

- updating the FTSU policy so it met with requirements of the national FTSU policy
- production of a video of the ethnic diversity group (EDG) staff network experiences to be promoted at senior trust committees and for inclusion in 'Respect' training

- for staff survey results and barriers to be discussed at an EDG meeting.

After our inspection, senior leaders provided the freedom to speak up report for April to September 2022. It showed that 7 staff responded to anonymous feedback of the FTSU process. When asked if they would speak up again 5 said they would. No respondents said that they suffered disadvantageous or demeaning behaviour as a result of speaking up.

However, some staff who had raised concerns told us they lacked confidence in the FTSU process as they were asked to attend face to face meetings which would not protect their anonymity.

People and culture plan

The trust's draft 'people and culture plan' indicated limited aspirations related to bullying and harassment over its planned 3 years duration. Within the theme of 'treating our people fairly' the measure to know when this was achieved was set out as;

- the percentage of staff experiencing harassment, bullying or abuse from managers and staff; between 9.5% and 16.2% was the baseline, with an aim to reduce this to 5% or 8% by year 3.
- the percentage of staff experiencing discrimination from a manager or colleague had a baseline of 5.4% with a 3-year target of 3%.

We asked senior leaders why these targets were not set at zero tolerance to bullying, harassment or discrimination. We were told that it "had to be started somewhere". We were concerned this sent a message that bullying, harassment or discrimination was acceptable. Senior leaders afterwards told us they were considering rethinking the targets.

Following our inspection, the trust told us they believed it would be unrealistic and lack credibility to set a target for achievement of zero bullying and harassment within a 3-year timescale. They told us it did not detract from their aspirations or the assurance processes undertaken to investigate reports of such behaviour.

The trust shared its positive working relationships policy, approved in August 2018, that outlined the duties of managers and staff to create a positive working environment. It included both informal and formal methods to manage negative relationships at work. This policy had a statement of intent which said "We are committed to eliminate discrimination, bullying and harassment in line with the Equality Act 2010 and therefore we have a zero tolerance approach to any such behaviour or attitude".

Equality, diversity and inclusion

Equality diversity and inclusion (EDI) had not previously been successfully promoted and delivered within the organisation and the wider community. Staff, including those with particular equality characteristics had not always felt they were treated equitably. There had been a lack of delivery on EDI issues at the trust.

The trust appointed its third EDI lead within 3 years in May 2022. We spoke with the EDI lead; they had a strong grip on what needed to be done within the trust. They told us an EDI strategy had not worked in the past as there were a lot of fundamental issues to be addressed first such as a lack of EDI training resources and lack of EDI champions.

The trust had an EDI Plan (2019-2023) which was received by the EDI programme board in October 2019. Senior leaders told us that the EDI plan was their EDI strategy.

Our findings

In response to COVID-19 the trust took some key actions related to EDI such as adapting Ramadan guidance and reasonable adjustments for disabled staff. Between 2020 and 2022 the trust promoted EDI through various staff events, groups and activities. They had drafted a focused one-year delivery plan with 3 strategic aims. The EDI delivery plan (2022-2023) was approved by the EDI programme board in July 2022. The aim of the delivery plan was to progress EDI at the trust and provide a structure to ensure the trust met its EDI aims, objectives and statutory duties.

However, the trust acknowledged in their EDI delivery plan that "there was minimal progress made in implementing the objectives in the EDI Plan due to COVID-19 from 2019 and 2022 which resulted in EDI taking less of a priority across all trust activities. There had also been a change in EDI Managers during that time which had halted momentum in driving the EDI agenda across the organisation".

The EDI delivery plan incorporated actions arising from the workforce race equality standards (WRES) plan and the workforce disability equality standards (WDES) plan. There were 3 aims:

- Workforce data and information, to ensure data is captured, analysed and action plans developed
- Governance, policy and decision making, to review and develop policies which meet the Equality Act (2010) and the human Rights Act (1998)
- Mainstreaming equality, diversity and inclusion, to integrate and embed EDI across all the trust

An EDI programme board was established and would monitor progress with the objectives. Following our inspection, the trust provided a copy of the EDI delivery plan. It showed actions with expired timescales and no updates on progress or outcomes recorded. It was not clear if the actions had been completed or not.

A new EDI strategy was planned for 2023 following a review of the trust values and behaviours framework.

The trust submitted its WRES and WDES data in August 2022 in line with the national requirements. The WRES consists of 9 indicators of workforce race equality, including the profile of the workforce, and data from the national staff survey indicators. It highlights differences between the experience and treatment of White staff and staff from ethnic minority groups and provides a way to take necessary action on the causes of ethnic inequalities.

Some progress was made on performance against a number of WRES metrics. For example, the difference between board members from ethnic minority groups and White board members had decreased by 7.5 % from 2021. However, there was also deterioration in several indicators and most significantly in relation to bullying, harassment and discrimination by managers and other staff and opportunities to develop career aspirations. Staff survey results showed that 21.8% of staff from ethnic minority groups reported harassment, bullying or abuse from staff in the last 12 months (actual national 28.8%), compared to 19% of White staff (actual national 23.2%). These rates were high for both groups of staff but better than the England average.

White staff were 3 times more likely to be appointed after being shortlisted for a job, and 12.8% of staff from ethnic minority groups reported discrimination at work compared to 4.1% of White staff. There were 68.4% of White staff in senior roles (band 8a and above) compared to 9% of staff from ethnic minority groups. The trust acknowledged progress was needed on all 9 WRES indicators and an action plan had been developed.

The WDES consists of 10 indicators of workforce disability equality, including the profile of the workforce and data from the national staff survey indicators. It highlights differences between the experience and treatment of disabled staff and non-disabled staff and provides a way to take necessary remedial action on the causes of disability disparities or differential treatment of disabled staff. There was mixed performance against the WDES indicators. Again, there was

some improvement in a small number of indicators, for example 4.1% of staff reported they had a disability, an increase of 0.5% from the previous year. However, there was deterioration or lack of progression in other areas, for example, the relative likelihood of disabled staff entering the formal capability process was 8 times higher compared to non-disabled staff. This was a significant increase from around 3 and a half times in the previous year.

The trust acknowledged further progress was needed so that disabled staff had equality in all aspects of their working lives. An action plan had been developed and was due to be approved in November 2022.

The national equality delivery system (EDS) supports NHS organisations to improve the services they provide for their local communities and provide better working environments, free of discrimination for the workforce. Trusts assess themselves against a framework, give themselves a score or rating and submit their results.

An EDS 2 working group was set up in September 2022 to support the self- assessment and evidence gathering process. Engagement with key stakeholders was planned to determine the final scoring and rating before submitting the report, action plan and a case study. An assessment was carried out to determine if the trust was compliant with the Accessible Information Standard (AIS). The AIS is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The trust was not fully compliant yet, despite AIS coming into legislation in 2016.

Numerous actions had been undertaken since 2016 to work towards compliance. These included training, meetings, task and finish groups and action plans. In October 2021 it was noted by the director of workforce that “the work had not developed further to become a standard part of their service and how they communicate with patients”.

There was no national reporting requirement, however the trust monitored this through their EDI board. This remained on the trust risk register and senior leaders told us they had invested in an associate CN for quality and patient experience. The role was due to commence in November 2022 and the AIS would be within their portfolio. Trust documents indicated an AIS subgroup would be set up in January 2023 to take this work forward.

The NHS staff survey 2021 benchmarked the trust against 12 other specialist trusts in England. Staff morale at the Christie reflected the trend and pattern at other trusts. Morale at the Christie was scored slightly less than the best morale score, and either the same or slightly better than the average (median) for the last 3 years. The survey report noted there was a statistically significant change (fall in morale) from 2020 to 2021. The scores for the last 3 years are below;

- Best score 2019 was 6.5 The Christie scored 6.3 The average score was 6.3
- Best score 2020 was 6.6 The Christie scored 6.4 The average score was 6.3
- Best score 2021 was 6.3 The Christie scored 6.0 The average score was 6.0

Gender pay gap

The gender pay gap is an equality measure which shows the difference in average earnings between women and men. The gender pay gap does not show differences in pay for comparable jobs (unequal pay). It is mandatory for all public sector employers with more than 250 employees, such as the trust, to measure and publish their gender pay report each year. The trust’s 2021 report was published in March 2022.

Our findings

In March 2021, the workforce of the trust was 73.6% female and 26.4% male. In pay bands 1-8, women were in the majority. Whereas men were in the majority for bands 9 and consultant or specialist. 'Quartile pay band' means each of 4 equal groups of workers into which they were divided according to their pay levels, from the lowest to the highest. At the Christie, the highest proportions of male staff members were in the upper quartile. Over 70% of staff in the lower, lower middle and upper middle quartiles were female. The mean (average) gender pay gap had increased from 17.2% in 2020 to 17.5% in 2021, after previous years when the gap had decreased. The median gender pay gap had increased from 4.8% in 2020 to 5.5% in 2021.

As an NHS trust, bonus payments are included into the gender pay gap report. Clinical excellence awards are paid to NHS consultants and specialists who are found to have performed above and beyond standard expectations of their role. At the trust, 0.5% of female employees received a bonus compared to 3.6% of male employees.

The trust gender pay gap report (March 2022) stated an action would be produced by the equality, diversity and inclusion board.

Medicines culture

Staff feedback was collected mostly via NHS national staff surveys. The chief pharmacist had conducted a local questionnaire for pharmacy staff to give feedback. Staff expressed concern about current facilities in pharmacy, especially in areas used for clinical trials and the aseptic unit. We were told this had been taken on board in the current trust building program and that the new outpatient pharmacy area would include facilities for clinical trials.

After our inspection, leaders sent us a project presentation which was shown to the trust board on 24 November 2022. The project was aimed at enhancing diversity in clinical trials and was funded by external bodies.

Governance

Leaders mostly operated consistent, effective governance processes and they were clear about their roles. However, some essential policies had passed their review date and some assurance committees had only recently been formed.

There were structures, processes and systems of accountability in place to support delivery of the trust's strategy. The board met 8 times a year both in public and also in private. We spoke with the director of governance; this role was within the portfolio of the executive CN. They worked closely with the medical director. As director of governance, the CN chaired the weekly executive review group, and also the risk and quality governance committee.

There were 2 main divisions at the trust, clinical networked services and clinical support and specialist surgery. Each division had a governance structure which included divisional general managers, directors and nursing and medical leads.

The trust had set up a multidisciplinary clinical advisory group during the pandemic to discuss COVID-19 clinical issues and to advise the board. The group included senior nurses, scientists, technicians and medics. This covered cross-divisional and trust wide clinical developments. We were told that the meetings provided clinical time to scrutinise clinical strategies, service developments, policies, and procedures. The clinical advisory group had continued to hold these meetings monthly and outcomes were shared with all staff.

Committee structures

Our findings

There were committees and sub committees with risk management responsibility. The board had oversight of the committee structures which were divided into statutory, assurance and operational committees.

The statutory committees were the renumeration committee and the charitable funds committee, which were each chaired by a NED.

There were 3 assurance committees; the quality assurance committee, the audit committee and the workforce assurance committee. The latter was formed in July 2022 to bring more focus and time to the workforce agenda. These were also chaired by NEDs.

The quality assurance committee was responsible for monitoring and reviewing the governance processes in the trust to fully assure the board that effective risk, control and governance processes were in place.

The operational management board was led by the CEO. Sub committees of the management board were; the Christie research strategy committee, the staff forum, the workforce committee, divisional service and operational reviews, the divisional boards, the investment and capital planning group, the digital board and the risk and quality governance committee.

The risk and quality governance committee was underpinned by the health and safety committee, the clinical and research effectiveness committee, the patient experience committee and the patient safety committee.

The committees worked effectively and interacted with each other appropriately.

Medicines governance

The chief pharmacist told us that medicines optimisation was integrated into the trust governance structures. The chief pharmacist told us the governance structure document (known as the 'organogram') was slightly out of date, although it was dated '2022'. The drug and therapeutics committee reported primarily to the safe medicines practice committee; this fed into the risk and quality governance committee. The safe medicines practice committee reviewed medicines incidents and provided assurance to the patient safety committee that all medicines risks were appropriately identified, assessed and managed. The same committee also managed the clinical audit programme which the pharmacy team inputted into.

Policy governance

During the core service inspection, it was noted that there were policies that had passed their review date, for example, the national early warning score (NEWS2) policy and the consent policy. Eight policies had had been due for review in 2020. This meant staff did not always have the most up to date policy or guidance to follow. We spoke with leaders about this and they told us there was a period of time between a policy being reviewed, approved and republished as an updated policy.

Board assurance framework

NHS England sent us information about governance before our inspection. They told us they had evidence that governance arrangements had been established aligned to the strategy. They told us there was a strong system for governance and accountability.

Our findings

The board assurance framework (BAF) brought together in one place all of the relevant information on the risks to the board's strategic objectives. The trust company secretary had responsibility for day-to-day management and presenting the BAF to board. The BAF was reviewed by directors each Monday and was presented at the various committees each quarter before it was represented at trust board.

During our inspection we observed the BAF. It contained the 8 strategic objectives, the controls, risks, and any gaps in assurance. The BAF was up to date, it identified 25 principle risks and which director led on management of each risk. The 2 top risks on the BAF were cyber security (current risk score of 20), and the risk to services related to recruitment and retention of the workforce (current risk score of 15).

We noted that the risk appetite section was completed appropriately throughout the BAF, as was the 'gaps in control' section. However, the risk position remained the same for all documented risks on the BAF through the year, apart from 2 risk scores which were reduced; (these were the risk to delivery of the School of Oncology strategy and the change in financial regime risk).

As the BAF records the principle risks that could impact on the trust's ability to achieve its strategic objectives, failure to reduce the risks could potentially lead to the trust not being able to achieve its strategic objectives or its statutory obligations.

