NHS
The Christie
NHS Foundation Trust

Annual report and accounts

2018/19

The Christie NHS Foundation Trust
Annual Report and Accounts 2018/19

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Chair and Chief Executive's statement

Welcome to our annual report and accounts for 2018-19.

This year The Christie was delighted to play a major role in celebrating the 70th birthday of the NHS. Of course The Christie itself has a significant history of pioneering cancer treatment, research and education and has been at the forefront of cancer care for more than 100 years.

Events like this are important. Not only do they allow us to celebrate and reflect on our achievements over the years, they are also a key driver in our continued strive for excellence. We can't help but be proud of our history, but it is vital we use that history to inspire us to pursue innovation and progression in our aim to provide world class care and treatment for all our patients. We know there is always more we can do.

This year, having successfully achieved what we set out to do in our 2020 Vision strategy two years early, our new five year strategy was introduced, outlining our ambition to grow services even more for the benefit of our patients. We went through an extensive process of consultation and engagement over the course of 12 months, adapting our original plans to embrace our vision for a truly world-class cancer centre.

Our strategy remains focused on four key themes; Leading cancer care, The Christie experience, Local and specialist care, and Best outcomes. And we work hard to ensure everything we do is focussed on achieving our goals in these areas. We have some wonderful examples this year of our progression. Most notably, we were privileged to open the NHS's first high-energy proton beam therapy centre. The treatment we are now providing will make a huge difference to patients who previously had to travel abroad for this specialist form of radiotherapy.

As well as continuing to develop our main site in Withington, The Christie also remains committed to promoting care closer to home for as many patients as possible. This year we continued to expand our chemotherapy outreach provision with a new service in Winsford in Cheshire. We also announced our plans to build a new Christie cancer centre in Macclesfield, allowing thousands of patients in the East Cheshire catchment area to benefit from chemotherapy, radiotherapy and other services far closer to home. Our charity will play an important role in this project which we hope will open during 2021.

We were also delighted to mark the completion of a brand new £7m outpatient facility at The Christie, which offers a more accessible, spacious and comfortable environment for the 95,000 appointments that take place there each year. Fully funded by The Christie charity, it aims to offer patients a more seamless experience with more consultation rooms, improved access to testing facilities and a new appointment system with self-check-in screens that will help to reduce patient waiting times and increase capacity.

The Christie is well known for many world-firsts which have advanced cancer treatment on a global scale. We have an excellent reputation as an international leader in research and innovation, which is further strengthened by being a partner in the Manchester Cancer Research Centre (MCRC) and this year our plans to build a new research centre to replace the Paterson building have been further developed.

The number of clinical trials that are recruiting patients at The Christie has increased by 11 per cent in the last year, with more than 1800 patients benefitting from the latest treatments available. The National Institute for Health Research (NIHR) acknowledges that The Christie remains one of the most active NHS clinical research organisations in the UK, reflecting our vibrant research culture. These studies not only have the potential for improving outcomes for

those patients taking part, they also enrich our understanding of cancer and benefit patients in the future.

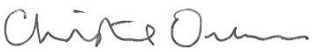
Above all, our biggest commitment at The Christie is to put patients at the heart of everything we do and to ensure we provide the highest quality care and treatment with very real patient benefits. Our performance in national surveys and the positive feedback we receive from our patients continues to be a source of pride and encouragement.

2018-09 saw The Christie once again rated Outstanding by the Care Quality Commission (CQC), making us the first specialist trust in the country to be given its highest accolade twice. The CQC described The Christie as 'a leader in cancer care' and a pioneer in developing innovative solutions to cancer care'. It also praised the positive culture, our compassionate and effective leadership, and our exceptionally kind and caring staff who 'go the extra mile' to meet the needs of patients and their families.

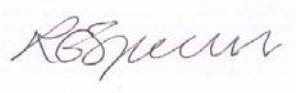
The rating is the highest we could have been given and is testament to the dedicated, expert staff in every Christie department who work tirelessly to give the very best care and treatment to our patients.

None of our achievements would be possible without our staff, partners, governors, members, volunteers, charity, patients and so many others we work with across Greater Manchester and Cheshire, as well as nationally and internationally.

We thank you for your continued support, commitment and dedication in our goal to provide the very best care for our patients, and to develop treatments that will transform cancer care for patients for many years to come.



Christine Outram
Chairman



Roger Spencer
Chief Executive

About us

At The Christie, we are proud of our history at the forefront of cancer care for more than a century, but we are even more proud of our forward thinking nature and our desire to constantly innovate and develop our services for the benefits of patients. We continue to lead the way in cancer care, research and education and remain committed to helping all those affected by cancer, both now and in the future.

We are the largest single site cancer centre in Europe treating more than 44,000 patients a year and the first UK centre to be accredited as a comprehensive cancer centre.

As part of the NHS, we provide radiotherapy in one of the world's largest radiotherapy departments and at our local centres in Oldham and Salford. We are also home to the UK's largest brachytherapy service.

We deliver chemotherapy treatment through the largest chemotherapy unit in the UK, as well as via 10 other sites, our mobile chemotherapy unit and in patients' homes. We also provide prostate cancer community clinics at five different locations.

We provide highly specialist surgery for complex and rare cancers and a wide range of support and diagnostic services.

And this year, we became the first NHS organisation in the UK to deliver high energy proton beam therapy, providing untold benefits to hundreds of patients nationally who would have previously been treated with this highly specialist form of radiotherapy overseas.

The Christie School of Oncology provides undergraduate education and clinical professional and medical education - the first of its kind in the UK.

We serve a population of 3.2 million people across Greater Manchester and Cheshire while more than a quarter of our patients are referred to us from across the UK.

This year we were once again rated Outstanding by the Care Quality Commission (CQC), becoming the first specialist trust in the country to be given its highest accolade twice, and warmly described by the CQC as 'a leader in cancer care' and 'pioneers in developing innovative solutions to cancer care.'

We have a number of component parts to our structure which includes The Christie NHS Foundation Trust, The Christie Charity and The Christie Pharmacy Company (a wholly owned subsidiary providing pharmacy dispensing services to the Trust). We are also a partner in two joint venture entities; The Christie Private Care, a joint venture partnership with HCA (HCA International Limited) for the provision of private oncology activity and The Christie Pathology Partnership where we partner with Synlab UK to deliver oncology pathology services.

We are ranked as the most technologically advanced cancer centre in the world outside North America, and have been named, by the National Institute for Health Research, as one of the best hospitals providing opportunities for patients to take part in clinical research studies.

We are part of the Manchester Cancer Research Centre (MCRC) working with The University of Manchester and Cancer Research UK. The MCRC partnership provides the integrated approach essential to turn research findings in the laboratory into better, more effective treatments for patients. Building on Manchester's strong heritage in cancer research, the MCRC provides outstanding facilities where scientists, doctors and nurses can work closely together.

We are also one of seven partners in the Manchester Academic Health Science Research Centre. We share a common goal of giving patients and clinicians rapid access to the latest research discoveries, and improving the quality and effectiveness of patient care. There are only six health science centres in the country.

Globally, The Christie is recognised as a leader in providing high quality patient-centred cancer care and has become increasingly influential internationally. During the year we retained our international designation as a Comprehensive Cancer Centre of Excellence and also joined the Union for International Cancer Control (UICC) in its ambition to reduce the global cancer burden. Our experts are in demand to provide advice to cancer developments across the world and during 2018-19 have worked with Cork University Hospital (Eire) to help create a new radiotherapy centre and have been chosen to provide advice on the cancer care element of a new hospitals development in China.

The Christie is home to a Lord Norman Foster designed Maggie's Centre which is based on our site and offers emotional and practical support to our patients and their families. Run by the Maggie's charity, it is the first of its kind in the North West.

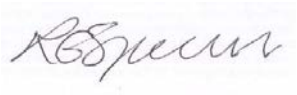
Our charity is one of the largest NHS charities in the UK, providing enhanced services over and above what the NHS funds. It has over 50,000 supporters who helped raise £13.9m this year.

All of our achievements and successes are only possible due to our dedicated and specialist staff, hardworking volunteers, generous and loyal supporters and fundraisers and our interested and enthusiastic public members, all bringing with them a wealth of experience, knowledge and understanding.

The key issues and risks that could affect us as a Foundation Trust in delivering our objectives are managed on a monthly basis through our board assurance framework which can be viewed in our public board papers available on our website. More detail relating to the key risks in 2018-19 are set out in the Annual Governance Statement on page 205 of this report.

Our overall performance in 2018-19 has been excellent and we have continued to deliver the 31 day referral to treatment target. Our 62 day cancer waiting time performance has not been achieved following changes to the reporting mechanism.

The Christie is one of only eight specialist trusts in England deemed to have maximum autonomy and no potential support needs by NHS Improvement. This places us in the top 15% of NHS providers in the country.



Roger Spencer
Chief Executive
23rd May 2019

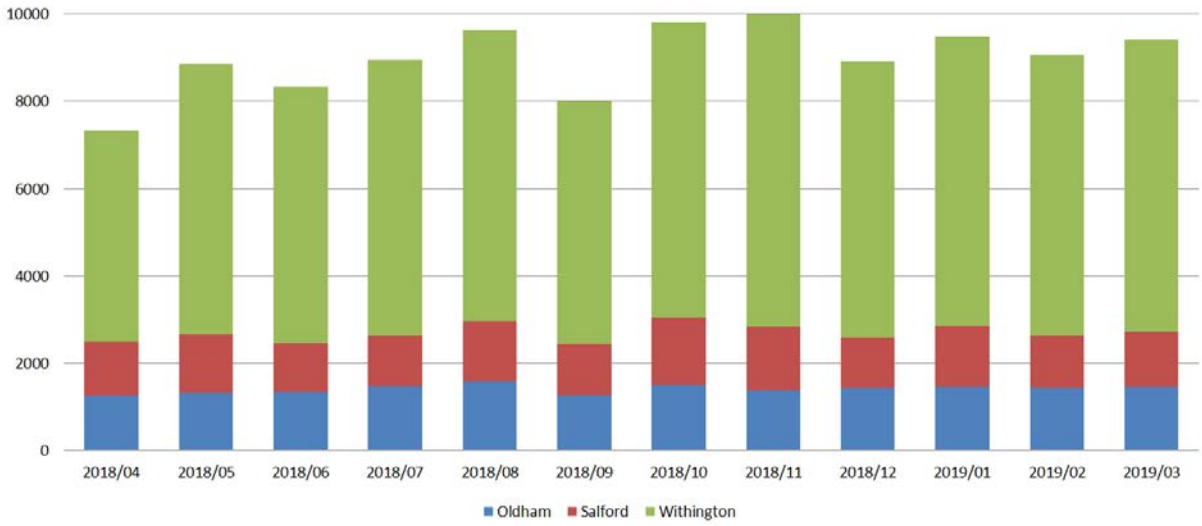
Radiotherapy

We have delivered major service improvements during the year and we have dedicated significant investment to support the development of cutting edge radiotherapy.

Our radiotherapy department has continued with its tradition of supporting innovation and research in ensuring our patients have access to the latest equipment and treatments as well as access to the latest clinical trials. We have two other radiotherapy centres in Oldham and Salford; the Salford centre also offers a specialist stereotactic radiosurgery service which is used to treat small malignant and benign brain and spine lesions, providing a highly specialist state of the art service to Greater Manchester and Cheshire.

Radiotherapy fractions

Almost seven and a half thousand patients have been treated with radiotherapy during 2018/19 which equates to over 104,000 treatments, delivered over our three sites.



Equipment provision

We have ten linear accelerators (or linacs) at our Withington site, with two linear accelerators at our Salford site and two at Oldham as part of our strategy to treat patients closer to home.

During the year we have replaced one linear accelerator on our Withington site, completing the current phase of the replacement programme and ensuring that all linacs on this site are capable of volumetric intensity modulated radiotherapy. The replacement linear accelerator has a higher technological capability including the ability to deliver Flattening Filter Free (FFF) radiation beams. The upgrades have seen the total number of FFF-enabled linear accelerators increase to seven out of nine. This technology provides larger dose treatments that cannot be delivered traditionally.

During 2018-19 we continued the introduction of a method of reducing the dose of radiation delivered to the heart and its associated arteries during breast radiotherapy. Deep Inspiration Breath-Hold (DIBH) has the potential to reduce long term adverse events. The treatment is now routinely delivered with four linear accelerators capable of this treatment. The Trust has used this technology innovatively to develop a method of using the DIBH technique in patients with lymphomas in appropriate disease sites.

Technique improvement

As older models of linear accelerators have been phased out on our Withington site, capacity for improved treatment techniques have increased. This has seen the use of Volumetric Modulated Arc Radiotherapy (VMAT) increase and offered to additional patient groups. The rolling linac replacement programme has seen the removal of wedged-based radiotherapy techniques at our Withington site so that all appropriate curative patients are now offered intensity modulated radiotherapy.

The stereotactic radiotherapy programme has expanded during 2018-19. In addition to lung, spine and liver Stereotactic Ablative Body Radiotherapy (SABR), The Christie now offers SABR for adrenal, lymph nodes and bone disease.

Magnetic Resonance (MR) linear accelerator

The radiotherapy service includes a prototype MR-guided linear accelerator. The MR-linear accelerator offers the possibility of advancing radiotherapy to enable us to deliver more targeted and more personalised radiotherapy for patients. The Christie is part of the Atlantic Consortium consisting of clinical, academic and industrial partners in four countries to research the use of MR-guided radiotherapy and move it from a development stage to clinical implementation. Significant training activity has been undertaken to upskill staff on this novel treatment device that includes the precision treatment of a linac with the enhanced imaging capabilities of a magnetic resonance imager. This is one of only twelve in the world.

As a marker of the role of The Christie in this project, Manchester was chosen to host an Atlantic Consortium scientific and technical conference in 2018.

The first patient treatment is expected in the first quarter of 2019-20.

Magnetic Resonance (MR) linear accelerator

Proton beam therapy centre

The Christie has opened the first of two proton beam therapy centres as part of a national proton beam therapy service. Having received handover of the building in early 2018, the first patients were imaged in the new centre mid-year and the first patient was treated in December.

Working with our partners at UCLH, the Department of Health and Manchester Foundation Trust, we have continued to lead the patient pathway design process. The number of patients being treated is increasing as planned paving the way for the repatriation to the UK of all proton beam treatments once the second national unit opens in London.

Christie Medical Physics and Engineering

Christie Medical Physics & Engineering (CMPE) is a division of the Trust providing physics and engineering expertise for treatment and research at The Christie and has been established for over 70 years. We provide peripatetic services to other NHS trusts throughout the North West region and have groups of clinical scientists, technologists and engineers in the Manchester Foundation Trust at Wythenshawe Hospital and The Christie centres in Oldham and Salford. Our role spans service delivery, requiring the application of scientific skills and judgement, and original research driving innovation and furthering knowledge.

We are organised into several operational groups supported by general management, central administration and mechanical engineering workshop facilities.

The operational groups based at The Christie are radiotherapy physics, imaging physics and radiation protection and nuclear medicine.

The Radiotherapy Physics group supports clinical radiotherapy services at The Christie and at our Oldham and Salford centres.

The medical engineering group is based at The Christie and in the Manchester Foundation Trust site at Wythenshawe to provide medical engineering services.

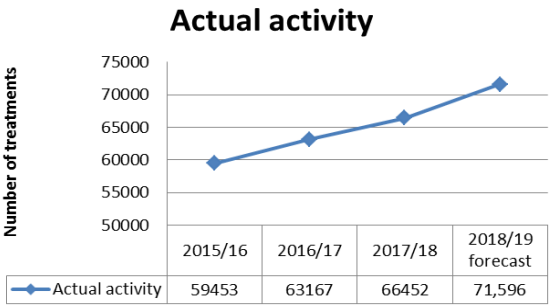
The Imaging physics and radiation protection group include the specialist areas of diagnostic x-ray imaging, radiation protection, magnetic resonance imaging, ultrasound and optical radiation. The group supports activities at The Christie and also provides scientific support services to many hospitals in the North West and other private healthcare organisations locally and nationally.

The nuclear medicine group provides diagnostic nuclear medicine, PET-CT and molecular radiotherapy services at The Christie. Research and development in these areas are carried out in collaboration with national, international and commercial partners. Through our regional radiopharmacy, we manufacture and provide radioactive tracers to The Christie and eight other nuclear medicine departments in the North West. The group also provides scientific and regulatory advice to those departments and others. In 2017, the group led a successful bid to NHS England to provide an expanded network of PET-CT scanning in Greater Manchester which commenced on 1st April 2019. On a wider level, the group provides medical physics oversight to the national PET-CT contract provided by Alliance Medical Ltd.

Systemic Anti-Cancer Treatment service (SACT)

With new targeted treatments and more treatment options available for patients diagnosed with cancer, the number of treatments we deliver is rising every year. In 2018-19 we will have delivered over 70,000 treatments.

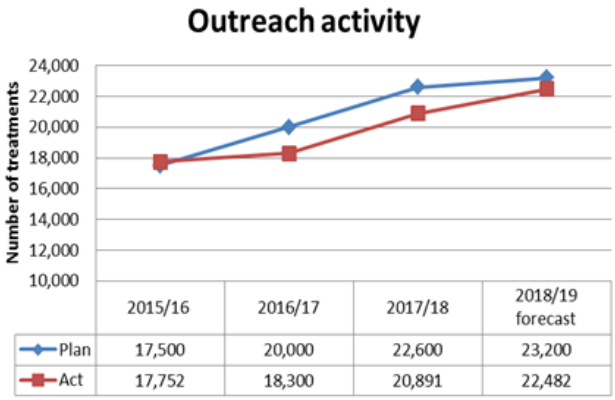
Our service provides 50 treatment spaces for solid tumour treatments with separate facilities for phase I and II clinical trials, haematology and teenage and young adult oncology. We also have an extensive outreach and home care service.



	2015/16	2016/17	2017/18	2018/19 forecast
Actual activity	59453	63167	66452	71,596

A key part of our SACT strategy has been to provide more treatment closer to our patients' homes. The development of our outreach chemotherapy services has resulted in improved patient experience, a reduction in patient travel time and has released capacity on the main hospital site. Together with our own nurse led home service, we also deliver treatments in the following areas:

- Arden House medical practice (New Mills)
- Bolton (Mobile unit)
- Bury (Townside primary care centre)
- Leighton (Mid Cheshire)
- Macclesfield (East Cheshire)
- Oldham (Hospital site and mobile unit)
- Rochdale (Mobile unit)
- Salford (Salford Royal)
- St Luke's Hospice (Winsford)
- Stockport (Stepping Hill hospital)
- Tameside (Tameside general hospital)
- Trafford (Mobile unit)
- Wigan (Wrightington, Wigan & Leigh)



	2015/16	2016/17	2017/18	2018/19 forecast
Plan	17,500	20,000	22,600	23,200
Act	17,752	18,300	20,891	22,482

Developments during 2018-19

- Expansion of the Christie at Home service including intravenous treatments.
- Opening of a new treatment facility at St Luke's Hospice in Winsford.
- Introduction of five local phlebotomy services.
- Implementation of nurse led oral SACT clinic.
- Implementation of the use of handheld devices for nursing staff on the treatment floor.