The three assurance committees provided non-executive oversight of governance and assurance. We spoke with the NED chair of the audit committee and they were clear about its role. They told us there was a "weakness" in having 4 committee meetings a year, and the workforce risks were too great, so the workforce assurance committee was recently formed to look at people issues separately.

The trust had internal and external audit programmes. The audit committee reviewed a number of internal audits in 2021 and 2022, obtained varying levels of assurance and made recommendations.

There were 2 audits which gave limited assurance in 2022; the electronic chemotherapy prescribing system audit identified 4 high and 2 medium level actions were needed for high risk areas. The high-risk areas were around data security and information governance and risk management.

The Christie clinical web portal (CWP) system audit resulted in limited assurance; 2 high and 3 medium level actions were needed. The CWP system had been developed 'in house' and although the audit found areas of good practice, recommendations were made to strengthen some high-risk areas including user management, service continuity and recovery and change management.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Corporate risk

There was a 3-year risk management strategy and policy (2021 to 2024) in place. There were 3 objectives within the strategy;

- Increase involvement, knowledge and accountability of staff in the risk management process

Our findings

- Greater insight, transparency and triangulation of data
- Refine and improve processes and systems to build effective risk management

The corporate risk register contained risks identified through the corporate and departmental or ward risk assessments processes. For example, the risks which could have a potential impact across the whole of the trust. Risks within the corporate risk register were managed by a named individual with that risk within their sphere of responsibility. However, the board had overall responsibility for the corporate risk register. The corporate risk register contained 5 risks which the trust had rated as 'extreme'. The risks were;

- Risk of failure to meet the national cancer waiting times; this had been on the risk register since 10 January 2018 and had a current risk level of 15
- The risk of trust wide staffing gaps had been on the risk register since 28 March 2018 and had a current risk level of 15
- The risk of prolonged disruption to services from a severe cyber-attack had been on the risk register since 15 December 2021, and had a risk score of 15
- Achieving the 2022/ 2023 break even financial plan was added to the register on 29 June 2022 and had a risk score of 16
- Timely appointments not being made resulting in risk to patients being 'lost to follow up' had been added to the register on 7 July 2022 and had a risk level of 15

The risk register was due for review at the end of November 2022.

The board reviewed the risk register on a regular basis in the public board meetings. The risk register was overseen by the risk committee to ensure that appropriate controls were in place, it was also reviewed by the assurance committees. There had been a 'head of risk' in place since 2008. A new position of patient safety specialist & head of risk was appointed at the trust in October 2022. They had begun a review of the corporate risk profile of the trust using the recommendations of a 2021- 2022 audit conducted by an independent company.

The quality assurance committee received reports from the risk and quality governance committee in order to seek assurance around management of risk. The board and the risk and quality governance committee received a 'key risks report' on a monthly basis as part of the integrated performance report. Any risks that cannot be controlled or involved substantial risk to achieving the corporate objectives was escalated to the board and added to the BAF.

The risk and quality governance committee received reports from the patient safety, patient experience and clinical & research effectiveness committees. They also received reports from the health and safety committee.

The audit committee had responsibility for financial risk and associated controls, corporate governance and financial assurance.

Operational risk

There was an effective risk management structure in place to manage operational risk within the trust. There was a patient safety and risk team which collated information on risks, monitored risk management and acted as a central point for risk management issues within the trust.

Our findings

Operational staff reported risks using an electronic reporting system. It was set up so that certain trust-wide information was consistent across all parts of the system, for example by division. This meant information could be managed more effectively. The risk information was monitored and acted on at operational level, divisional level and trust level.

There were divisional governance leads who were responsible for providing advice and support to trust staff on all issues relating to the risk strategy. They ensured departments had an active risk register, and that risk assessments were undertaken. The divisional governance leads also ensured systems and processes were established with the divisions to manage risks and incidents.

Risk appetite

Risk appetite in the NHS refers to the amount of risk a trust might be willing to accept in the pursuit of its long-term objectives. Having risk appetite is important in managing risks, it is usually classified as averse, cautious or eager. The BAF at the trust included a clear risk appetite section; the trust did not have an 'eager' risk appetite for any of the 25 risks to achieving the corporate objectives.

Medicines risk

The dispensary services at The Christie were a wholly owned subsidiary and outsourced service but managed by a separate board set up by the trust. Chemotherapy dispensing was also outsourced to another independent provider. The trust monitored the risks and performance by reporting to the clinical networked services divisional boards.

The trust had systems and processes in place to enable staff to report medicine related issues and incidents. These were then reviewed by the medication safety officer and discussed at the patient safety committee. They were also scrutinised at the safe medicines practice committee who reviewed medicines related incidents, identified trends and risks. Learning was cascaded via the divisional groups.

The chief pharmacist managed the medicines related risk register. The pharmacy team regularly monitored performance and quality of pharmacy services in the trust.

Performance

There were processes to manage current and future performance at the trust. There was an integrated performance quality and finance report which included performance measures for how the trust was delivering key services.

The trust used the CQC key lines of enquiry (safe, effective, responsive, caring and well led) as a framework and summary dashboard to provide an overview of performance. However, the trust used the well led area to report solely on finance, and not on other aspects such as leadership, vision and strategy, culture, governance, learning and improvement. We discussed this with senior leaders, and they told us they hadn't considered including those as part of well led.

The trust is a tertiary cancer centre which meant they cared for patients who had already been diagnosed and referred to them by other hospitals, which may add time delays to treatment. Some patients were awaiting a diagnosis, some already had advanced cancer. After our inspection, senior leaders told us that 98% of their patients are referred having already been diagnosed at other hospitals.

Our findings

There are national standards for cancer waiting times. The trust had achieved or exceeded the national 31-day standards consistently since April 2022. However, the trust did not always achieve the 62-day standard. From September 2021 to September 2022, this standard had only been met in November 2021 and July 2022. After our inspection, senior leaders told us that between September 2021 and September 2022 approximately 9% of their patients were on a 62 day pathway and that more than half of these patients who breached the target were referred to the trust after day 62 of their pathway.

The trust reviewed all breaches of the standards to ensure any delays were understood and there was an action in place.

Patient flow

One of the principle risks on the BAF was 'Lack of on-site capacity for Christie patients resulting in additional pressure on neighbouring organisations.' Board papers for September 2022 showed some controls around the risk were measures being taken to reduce length of stay such as twice daily 'huddles' and monitoring length of stay in the integrated performance report. There were also patient flow meetings

There were effective processes for admitting patients who needed to be assessed, treated or admitted on an unplanned basis. The trust used the acute assessment unit (AAU) and ambulatory care unit (ACU) to support patient care and admissions. On average 35 patients a day were admitted to the AAU which was open 7 days a week. Patients who were admitted for elective (planned) care were admitted directly to ward 2.

There was a discharge and transfer policy, however it did not include any process related to delayed discharges or transfers of care. We asked senior leaders how they knew if there were any delays, and how they targeted work on issues which resulted in delays, for example awaiting equipment, medications, a care 'package' needed for discharge, or awaiting a hospice bed. They told us that all the trust's in-patients had a 'right to reside' category. The trust did not measure specific reasons for patients remaining in hospital when they were ready to be transferred or discharged. This meant the trust would not know which areas to target for improvement.

However, due to the nature of the patient group, the number of patients with no criteria to reside was small. At the time of our inspection they had no patients waiting for transfer to a nursing or residential home and one patient awaiting transfer to a hospice.

We asked senior leaders and the supportive care team how the trust knew they could make sure patients nearing the end of life were discharged to their preferred place of death. We were told that no audits were undertaken to measure for this. Senior leaders told us they could "probably pull data" and it was on the 'to do list' to capture information and develop an end of life model.

This meant the trust could not be assured that they delivered on patient's wishes and preferences for their preferred place of death.

However, data from the National Audit at End of Life (NACEL) in 2021 showed that that the preferred place of death was documented as indicated by the patient as 81%. This was significantly better than the national average score of 30%. NACEL is a national audit which compares the quality and outcomes of care experienced by those in their last admission (before death) and those close to them. The audit method was for trusts to submit case notes for 20 consecutive deaths occurring between 12 April 2021 and 25 April 2021, and 20 further sets of notes for consecutive deaths between 1 May 2021 and 14 May 2021.

Our findings

Although the NACEL results were positive, the data submitted did not meet the NACEL sample target because only 16 deaths occurred during this reporting timeframe. All 16 case notes were submitted to NACEL for the 2021 audit. There were 32 letters sent to family /carers (12 responses were received by NACEL, a 37% response rate) and 38 staff surveys were completed as part of the audit against a target of 100.

The trust results were better than the UK average for 9 out of 10 questions. Some of the results are below.

- Case notes recorded the patient might die within hours/days: 100% (UK result 87%)
- Case notes recorded a discussion with the patient regarding the plan of care: 100% (UK 95%)
- Case notes recorded a discussion with family regarding the possibility the patient may die: 94% (UK 98%)

Financial performance

The trust had a strong recent track record of delivering on its financial plans, managing cash, capital and revenue effectively. The trust was now engaging with the broader Greater Manchester system to ensure collective delivery on the financial challenges the system faced.

There was no indication that financial pressures had compromised patient care. There was a £58,000 surplus halfway through the 2022 to 2023 financial year, which was in line with the trust plan. The financial plan included additional revenue to support changes caused by inflation and rising energy process. The trusts own measure of financial performance was primarily a 'green' rating. The cost improvement programme achieved against the target was rated as 'amber'; £3.2 million had been achieved against a £7.3 million target.

The trust spent more on agency and bank staffing in September 2022. Spending on agency staff had increased by £60,000 to £271,000 and increased by £51,000 on bank staffing.

A routine anti-fraud audit was carried out by an external company in July 2022. The report was published October 2022. The report set out the activities undertaken, outcomes achieved in accordance with the trusts agreed anti-fraud work plan, compliance with counter fraud standard requirements, and in response to any referrals or investigations reported. There had been cases for investigation such as agency staff falsifying timesheets and locums adding time to timesheets for days not worked. These had been appropriately addressed within the trust and the audit found no corrective actions were necessary.

Information Management

The trust collected data and information and analysed it. Staff could find the data they needed, to understand performance, make decisions and improvements. The information systems were secure. Data or notifications were consistently submitted to external organisations as required.

There was a senior information risk owner (SIRO); the COO held the post. They were accountable and responsible for information risk across the organisation. They ensured that everyone was aware of their personal responsibility to exercise good judgement, and to safeguard and share information appropriately.

Our findings

There was also a chief information officer (CIO); their role was to make sure the trust used information as a planned resource to support productivity, drive improvements and help shape delivery of services. The trust had a focus on aligning digital services with operational services and they had recently appointed a chief clinical information officer to support the alignment. Any information or data incidents were reported through operational groups to the SIRO, CIO and executive team via quarterly reports.

Cyber security and the risk to prolonged service disruption was one of the trusts 5 extreme risks. The risk score had reduced from 20 to 15 due to 'in house' work and moving the IT servers off site. There had been phishing attacks, such as scam emails to staff.

Data security risks were managed through internal and external reviews and subsequent actions.

The risks were managed using the data security and protection toolkit which was mandated by NHS Digital. The toolkit was a self-assessment tool which allows organisations to measure their performance against 10 data security standards. Any data security or information governance incidents were notified to the to the independent 'Information commissioner's office' using reporting tool. There had been no data breaches during 2021- 2022.

Information governance training across the trust was at 95% compliance which provided assurance that staff knew what procedures to follow.

The trust used a mixture of paper and electronic records. There were risks of information breaches when paper records were transported in taxis from hospital to hospital. As part of the COVID-19 response, there were efforts to scan paper documents to reduce this risk. There was a standard operating procedure in place to track the transportation of patient records and mitigate the risks.

The trust had moved to a more secure NHS email provider in 2020. An issue had been identified where staff left the trust yet still had access to trust information via NHS emails. Work had been done to ensure staff who left the trust no longer had such access.

There were measures to protect information when staff were based off site or worked from their home address, for example, secure laptops were provided to staff, printers were not to be used and staff were asked to wear headphones when on video calls.

The trust had its own electronic patient record (EPR). It had been developed internally with clinicians and was custom made to meet the needs of the trust, especially in relation to research formats. During our inspection we were told there were interoperability problems with other systems in the trust and with shared systems in the wider community. Following our inspection, leaders told us the Christie was able to share data with the Greater Manchester care record and into the Cheshire care record.

Acute oncology services at the other trusts in the region could access the EPR if a patient under the care of The Christie was seen in the emergency department or admitted to another trust. Some additional local interoperability was in place with one trust but not with all trusts in the region. After our inspection, senior leaders provided evidence to demonstrate how the trust's EPR integrates with both internal and external systems. They told us that work was ongoing to improve access.

During the inspection we spoke with senior leaders about health inequalities and how they could use data and information to help improve outcomes for patients. Leaders told us it was a challenge which needed further work. They

said they needed to improve the completeness of data and to not repeatedly ask patients the same questions. For example, the recording of patients' ethnicity was less than 50%. Monthly monitoring of this was now being reported to the executive team. They also told us the new digital strategy and new clinical outcome strategy would link this work on inequalities and build technology to support the data. There would be a clinical outcome objective to improve how data on inequalities is recorded. Both strategies were due to be approved and published in March and April 2023.

Medicines information management

There was electronic medicine prescribing in some areas of the trust, but not others. Electronic medicine prescribing increases safety for patients and makes more efficient use of clinician time.

Following our inspection, senior leaders told us they recognised the need to implement electronic prescribing consistently across the trust. A software programme formed part of the current electronic prescribing and was used for all chemotherapy medicines, and in some outpatient areas. There was a project to expand trust wide electronic prescribing and link it with the current system. We were not told when this would be implemented.