Surgery

Our directorate of surgery is a specialist tertiary surgical referral centre that concentrates on rare cancers, specialist procedures and multi-disciplinary cancer surgery. All of our specialties work as a single service in a network across populations ranging from 1.5m to 25m. In most cases, our teams of surgeons, anaesthetists, nurses and allied health care professionals work in a network across more than one hospital or community site.

Surgery is an integral part of the comprehensive cancer centre. Working with all clinical groups allows for specialist multidisciplinary care of patients requiring multimodality therapies to occur under one roof. Additionally, many patients undergoing radiotherapy or chemotherapy for their cancer may suffer from complications or side effects that require surgical opinions or management.

We provide a crucial service to local, regional and national populations. Much of our work is based on rare and specialist cancers under the remit of specialised and highly specialised commissioning, whilst ensuring patients being treated non-surgically, within the comprehensive centre, are supported appropriately.

The following specialties are represented within the directorate

- Colorectal and peritoneal surgery
- Urological surgery
- Gynaecological surgery
- Plastic surgery

Our current services and populations served are summarised below:

- Rare cancers
- Anal cancer: 3.2 million
- Peritoneal tumours and appendix neoplasia (pseudomyxoma peritonei):25 million
- Penile cancer: 8 million
- Retroperitoneal/abdomino-pelvic sarcoma: 5.45 million
- Testicular cancer: 6 million
- Vulval cancer : 1.5 million

Specialist procedures

- Electro-chemotherapy: 3.2 million
- Intraoperative peritoneal chemotherapy: 25 million
- Photodynamic therapy: 4 million
- Post-radiation and post-chemotherapy side effects requiring surgical management: 3.2 million
- Robotic surgery: 3.2 million (urological, colorectal, gynaecological)
- Specialist abdominal wall reconstruction: 3.2 million
- Specialist diagnostics: 3.2 million (including multi-disciplinary cancer team (MDCT) approach, virtual MDCT, and template prostate biopsies)

Multidisciplinary treatment

We formed the UK's first MDCT, which has been functioning since 1970 and has grown significantly over the last three decades. The MDCT undertakes the management of specialist pelvic cancer and retro-peritoneal cancers and conditions including:

- Advanced and recurrent rectal, anal and colon cancers requiring combined chemo-radiation and multispecialty surgery, including perineal reconstruction.
- Advanced gynaecological malignancy requiring multispecialty surgery, including ovarian debulking and cytoreductive surgery.
- Retroperitoneal / abdomino-pelvic sarcomas requiring chemotherapy, radiation and/or surgery.
- Melanoma requiring reconstruction, chemotherapy and on rare occasions MDCT surgery.
- Prophylactic breast cancer surgery.
- A multidisciplinary approach to living with and beyond cancer: treating radiation and cancer induced fistulae, bleeding and intractable symptoms of urinary tract and bowel, recurrent tumours post radiation and chemotherapy, and late onset radiation induced tumours.

Colorectal and Peritoneal Oncology Centre (CPOC)

The Christie CPOC is an internationally renowned centre for highly specialised surgery offering a national and regional service to the UK NHS and was awarded the 2013 BMJ Cancer Care Team of the Year Award. It specialises in:

1. **Peritoneal surface malignancy** - One of two centres commissioned by NHS England providing cytoreductive surgery and heated intraperitoneal chemotherapy (CRS/HIPEC) for patients with appendix tumours and colorectal peritoneal metastases (CRPM).
2. **Advanced pelvic and retroperitoneal malignancies (primary and recurrent)** - CPOC offers a regional and national multi-visceral resection service for patients where radical surgery necessitates collaborative colorectal, urology, gynaecology and reconstructive surgery. The UK National Bowel Cancer Audit recognises it as one of three tertiary cancer centres in the UK.
3. **Anal cancer** - The largest anal cancer unit in the western world with an established database since 1988 of over 750 patients, with 80 new cases diagnosed per annum. CPOC has actively contributed to the development of the leading international anal cancer clinical trials and remains in the highest centile for recruitment to those trials.
4. **Neuroendocrine tumours** – CPOC is recognised by the European Neuroendocrine Tumour Society (ENETS) as an accredited centre of excellence for the management of these rare neoplasms. CPOC is a core member of the neuroendocrine endocrine tumour MDT engaged with treatments for small bowel, appendix, colonic and rectal tumours.
5. **Organ preserving treatments for rectal cancer** - A leading international centre with expertise in managing patients with complete clinical response following long course chemoradiotherapy. Initially working through the GI disease group, CPOC established the 'Oncological Outcomes after Clinical Complete Response in Patients with Rectal Cancer' (OnCoRe) database from a North West England and Wales collaborative initiated in 2005, reporting outcomes in Lancet Oncology in 2016. OnCoRe is a major contributor to the international collaborative watch and wait database recently reporting outcomes from a cohort of 1,009 cases (Lancet 2018).

The team hosted the national PTS meeting in January 2019, which included a discussion of data from all units with a view to improving patient outcomes.

The team have continued to develop educational projects to improve the appropriateness of referrals. With this in mind, the team now runs a programme inviting MDT participants to attend a course explaining what they need to know in this field.

In 2018, an additional consultant was appointed to support the activity which will be generated from the development of the total pelvic exenteration service for advanced and recurrent rectal cancer. For a more detailed review of the service, please refer to the CPOC Annual Report for 2018-19 (Cpoc-service-annual-report-jan-2018)

Urological surgery

The Christie uro-oncology team provides surgical management for patients with prostate, renal, penile, testicular and other rare types of urological cancer including abdomino-pelvic sarcomas.

The North West Penile Cancer Network (NWPCN) covers a population of 8.7 million, over a large geographic area and a diverse population. It provides specialist diagnostic, chemotherapy, radiotherapy and surgical treatments (including reconstruction) for patients with suspected or diagnosed penile cancer. The service offers the full range of penile cancer treatments including the latest up to date penile sparing and reconstructive techniques. Reflecting the national trend, the team has developed additional capacity and

capability to deal with the increase in robotic prostatectomy cases over the last financial year. The team is recognised as a national training centre for robotic prostatectomy surgery.

The Christie team is the key provider in the GM wide reconfiguration of cancer urology services. The lead and key providers are tasked with delivering a single urology cancer surgery service for Greater Manchester. The single service will integrate services across the whole pathway What has been recognised as part of the reconfiguration is that patients in GM have different pathways depending on which unit or part of the city they are geographically located in, hence it has been agreed that new pathways will be designed to meet the demands and standardise care for the population served.

During 2018 the team has worked with colleagues from across the region to implement changes to the prostate pathway.

The academic credentials of the urology research team are internationally renowned: encompassing FASTMAN prostate centre, a long history of laboratory and clinical research and leading one of the world's largest prostate cancer trials (stampede). The team are also are urogenital cancer leaders within the European Reference Network eUROGEN and are recognised in research within rare cancers.

Gynaecological surgery

Established in December 2014, The Christie gynae-oncology multidisciplinary team provides services to over half the population of Greater Manchester and East Cheshire. The service has grown since its inception in 2014.

The gynae-oncology team provide surgical management to patients with endometrial, ovarian, cervical, vulval, vaginal and other rarer gynaecological cancers. As well as providing high quality traditional gynaecological surgery, the team employs a range of techniques and cutting edge technologies including robotic and laparoscopic surgery, sentinel lymph node technology and electro-chemoradiotherapy.

The team has an established track record in providing enhanced recovery, fertility sparing surgery and exenterative surgery. With surgical colleagues from urology, colorectal and plastics, the gynaecology surgeons also provide supra-radical exenterative surgery, cytoreductive surgery and complex reconstructive surgery. In 2018, the team undertook 50 joint procedures with surgical colleagues.

The team is highly regarded for its educational activities and is recognised as a training centre for gynaecological robotic surgery. The service is delivered in a networked (hub and spoke) manner ensuring that regular attendances for outpatients and diagnostics are provided closer to home, with specialist cancer surgery being delivered on a central site.

Plastic surgery

The plastic surgery team ensures we can provide integrated cancer surgery and oncological care in a multidisciplinary, one site service. The team is co-located with surgical and non-surgical oncology teams, often working in parallel or shared clinics for the provision of one stop, comprehensive cancer management with dedicated nurse specialists working across specialties for continuity of patient care. This year we have moved outpatient clinics and local anaesthetic daycase procedures to the new Integrated Procedures Unit. This allows for the most efficient and effective care, whilst optimising the patient experience.

The plastic surgery team provide two main models for delivery of care: that of a primary resection and reconstructive service and also delivering the reconstructive options for the other three surgical specialties. Similar to 2017, we have delivered almost 2,000 treatment episodes this year and

over 10,000 outpatient consultations. We undertake primary resections and reconstructions for patients with skin malignancy. This includes the provision of the Cheshire and Greater Manchester Sentinel Lymph Node Biopsy (SLNB) service, undertaking approximately 180 SLNBs per year. This element of the plastic surgery service encompasses block lymph node dissections of the head and neck, axillary, inguinal and ileoinguinal regions, undertaken for skin cancer. The latter is performed as part of a multidisciplinary minimally invasive surgery team, in order to minimise morbidity and optimise recovery and discharge. The team have also continued to look to expand the lymphedema service in conjunction with the physiotherapy team.

In addition, the team supports and liaises closely with the specialist pelvic MDT, to provide reconstructive solutions for difficult cases which would be otherwise inoperable or leave patients with suboptimal results or debilitating/chronic wounds. The plastic surgery team operates on approximately 45-50 such cases per year, including reconstruction of vulval defects utilising local or pedicled flaps, pelvic obturation and perineal closure following total pelvic clearance or abdominoperineal resection, pelvic brim resections and abdominal wall reconstructions, abdominolipectomy to aid pelvic access and optimise wound healing.