Engagement

Leaders and staff actively and openly engaged with patients. The trust engaged with external stakeholders and local partners to help improve services for patients. However, staff, particularly those with particular equality characteristics, did not always feel engaged or supported.

Patient engagement

The trust actively engaged with patients and those close to them, to involve them in decision making and care and act on their feedback.

The trust had recently completed a trust wide survey to gather instantaneous feedback on patient care. Non-clinical staff interviewed patients on the wards and other clinical areas to have discussions in real time rather than wait for survey results. Future plans included the aim to move survey software online and link them to electronic tablets. They recognised that some patients still preferred to use paper forms and received most of their feedback from paper surveys.

The trust had collected and analysed equality monitoring information annually for their patients. However, the latest published report was dated March 2020 and gaps in some data had impacted on the quality of data collected. For example, there was no ethnicity data for 26% of patients, no religion or belief data for 33.3% of patients and no sexual orientation data for 83% of patients.

There was no patient experience strategy or plan to describe how this would be achieved. The patient experience lead told us that the patient experience strategy was on the agenda and they were looking at data and themes to help develop this. Following our inspection, senior leaders told us they had recognised the need for a specific patient experience and engagement strategy. They also told us that the patient experience strategy was incorporated into the trust strategy and quality strategy.

The trust had recently been involved in a regional meeting and had offered to be a pilot site to test the revised national patient improvement framework. It was not known what this would involve or when work would start. The trust told us the development of the national framework was expected to be communicated to them at the end of November 2022.

Our findings

An associate CN for quality and patient experience was due to commence in post in late November 2022. They would be responsible for developing the trust strategy and associated workplans. There was a patient experience committee which was chaired by a medical oncologist.

The trust took part in the national in-patient survey 2021. There was a 56% response rate (619 completed responses). In comparison with other trusts, the Christie performed 'much better than expected' overall. The proportion of respondents who answered positively to questions, across the entire survey, was significantly above the trust average. The top 5 scores compared with trust average were;

- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? (scored 9.7 out of 10)
- Were you able to get hospital food outside of set mealtimes? (scored 7.8 out of 10)
- How did you feel about the length of time you were on the waiting list before your admission to hospital? (scored 9.2 out of 10)
- How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital? (scored 8.5 out of 10)
- Were you ever prevented from sleeping at night by noise from other patients? (scored 7.3 out of 10)

The bottom 5 scores compared with trust average were;

- During your hospital stay, were you ever asked to give your views on the quality of your care? (scored 1 out of 10, the England highest score was 3.4)
- Were you ever prevented from sleeping at night by hospital lighting? (scored 8 out of 10, highest England (best) score was 9.4)
- Were you ever prevented from sleeping at night by noise from staff? (scored 8.3 out of 10, England highest (best) score was 9.5)
- Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff? (scored 8.1 out of 10; England highest (best) score was 8.9)
- To what extent did you understand the information you were given about what you should or should not do after leaving hospital? (scored 9.2 out of 10; England highest (best) score was 9.5)

The trust also participated in the cancer patient experience survey 2021. There was a 54% response rate (694 completed responses). Data showed that out of 59 questions, the trust scored above the expected range (better than the national average) for 12 questions. The top scores included privacy when receiving diagnostic test results (96%) compared to the national average (94%). Patient was always treated with respect and dignity while in hospital (94%) compared to the national average (89%). Patient received easily understandable information about what they should or should not do after leaving hospital (94%) compared to the national average (89%). Patient completely had enough understandable information about surgery (93%) compared to the national average (89). Patient's average rating of care scored from very poor to very good (9.1) compared to the national average (8.7).

The trust scored below the expected range (worse than the national average) for 5 questions. These included cancer diagnosis being explained in a way the patient could completely understand (73%) NA (76%). Patient was definitely told about their diagnosis in an appropriate place (81%) compared to the national average (84%). Patient was told they could

go back later for more information about their diagnosis (79%) compared to the national average (83%). Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options (68%) compared to the national average (75%). Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right (68%) compared to the national average (79%).

Staff engagement

Results for the NHS 2021 staff survey showed that 44% of trust staff responded. The response rate had fallen from 48.6% in 2020 and was the lowest rate for the trust since 2017.

By comparison, the highest response rates for other trusts from 2020 and 2021 had been 66% (2020) and 69% in 2021. The average (median) response rate for 12 other specialist trusts had been 56% in 2020 and 54% in 2021.

The trusts highest scoring areas were compassion and inclusivity and staff engagement.

Staff engagement scores in the survey reflected a nationwide trend; the Christie scores were the same or slightly better than average but slightly less than the best scores. For example:

- Best scores 2019 were 7.7 The Christie score was 7.5 The average was 7.5
- Best scores 2020 were 7.6 The Christie score was 7.5 The average was 7.4
- Best scores 2021 were 7.5 The Christie score was 7.3 The average was 7.3

The trusts lowest scoring areas included learning and there had been a statistically significant change (fall) in staff morale at the trust from 2020 to 2021. However, these were still in line with the average when compared with similar trusts. 60% of staff felt that they got recognition for the work they did, this had deteriorated from 65% in 2020. 52% of staff felt their work was valued, which had deteriorated from 56% in 2020. 79% of staff said they felt able to raise concerns about unsafe clinical practice, which was an increase from 74% in 2020. However, only 67% of staff felt confident that the trust would address the concerns raised.

The NHS 2022 staff survey which was not available at the time of the inspection but was published on 9 March 2023 indicated improvement in 'we are compassionate and inclusive', 'we are a team' and 'staff engagement'. The response rate remained at 44%.

The trust used other methods to engage with staff and obtain their views and experiences. There had been quarterly 'pulse' surveys during 2022. In July 2022, we saw that 137 members of trust staff responded to the survey. This was more than the 84 members of staff who responded to the April 2022 pulse survey.

Feedback for the trust proactively supporting staff wellbeing was 46.7%, and 27.7% of respondents responded negatively. Just over 43% of staff felt informed about important changes, and 33.6% of respondents said they were not well informed. However, team support for each other was strong; 74.5% of respondents felt their team supported each other.

The engagement scores from the July 2022 pulse survey were lower compared to January 2022 scores but had generally increased from April 2022.

Our findings

- I look forward to going to work (36.9% July 2022) was 6.7% lower than the NHS overall score. This was worse than (46.7% January 2022) but was better than (34.7% April 2022).
- I am enthusiastic about my job (53.3% July 2022) was 5% lower than the NHS overall score. This was worse than (58.9% January 2022) but better than (52% April 2022).
- Time passes quickly when I am working (57.4% July 2022) was 9.3% lower than the NHS overall score. This was worse than (68.2% January 2022) and (62.7% April 2022).
- Frequent opportunities to show initiative in my role (61.5% July 2022) was 0.1% lower than the NHS overall score. This was worse than (72.9% January 2022) but better than (53.3% April 2022).
- Able to make suggestions to improve the work of my team (68% July 2022) was 4.2% higher than the NHS overall score. This was worse than (76.6% January 2022) but better than (61.3% April 2022).
- Able to make improvements happen in my area (54.9% July 2022) was 4.9% higher than the NHS overall score. This was worse than (65.4 % January 2022) but better than (45.3% April 2022).
- Care of patients is my organisation's top priority (76.2% July 2022) was 10.3% higher than the NHS overall score. This was worse than (83.2% January 2022) but better than (69.3% April 2022).
- I would recommend my organisation as a place to work (49.2% July 2022) was 2.4% higher than the NHS overall score. This was worse than (62.6% January 2022) but better than (40% April 2022).
- If a friend or family needed treatment, I would be happy with standards of care provide by this organisation (85.2% July 2022) was 28.8% higher than the NHS overall score. This was similar to (86% January 2022) and better than (82.7% April 2022).

Pulse survey results showed 'high workload' and 'unsupportive management' were the highest scoring themes in relation to staff feelings (15.6% and 11.1% respectively for April 2022 and 23.7% and 23.7% in July 2022)

Following the July 2022 survey report, actions were put in place which included the promotion of the Greater Manchester resilience hub for accessing mental health support, supporting new starters and re introducing therapies for staff. The report also suggested further steps to increase staff engagement such as utilising a proposed 'employee voice' group, using a stall in the dining room and posters in staff rooms.

The trust engaged with unions (known as staff side), to gain feedback from trust staff who were union members. The trust told us that weekly informal meetings had been scheduled between union representatives and the director of workforce. However, the union representatives told us there was a staff side committee that met monthly and an informal monthly meeting with HR operations. Alternative months there were formal meetings with senior leaders at the trust; the leaders included the director of nursing (DON), the DOW, the COO, the CN and divisional directors. The terms of reference for the formal meeting had started to be reviewed in June 2022 and were to be finalised. Union representatives told us most of their engagement was with the director of workforce, and there wasn't a lot of visibility from other executive leaders. They told us planned meetings with the CEO were meant to take place twice a year, but the CEO had not attended meetings for 18 months.

Following our inspection, senior leaders told us that there were no requirements for the CEO to attend staff side groups. They provided evidence that the CEO attended quarterly formal meetings for the medical staff committee with staff representatives alongside the deputy CEO, the COO, the MD and the DOW. These meetings were attended by staff and trade union representatives. They included a trust update in addition to a question and answer session with the CEO. The CEO also attended the local negotiating committee with the MD, the DOW and the COO.

Our findings

Staff networks

There were 4 staff networks within the trust. We met with representatives from the disability network, the ethnic diversity network, the LGBT+ network (lesbian, gay, bisexual, transgender, plus others) and the newly formed 'faith and belief' network. The networks each had an executive sponsor. We were told the networks had not been effective, but work was being done to make them better. Staff with particular equality characteristics had not always had their views and experiences considered, but this had improved recently.

System engagement

The trust was an active partner with the local health and care systems and the Integrated Care Systems. The Christie was part of 2 integrated care systems (ICS), the Greater Manchester ICS and the Cheshire and Mersey ICS. Senior leaders from the trust also met and gave input into regional and national cancer care organisations, for example the Greater Manchester cancer alliance. The Christie took the lead on the regional Greater Manchester cancer programme. Over recent years the trust had developed a more outward looking system wide view. There were partnerships with other local NHS trusts in the form of Christie treatment centres onsite, for example 'The Christie@ Macclesfield', 'The Christie@ Salford, and 'The Christie@ Oldham'. The Christie buildings on site at other trusts purposefully 'mirrored' the Christie main site building to give a message to patients that they were receiving 'Christie care'. There were good outreach services such as blood tests and chemotherapy care which enabled some patients to received care and treatment closer to home.

There were other effective partnerships; for example, with the local university, the commercial sector and international centres of excellence. There had been system wide mutual aid during the pandemic, for example, surgeons at the Christie carried out operations on patients who had been waiting for care at other trusts. Work on health inequalities in the region had started. For example, the trust had started a project to tackle lung cancer inequalities in partnership with the Greater Manchester cancer alliance.

Medicines Engagement

The trust provided mainly specialised tertiary services. This meant senior pharmacists worked in partnership with NHS England and NICE (national institute for health and care excellence) to collate cancer guidelines, recommendations, commissioning policies and new medicines.

The pharmacy team encouraged feedback from other teams when developing pharmacy services or policies. The medicines optimisation team worked with colleagues in adjacent trusts through networking groups including the chief pharmacist network.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. The trust reported and investigated complaints, incidents and mortality. However, these were not always completed in a timely manner and learning was not always shared with relevant staff across the trust.

Although learnings and required actions from incidents, complaints and claims were shared this was delayed.

Our findings

Lessons learned were discussed at a daily safety huddle, weekly executive review group (ERG), fortnightly Friday FoCUS (Focus on Care Understanding Safety) and the monthly risk and quality governance committee. Learning was also cascaded to front line staff via patient safety newsletters and improvement bulletins. There were quarterly reports on patient safety and experience which were presented as 'themes for learning' at the patient safety committee and the patient experience committee. The board assurance framework contained a principle risk of failure to learn from patients' feedback, complaints and PALs. There were no gaps in the controls and assurance was in the form of the board reviewing the integrated performance report.

Complaints

The trust had a complaints and patient advice and liaison service (PALS) and there was a complaints handling policy in place at the time of our inspection. The policy reflected best practice guidance such as the Parliamentary Health Service Ombudsman's (PHSO) NHS complaints standards 2021.

The trust policy stated that formal complaints should be acknowledged in writing within 3 working days and that a written response will be provided within 25 days. The trust provided data which showed that between November 2021 and October 2022 the trust received a total of 134 formal complaints, an average of 11 per month. Trust data showed that only 57 (43%) of the complaints were responded to within their timescales.

The DON told us the trust had set its own complaints response standards, they were; to have an initial response within 48 hours, followed by a full response within 20 or 25 days for non-complex complaints. We were told that deadlines sometimes were missed where cases were complex. Due to the trust being a tertiary service, some complaints spanned the patient pathway across other trusts and services; more of these were now being investigated jointly. Senior leaders told us that they kept complainants informed when an investigation takes longer than expected and apologies are given.

The trust received an average of 14 complaints a month between July and September 2022. During our inspection we reviewed a sample of 8 complaints selected at random. We saw that complaints were usually acknowledged within 3 working days; apologies were given and there was evidence of action taken where applicable. However, some complaint investigations and responses took 6 or 7 months to be concluded. This meant that learning from those complaints could be delayed. However, one of these cases had been reopened and showed the trust had taken many actions throughout the complaint process. These included letters of apology, a detailed investigation and a face to face meeting with the patients family.

Serious incidents

The trust identified, reported and investigated serious incidents in line with the NHS serious incident framework. However, these were not always completed within the required timescales.

The trust provided audit data for all serious incidents reported between April 2021 and March 2022. Incidents ranged from minor harm to serious harm. The trust had reported 3 serious incidents between April 2021 and March 2022. A total of 165 records were audited and selected at random. Compliance for reporting incidents within 48 hours was 92% but only 48% of incidents were closed off within the required timescales. There was a need to improve compliance in terms of the length of time for investigations to be completed. However, we acknowledged that some delays were outside of the trust's control.