As part of the overall provision of reconstructive services, the team performs microvascular free tissue transfers, allowing reconstruction of large or complex defects by the provision of tissue from distant donor sites. This service saw growth in 2018-19, with an expected increase to 35 cases from the 25 that were undertaken the previous year.

Clinical Support Services

Clinical Support Services play an important role across the Trust, working closely with other professionals to ensure our patients' and families physical and emotional needs are met. Services offered are both clinical and non-clinical.

Clinical services

Nutrition and dietetics

This service provides evidence based treatment to inpatients, head and neck outpatients and the upper GI and gastrostomy drop-in-clinic. The team also lead in the development of nutrition policies and standards, regular audits and research and engage in patient satisfaction work to help improve outcomes, improve the patient pathways and ensure compliance with national standards and guidance.

We recently improved the management of nasogastric and gastrostomy tube management with improved training, a self-assessment form and placement chart.

We have demonstrated compliance with the national guidance framework 'the British Dietetic Association (BDA) nutrition and hydration digest'.

Working closely with Salford Intestinal Failure Unit (IFU) we have successfully implemented a remote discharge home parenteral nutrition (PN) pathway, and the results have been shared nationally by the British Association of Parenteral & Enteral Nutrition (BAPEN) and the European Society for Clinical Nutrition (ESPEN). This has provided the opportunity for greater research and enhanced the patient experience. This research will be published.

Physiotherapy/Occupational therapy (OT)

Physiotherapy and OT support patients in an inpatient and outpatient setting to return to their earliest independence often by a rehabilitation programme involving movement, exercise and functional activities. They are involved in discharge planning and ordering specific equipment or adjustments to prolong the patient's independence wherever possible in the home setting or arranging intermediate care.

The physiotherapists also work closely with other medical professionals in providing advice and rehabilitation for metastatic spinal cord patients and patients who have respiratory problems including those on the Oncology Critical Care Unit.

Recently the service has introduced a staffing system to meet our objectives of working towards seven day working.

In the last year, physiotherapy has expanded to provide a lymphoedema service to clinics covering Bolton, Stockport and East Manchester, which has proved to be extremely successful.

Speech and language therapy

We provide a speech, language and dysphagia service to our inpatients, head and neck team and the new proton beam therapy outpatient service. The team has been working hard to ensure the new national patient safety alert IDDSI is fully implemented across the Trust.

Transport and interpreters

The transport and interpreter services are integral to operational services across The Christie. The transport service provides non-emergency patient transport to patients who have no other means to travel to our services or have a medical reason which would affect their ability to drive or use other means of transportation.

The interpreter service continues to provide an enhanced interpreter service consisting of face to face, telephone and British Sign Language support to patients who have difficulty understanding English or have a hearing impairment.

We continue to work with service providers to improve our services and to ensure patients receive the best experience.

Living with cancer

The living with cancer service focuses on the physical and emotional impact that cancer can have on people. The department offers an array of support services including wigs, an art room, the Cancer Information Centre and the Chaplaincy.

Cancer Information Centre (CIC)

The cancer information centre provides a drop in service to offer support to patients and visitors. This can be in the form of listening to their concerns, signposting them to relevant support services or providing relevant information verbally and in booklet format etc. A key part of the role is to support patients experiencing hair loss through the side effects of treatment, providing them with emotional support, information and advice, as well as enabling them to access the wig room and other services to manage the practical element of hair loss. The wig room provides a drop in service five days per week and patients can usually collect their wig the same day.

The centre also provides additional support in arranging weddings on site for our end of life patients. One member of staff was nominated for an unsung hero award and the centre was twice featured as a Christie Hero for the NHS 70 celebrations.

Chaplaincy

The chaplaincy team is committed to supporting patients and visitors at a time when they may be experiencing challenges around their beliefs and identity. They are trained to help people of faith, or any individual, with questions around spirituality, meaning and value. They are available for patients, visitors, staff and volunteers. The chapel and prayer room are always open and may be used for prayer, worship, meditation or quiet time. The multi-faith space in the chaplaincy suite is suitable for all faiths as well as those who do not have a particular religious belief.

Art room

The art room offers patients and their care givers the opportunity to spend some time in a supportive and non-clinical safe environment, where they can experience a period of rest within which they are able to forget real world illness or work related pressures and reaffirm a confident sense of self-esteem, potentially learning a new skill.

Complex discharge team

The complex discharge team consists of an MDT including nurses, occupational therapist and social workers who work closely with other multi-disciplinary professionals to support and facilitate discharges for patients with complex health and social care needs. These can be patients who may wish to return home with nursing needs or go to a nursing home or hospice.

The team provide practical and emotional advice to patients and their families to help them make the right decision to ensure patient needs and choice can be accommodated, whilst maintaining a safe discharge.

Over the past three years, we have been able to provide an adult social work service on site, working in collaboration with an external organisation. The service provides advice about services which are available in the community setting and allows our patients to voice their preference for packages of care that meet their needs. This is an essential service for patients and their carers, as it provides support, advice and information about the services available within the community, as well as assisting patients who are in a less fortunate position, for example, homeless patients or those seeking asylum. The

Social workers also work closely with the safeguarding, psycho-oncology and dementia teams to provide advice and assessment.

Complementary health and wellbeing

Our award winning complementary therapy service supports patients and carers through all stages of their cancer journey. Diagnosis and subsequent treatment can bring on many emotions and symptoms including stress, depression, fear, worry and anxiety induced nausea. It is a specialist service which is unique nationally due to its size, diversity, the level of integration it has with acute cancer services and the level of activity it has within clinical, research and educational fields.

The team has multiple skills and offers an array of therapies to support and alleviate some of the symptoms experienced above, which are the side effects of treatment and illness. It also accommodates the health and wellbeing smoking cessation service.

The service has recently appointed several new roles and continues to be supported through The Christie charity.

Providing services to the pre-operative surgical team has been a great success this year with much improved patient outcomes and compliance.

Psycho-Oncology Service

We deliver an adult and later life liaison psychiatry inpatient and outpatient service along with an outpatient psychology, counselling and psycho-sexual therapy service. We support all other clinical teams with the management of psychiatric illness and behavioural disturbance be it pre-existing, arising as a consequence of diagnosis and treatment or as a direct consequence of disease processes. We provide teaching and supervision throughout the Trust. Through our programme of engagement events and participation in trust events, we promote mental health and psychological wellbeing. Our aim is to ensure parity of esteem for mental health problems and psychological difficulties with cancer-related physical symptoms.

We are a unique service offering integrated psychiatric and psychological care to our patients.

In the last 12 months, we have delivered 2,442 outpatient contacts and 1,217 inpatient contacts.

Liaison psychiatry

We provide liaison psychiatry input to the inpatient wards for adults and manage pre-existing mental illness and psychiatric symptoms arising during or as a consequence of cancer diagnosis, disease process and treatment. This includes risk assessment and management of those with suicidal ideation and thoughts of harm to others along with supporting the medical teams and ward staff in looking after these patients. On the wards, we assist with the management of behavioural disturbance resulting from the disease process, delirium or psychiatric diagnoses. The team is also involved in complex capacity and best interest decisions, supporting the clinical teams and work closely with safeguarding and the complex discharge team. We also ensure continuity of psychiatric care post discharge.

The team also provide outpatient psychiatric assessment and follow up for our patients, liaising with their local services as necessary. We support other outpatient areas and clinics in the management of those with psychiatric symptoms.

We also attend ward multi-disciplinary meetings to support staff with the management of patients with mental health problems and to work with them to provide early intervention, if required.

Counselling and psychology

We provide evidence based psychological therapies including counselling, cognitive behavioural therapy, cognitive analytical therapy and psychotherapy to outpatients at all stages of treatment and follow-up. Our clinical psychologist is an expert in the treatment of complex trauma. A consultant in psycho-sexual medicine attends twice a month to provide therapy.

Dementia and later life liaison services

The later life mental health liaison service offers clinical assessment and support in both inpatient and outpatient settings for those patients aged 65 and over experiencing mental health issues. This service also contributes to discharge planning.

We also offer a service providing support for our patients with dementia or memory issues who are receiving treatment. This is a unique nationally recognised service that provides dementia and oncology education both internally and externally. We showcase our work at conferences locally, regionally and nationally.

The service also provides clinical assessments, practical advice and support for our patients with dementia and their carers and in addition patients having cancer treatment who care for people with dementia. Staff also have the opportunity to seek advice around any concerns or personal issues they may have in relation to dementia and their loved ones with the aim of reducing their stress and improving their wellbeing.

As a result of research taking place around cancer and dementia in collaboration with The Christie and Manchester University, various papers were published in 2018 around this unexplored area of work.

Supervision

The psycho-oncology team provide clinical supervision to individuals and groups of staff including specialist nurses and AHPs, complementary therapy and information centre staff. We deliver psycho-sexual supervision to staff working with patients who present with sexual difficulties.

Education

The team also delivers a teaching programme entitled Introduction to Psychological Aspects of Cancer for staff banded 1 to 6. We deliver Level 1 and 2 psychological support training to trust staff.

We contribute to external and internal study days including the Postgraduate Certificate of Oncology Course and the Postgraduate Certificate of Breast Oncology Course (both at the University of Manchester) and contribute to the Trust's patient health and wellbeing events and to patient support groups.

We are members of the Psychological and Mental Health Pathway Board, the Trust's Healthy Workplace Steering Group and the Schwartz Round Steering Group.

Mental health Promotion

We regularly run events to promote the mental health of patients, staff and visitors.