Our findings

The outcomes and recommendations from serious incidents were presented to a panel chaired by a NED and 2 executives before being presented to the board and submitted to the commissioners. However, outcomes were not always shared with staff who had reported the incident. The audit data related to all incidents (from minor harm to serious harm) for April 2021 to March 2022 showed that only 55% of incidents had learning shared with the reporter.

The audit did not include information on the reasons why learning had not been shared with the reporter. After our inspection, senior leaders told us that when a staff member reports an incident, they could choose to receive feedback, decline feedback or feedback was not applicable. However the trust did not provide data to show the most prevalent reason as to why the remaining 45% of reporters had not received feedback.

Root cause analysis (RCA) is a structured method used to analyse serious incidents. We reviewed a random sample of 7 RCA's and found the investigations met NHSE guidelines and, overall, the investigations were sufficient to identify appropriate root causes of the incidents. All incidents we reviewed were completed within the 60 day target.

The investigation reports identified the level of harm caused and whether duty of candour was completed. The reports clearly identified who had investigated the incident and the CN told us that the staff members were trained in the relevant root cause analysis (RCA) processes.

Each report described the incident, the investigation, analysis of the findings and a detailed timeline. The reports also included a comprehensive action plan with a sign off date by the ERG. ERG is an executive led group that reviews all RCA's, signs them off and maintains oversight of the action plan. Learning points were identified, and it was recorded how the information was shared.

The reports did not have an executive summary, this is an area that the trust may want to consider including in the future.

Staff presented a patient safety and experience quarterly report to the risk and quality governance committee and quality assurance committee. A summary of this report was shared with the board of directors. This included feedback on current incidents and complaints.

There was also divisional governance days and numerous seminars for staff on patient care and safety.

The trust had a variety of mechanisms for shared learning such as through safety huddles, team meetings, ward newsletters and 'Friday FoCUS' every 2 weeks. Feedback from staff was mixed regarding these processes. Some staff told us that learning was shared well using these methods but staff on different wards told us that learning from incidents was not discussed at 'Friday FoCUS' meetings.

Mortality

Mortality reviews were completed in accordance with accepted practice by a team of medical examiners. Each was suitably skilled and experienced for the role.

The trust reviewed 30 to 40% of patient deaths using a structured judgement review (SJR). As part of the inspection we sampled 7 mortality reviews. Each was completed to an appropriate standard and identified areas of learning for dissemination across the trust. However, there was evidence of delayed learning when the SJR process was suspended during the pandemic. One review showed that an SJR had taken place 612 days after the patient had died.

Our findings

During the inspection we expressed our concerns about delayed learning because of the significant backlog of SJR's. Following the inspection, the trust told us that they also accepted and had recognised this. Delays in the SJR mortality review process resulted from reviewers being redeployed to clinical duties during the pandemic.

The trust told us that their mortality review process ensured that any learning from on-site deaths was escalated, screened, and monitored through the ERG. If required, an exceptional SJR would be undertaken if a concern had been raised to mitigate against any delays in learning.

The trust shared data from the Mortality Surveillance Group annual report and told us that 99 of 251 on site deaths in the year 2021-2022 had met the criteria for review. Of these, 43 (43%) reviews had been completed and they were working to the recommendations of a commissioned audit by their internal auditors,

An internal audit report covering mortality was reported to the Quality Assurance Committee in September 2022. The trust had been assigned moderate assurance. We were told the trust was on trajectory to have caught up on SJRs by December 2022.

Medicines learning

The pharmacy leadership team told us that continuous learning, improvement and innovation was sustained by the pharmacy team involvement in clinical services on wards. The team was working in collaboration with the pharmaceutical industry and the trust IT department to integrate the administration systems. For example, scanning a QR code on dispensed chemotherapy medicines that when scanned, automatically programs the pump to give the chemotherapy medicines at the right rate for the right patients rather than nursing staff having to do this manually.

Quality improvement

There was a lead for quality improvement (QI) and clinical audit. They worked closely with the CN and a consultant medical oncologist who was the lead for clinical outcomes and patient reported outcomes. The lead for quality improvement (QI) told us they followed an integrated process with a patient focused approach that incorporated patient safety, experience and outcomes. Audits and service evaluations were undertaken at all levels from consultants to ward staff.

At the time of inspection there were 400 research projects registered and 15% of them were QI projects. The CN and lead for QI ensured any proposals/projects were allocated into the correct category of QI, or research bracket or any relevant ethics committee approval.

Training in QI was available for staff online and the QI team met with staff and offered one to one support for projects.

There was a QI group chaired by the lead for clinical outcomes and a clinical research effectiveness committee. Outcomes were shared at a quality assurance committee first before being sent to the board.

The trust had seen positive outcomes from the projects carried out so far. For example, a frailty assessment QI project was undertaken for over a year and the results were used to build a business case for the hospital to have its own frailty team which started in September 2022. Expected outcomes included an improvement in upfront care for frailty patients and an increase in treatment completion.

Our findings

It had been recognised that falls risk assessments were not always done in timely manner. This had been discussed in a quality assurance meeting with the decision to move falls assessments to bedside handovers. This was now a QI project in progress.

The team were committed to raising the profile of QI through the introduction of QI awards in 2021 which had included 26 projects and a winner was their satellite Oldham site. The CN told us they had improved engagement as illustrated in their dashboard and had increased the number of QI projects.

Research and innovation

There was a strong focus on research and innovation at the trust. A corporate objective was 'to be an international leader in research and innovation to benefit patients at all stages of their cancer journey'.

The trust was recently named as the first European Prostate Cancer Centres of Excellence in the UK.

The trust was a participant in The National Institute for Health Research (NIHR) Pre-Doctoral Clinical Academic Fellowship (PCAF) Scheme. This was chaired by the CN and supported staff to undertake Masters' level academic training and to apply for a doctoral level research training fellowship whilst maintaining clinical practice.

The NIHR Manchester Clinical Research Facility (CRF) at The Christie specialised in early phase clinical research trials. The CRF included outpatient, phlebotomy and day-care treatment areas and a pre-analytic processing laboratory. It also provided specialist staff, supported volunteer participants, administered treatments and monitored clinical trials. It was one of 19 clinical research facilities funded by NIHR across the country.

There had been 1,830 patients recruited for clinical research between November 2021 and October 2022.

The Manchester Academic Health Science Centre (MAHSC) had recently awarded 3 members of staff honorary clinical chairs for their contribution to cancer services, research and education. This included research into peritoneal cancers to improve outcomes for patients with these rare tumours and clinical trials that had improved outcomes for lung cancer patients with advanced disease.

A staff member had also been appointed as an Honorary Clinical Professor at the University of Liverpool in recognition for their work in radiotherapy and proton beam therapy research. An expected outcome of this would be stronger research links between Manchester and Liverpool to develop research programmes further and improve outcomes for patients with head and neck cancer.

The CN also led a Christie Patient Centred Research (CPCR) team with a new honorary associate CN research post. The aim was to further develop the clinical-academic career pathways for nurses and allied health professionals at the trust.

A new research facility was due for completion in April 2023 onwards. The new Paterson building based at The Christie main site was in collaboration with the University of Manchester and Cancer Research UK. The new facility would bring together scientists, doctors and nurses across Europe and enhance the progress for cancer patients.

The new research facility would further increase the demand on digital services and the expectation of high-quality trusted data would also increase. Any risks related to research or patient access to trials through reduced funding and changes to funding streams were documented on the board assurance framework. Levels of risk and mitigation were reported through the research division board and Christie research strategy committee.

Our findings

Another corporate objective was 'to integrate clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre'. The trust recognised they had gaps in the availability of comprehensive data with which to benchmark themselves. However, the trust was re-accredited in 2018 by The Organisation of European Cancer Institutes (OECI) as a comprehensive cancer centre. This accreditation illustrated that the trust met the international standards for cancer care and was valid till September 2023. The trust was looking at ways to be part of international benchmarking.

The trust worked in partnership with Health Innovation Manchester and the NIHR Manchester Biomedical Research Centre (BRC).

The trust opened the first high energy proton beam therapy (PBT) centre in the UK in 2018 and the first proton beam therapy clinical trial in the UK started in 2021. The trial was co-led by the trust and the Institute of Cancer Research to explore whether the use of proton beam therapy reduced long-term side effects and improved quality of life for patients treated with radiotherapy for throat cancer. In total 183 people have taken part in the study.

The trust has held European Neuroendocrine Tumour Society (ENETS) centre of excellence status since 2011. In March 2019, they were fully re-accredited for a further five years. They also held Joint Accreditation Committee ISCT-Europe (JACIE) accreditation for their transplant and cellular therapy service.

Another example of continuous improvement was the use of a new robotic pharmacy dispensary. This technology helped to deliver real-time pharmacy optimisation, offered insights and released time for clinicians. The trust was also planning to increase capacity by creating 20 new inpatient beds within the main hospital building.

Current Digital Maturity

The trust had a digital strategy in draft form due for publication in March 2023. This stated that the operating model for digital services would change to meet the strategic aims set out in this strategy. The strategy had 7 missions including 'digitally supported research and clinical outcomes'.

The strategy outlined plans to use the Gartner IT score as a measurement of maturity over the strategy period. The Gartner Score measures an organisation's maturity across a comprehensive set of critical activities and evaluates the current maturity level for each activity. They are evaluated against objective, research-based performance standards.

The strategy showed that the trust's current score was between 1 and 2 (out of 5). The target maturity by the end of the strategy period (2028), was set at above 3.

NHS England released the 'what good looks like framework' in 2021. It defines success criteria for digital services at an organisation level. The digital maturity score for the trust was moderate in most categories but low on scores for 'ensuring smart foundations' and 'empowering citizens'.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡅	🡅🡅	🡇	🡇🡇

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement 🡇 May 2023	Outstanding ➔🡐 May 2023	Outstanding ➔🡐 May 2023	Outstanding ➔🡐 May 2023	Requires Improvement 🡇🡇 May 2023	Good 🡇 May 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Christie Main Site	Requires Improvement ↓ May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Good ↓ May 2023
Overall trust	Requires Improvement ↓ May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Requires Improvement ↓↓ May 2023	Good ↓ May 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for The Christie Main Site

	Safe	Effective	Caring	Responsive	Well-led	Overall
Chemotherapy	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Critical care	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
End of life care	Good Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Good Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016
Radiotherapy	Good Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Good Nov 2016	Outstanding Nov 2016
Surgery	Requires improvement Oct 2018	Good Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018
Outpatients	Good Oct 2018	Not rated	Outstanding Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018
Medical care (including older people's care)	Requires Improvement May 2023	Good May 2023	Good May 2023	Good May 2023	Good May 2023	Good May 2023
Overall	Requires Improvement ↓ May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Good ↓ May 2023

The Christie Main Site

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Withington
Manchester
M20 4BX
Tel: 01614463000
www.christie.nhs.uk

Description of this hospital

The Christie NHS Foundation trust provides specialist oncology services. There are around 3,400 staff employed at the trust. It is a the largest single site cancer centre in Europe, treating more than 60,000 patients a year. Around 95% of patients receive ambulatory care on an outpatient basis.

Based in Manchester, the trust serves a population of 3.2 million people across Greater Manchester and Cheshire; more than a quarter of the patients are referred from elsewhere across the UK.

From the main hospital site, the trust provides radiotherapy, chemotherapy, outpatient and acute oncology, complex surgical care, research and education, specialty diagnostics and other regional and national services. The UK's largest brachytherapy (internal radiation) service is on the main site. The trust was the first NHS organisation in the UK to deliver high energy proton beam therapy.

Other sites, closer to some patients' homes, are known as the 'Christie@Salford' and the 'Christie@Oldham'; these provide radiotherapy, chemotherapy and acute and outpatient oncology. The 'Christie@Macclesfield' provides radiotherapy, chemotherapy, haematology and outpatient services in addition to oncology services. The trust also gives chemotherapy care in ten community locations and offers outpatient appointments and blood tests closer to people's homes. There is a 24 hour, 365 days a year telephone 'hotline' for patients, families and professionals to use; there are around 35,000 hotline contacts each year.

We carried out an unannounced inspection of the acute medical services on 11 and 12 October 2022, as part of our continual checks on the safety and quality of healthcare services.

This inspection relates to the medical care division, at the Christie hospital medical care was part of the Acute and Supportive Cancer Services.

Our rating of this service went down. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff kept good care records. The service managed safety incidents well and learned lessons from them.

Our findings

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service provided mandatory training but not all staff completed it on time including mandated annual updates. Medical staff did not always complete life support and safeguarding training in a timely manner.
- Staff did not always complete and review risk assessments for patients in a timely manner.
- The service did not always manage medicines well.
- Some essential policies were passed their review date.

How we carried out the inspection

During our inspections we spoke with a variety of staff, including allied health professionals, nurses, doctors, research staff, health care support staff, and consultants. We also spoke with patients and relatives. We visited clinical areas and non-clinical areas across the hospital site. We reviewed patient records, regional and national data and other information. We also reviewed other information sent to us from external sources.

We held several staff focus groups to enable staff to speak with inspectors. The focus groups included nursing staff, allied health professionals, research and innovation teams, junior doctors and consultants.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Medical care (including older people's care)

Good

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it.