Acute Oncology Services

We deliver a comprehensive acute oncology service. Ambitious performance standards and new ways of delivering cancer care continue to increase acute patient episodes and the requirement to care for a more diverse set of cancer toxicities.

We deliver an acute medicine service which has proved transformative in improving patient care across the Trust. Working in collaboration and partnership under a service level agreement has enabled enhanced level 3 critical care support, as well as the on-site provision of acute medical specialty input. The majority of our patients are ambulatory. However, patients with acute problems relating to their cancer or cancer treatment, are admitted via the acute oncology management service (AOMS) to the oncology assessment unit (OAU) staffed by acute physicians, oncologists and acute oncology nurse practitioners.

Acute oncology management services (AOMS) and metastatic spinal cord compression (MSCC)

The acute oncology management service is a 24 hour telephone helpline service (Hotline) that is available to our patients, their carers and professionals for advice management on the side effects and complications of cancer treatments. The hotline supports the enhanced supportive care clinic by directly booking patients into the clinic. This option has helped to reduce the need to contact GPs. The past year has seen the incorporation of the MSCC into AOMS service as part of a network wide provision of care, advice and support for patients with spinal cord compression due to cancer.

Oncology critical care unit (OCCU)

The eight bedded mixed level 2 and level 3 critical care unit provides specialist support for nearly 700 admissions per year, following major surgery or patients suffering from complications of cancer or its treatment. Activity rises year on year by 10%.

Enhanced supportive care (ESC)

Over the last 12 months, we have continued to work towards the development of an ambulatory care setting to transform our acute services and unplanned care.

The ESC model continues to offer patients rapid access to immediate specialist oncology acute or supportive care for any of our patient presenting with problems due to their cancer, or cancer treatment.

Oncology assessment unit (OAU)

All unplanned admissions are routed through the oncology assessment unit (OAU). The demands placed on the OAU have increased dramatically over the past few years with changes in practice for admissions, wider ranges of treatments being given in an outpatient setting, more complex patient demographics and advances with exciting new treatments in R&D and surgery.

Pre-operative assessment

The anaesthetic high risk pre-operative assessment clinic has continued to develop its capacity to provide assessment, optimisation and risk stratification for patients who are due to undergo surgery. To aid this we have developed the UK's first virtual surgery school that aims to prepare patients for surgery by working with patients to reduce the incidence of postoperative complications. he success of this has attracted outside agencies who are in discussions about linking to the Christie Virtual Surgery School. Future developments include the introduction of cardio-pulmonary exercise (CPEX) and lung function testing on site. The aim is to aid patient assessment and pre-operative optimisation and prevent the delays currently experienced with patients having to attend other hospitals for these investigations. We are working to develop a pre-operative anaemia clinic to diagnose and treat pre-operative anaemia to improve patient safety and reduce transfusion requirements.

Radiology

The Directorate of Radiology is responsible for the service delivery of MRI Scanning, CT Scanning, x-ray, fluoroscopy and interventional radiology, ultrasound and for PET-CT reporting. The department currently supports 24 disease related clinical Multidisciplinary Team Meetings (MDTs) with each MDT having a lead consultant radiologist

Radiology reporting turnaround times continues to be met in the backdrop of increased demand across the majority of imaging modalities. The continued increase in imaging is a local and national trend. The directorate continues to run under its establishment for trained radiographers due to a national shortage of this staff group. To mitigate against this the directorate is undertaking a skill mix review to determine future recruitment plans and succession planning.

A means to try to manage demand and ensure patients are not over-exposed to imaging radiation has seen the directorate and clinical stakeholders develop a number of imaging protocols which have been incorporated into the Trust Clinical Web Portal (CWP). The system reminds clinical referrers of the agreed protocols prior to referring. Work to implement the protocols for other disease groups is continuing.

We support a number of Multi-Disciplinary Team (MDT) meetings across multiple disease groups; with activity and complexity continuing to grow. MDTS are accommodated into radiologist job plans.

We also have a vital role in supporting research at The Christie, through provision of a comprehensive biopsy service and the reporting of clinical trials scans.

CT Scanning

We have performed over 24,600 CT scans this year; an activity increase of 5.8%. Significantly, the CT biopsy activity has increased by 16.5%.

Extended working days are well established; as a means of meeting demand as well as offering our patients a choice of appointment times to fit around their personal commitments. There are plans to increase our service portfolio, with the introduction of CT guided ablation.

MRI Scanning

We have performed nearly 10,000 MR scans this year; an increase of 11%. As for CT, the department operates an extended working day. The department is reviewing options to increase scanning staffing capacity as well as achieving the implementation of a 7 day service.

X-ray

We have seen no significant change in activity for this modality. The proposed refurbishment and co-location of general radiology facilities would assist with the proposed introduction of an assistant practitioner role. We are mindful of the advanced practice role for chest x-ray reporting, and looking to train staff as staff turnover.

Interventional Radiology

Overall activity has increased by 19.9% over the last year, with over 2,000 procedures performed. One notable recent development is the conversion from femoral to radial access for suitable patients and procedures, which has allowed cases to be changed from inpatient stays to day case procedures. A planned further development is to implement same day admission for gastrostomy patients; reducing overall length of stay.

Ultrasound

We have performed nearly 5,000 diagnostic and interventional US examinations this year; an activity increase of 9.6%. We operate this service from the Integrated Procedures Unit and from the Radiology 2 facility. The directorate is to evaluate the possible introduction of non-medical sonography, as part of the skill mix review.

PET-CT Reporting

We are responsible for Nuclear Medicine reporting, including PET-CT scans.

The Academy continues to provide teaching and training modules, facilitating the expansion of further PET-CT reporters. The service has secured award of the National Contract 2. Other developments have included the establishment of a partnership board with MFT and collaboration continues between Christie, WMIC and Alliance Medical Ltd to develop novel tracers and to enhance research and clinical trials opportunities

Research and Innovation

We have built on last year's achievements and are increasingly recognised both nationally and internationally as a major contributor in practice changing cancer research. Such recognition is on the basis of the depth and breadth of its research programme and its reputation for improving patient outcomes by driving continuous clinical improvement through research and innovation.

Our research focuses on prevention and early detection, developing personalised medicine approaches that target specific therapy to an individual's cancer, through to living with and beyond cancer. We are investigating everything from understanding the molecular and cellular basis of cancer to the development and testing of novel treatments.

Partnerships

The strength of our research is built on deep and effective partnerships. Working with the University of Manchester and Cancer Research UK, under the umbrella of the Manchester Cancer Research Centre (MCRC), professionals from different disciplines work together to realise the shared aim of delivering groundbreaking research for the benefit of patients.

A series of "town hall' forums were launched in 2018 and involved such disease areas as breast, lung, prostate, skin, gynaecological and blood-based cancers. Scientists, nurses, surgeons, radiation and chemotherapy specialists, imaging and biopsy technicians, and importantly, patients came together to agree on a common challenge, that had a unique 'Mancunian' focus and would be deliverable within 2-3 years. The outputs from these events are helping to form our future research strategy.

Innovation

Our partnerships with industry – pharmaceutical and technological - are also crucial in our pursuit to develop new personalised therapies for cancer.

We are working with industry partners to create the UK's first rapid learning health system for oncology. These partnerships will mobilise and surface real-time patient outcome data, linking genomics data and patient reported feedback whilst extending its utility to the wider healthcare network. We believe these partnerships will catapult Manchester and subsequently the UK to become a leader in real world data driven research, discovering and developing the next generation of cancer medicines, realising the benefits of personalised healthcare and contributing to the fulfilment of the UK Government's Life Sciences Industrial Strategy ambition.

In December 2018, we formed a strategic precision cancer research partnership with Roche, one of the world's leading pharma companies. Over the next 3 years, Roche will fund up to £20 million to merge cutting-edge genomic technology with data analytics to accelerate the next generation of digital clinical trials in rarer cancers. The collaboration should help Greater Manchester become a leading global hub for clinical research trials.

There is considerable worldwide interest in developing new medicines based on genes and human cells/ tissues. These are called advanced therapy medicinal products (ATMP's). Such an example would be new immunotherapy medicines where human immune cells are removed from a patient, activated to certain proteins that attack cancer cells and then re-infused. A Manchester based consortium led by The Christie – iMATCH - was awarded £7m of funding from Innovate UK (an arm of government) in 2018 to streamline the assessment and processes enabling patients to access these new drugs more easily via research trials. In November 2018 it was also successful in winning an additional £2m from Innovate UK to work with other advanced therapy centres to develop a standardised approach for the collection of tissue and cell samples.

Infrastructure

The £12m National Institute for Health Research (NIHR) Manchester Biomedical Research Centre (BRC) funding for the discovery and translation of laboratory-based science into cutting-edge cancer treatments has delivered strongly through 2018/19 with the three cancer themes – advanced radiotherapy, precision medicine and prevention and early detection – making strong progress. Plans are already in place for the development of further themes, such as survivorship, in time for the next NIHR BRC competition in 2022.

The NIHR Manchester Clinical Research Facility (CRF) at The Christie which receives annual funding of c£1m for the continued development of specialised, early-phase experimental cancer research studies has supported early phase clinical research, focussing on patients taking part in clinical trials of the newest anti-cancer drugs which are not yet available as standard of care treatment. The centre continues to be the leading UK site and is still on track to become one of the top three Experimental Cancer Medicine Centres for the delivery of precision medicine in Europe by 2020, through augmentation of its scientific and clinical experimental cancer medicine capabilities by supporting over 500 patients/annum receiving investigative medicinal products.

A priority over the next few years will be to further increase the quantity and quality of clinical research and provide greater access to these trials for more impoverished and ethnically diverse communities. Our CRF team were recognised at this year's GM Clinical Research Awards for their achievements in this space.