Staff received but did not keep up to date with their mandatory training. The trust had set a target of 94.5% of staff to have completed mandatory training. Data provided by the trust showed the following compliance rates, in October 2022, for nursing staff were:

- Equality, diversity and human rights 72%
- Fire safety: 69%
- Health, safety and welfare: 70%
- Infection prevention and control level 1: 70%
- Infection prevention and control level 2: 63%
- Information governance and data security: 80%
- Moving and handling level 1: 33%
- Moving and handling level 2: 46%
- Preventing Radicalisation: 80%
- Resuscitation Level 2 – Adult Basic Life Support: 71%

Data provided by the trust showed the following compliance rates, in October 2022, for medical staff were:

- Equality, diversity and human rights: 100%
- Fire safety: 85%
- Health, safety and welfare: 85%
- Infection prevention and control level 1: 71%
- Infection prevention and control level 2: 71%
- Information governance and data security: 100%
- Moving and handling level 1: 42%
- Preventing Radicalisation: 85%

- Resuscitation Level 2 – Adult Basic Life Support: 85%

The training was aligned to the skills for health core skills framework but did not include all key topics. For example, staff were not required to complete conflict resolution training and the trust did not include immediate and advanced life support training in their mandatory training package. We requested, however the trust did not provide data for these courses. The trust said no one in the medical division was trained in ILS or ALS. This meant there was a risk that staff may not have the skills to act as a first responder in an emergency until more qualified staff arrived.

Nursing and Medical staff received training to support patients with dementia and delirium. Training to support patients with learning disabilities and autism was delivered as part of the trusts safeguarding training, however staff did not always complete this in a timely manner. Following our inspection, the trust told us that Oliver McGowan training was available on the Christie Learning Zone from November 2022.

Sepsis management training was not considered as mandatory for staff which was not in line with the National Institute for Health and Care Excellence (NICE) clinical guideline CG151- Neutropenic Sepsis: prevention and management in people with cancer. Following our assessment, the trust provided sepsis training compliance data. Only 61% of healthcare assistants and 48% of nurses had received sepsis training. Following our inspection the trust provided details of sepsis training for medical staff during trust induction, however we were not provided with evidence regarding sepsis update training for any staff groups.

Managers monitored staff attendance at mandatory training and said they alerted staff when they needed to update their training. Each area had an electronic system to monitor when staff training was due and notified staff to complete the training. Ward managers told us staff who had yet to complete training had a date to do so.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse.

Not all staff received training specific for their role on how to recognise and report abuse. The trust had set a target of 94.5% for staff attendance at safeguarding adults and children training. Data provided by the trust showed that compliance rates, in October 2022, for nursing and medical staff were below the 94.5% target for all aspects of safeguarding training.

Data provided by the trust showed the following compliance rates, in October 2022, for nursing staff were:

- Safeguarding adults level 2: 76%
- Safeguarding children level 1: 70%
- Safeguarding children level 2: 88%
- Safeguarding children level 3: 42%

Data provided by the trust showed the following compliance rates, in October 2022, for medical staff were:

- Safeguarding adults level 2: 85%
- Safeguarding children level 1: 57%

- Safeguarding children level 3: 42%

We were not provided with safeguarding children level 2 training data for medical staff by the trust.

Following our inspection, the trust told us that staff were expected to complete a safeguarding referral for all patients with autism or learning disability and the safeguarding team would provide extra support and make reasonable adjustments. The trust safeguarding policy included a pathway for the management of patients with learning disabilities and autism, however not all staff we spoke with were aware of the pathway.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff could clearly describe what a safeguarding concern was and how to make a referral. Each area had visual prompts and posters for the process and the safeguarding adult and children's policies were available for reference on the trust intranet. We reviewed three safeguarding referrals and found them to be completed correctly. Staff described good links and support from the trust safeguarding team.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff could describe caring for patients with protected characteristics and how to keep them safe. We reviewed the documentation for patients with particular protected characteristics and found them both to be fully completed.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were visibly clean and well-maintained.

Ward cleaning audits were up-to-date and showed all areas were cleaned regularly. Cleaning audits provided by the trust for the period April 2022 to October 2022 showed an average overall compliance rate of above 98%. However, there were no cleaning schedules on display in any ward area and cleaning staff could not evidence areas that they had cleaned by way of any form of checklist. The trust provided evidence following our inspections that national cleaning standard schedules and checklists had now been introduced. This included posters which showed detailed information of ward cleaning schedules for patient and visitors.

Cleaning staff were trained how to clean to minimise the spread of infection. All staff took pride in the cleanliness of the ward areas.

Staff followed infection control principles including the use of personal protective equipment (PPE). All ward areas had dispensers of clean gloves, aprons and masks. Antibacterial hand gel dispensers were available, and posters prompted staff and visitors to clean their hands regularly.

Staff were all bare below the elbow and during the inspection all grades of staff cleaned their hands regularly. Each bay and side room on the wards had clinical handwashing sinks and a poster reminding staff of the five moments of hand hygiene.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Each department was required to complete regular commode audits. The trust had recently identified reduced compliance levels and therefore the trust infection prevention and control team had created an action plan and were performing daily commode audits until compliance improved.

The infection prevention and control team with support from estates and facilities performed regular environmental walkarounds. The frequency of these walkarounds was determined by the level of compliance against 8 key areas. At the time of our inspection, environmental walkaround had been completed on 4 of the 6 medical wards. One ward was considered fully compliant and 3 wards were partially compliant. Actions and timescales for improvement had been identified. Environmental walkarounds on the other 2 medical wards had been postponed due to staff availability. Following our inspection the trust provided information that both wards had environmental walkarounds completed in November 2022 both scoring 98% compliance.

The trust had a number of policies for staff to follow in relation to infection prevention and control. We reviewed a sample of these policies.

The trust waste management policy was dated June 2022 and was due for review in 2027. The policy outlined the responsibilities of all staff groups and referenced relevant national guidelines.

The trust aseptic non-touch technique (ANTT) policy was dated March 2022 and was due for review in 2024. The policy outlined processes which staff were expected to follow and referenced relevant national guidelines and other trust policies.

The trust Standard Operating Procedures (SOP) for management of disposable curtains in clinical areas was dated January 2020 and was due for review in September 2024. The policy outlined how often curtains should be changed and who was responsible for this process. We found all curtains we viewed had been changed in accordance with the trust policy.

The trust policy for the decontamination of medical devices and the environment which was dated April 2021 and was due for review in April 2023. The policy outlined the responsibilities of all staff groups and referenced relevant national guidelines.

The division had 24 cases of clostridium difficile in the last 7 months. Each case was investigated by the trust and a reduction strategy was in place. Ten of 24 cases were identified on the acute assessment unit and 9 of these were found to be community onset.

The division had 4 COVID outbreaks in the last 6 months. Investigations were still ongoing at the time of our inspection for 3 of these outbreaks. One outbreak investigation was complete, and we saw that areas for learning had been identified and appropriate actions had been taken.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. All areas met the standard set out in Health Building Note 04 – In-patient care.

Medical care (including older people's care)

Staff carried out daily safety checks of specialist equipment. Safety checks were carried out on all specialist equipment including the resuscitation equipment and records of this were fully completed.

Audits of the emergency resuscitation trolley checklist completion had been performed on all medical wards. All trolleys were found to have a checklist and all checklists had been completed. All trolleys were correctly sealed with a numbered tag. However, despite the checklists being complete, trolleys in two areas had items missing and 4 trolleys contained expired items. The audit did not identify if action had been taken or if learning had been shared to prevent reoccurrence.

Electrical equipment in each area had been safety checked and maintained so was safe to use. Each piece of equipment had an asset number which allowed the trust to monitor when it was due for routine maintenance.

Each ward had fire extinguishers which had been serviced in the last 12 months. Fire exits were signposted clearly, and the wards had chairs and slides to move patients in an emergency.

Patients could reach call bells and staff responded quickly when called. Patients who needed enhanced observation were allocated beds in bays next to the nurse's station.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients. Staff could access all the equipment they needed to provide care.

We reviewed a sample of waste audits that had been completed on medical wards in October 2022. Not all areas were fully compliant, and we saw that action plans were not always effective. Action plans outlined areas of non-compliance but did not identify how these would be managed and who was responsible for this.

However, during our inspection we saw staff disposing of clinical waste safely. Waste was separated and stored securely before being disposed of safely. Sharps boxes were assembled, used and disposed of correctly.

The trust had completed an audit of sharps safety in June 2022. The audit found some areas for improvement. For example, three sharps containers were found to have the wrong lid, four sharps containers contained significant inappropriate non sharp items and four containers did not have the temporary closure mechanism in place. The trust had developed an action plan as a result of the audit and each action was assigned to a responsible person with an expected date of completion.

Endoscopy scopes were managed and maintained in accordance with health technical memorandum (HTM 01-06) Management and decontamination of flexible endoscopes.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. However, they did not always carry out risk assessments and administer treatments in a timely manner.

Medical care (including older people's care)

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. However, these were not always completed in a timely manner. Of the 23 patient records we reviewed, 12 risk assessments were either not completed or had not been reviewed in a timely manner in line with the trusts own policy. The electronic patient record included a range of risk assessments which included – falls, pressure areas, sepsis, nutrition and venous thromboembolism (VTE).

During our inspection we escalated our concerns about the lack of timely completion of risk assessments to the trust. Following our inspection, they told us that this issue had already been identified internally and an improvement plan had been implemented.

Data provided by the trust for September 2022 showed that within the medical division, 97% of patients had a VTE assessment which was above the trust target of 90%.

The trust monitored the percentage of patients who had received antibiotics within 1 hour of a suspected or confirmed sepsis diagnosis. Between January and September 2022, the inpatient compliance rate on medical wards had been above the trust target of 90% for 4 months and below target for 5 months with the lowest compliance rate being 83% in September 2022. Between January and September 2022, the emergency admissions compliance rate on the acute assessment unit (AAU) and the acute ambulatory care unit (AACU) remained above the trust target for the whole period and achieved 100% compliance in April, May and September 2022.

The trust had identified that staffing issues and high numbers of newly qualified nurses and therefore a lack of nurses trained in patient group directions were contributing factors in poor sepsis compliance on medical wards. It was also noted that 60% of occurrences of antibiotics not being administered within 1 hour occurred at night due to reduced medical presence on ward areas. The trust had identified actions to improve compliance and a dedicated sepsis specialist nurse was responsible for sharing learning and reviewing ongoing compliance.

Staff used a nationally recognised tool to identify deteriorating patients. The National Early Warning Score (NEWS) 2 was used in the service to identify patients at risk of deterioration. The form was within the electronic patient record. Scores were completed correctly. When a concerning score had been calculated the patient would be escalated for medical review.

Staff shared key information to keep patients safe when handing over their care to others. Staff used a handover sheet to record key information when handing over care to other staff.

Shift changes and handovers included all necessary key information to keep patients safe. Each area had a safety huddle at least twice a day. All staff on duty attended the huddle and were updated on all key information.

In the endoscopy unit, staff completed the World Health Organisation (WHO) checklist. Staff participated in resus simulations and emergency training scenarios.

Nurse Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Medical care (including older people's care)

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust used the Safer Staffing model to adjust the planned staffing numbers according to patients' needs.

At the time of our inspection, the service had 35.93 whole time equivalent nursing vacancies. The service was over established for allied health professionals and medical staff.

The trust had recently recruited 12 HCAs into substantive posts to work flexibly across the inpatient wards to support staffing challenges and patient acuity. The trust reported that this successful recruitment campaign was to remain an ongoing process to maintain the HCA flexible model of working.

Data from November 2022 showed that planned vs actual nurse staffing varied across the wards. For example, on the acute assessment unit, days shifts were above planned at 105%. However, on ward 11 only 74% of day shifts were filled. Fill rates for healthcare assistant day shifts were also varied. The acute assessment unit fill rate for healthcare assistants was 39% compared to ward 11 which was 101%. The actual staffing for nurse and healthcare assistant night shifts was also below planned for the majority of wards. The acute assessment unit had a night shift fill rate of 89% for nurses and 77% for healthcare assistants. The fill rate is the proportion of the number of staff working compared to the required number.

The trust performed bi-annual audits of patient's acuity and dependency since 2010 using the National Institute for Health and Care Excellence (NICE) Safer Nursing Care Tool. We reviewed the safe staffing board report from September 2022 and saw that it was acknowledged that there had been some challenges in maintaining nurse staffing numbers, but appropriate skill mix had been maintained and no patient safety concerns had been raised. The trust had reported that nurse staffing of 1:7 during the day and 1:8 at night had been maintained. The trusts nurse leaders deemed the staffing establishment to be safe.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. Staff were classed as supernumerary during their induction period. During the inspection staff could describe how they orientated a temporary member of staff to ensure patients were kept safe.

In September 2022, 6% of nursing shifts were filled by agency staff and 16% were filled by bank staff. The highest rate of bank and agency use in the division in September 2022 was on Ward 4 and 4a where 13% of shifts were filled by agency staff and 24% of shifts were filled by bank staff.

The service had low turnover and sickness rates. In September 2022 the turnover rate for registered nursing staff was 1.4% which had dropped from 3.4% in April 2022. In September 2022 the absence rate for nursing staff was 6.9% which had reduced from 7.4% in August 2022.

Staffing issues were discussed monthly at divisional and trust board meetings and actions were agreed to make any necessary changes.

There were opportunities for further learning and development; nursing staff said there were opportunities for them to progress.

Medical staffing

Medical care (including older people's care)

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Staff told us the service always had a consultant on call during evenings and weekends.

Records showed the medical staff on duty matched the planned number. Data we received following our inspection showed that for the period 3 October 2022 to 16 October 2022 planned versus actual consultant cover was 100%. Overall medical staffing during the same period was 97.4%.

The service had low vacancy rates for medical staff. There was also a low turnover rate for medical staff but some reliance on locum staff. The turnover rate medical staff had remained at 0% from April to September 2022. The absence rate for medical staff in September 2022 was 0%.

Managers could access locums when they needed additional medical staff. They made sure locums had a full induction to the service before they started work.

Staffing issues were discussed monthly at the trust board meeting and actions were agreed to make any necessary changes.

Junior medical staff we spoke with said they had access to support and teaching and felt the hospitals academic and research links were an advantage to their ongoing development.