In late 2018, MCRC was successful in a highly competitive process run by CRUK to become 1 of 6 UK and US centres to work collaboratively on large scale cancer research into earlier diagnosis. The award is worth several million pounds over the next 5 years. Its principal driving ethos is to foster earlier diagnosis of cancer via early identification of patients often before they have symptoms via new techniques/ models (eg novel blood markers and new types of selected screening). An added advantage of this international network is to be able to offer innovations from other world leading centres to our GM population earlier than would otherwise be the case.

Other highlights:

National funding was obtained in December 2018 to start the world's first randomised trial of surgery versus radiotherapy in addition to systemic anti-cancer therapy in a potentially curable type of lung cancer with the patient's quality of life (as opposed to survival) as the primary outcome measure.

The development and delivery of a world leading Patient Reported Outcomes/Experience Strategy. Working with platform supplier DrDoctor, a new system has been implemented in our clinics and new outcomes measures have been defined and rolled out. Continued development of this work will be a key priority for us over the next year.

Leadership

Our academic investment plan continues to drive the strategic recruitment of world leading academics across multiple disciplines and disease groups. Recruits over the past year include Professor Peter Hoskin, Chair in Clinical Oncology, who arrived in May 2018 and will drive the strategic growth of radiation related research. Professor Silke Gillessen, Professor and Chair in Genitourinary Oncology Systemic Therapy Research and Honorary Consultant in Medical Oncology, took up her role in July 2018. She will develop and lead a programme of novel biomarker-driven systemic Phase II trials using molecular-targeted drugs and immunotherapy as part of the Urology/STR research group.

Professor Tim Illidge, Clinical Lead in the Advanced Radiotherapy theme and programme

lead for 'New Radiotherapy Immunotherapy combinations' was selected as a new NIHR Senior Investigator and will become a member of the NIHR College of around 200 Senior Investigators.

Performance

In 2018-19 Christie Research continued to increase the number of patients on clinical trials. Excluding screening failures, there was an increase in consented patients on trials by 10% at the end of the year.

The research and innovation division continued to perform well against the NIHR study set up performance target, reducing the number of days taken from 61 days in the fourth quarter of 2017-18 to 31 days in the third quarter of 2018-19 against a target of 40 days.

In clinical trial delivery, the recruitment to the time and target performance measure increased from 33% in the fourth quarter of 2017-18 to 63% in the third quarter of 2018-19. We are also in the top 5% of all NHS Trusts for the number of studies opened during the third quarter of 2018/19 and the top 3% of all NHS Trusts for commercial studies closed during the period.

The division met the Greater Manchester Clinical Research Network (CRN) recruitment target by December 2018 and is expected to exceed this by 20% at year end.

It has increased its commercial income by 28% from 2017-18 and remains the biggest oncology commercial clinical trials centre in the UK.

In multiple clinical trials, The Christie has recruited the first global and UK patients and been the top UK and global recruiter.

High impact patient case studies

Richard Jackson

Richard Jackson (50), a primary school head teacher from Chester was diagnosed with malignant melanoma in 2003. Despite treatment, his cancer returned three years later and had spread to his chest. He was given between six and nine months to live. The news was devastating for Richard and his wife Judith who had a young family at the time.

We added him to a trial for an exciting new immunotherapy drug as the sole patient under the compassionate use programme.

"The results were remarkable," said Richard. "Within 24 hours of my first treatment, Judith started to notice the huge lump on my neck visibly shrinking. To see it disappearing was miraculous."

Now more than ten year's cancer free, the trial has enabled Richard to see children Archie (15) and daughter Mabel (12) grow up. "I have lived to tell my story and see things I should not have," says Richard. "I've taken my son to watch Manchester City, my daughter to dancing lessons and even watched England in a World Cup semi-final for the second time in my life!"

Richard's consultant, Dr Paul Lorigan added: "We've gone from immunotherapy being a novel but promising experimental therapy through to it being a standard line of treatment for some melanoma patients. Prior to 2010, the median expected survival for someone with advanced melanoma was just 6 to 9 months, now it is 30 to 36 months, with some patients being long term survivors and potentially cured."

Barbara Stojkovic

Barbara Stojkovic, aged 69, a retired secretary from Birmingham, was diagnosed with ovarian cancer five years ago. She was referred to The Christie early in 2017 because her tumour wasn't responding well to conventional chemotherapy.

The first trial Barbara was placed on proved to be unsuitable for her and doctors decided she would be an ideal candidate for the TARGET trial.

The TARGET trial involves the analysis of DNA from a patient's tumour tissue and blood sample

to identify the faulty gene or genes driving their cancer. If a faulty gene (or mutation) is found, doctors may be able to match this up to a treatment directed specifically against that mutation, usually as part of a clinical trial.

Barbara was genetically matched to a 'Wee1 inhibitor', a drug which induces damage in cancer cells. While on this trial, CT scans revealed that Barbara's tumour had shrunk by a remarkable 57%.

Barbara later tried another drug matched specifically to her cancer. For this trial, Barbara is travelling to The Christie once a week for chemotherapy and capsules of a new drug called SRA737 to take during the week.

Barbara is currently feeling fit and well. She said: "I'm grateful to be given the opportunity to have been on three different clinical trials. The clinical trials team at The Christie gave me hope. I know I'm being treated in the right place for my cancer. The level of support and care they provide to patients is above any expectations and I am so grateful.

School of Oncology

The Christie School of Oncology continues to lead the way in the delivery of local, national and international programmes of education and training. This year has been a particularly busy period for the School with all aspects of its service seeing major developments, including involvement in a number of projects with regional and national significance.

The School remains in the centre of cancer education delivery across Greater Manchester, and this year has seen the appointment of Dr Cathy Heaven to the post of Director of the GM Cancer Education Programme.

Teamwork and partnership have been a theme for all services across the School over the last year with a range of opportunities for us to work internally and regionally to develop new initiatives. We have been keen to build relationships which help to improve the quality of service offered. This approach has been applied on a local, national and international basis leading to the development of a range of partnership opportunities.

The **clinical skills** team has contributed significantly to the work across the Trust in consolidating and developing a more strategic approach to the delivery of SACT training. This has involved working closely with clinical services, and a national organisation to support the introduction of the UKONS (UK Oncology Nurse Society) systemic anti-cancer therapy (SACT) competency passport. The development has been supported through the implementation of study days as well as the development of online learning opportunities. The team have also provided support for new roles including trainee nurse associates (TNAs).

The **medical education** team has worked closely with the University of Manchester and clinical colleagues to support the placements of Y1 physician associates. These have been well evaluated and will continue for the next academic year. This has also led to the addition of four qualified physician associates into the workforce structure and ongoing development of these innovative roles is being planned.

The **professional development** team has worked closely with all services across the Trust to facilitate the uptake of apprenticeships. This has involved supporting the development of new opportunities for both current and future staff. Alongside this, the team has worked closely with HR, Stockport and Trafford College, the Job Centre and all services to provide pre-employment placements. Other projects to meet the Health Education England (HEE) targets have included working with Manchester College in providing work experience placements for BTEC Level 3 students across a range of clinical placements.

Our **practice education facilitator** has continued to support mentors and students, working closely with clinical services and higher education institutions (HEIs). This has also involved the development of new mentors and a new placement for student radiographers from the University of Cumbria. A source of pride across the Trust is that the Oak Road Treatment Centre has been voted top placement of the year 2018 by University of Manchester Nursing students in the Recognising Excellence and Achievement Awards. This reflects the commitment across the Trust for developing our future workforce.

Work is also taking place in aligning a number of online learning systems to ensure that the School continues to be responsive to new developments in technology and support the learning and development of staff.

The **education events** team has delivered a diversified portfolio of events across the year; a particular highlight being the Greater Manchester Cancer Conference, attended by over 500 people from all clinical and patient backgrounds. This

event was a particularly important showcase for the work of the team, with excellent feedback. Another exciting event was the Enhanced Supportive Care Conference, with over 130 attendees. The team has also expanded its reach into the delivery of conferences for a range of national charities and has also continued collaborative working with the complementary therapies team and the research division, to provide a range of learning opportunities.

The Kostoris library team has also expanded the theme of collaboration through writing blogs and providing resources to support events. This ensures that events are supported through the provision of evidence based materials. The library continues to offer a range of diverse and creative approaches to knowledge service delivery, which has included reviewing module delivery to make them even more accessible to a range of staff. One interesting piece of work has been the introduction of two new projects, randomised coffee trials and the introduction of a reading group. The library is particularly excited to have received a grant to develop virtual reality education.

The **education centre** continues to provide a hub for the delivery of meetings and events. A key piece of work has been to promote the use of 'live-streaming' within the Trust. This work has included opening up accessibility to team briefing. In addition, both grand rounds and specially selected study days are now available for either 'live-streaming' or 'on-demand'. This is an exciting development across all School teams as it allows access to education from anywhere in the world. This has also included patient health and wellbeing events. The team will continue to work closely with technology enhanced learning colleagues on continuing to identify opportunities.

The **technology enhanced learning (TEL) team** is an important resource for all of the School's education work, although they particularly support the work of both GatewayC and the PET-CT projects. The regional rollout of **GatewayC** has meant a significant increase in the work of the team, alongside identifying innovative ways of delivery for all education, including the masters programmes which the School runs with the University of Manchester. The team is also an integral part of the virtual reality education bid with the library. This year has also seen the initial development of a new range of online learning opportunities under the banner of ChristieLearn!

The **Maguire communications team** has continued to deliver its programme of education across the UK, which this year has included the delivery of open access workshops in London, as well as a number of workshops in Gibraltar. The team are also working closely with a number of other projects, including GatewayC and PET-CT, alongside contribution to the online development of ChristieLearn!