We reviewed the contents of the August 2022 integrated performance, quality and finance review and saw that workforce capacity, specifically consultant cover on AAU was escalated as a risk. It was noted that there were issues with rota gaps and long-term absence and that a strategy was being developed that would include the employment of a third AAU consultant to improve cover.

Records

Staff kept detailed records of patients' care and treatment. Records were clear and up to date and easily available to staff. Records were stored securely.

Patient notes were comprehensive, and all staff could access them easily. The electronic system contained relevant risk assessment bundles such as falls, nutrition, pressure ulcers and sepsis. Risk assessments had been carried out when patients had been admitted to the wards and do not attempt cardiopulmonary resuscitation forms (DNACPR) and deprivation of liberty safeguard (DoLS) forms had been completed correctly if needed. The records reviewed were contemporaneous, legible and there was clear evidence of multidisciplinary working.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff including locum staff told us that they could access all patient records easily.

Electronic record systems were accessed through computers throughout the ward. These computers were username and password protected. Staff ensured that computers were locked when they were not attended. Staff told us that they had enough computers to allow patient records to be completed contemporaneously.

We reviewed 23 patient records. All records reviewed had risk assessments, care plans, observations and NEWS2 scores recorded though not all risk assessments had been reviewed in a timely manner.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Not all staff had received training in the safe management of medicines.

Medicines reconciliation was completed by pharmacy staff and records showed the trust averaged 97.2% in 24 hours following admission during the period April 2022 to September 2022 which is above the 70% average across NHS provider trusts. However, this target was not compliant with the current guidance National Institute for health and Care Excellence (NICE) guidance which indicates 100% of patients' medicines should be reconciled within 24 hours or sooner if clinically necessary.

All ward areas were prescribing antimicrobials in line with trust guidelines or advice from microbiology, however, documentation of antimicrobial prescribing was the weakest area on all medical wards. Antimicrobial prescribing audits had been completed on all medical wards between March and September 2022. The audit had 4 criteria which each ward was measured against. Only 34% of prescriptions had a duration recorded on the drug chart and only 61% had an indication (a reason for the prescription) recorded on the drug chart. The overall compliance on all medical wards was poor. For overall compliance the lowest score was 62% and the highest score was 88%. None of the medical wards were considered as compliant overall. Documentation of antimicrobial prescribing was the weakest area on all medical wards.

We reviewed the trust quarterly ward controlled drug report. Pharmacists had audited controlled drug management against a set of 18 standards. The trust target was 100% for all standards. In the report for April 2022 to June 2022, all standards had 100% compliance except for a weekly controlled drug check being performed and recorded, and CD records being made in black indelible ink which both scored 50%. The report showed improvement in 4 standards from the previous report from January to March 2022. Actions had been identified as a result of audit findings and we saw that the report had been disseminated to all ward areas for learning.

The cabinets were replenished three times a week by pharmacy staff.

Medicines management training was mandatory for nursing and medical staff. 70% of nursing staff and 57% of medical staff had completed this training.

Safe use of insulin training was considered mandatory for nursing staff. The compliance rate for this training was 78%.

Transfusion administration was considered mandatory for nursing staff. The compliance rate for this training was 60%.

The service had an electronic system for managing medicines, a plan was in place when IT issues meant records were not available.

Staff stored and managed all prescribing documents securely. The pharmacy team visited wards to review stock levels and medicines expiry dates.

Medicines including controlled drugs were generally safely stored with the trust's quarterly audits showing improved overall compliance from April 2022 to September 2022. Any areas for improvement were shared with ward managers in order that action could be taken.

We found records of emergency medicines and equipment checks were completed.

Some medical wards had access to a large code operated automated dispensing cabinet for use outside pharmacy hours. Staff all had their own unique code to use the system for audit

In September 2022, there had been 132 medication incidents reported in the trust, 65 of these were from the Clinical Support and Specialist Surgery (CSSS). Of those incidents, there were 19 administration errors in total of which 3 were omissions only errors, all of which were no harm or minor harm.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Between April 2022 and September 2022, the trust told us that there were 969 incidents for the medical division. Of these 3 incidents were categorised as patient deaths, 11 were categorised at moderate harm and the remainder recorded as minor or no harm. Each incident had action plans and lessons learned where appropriate. The trust had not reported a never event since January 2020.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy using an electronic reporting system. Staff said they were encouraged to report incidents and near misses.

Serious incidents were investigated jointly between medical and nursing staff. Patients and their families were involved in these investigations where appropriate. We reviewed 3 incident investigations. They were detailed, provided the root causes of the issues which had contributed to the incident, actions were proposed with an action plan owner and review date to ensure continuity. Staff involved in reporting were given feedback at the conclusion of any investigation.

Managers shared learning with their staff about never events that happened elsewhere in the hospital and trust. There were no never events on any medical wards in the 6 months prior to our inspection.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at a clinical leads meeting and learning from incidents was fed back to staff in safety huddles and by email. We reviewed ward team meeting minutes and found that incidents and learning were discussed.

Medical care (including older people's care)

Managers debriefed and supported staff after any serious incident. It was evident the wellbeing of the staff involved in incidents was considered and they were supported throughout the investigation process.

Staff told us that they felt informed about incidents that had happened on their ward and serious incidents elsewhere and that learning from incidents was shared well.

We reviewed the trust learning from deaths report for 2020 to 2021. As a tertiary specialist trust managing only patients with a cancer diagnosis, the trust does not participate in hospitalised standardised mortality ratios (HSMR) and summary hospital-level mortality indicator (SHMI) ratios. We saw that all deaths at the trust were screened against a set of triggers. A comprehensive review was undertaken for all deaths found to have one or more triggers using the structured judgement case note review tool (SCR) recommended by the Royal College of Physicians.

The outcomes of these reviews were then discussed at the trust mortality surveillance group and any risks or concerns escalated to the executive review group. Of the 213 deaths in the period 2020-2021, 58 were identified as needing a review. 56 of these patients were deemed to have received good or excellent care and 2 patients had received adequate care. No concerns were identified by these reviews, but some learning was identified, and we saw that this information was shared appropriately for trust wide learning.

Root cause analysis training was included in the mandatory training requirements for some staff. Of the 27 people required to complete this training, only 9 had completed this training.

Is the service effective?

Good

Our rating of effective went down. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. However, we identified 8 policies from circa 200 that were accessible on the Christie intranet (HIVE) showing as being passed their review date. Following our inspection, the trust provided evidence that 2 of the policies were within one month tolerance for renewal and were renewed as planned by their safeguarding committee on 24 October 2022 with a further 2 policies having their review dates formally extended by their overseeing committees, to allow for updating with new legislation, policy and best practice guidelines.

Staff said guidance was easy to access, comprehensive and clear to follow. They showed us how they accessed the guidance.

We saw clinical practice reflected guidance and best practice. Key issues in patient care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff and ensured patients received care and treatment based on national guidance.

Clinical audit was being undertaken and there was good participation in national and local audits. The trust performed in line with national clinical audits and had shown improvement in all areas since the last inspection.

The trust had completed an audit of chest drain management. The audit reviewed the notes of 61 patients who had chest drains inserted between September and December 2021. The audit showed poor documentation of chest drain output which had not improved since the last audit in 2019 and was thought to be unnecessarily elongating length of stay. However, the trust had introduced a dedicated chest drain team and this was noted to have had a positive impact. The introduction of the dedicated team had reduced the average amount of time a chest drain was insitu from 3.8 to 3.4 days. In addition, the number of patients waiting for less than a day between the request for chest drain and the insertion had improved from 44% to 53%. Following our inspection the trust told us this audit was an unvalidated piece of work.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw patients regularly being offered hot drinks and snacks. Fresh water was freely available and kept topped up by staff. Patients were supported to eat and drink if needed. Patients we spoke with during the inspection were positive about the quality and quantity of the food provided.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Patient records in relation to nutrition were complete and up to date with dietitian reviews if needed. Nutrition and fluid care plans were followed with fluid balances totalled and acted upon appropriately.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff gave us examples of supporting patients with specific dietary requirements. We looked at the menus used, which were varied and included suitable alternatives for a range of religious or cultural needs.

A re-audit of protected mealtimes had been completed in July 2022. The audit found that there had been improvements from the previous audit in May 2021. The audit showed that all patients were helped into an appropriate position (when appropriate) to help them to eat and drink and all patients were given the opportunity to wash their hands or were provided with a hand wipe at mealtimes. There were two standards which had deteriorated since the last audit and two standards which had not improved. Not all wards closed the ward entrance doors before protected mealtimes. Not all staff wore a blue apron whilst serving meals. No wards were seen using red serviettes for patients identified as needing assistance, and some patients were seen to be unnecessarily interrupted during meals. An action plan with timeframes and responsibilities was created as a result of the audit findings.

In the NHS adult inpatient survey 2021 the trust scored above the England average on the survey questions which asked about choice, quality and availability of food and drink.

Pain relief

Medical care (including older people's care)

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

The hospital had a pain team who supported the ward areas to manage patients' pain as needed. Staff told us the hospital pain team were very responsive to requests for support and were available 24 hours a day. Patients that we spoke with said that their pain was being managed well and that staff were attentive if they observed any changes to their level of pain. Patients told us that pain relief would be administered soon after requesting it. We saw positive interactions between patients and staff in relation to pain management.

Staff had access to a palliative care team that supported patients in a range of areas including pain and nausea.

Staff had access to visual aids for patients who were unable to verbally communicate to help score pain.

In the NHS adult inpatient survey 2021 the trust scored above the England average on the survey questions which asked about staff doing everything they could to help control pain.

The trust took part in the NHS cancer patient experience survey 2021. 91% of patients said that staff did everything they could to help the patient control pain, which was above the national average of 86%.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers and staff used the results to improve patients' outcomes. Staff completed a variety of clinical and environmental audits to provide assurance about local practice in their areas.

The service participated in relevant national clinical audits. The trust had submitted data to the national cardiac arrest audit 2021. It was acknowledged that due to the nature and number of events in the last year, it was difficult to compare against national data. However, the audit highlighted no immediate concerns and learning outcomes were identified.

The trust had submitted data to the national lung cancer audit 2021. The trust Lung Group had reviewed the national audit findings and had identified actions. The results of the audit showed that the data submitted by the trust mirrored England trends and the trust was not identified as an outlier.

The trust were above the national average for the proportion of patients who experienced a gastrointestinal complication within 2 years of radical radiotherapy.

The endoscopy service was accredited with the endoscopy Joint Advisory Group for gastro-intestinal endoscopy (JAG).

Competent staff

Medical care (including older people's care)

The service made sure staff were competent for their roles. Managers appraised staff's work performance to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Staff told us the trust induction programme was detailed and comprehensive and provided all the information and support they needed to do their jobs.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Specialist teams provided regular bite size training to ward staff to maintain their specialist skills. However, some staff told us that there were often a lack of altered airway trained staff on duty. Data provided by the trust showed that only 64% of nursing staff had received training in tracheostomy care, in addition this was on trust risk register.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings minutes for the previous three months showed they were well attended by all grades of staff. A hard copy of the minutes was on the notice board and an electronic copy was emailed to the team.

Following our inspection, we requested appraisal data from the trust. The data provided showed that 90% of nurses had received an appraisal in the last year. Following our inspection the trust told us they were unable to provide appraisal data for doctors as it was not recorded.

The trust had a clinical supervision policy for nurses and allied health professionals dated May 2022. The policy outlined the importance of staff having protected time to take part in clinical supervision and clear responsibilities for staff to follow. Most staff we spoke with said they received good clinical supervision. However, some allied health professionals we spoke with who were undertaking advanced clinical practitioner (ACP) training at the trust told us that they were not always provided with supervision and support.

The trust had relaunched Schwartz rounds in September 2022 to provide all staff with an opportunity to reflect on the emotional and social aspects of working in healthcare. These had been conducted virtually during the pandemic.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Throughout the inspection we saw multidisciplinary team working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within medicine and felt part of the team.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff on all wards told us that they have a multidisciplinary meeting every day attended by doctors, nurses, speech and language therapists (SALT), pain team, dietitians and allied health professional such as physiotherapists and occupational therapists. Topics such as concerns about patients and estimated discharge dates were discussed.

Medical care (including older people's care)

Staff we spoke with commented on the positive culture throughout the medical wards, they said they felt there was good team working across all clinical staff.

Ward staff across the division had access to Pyscho-oncology services that provided psychiatric assessment and treatment, psychotherapy, cognitive behavioural therapy and counselling to patients. Staff also had access to a frailty team and could access dementia support from the hospital safeguarding team.

The transfer of care team would support staff to facilitate discharges for patients with complex needs from the hospital ensuring essential equipment was in place and supported ward rounds as required.

We reviewed the minutes from the Greater Manchester cancer board in July 2022 and saw that appropriate representatives from the trust had attended.

Seven-day services

Key services were available seven days a week to support timely patient care.

Most services within the division operated 24 hours a day for seven days and included a dedicated 24 hour, 365 days a year telephone 'hotline' for patients, families and professionals for advice or management on the side effects and complications of cancer treatment. A mobile text service was also available for patients who were communication and speech impaired.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day on seven days a week.

There were medical consultants working seven days a week. Allied health professionals which included physiotherapists, occupational therapists and pharmacists were available seven days a week.

Endoscopy provision was provided Monday to Friday from 8am until 5pm with enough staff to cover until the last patient left the unit. Acute Ambulatory Care Unit (AACU) provided a nurse led service Monday to Friday from 8am to 9pm and Saturday and Sunday 9am to 5pm.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information and posters promoting healthy lifestyles and support on the wards.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

We saw that there was health promotion information available on wards to promote better health. These were available in different languages on request.