This year has been a significant year for many of our colleagues, particularly in proton beam therapy. The School is really excited to work in partnership with our colleagues to support the development of the **International Proton School**. We are developing a portfolio of learning opportunities and an education space in the newly opened proton beam therapy centre.

GatewayC continues to go from strength to strength with its innovative online education programme for GPs and primary care to support early cancer diagnosis. The portal is now available across the North of England and in selected parts of the South. The team has been working hard with commissioners across the UK in facilitating take up with the use of innovative marketing techniques. Education which has been developed continues to be innovative and creative. This year has seen the inclusion of eight new modules on the system, including lymphoma, brain tumours and leukaemia, and a specific general module on

improving the quality of referral specifically developed to support early detection targets nationally.

The Christie established the **PET-CT Academy** in 2017, since then its reputation has grown nationally and internationally. This is, in part, due to the unique blended learning approach to the training of PET-CT reporters that is currently being piloted and has proven successful amongst radiologists internally and externally. Nationally there has been an increase in the use of PET-CT. Reporters internally, and across the NHS, who do not report PET-CT are choosing to upskill, some using our course.

The PET-CT Academy has also found success in introducing a new suite of face to face mandatory training for our partners Alliance Medical Ltd. Staff are now accessing communication skills and sessions on managing patients with dementia. The teams have trained over 500 diagnostic imaging staff nationally. The Academy has launched a novel blended training course for radiographers and technologists, the first phase of the course was completed in 2017 and the second phase is due to be completed in 2019. A new course for clinical assistants which tracks the patient pathways is also currently being piloted, for release in spring 2019.

The Academy is working with experts nationally and internationally to develop the most up to date training in PET-CT and continues to work on its current research projects and look for research opportunities internationally, an area the team will be focussing on in greater detail in 2019.

Our financial performance 2018-19

Our ability to take care of our patients reflects the financial health of the organisation. Every penny that we spend is used to support the people we care for so it is really important that we manage our finances well.

2018-19 was another strong year for the Trust financially, reflecting the hard work and dedication from all of our staff to ensure that services are delivered in the most efficient and effective way for patients.

Financial highlights

Our regulator, NHS Improvement, sets out a comprehensive framework to assess and monitor the financial performance of NHS trusts. Financial performance is evaluated across several financial metrics to arrive at an overall 'use of resource' score, where 1 represents the lowest financial risk and 4 the highest level of risk.

For 2018-19, The Christie achieved the best financial rating available from NHS Improvement. Throughout the financial year, we have recorded a 'use of resource' score of 1.

Performance

The financial trading results for the year ending 31st March 2019 were better than the original plan agreed with NHS Improvement.

Importantly, against the backdrop of continued resource constraints in the health service, the Trust continues to operate sustainably, whilst continuing to provide the highest levels of quality, safety and care. This is supported by the Trust's efficiency programme, which has delivered improvements of £7.8m in 2018-19.

The Christie charity is a critical part of the organisation's overall financial wellbeing. In line with our accounting policy, we are required to consolidate our accounts with those of The Christie charity. This means that we present Group accounts which combine the charity and the Foundation Trust alongside the Foundation Trust's individual accounts.

Our performance for the financial year ended 31st March 2019 is shown overleaf.

Performance for the financial year ended 31st March 2019

	Group			Trust		
	2018-19 actual	2017-18 actual	Year on year change	2018-19 actual	2017-18 actual	Year on year change
	£m	£m	£m	£m	£m	£m
Total income	336.8	343.4	(6.6)	335.8	341.3	(5.5)
Total operating expenditure (excluding depreciation and net impairments)	(271.9)	(250.5)	(21.4)	(272.2)	(250.5)	(21.7)
EBITDA*	**65.0**	**93.0**	**(28.0)**	**63.6**	**90.8**	**(27.2)**
Gain / (loss) on revaluation and disposal of investment assets	(1.8)	0.0	(1.8)	0.0	0.0	0.0
Gain / (loss) on disposal of assets	(0.2)	0.0	(0.2)	(0.2)	0.0	(0.2)
Depreciation and amortisation	(14.2)	(11.5)	(2.7)	(14.2)	(11.5)	(2.7)
Dividend	(7.4)	(7.2)	(0.2)	(7.4)	(7.2)	(0.2)
Net finance charge	(0.6)	(0.7)	0.1	(1.0)	(0.8)	(0.2)
Corporate tax expense	(0.1)	0.0	(0.1)	0.0	0.0	0.0
Share of Joint Venture (equity method)	5.9	5.1	0.8	5.9	5.1	0.8
Retained surplus (before exceptional items)	**46.5**	**78.7**	**(32.1)**	**46.8**	**76.4**	**(29.6)**
Exceptional items**	(18.0)	(7.7)	(10.3)	(18.0)	(7.7)	(10.3)
Retained surplus / (deficit)	**28.5**	**71.0**	**(42.4)**	**28.8**	**68.7**	**(39.9)**

* EBITDA is earnings before interest, tax, depreciation and amortisation
**Exceptional items represent building asset impairment and reversal of impairments

The results represent increasing levels of activity, improved efficiency and cost control across all areas of the organisation. The financial position was also improved by additional resource from the NHS Provider Sustainability Fund (PSF) of £26.6m, which was made available to trusts who exceeded their financial control total.

Activity and income

The Trust receives the majority of its income for delivering patient care, which equated to £238.3m in 2018-19. Of this total, the Trust received £200.5m during the year from its principal commissioner, NHS England, and £30.0m from clinical commissioning groups. Total clinical income has increased by £20.6m (9.5%) over the last 12 months. This represents a significant investment by our commissioners to provide additional cancer treatments and the best safety and quality of care available for the population we serve.

Provision of goods and services

Section 43(2A) of the NHS Act 2006 requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes; The Christie NHS Foundation Trust has met this requirement. Any surplus derived from the limited diversification of income has helped support the Trust in delivering high quality healthcare services for our patients.

Value for money and improved efficiency

Our total operating expenses for the Trust, excluding depreciation, amortisation and impairment, increased during the year to £272.2m (£250.5m in 2017-18). Of this, £132.2m was spent on staffing, ensuring we continued to attract and retain over 282 doctors, 698 nurses, 615 scientific, technical and therapeutic staff and 207 health care assistants and support staff.

Over 24% of our total operating expenses were spent on chemotherapy and other cancer treatment drugs and has helped ensure our patients continue to have access to the latest and most effective treatments.

The surplus was achieved by delivering £7.8m of efficiency savings. These have been achieved through a combination of quality led service change, improved productivity, procurement and a reduction in wastage.

Quality Innovation Productivity & Prevention (QIPP)

QIPP is a national scheme supported by NHS England which is recognised as the major vehicle to encourage organisations to transform their services and deliver the savings required by the NHS. In 2018-19 the Trust delivered £2.3m of QIPP savings which were passed directly on to our commissioners through schemes such as the Improving Access to Medicines Scheme which saw the transfer to generic and biosimilar drugs for patients on certain chemotherapy treatments.

Joint ventures

The Christie Clinic LLP was formed on 15th September 2010 and is a joint venture partnership with HCA (HCA International Limited) for the provision of private oncology activity. In 2017-18 the LLP was renamed The Christie Private Clinic LLP. The joint venture profit share in 2018-19 is £5.7m, as per the terms of the LLP membership agreement.

In June 2014 we entered into a joint venture partnership with Synlab UK, the UK division of one of the largest European independent providers of pathology services. The Christie Pathology Partnership LLP will allow the Trust to develop further its pathology services drawing on the European expertise of Synlab UK combined with the established cancer expertise at The Christie. The joint venture profit share in 2018-19 is £0.1m, as per the terms of the LLP membership agreement.

Subsidiary companies

On 11th December 2017, The Christie Pharmacy Limited (Company Number: 11027496) was formed, to provide pharmacy dispensing services to the Trust. The company is a wholly owned subsidiary of the Trust and its financial performance is included in the consolidated group accounts.

For 2018-19 the principal impact for the group has been a financial surplus of £0.3m, which is in line with the Trust's expectation.

Charitable funding

We are fortunate to be supported in our activities by The Christie charity. These funds are administered by a separate charity for which the Board of Directors acts as corporate trustees. The charity is considered a subsidiary and

therefore there is a requirement to consolidate its accounts with that of the Foundation Trust. The charity accounts will also continue to be reported in its separate annual report.

Over the past 12 months, we spent £4.4m on capital projects from charitable grants and we received a charitable revenue contribution of £8.0m to enable us to enhance our services.

Value of our buildings and land

All property, plant and equipment are measured initially by cost. Our land and building assets are subsequently measured at fair value in line with our accounting policies. As part of this, the Trust's land value is based on an alternative site methodology. To ensure an independent and fair value of our estate we engage with the District Valuer, who reviews our asset values. The proton beam therapy facility was brought into use in a year and was impaired by £16.6m. Together with a decrease in building value indices, there was a total downwards net revaluation of our assets of £17.4m in 2018-19.

Capital investment

The Trust has continued to invest in its estate and equipment assets with another comprehensive capital investment programme for 2018-19.

The Proton Beam Therapy facility was completed in 2018-19 and is now fully operational. This development provides patients from across the region and beyond with access to the latest and most precise forms of radiation treatment. The facility also houses our newly opened outpatient department, which provides state of the art clinical and non-clinical space.

The development of an ambitious integrated research facility on the site of the fire damaged Paterson research building is progressing at pace. The Trust is working in partnership with the University of Manchester and Cancer Research UK to ensure Manchester remains at the forefront of research to support better outcomes for patients. Demolition of the previous site is underway, and plans are being finalised for the new development, which will be completed in 2021-22.