Medical care (including older people's care)

The trust took part in the NHS cancer patient experience survey 2021. 94% of patients said that they received easily understandable information about what they should or should not do after leaving hospital, which was above the national average of 89%. 77% of patients also stated, 'they definitely got the right level of support for their overall health and wellbeing from hospital staff', which was above the national average of 76%.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Not all staff had received training in consent and the Mental Capacity Act. However, staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records in all the notes we reviewed.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. During the inspection staff could clearly describe the correct process for establishing the capacity of patients to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, considering the patients' wishes, culture and traditions. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were completed correctly.

Records showed managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. Staff could access the trust safeguarding team for assistance and guidance with completion of DoLS applications.

Staff could describe and knew how to the access policy and get accurate advice on Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. Staff we spoke with could describe the policies and show us where to access them on the intranet. However, the trust consent policy had expired in April 2020 and the trust MCA/DoLS policy had expired on 01 October 2022.

Mental Capacity Act training was mandatory for nursing and medical staff. Compliance rates were 67% for nursing staff and 71% for medical staff. The trust had set a target of 94.5% for all staff in all mandatory training topics.

Consent training was mandatory for nursing staff but not for medical staff. The compliance rate for nursing staff was 66%.

The trust had a safeguarding dashboard which meant that compliance with capacity assessments and best interest meetings could be monitored contemporaneously. This dashboard was reviewed at the weekly safeguarding team meeting. Data provided by the trust from this dashboard showed that in June 2022 there were 6 applications for deprivation of liberty from the medical division.

Trust wide data showed that in September 2022 16 patients had been deemed to have no capacity and 6 of these patients had not had a best interest meeting. Of the 6 patients, 3 of these were from the medical division. We were provided with information that showed that these patients had been followed up by the safeguarding team and the best interest meetings had not been held due to a change in the patients condition. Some learning had been identified and actions were in progress at the time of our inspection.

Medical care (including older people's care)

The results of the endoscopy patient satisfaction survey in June 2022 showed that 98% of patients said the endoscopist explained the risks and possible complications before gaining consent. 2% did not respond to this question. 82% of patients said that they were given the opportunity to ask any questions before being asked to sign a consent form. 18% of patients did not respond to this question.

Is the service caring?

Good

Our rating of caring went down. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Call bells being answered promptly by staff. Therapy staff used bedside curtains when carrying out bedside therapy with patients to ensure that their privacy and dignity was maintained.

We observed a consultant and ANP start ward rounds on the acute assessment unit (AAU) at 6.15am to identify patients for potential early discharge or to assess treatment needs ahead of the shift handover. They did this by moving from bay to bay interacting with only patients that were awake and not disturbing those still asleep.

We observed staff of all grades spending time interacting with patients. Staff demonstrated a strong Christie ethos of kindness and positivity.

We spoke with 9 patients and the relatives of another 3 patients. They were very complimentary towards the staff and gave us very positive feedback about ways in which staff showed them respect, ensured that their dignity was maintained and took time to understand and meet their needs. The comments received included: “I have been an inpatient twice and the treatment has been excellent”, “the consultant and nursing staff have been amazing from the minute I arrived on the unit” and “I can't thank the staff enough for looking after my husband”.

Staff followed policy to keep patient care and treatment confidential.

The trust took part in the NHS cancer patient experience survey 2021. 94% of patients said that they were always treated with dignity and respect whilst in hospital which was above the national average of 89%.

We saw examples of positive feedback that patients and relatives had provided to the service. One patient said they couldn’t have been treated any better and that the staff were very kind and helpful. Another patient described their care as exceptional and that they were treated with patience, support and kindness.

In the endoscopy patient satisfaction survey in June 2022, 100% of patients said they were given enough privacy when preparing for a procedure and that their privacy and dignity was respected in the waiting area.

The trust had a dedicated end of life wedding co-ordinator who arranged wedding ceremonies for end of life patients who wished to get married.

The trust submitted data to the national audit of care at the end of life 2021. The trust scored above the national average in all areas of the audit. The audit results showed that 100% of patients had an individualised plan of care and a recorded discussion with the patient regarding their plan of care.

We reviewed responses to 3 complaints that had been made to the service between May and September 2022. All three complaints were in relation to staff attitude on three different wards and were upheld by the trust.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. All staff we spoke to clearly understood patient needs.

Senior nurses across the division had access to a 2-day end of life communication and conversation course. Junior nurses completed a palliative enhanced communication course.

The hospital had a multi faith spiritual care service with 24hour access to a multi faith prayer room and a bereavement service which staff could access to provide support to patients and their relatives.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The psychological needs of patients, relatives and their carers were considered by staff.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

The hospital worked closely with a national cancer support service who offered psychological and emotional support for patients and families. They provided a walk-in service and no appointment was needed and the support was free. Wards had leaflets for this service.

The trust ran a bowel cancer networking group every month which patients, relatives and carers could attend. It was set up to provide emotional support and information and the opportunity to meeting other people who have had similar treatment. There were posters displayed throughout the hospital advertising this group.

In September 2022, the trust had held a free virtual event called supporting carers of newly diagnosed patients.

Understanding and involvement of patients and those close to them.

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Medical care (including older people's care)

Staff made sure patients and those close to them understood their care and treatment. Patients told us staff had clearly explained their care and treatment and were involved in decision making about their care. We saw clear communication between staff and patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. All areas invited patients to provide feedback using the national Friends and Family Test (FFT) system. In September 2022, all ward areas had a 100% positive feedback response except for one ward which received only 50% positive feedback which was a deterioration from 100% in August 2022. We were unable to speak directly to patients on ward 11 during our inspection due to a COVID-19 outbreak. Ward 11 had achieved gold standard on the internal ward CODE (care, observation, documentation and experience) accreditation programme which seeks the patient view on multiple aspects of the patient experience.

The trust took part in the NHS cancer patient experience survey 2021. The overall rating of care was 9.1 which was above the national average of 8.9. 76% of patients felt involved in decisions about their care, which was above the national average of 70%.

The trust took part in the national in-patient survey 2021. There was a 56% response rate (619 completed responses). In comparison with other trusts, the Christie performed 'much better than expected' overall. The proportion of respondents who answered positively to questions, across the entire survey, was significantly above the trust average.

In the NHS adult inpatient survey 2021 the trusts highest score was in relation to patients being provided with information about who to contact if they were worried after leaving the hospital. The trusts lowest score was in relation to if patients had been asked to provide feedback during their stay. For overall experience, the trust was rated above the England average and was in the top three trusts in the region.

We asked for a copy of the action plans from the trust wide national patient surveys. We were told that action plans were still in development, but the trust internal accreditation process had been updated following the outcome of the inpatient survey.

Staff supported patients to make advanced decisions about their care. The trust had a supportive care team who specialised in palliative and end of life care. This team supported both patients and staff to make advanced decisions about care.

Staff supported patients to make informed decisions about their care. All areas had leaflets explaining procedures and medical conditions which informed patients about their care. Staff had access to specialist teams who supported patients.

The trust has completed a benchmarking exercise against the NHS England and NHS Improvement learning disability improvement standards. The exercise identified some areas for improvement, and we saw that the trust had an action plan in place to address the shortfalls. At the time of our inspection, these actions were not yet completed.

Is the service responsive?

Good

Medical care (including older people's care)

Our rating of responsive went down. We rated it as good.

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services to ensure they met the changing needs of the local population. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were all aware of the dementia specialist nurse within the psycho-oncology team and their contact details and reported a good collaboration with them.

The trust had a service level agreement (SLA) in place for ward staff to contact directly to arrange to take palliative patients' home or to a hospice. This service was available Monday to Friday from 9am until 6pm.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All wards inspected were adhering to the guidance regarding mixed sex accommodation.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had access to specialist lead nurses for people with learning disabilities, mental health problems and autism. Speech and language therapists, occupational therapists and dieticians were also available to support staff and patients.

Facilities and premises were appropriate for the services being delivered. Waiting areas, clinical rooms and bays contained the required equipment according to internal policies and national regulations. The premises were mostly airy and welcoming.

The trust had run a project to implement the MacMillan Recovery Package for every patient with cancer. We saw the project closure report from May 2019 which described how some ongoing deliverables were being transferred to other programmes of work to prevent duplication. Outstanding actions had clearly defined responsibilities.

The trust had started a project to tackle lung cancer inequalities in partnership with the Greater Manchester Cancer Alliance.

We asked the trust if they had any patient information or support for patients relating to the NHS Cancer Drugs Fund. The trust provided us with a copy of the NHS England guidelines for the NHS and interested stakeholders. We were told that the trust had chosen not to create a local policy or any patient information leaflets as the national guidance and patients' resources from relevant charities were used.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia via the psycho-oncology team or safeguarding team as required. Staff were aware of the psycho-oncology team and knew how to contact them for support. Staff told us they had a good relationship with the psycho-oncology team.

Staff could refer patients to the learning disability and autism service to help support them and their carers. Specialist learning disability nurses were available to help make reasonable adjustments and help co-ordinate care. For example, pre-admission planning, ward visits, communication advice and discharge planning.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Medical staff explored mental health with patients and sought to understand patients' individual needs outside of their immediate physical health condition.

Wards were designed to meet the needs of patients living with dementia, for example they had dementia friendly signage for toilets and showers and dementia friendly digital clocks with the time, day and date.

Patients living with dementia, autism and learning disabilities completed 'this is me' forms and 'patient passports' when they were admitted on to the ward. Staff told us that carers would be involved with patients to complete the form which provided information such as the best way to communicate with the person.

We witnessed nursing staff on several wards discussing patient 'this is me' forms during staff handover and demonstrating that they had taken time to read them.

Most wards used the nationally recognised flower symbol for patients with dementia and a leaf symbol for risk of falls on patient boards. Staff were able to give examples of adapting visiting times for patients with dementia and providing additional beds in rooms so that family could stay.

Staff knew how to book interpreters, translators and signers and were able to give examples of when they used interpreters to support patients and carers.

Staff had access to communication aids to help patients become partners in their care and treatment. Reception areas had hearing loops to communicate with patients and their carers or family. Staff had access to an equipment to support patients with learning disabilities, and patients who communicated in ways other than speaking. Staff showed us the materials and explained how they used them. Staff gave other examples of supporting patients with communication difficulties.

Dementia awareness was part of the mandatory training requirements for all staff. The compliance rates were 73% for nursing staff and 100% for medical staff.

The trust monitored compliance with completion of dementia assessments within 72 hours of admission, confusion and delirium assessments and referral to a specialist for further review. The trust target for all 3 of these measures was 90%. In September 2022, the medical division compliance was 90% for dementia assessments within 72 hours of admission and 100% for confusion and delirium assessments and referrals to a specialist.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and generally received treatment within agreed timeframes and national targets.

Medical care (including older people's care)

Managers and staff worked to make sure they started discharge planning as early as possible. The trust had a dedicated bed management team to manage and maintain patient flow.

There was a patient flow nursing team who were responsible for coordinating planned and unplanned admissions. They used an electronic database to monitor available beds and kept an up to date record of patients waiting to be admitted. The team coordinated meetings to discuss patient flow.

Some in-patient wards had discharge coordinators who were part of the ward team. This was a pilot aimed to improve discharge processes on the wards.

There was a complex discharge team who were responsible for enhancing patient discharges for patients with more complex needs. They worked across 7 days and facilitated discharges for patients nearing the end of life or going to a care home. Their role as stated in the 'patient flow operational policy' included coordinating discharge audits and maintaining a database on delays in discharges. We saw there was a spreadsheet, which recorded when patients were delayed by days, but no real time database.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. The service moved patients only when there was a clear medical reason or in their best interest.

Managers monitored patient transfers and followed national standards. Bed management meetings were held a minimum twice per day. These were held online and included discussion on patient moves, discharge plans and use of escalation areas.

Staff supported patients when they were referred or transferred between services. Staff supported patients with additional needs to be discharged to hospices, care homes or patients' own homes.

In November 2022, 98.5% of patients on the waiting list were treated within 18 weeks which was above the regional average of 56.3%.

In November 2022, 100% of patients were seen by a specialist within 2 weeks of an urgent GP referral.

In November 2022, 361 patients started a first definitive treatment following a decision to treat. This was a 17% increase compared to November 2019 and a 14% increase compared to October 2022. 97% of patients were treated within 31 days of the decision to treat which was above the national target of 96%. 82% of patients received a first definitive treatment within 62 days of an urgent GP referral which was above the national target of 85%. The trust had no patients waiting over 104 days for treatment.

The average number of referrals in 2021- 2022 was around 1,800 per month; in July 2022 the trust had received 1,996 referrals; 1,934 referrals were received in August 2022 and 1,865 received in September 2022.

Managers generally monitored patient moves between wards and ensured they were kept to a minimum. The service generally moved patients only when there was a clear clinical reason or in their best interest. Between April and September 2022, 25 bed moves occurred between 10pm at night and 8am in the morning. This was no more than 4 moves per month except in June where 10 patients were moved overnight.

The trust reported that within the medical division in the last 6 months, no procedures had been cancelled.

Medical care (including older people's care)

We asked the trust how many patients were currently in the hospital with no criteria to reside. The trust told us that they did not record this information due to the nature of the patient group. However, at the time of our inspection they had no patients waiting for transfer to a nursing or residential home and 1 patient awaiting transfer to a hospice.

On 1 November 2022, the overall occupancy of the trust was 85.4% which had reduced from 98% on 22 October 2022 and was better than the regional and England average.

Between April and September 2022, the medical division average length of stay had fluctuated between 3.7 days and 4.3 days.

At the time of our inspection, the trust did not have any medical outliers (medical patients placed on a non-medical ward). The trust patient flow operational policy included escalation procedures. This policy was created in March 2021 and was due for review in May 2022. The policy included a criteria that must be considered before a patient is deemed suitable to outlie in another inpatient area. The policy also identified that the trust patient flow team were responsible for ensuring that outliers received a timely medical review and be listed for repatriation to a speciality ward.

The discharge lounge was used to facilitate discharges for patients. Managers told us that delayed discharges were incident reported and appropriate investigations carried out.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and shared lessons learned with all staff but did not always investigate complaints in a timely manner. The service included patients in the investigation of their complaint.

Patients, relatives and carers we spoke with during the inspection knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. Staff were able to explain the complaints process, and give examples of when a complaint was received, how it was handled and the outcome. Wards and departments clearly displayed information about how to raise a concern. Staff told us how the duty of candour was met, including recording of the process and the involvement of patients and families.

External stakeholders were involved in the complaints process where relevant.

Feedback from complaints was shared with staff in daily safety huddles, on ward rounds and in team meetings. Serious incidents which were at the origin of complaints were discussed with staff and escalated. Staff gave examples of using patient feedback to improve daily practice.

The trust did not always respond to complaints within set timescales or follow their internal policies as well as the national guidance. We were told that deadlines sometimes were missed where cases were complex. Due to the trust being a tertiary service, some complaints spanned the patient pathway across other trusts and services; more of these were now being investigated jointly.

Between April and September 2022, the medical division received 8 formal complaints and 14 concerns raised through the patient advice and liaison service (PALS). During this period the division responded to 9 formal complaints and their overall response compliance rate was 33%. Complaints are graded to determine a suitable response target. Grade 1 complaints should be responded to within 20 working days. The medical division had 1 grade 1 complaint which was not

responded to within 20 working days. Grade 2 complaints should be responded to within 25 working days. The medical division responded to 3 out of 6 grade 2 complaints within 25 working days. Grade 3 complaints should be responded to within 40 working days. The medical division had 2 grade 3 complaints, and neither were responded to within 40 working days.

We saw that complaint responses were comprehensive, and concerns raised complainants were addressed. The trust had acted when learning was identified from complaints and learning was shared with the relevant teams and across the wider trust.

Is the service well-led?

Good

Our rating of well-led went down. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The trust had 4 directorates of which medical care sits within the trusts acute and supportive cancer services. The leaders worked in a multi-professional triumvirate which included a divisional manager, divisional medical director and divisional associate chief nurse. Acute and supportive cancer services were led by an clinical director who reported directly to the divisional triumvirate.

Staff told us that they felt well supported by ward managers and that they felt comfortable to approach senior leaders with any issues.

Ward managers that we spoke with said that they were supported by the directors and assistant directors for the division and that they had a visible presence on the wards.

We observed good leadership skills in all ward areas. Leaders were seen giving clear directions and support to junior colleagues.

Following our inspection, we requested minutes of the monthly medical triumvirate leadership meetings. We were told that although these meetings were held regularly, they were not formally minuted.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Medical care (including older people's care)

The vision of the trust was to be a leader in cancer care, to provide the best experience for patients, relatives, carers and staff, and to lead research into cancer care on a national and international basis.

In early 2018 the trust had refreshed its 5-year strategy to reflect where it wanted to be as an organisation in the future. There were 4 main themes in the strategy, 'leading cancer care, The Christie experience, local and specialist care and best outcomes.' The strategy was developed by the board following consultation with patients, staff, and governors. The current strategy was in its final year.

The division of medicine leaders told us that they shared the vision and strategy of the trust and that there were numerous focus groups within the division where sharing vision and strategy was planned and discussed. Most ward managers and staff across the division had a good understanding of the vision and strategy for the division and trust.

The division of medicine leaders told us that each of the division's specialities had developed their own departmental strategy and they were being introduced across the division at a strategy launch day on 4 November 2022.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

During our inspection most staff told us that the culture in the division was positive. They highlighted staffing as the main issue that impacted on their work and understood the challenges for their work areas and for the division. Team working was recognised as a strength and staff said that the pandemic had strengthened teamwork and how they valued each other.

Staff across the service described a culture of honesty, openness and transparency. Senior staff carried out the duty of candour responsibilities which detailed the involvement and support of patients or relatives in serious incident reports. Staff said there was an open and transparent culture where people were encouraged and felt comfortable to report incidents and where there was learning from mistakes. Leaders told us that the 'just culture' agenda was embedded in the weekly incident scrutiny panels.

Staff felt valued, supported and spoke highly of their jobs. Staff said there was good teamwork and peer support. Staff spoke enthusiastically about their jobs. Most staff felt they were able to progress and follow their clinical career path. Staff were passionate about getting the best results for the patients.

Staff were proud to work for the hospital; they were enthusiastic about the care and services they provided for patients. Some of the staff we spoke with had worked at the hospital for many years and described the hospital as a good place to work.

On the wards we saw multidisciplinary working which involved patients, relatives, and the clinical team working together to achieve good outcomes for patients.

During our inspection we heard repeatedly from staff that there was a perceived need to protect the reputation of the organisation which impacted negatively on some staff. This was clearly indicated from feedback by some staff during and after focus groups we conducted.

Medical care (including older people's care)

Leaders for the service told us that they continued to promote freedom to speak up (FTSU) to empower colleagues to report bullying, discrimination and abuse. FTSU training was mandatory for all staff. However, only 59% of nursing staff and 85% of medical staff had completed this training. The compliance rate for allied health professionals was 100%.

We were told that there had been no concerns raised via the FTSU in the last 6 months across the division and no ongoing action plan from any concerns raised before this period. Most staff we spoke with knew how to contact the trust FTSU guardian.

Due to the structure of the core services at the Christie, disaggregated data from the NHS staff survey 2021 for this service was not available for the medical core service alone.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders and staff told us there were clear governance structures within the division with good representation from all disciplines. Divisional governance meetings directly fed into the trust board governance meetings.

There was a clear governance structure within the division. We reviewed ward team meeting minutes and found that team meeting structures were different between ward areas and incidents, policy changes and performance were not always discussed.

We reviewed the minutes of the Quality and Governance Committee meetings in June, July and September 2022. The meetings were well structured with key topics covered as part of the standing agenda. Actions were clearly identified on an action log and followed up at subsequent meetings.

We reviewed the minutes of the Clinical and Research Effectiveness Committee from July, August and September 2022. We saw that appropriate sub-groups fed into this committee and national guidelines were discussed. The committee had a forward plan for the next 6 months of meetings and actions were logged and followed up at subsequent meetings.

We reviewed the minutes of the infection prevention and control (IPC) committee meetings in May, July and September 2022. The meetings were well structured and relevant topics were regularly discussed. Actions identified from the meetings were logged and appropriately followed up at subsequent meetings. The trust had relevant subgroups, for example a water safety group and a cleaning group, which fed into the IPC committee and escalated any concerns or risks.

The trust had an internal ward accreditation programme called CODE which was a framework for measuring quality. The framework was based on 16 fundamental care standards and each area was rated either gold, green or red. One of the wards was receiving additional support following the last CODE inspection. Two medical wards had achieved gold status.

The division had held a virtual governance day in April 2022. All staff were invited to intend. The agenda included learning from events, a review of serious incidents and an update on duty of candour processes.

During our inspection, it was noted that there were policies that had passed their review dates, for example, the National Early Warning Score (NEWS) 2 policy and the consent policy. Eight policies had gone passed their review date in 2020. This meant staff did not always have the most up to date policy or guidance to follow.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Risks were recorded at ward, division and trust level. Service leaders told us the top three risks identified within the division were cancer treatment waiting times, the availability of CT scanners and the limited staffing within the stricture dilation service. Following the inspection, we were provided with a copy of the risk register and found the top 3 risks were different to those identified by the service leaders. Two of the risks we were told about were not on the risk register. However, although not all risks were recorded, we did see that appropriate mitigated actions had been taken.

Throughout the division staff told us that clinical and non-clinical managers worked well together to identify risks and make improvements. Matrons and ward managers, we spoke with had a good understanding of the issues within their clinical areas.

Leaders at all levels could clearly describe the risks in their area of work and the mitigation in place to reduce the risks. The risk register was updated regularly, with risks added to the register relating to patient care, safety performance and current issues. Monitoring of risks and actions were allocated to named staff who recorded regular updates with the mitigations to reduce the risk. The division risk register was reviewed monthly at the divisional board meeting.

All staff who were required to complete risk management training had completed it.

It was recorded in the minutes of the Acute and Supportive Cancer Services Directorate meeting in May 2022 that the directorate had a total of 194 risks and 65 were overdue for review. At the next meeting in July 2022, 63 risks were still overdue review. However, by the meeting on 12 September 2022, some improvement had been made and 27 risks were overdue.

Following our inspection, we reviewed a copy of the risk register and found that 1 risk was overdue for review and that this was recorded as being due for review in April 2021. All risks on the risk register were graded in terms of likelihood and consequence, had a named lead, review date and identified controls and mitigations.

In the August 2022 integrated performance, quality and finance report, workforce capacity, specifically consultant cover on AAU, was escalated as a risk. We saw that this risk was recorded on the divisional risk register. The risk had recently been reviewed and actions that had been taken to mitigate the risk were recorded.

Fire risk assessments had recently been completed for ward areas and the trust had a fire safety action plan to address any areas of concern. All actions were assigned to a responsible person and had a target completion date. At the time of our inspection, some actions had been completed and some were in progress.

The trust is a tertiary cancer centre which meant they cared for 98% of patients who had already been diagnosed and referred to them by other hospitals, which may add time delays to treatment. Some patients were awaiting a diagnosis, some already had advanced cancer.

Medical care (including older people's care)

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The trust's website provided safety and quality performance reports, information on cancer research and developments. This gave patients and members of the public a range of information about the safety and governance of the hospital.

Staff could access policies, procedures and clinical guidelines through the trust intranet site though policies were not always in date. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

There was a secure electronic incident reporting system in place that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken.

There were enough computer terminals and laptops for staff to allow staff to access electronic patient records and test results. All staff had individual log on passwords and all terminals were locked when not in use.

The trust had its own electronic patient record. During our inspection we were told there were interoperability problems with other systems in the trust and with shared systems in the wider community. Senior leaders provided evidence to demonstrate how the trust's EPR integrates with both internal and external systems. They told us that work was ongoing to improve the access.

There was electronic medicine prescribing in some areas across the division, but not others. The contract for electronic prescribing and medicine administration (EPMA) was in place and the system was due to be implemented in 2024. Electronic medicine prescribing increases safety for patients and makes more efficient use of clinician time.

Information governance and data security was included the in mandatory training requirements. Compliance rates for this training were 80% for nursing staff, 100% for medical staff and allied health professionals.

The trust had 1 information governance incident and 2 information governance breaches in the last 6 months. The severity of these incidents did not meet the criteria to be reported to the Information Commissioner's Office (ICO). The trust had taken appropriate action to investigate the incident and mitigate any ongoing risk. We also saw that one ward had its own newsletter to share recent updates with the team.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services including a recently completed trust wide survey to gather instantaneous feedback on patient care. Non-clinical staff interviewed colleagues and patients directly on the wards and other clinical areas in real time rather than wait for survey results.

The management team said any good ideas put forward by staff were discussed at weekly ward and monthly team meetings. Useful suggestions and good ideas were passed on to the clinical and quality boards. Staff felt informed and involved with the day-to-day running of the service and its strategic direction.

Staff advised us there were regular staff meetings and that managers arranged these for different times and days to ensure all staff were able to attend regularly.

Staff told us there were 4 staff networks within the trust, a disability network, an ethnic diversity network, a LGBT+ network (lesbian, gay, bisexual, transgender, plus others) and a 'faith and belief' network.

Staff we spoke with were proud to share their experiences of participating in patient support groups that were active within the trust such as the advanced pelvic malignancy patient support group and the bowel cancel patient networking group.

We reviewed the most recent NHS staff survey results from 2021. 44% of trust staff took part in the survey. The trust scored above or in line with the average when compared with other similar trusts. Staff were asked if they were involved in decisions about changes that affected their working area; 45% of staff did not feel involved in decision making. This had deteriorated slightly when compared to the 2020 survey results. However, 75% of staff said they were able to make suggestions to improve their work area and 59% of staff said they were able to make improvements happen in their area of work.

A divisional newsletter was shared with each staff each month, which contained information about performance, celebrations of achievements, HR topics and details of internal and external events. The trust also had a learning for improvement bulletin which contained information from incidents, complaints and mortality reviews.

We reviewed the minutes of the Patient Experience Committee from July, August and September 2022. Each meeting had a patient representative present and attendance from relevant trust staff. The meeting was structured, and the standing agenda items included complaints and patient survey results. Any actions from the meeting were logged and followed up at subsequent meetings.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Staff and leaders, we spoke with told us there was a positive culture of learning in the division and we saw that staff at all levels wanted to improve services for patients and their relatives.

The trust had a number of clinical trials and quality improvement project ongoing and planned. The division gave quality improvement awards annually to individuals, teams and wards.

The division took part in the ward accreditation scheme to measure the quality of nursing care delivered by teams across the trust.

Medical care (including older people's care)

Following our inspection, the trust shared details of a quality improvement project around the management of acute kidney injury (AKI). The aim of the project was to identify changes and improvements to assist with the prevention and management of AKI. The project included development of an AKI care bundle, trust wide education in the form of face to face training and a newly created e-learning module and patient education and empowerment. Results of a trust wide fluid balance audit showed significant improvements in the monitoring and recording of fluid intake and output. For example, in July 2022 on ward 12, 6 hourly intake monitoring was only performed for 13% of the required patients and 6 hourly output monitoring was performed for 6% of required patients. In August 2022, both measures were completed for 100% of required patients.

In 2022, the trust had introduced a rapid discharge ambulance service for patients in the last days of life or those with a complex care package to support these patients to be discharged from hospital in a timely way. The service was transferring approximately 15 patients per week. The incident data collected showed that delays in patient discharge and transfer had been significantly reduced. After a successful 3-month pilot, the service contract was extended in December 2022 for 5 years.