The Trust has also replaced major diagnostic equipment, including a PET-CT. In addition, we have continued to invest in information technology and the estate maintenance programme that ensures our infrastructure continues to support effective patient care.

Investment	NHS Funded £m	Donate £m	Total £m
Land and Building	0.0	0.0	0.0
Assets under Construction	29.9	4.4	34.3
Plant and Machinery	5.8	0	5.8
Information Technology	0	0	0
Total	35.7	4.4	40.1

Cash flow and balance sheet

We ended the year with a cash and investments balance of £103.9m (£158.1m for the group). This is an increase on the previous year and reflects the balances generated through operational performance.

Public sector payment policy – better payments practice code

In accordance with the Better Payments Practice Code and government accounting rules, the Trust's payment policy is to pay creditors within 30 days of the receipt of the goods or a valid invoice, whichever is the later, unless other terms have been agreed. The Trust paid 96% of non-NHS trade invoices by value within 30 days.

Trading environment and financial risks

Whilst we have continued to maintain a healthy financial position during 2018-19, there have continued to be significant changes in the external economic and political environment which will impact on our operational and strategic plans for the future.

The implications for lower growth in health spending are continuing to be seen with an inherent efficiency factor of 1.1% in the income received from commissioners for 2019-20. Our financial strategy for 2019-20 is to continue to focus on delivering productivity and efficiency improvements and to reduce costs. Being a financially sustainable organisation is critical to support the delivery of safe services and deliver the investment required to fulfil our ambitious capital and programme.

In 2019-20 the Trust plans to achieve a £9.390m financial control total in line with the target set out by NHS Improvement. This is supported by the Provider Sustainability Funding of £1.130m. Achievement of this target is contingent on delivering a CIP target of £8.670m, whilst taking account of the investment requirements around staffing and non-pay required to deliver the anticipated activity growth and continue to meet all our performance targets.

Following the change in commissioning arrangements for the Trust in 2017-18, the main commissioner contract for all our English services remains with NHS England. CCGs responsible for treatments that are not considered specialist will commission services from The Christie on behalf of their populations. Our contract arrangements are based on the principle of equitable risk and reward with commissioners, which we have had in place over a number of years. This principle mitigates financial risk for both parties and enables us to develop and implement efficiency schemes that benefit the Trust and commissioners.

With the creation of Greater Manchester Health and Social Care Partnership, our future commissioning arrangements will change again and we are working closely with partners across the area to understand the impact for 2019-20 and beyond. We are hopeful that the strong working relationship we have with NHS England and local commissioners continues with the new commissioner framework and any further service changes.

Our partnership with HCA International in The Christie Private Care continues to perform well and our forward plans anticipate further growth which will secure support for our NHS services.

Going concern

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operation for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

External audit services

Grant Thornton LLP was appointed as our external auditor on 1st October 2017 for a period of three years.

We incurred £61k, (£93k for the group) in audit service fees in relation to the statutory audit of our accounts for the period ending 31st March 2019.

Non-audit services provided by the auditor

Our external auditor provides non-audit services in limited circumstances in accordance with a policy recommended by the audit committee and approved by the council of governors. Auditor objectivity and independence are safeguarded for any non-audit services provided by the auditor by

limiting the fees arising from such work in any one year to £50k + VAT and ensuring that different auditors carry out the work.

Grant Thornton LLP did not provide additional services relating to any non-audit related services during 2018-19.

Countering fraud and corruption

The board of directors attaches significant importance to the issue of fraud and corruption and has continued its increased investment during the year. Reported concerns have been investigated by our local counter fraud specialists in liaison with the NHS Counter Fraud and Security Management Service and the police as necessary.

We work hard to maintain an anti-fraud culture and have a range of policies and procedures to minimise risk in this area. A number of events were held over the year to highlight how staff can raise concerns and suspicions. As part of our mandatory training programme, we ask staff to complete anti-fraud awareness training.

Statutory framework

This is the twelfth set of annual financial results prepared since we became a foundation trust on 1st April 2007. Consistent with our statutory status, these accounts have been prepared under a direction issued by the independent regulator NHS Improvement.

In undertaking NHS business transactions, the Trust has complied with the cost allocation and charging requirement set out in HM Treasury and Office of Public Sector Information Guidance.

Statement of disclosure to auditors

In accordance with the requirements of the Companies (Audit, Investigations and Community Enterprise) Act 2004, the Trust confirms that for each individual who was a director at the time that the director's report was approved, that:

- so far as each of the Trust directors is aware, there is no relevant audit information of which the Trust's auditor is unaware; and
- each director has taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

For the purposes of this declaration:

- relevant audit information means information needed by the Trust's auditor in connection with preparing their report; and
- that each director has made such enquiries of his/her fellow directors and taken such other steps (if any) for that purpose, as are required by his/her duty as a director of the Trust to exercise reasonable care, skill and diligence.

A year in Focus

This year, having successfully achieved what we set out to do in our 2020 Vision strategy two years early, our new five year strategy was introduced, outlining our ambition to grow services even more for the benefit of our patients. We went through an extensive process of consultation and engagement over the course of 12 months, adapting our original plans to embrace our vision for a truly world-class cancer centre.

Our strategy at The Christie remains focussed on four key themes; Leading cancer care, The Christie experience, Local and specialist care, and Best outcomes. And we work hard to ensure everything we do is focussed on achieving our goals in these areas.

2018-09 saw The Christie once again rated Outstanding by the Care Quality Commission (CQC), making us the first specialist trust in the country to be given its highest accolade twice. The CQC described The Christie as 'a leader in cancer care' and a pioneer in developing innovative solutions to cancer care'. It also praised the positive culture, our compassionate and effective leadership, and our exceptionally kind and caring staff who 'go the extra mile to meet the needs of patients and their families.

The rating is the highest we could have been given and is testament to the dedicated, expert staff in every Christie department who work tirelessly to give the very best care and treatment to our cancer patients. Those patients are always at the heart of everything we do.

In July, we were proud to play a major role in celebrating the 70th birthday of the NHS. This gave us an opportunity to showcase some of our life-saving work nationally, and culminated with an open day, where hundreds of visitors were welcomed behind the scenes to view some of the facilities which help make us world leaders in cancer care.

This year, we were also proud to welcome NHS England Chief Executive Simon Stevens to view our new proton beam therapy facilities. After many years in preparation, we were delighted to finally start treating patients at the end of December. We have an expert team in place and are proud to be the first NHS organisation in the UK to provide this specialist cancer treatment.

We were also delighted in February to mark the completion of a brand new £7m outpatient facility at The Christie, which now offers a more accessible, spacious and comfortable environment for the 95,000 appointments that take place there each year. Fully funded by The Christie charity, it aims to offer patients a more seamless experience with more consultation rooms, improved access to testing facilities and a new appointment system with self-check-in screens, helping to reduce patient waiting times and increase capacity.

We also reaffirmed our commitment to providing specialist cancer care local to patients' homes where possible, by continuing to expand our chemotherapy outreach services. In July we opened a new chemotherapy and blood service in Winsford in Cheshire, which will save many of our patients a round trip of up to three hours to our main site in South Manchester.

We also announced our plans to embark on a fundraising project to build a state of the art new cancer centre in the heart of East Cheshire. The new Christie Cancer Centre will be built in the grounds of Macclesfield District General Hospital, providing Christie cancer care closer to home for more than 1,500 new patients a year.

The new centre will transform cancer care in East Cheshire, bringing together essential cancer services into one purpose-built unit delivering local specialist access to radiotherapy, chemotherapy, holistic support and information services, outpatient care, palliative care - and for the first time, clinical trials, meaning patients in

East Cheshire will be among the first in the country to access new treatments as they become available.

Meanwhile our plans for a new research centre to replace the Paterson building gathered pace. A public consultation was carried out to share our ambitious proposals for a new world-class cancer research facility. The new centre will integrate researchers and clinicians in one building, understanding and tackling the diversity and complexity of cancer to drive better outcomes for patients with the very latest discoveries and breakthroughs. The multi-million pound development will be led by The Christie on behalf of the Manchester Cancer Research Centre (MCRC), an internationally renowned and hugely successful partnership between The University of Manchester, Cancer Research UK and The Christie.

In addition to housing the Cancer Research UK Manchester Institute, the new development will be a major step forward in realising MCRC's ambition of becoming one of the world's top five centres for basic, translational and clinical cancer research by 2025.

The new building will also harness the potential of healthcare research within a catchment area of over three million people as part of the Greater Manchester Cancer Plan (part of the healthcare devolution project in Greater Manchester) and in partnership with Health Innovation Manchester.

Research, of course, continues to be of prime importance in everything we do.

The number of clinical trials that are recruiting patients at The Christie increased by 11 per cent during this year. Figures published by the National Institute for Health Research (NIHR) demonstrated that we recruited to 214 studies in the year ending in March 2018, compared with 193 the previous year. The figures show that the number of participants recruited to trials in the past year was 1,809, which is 31 per cent higher than the target set for The Christie by the Clinical Research Network (CRN), the NHS organisation that coordinates and supports research.

This means we remain one of the most active NHS clinical research organisations in the UK, and were ranked in the top five per cent in the NIHR's national 2017-18 research activity league table. We are ranked 10th of all the trusts in England for commercial research activity, having supported 89 commercial research studies, an increase of 22 per cent on the 73 studies it supported in 2016-17 – the fifth best increase in the country.

All of our research activity, and indeed everything else we do, is centred around patients and this year patients have once again rated The Christie as one of the top performing trusts in the country for patient satisfaction in the annual national inpatient survey published by the CQC.

The survey ranked The Christie as one of only eight acute specialist trusts to be given the CQC's top banding of 'much better than expected' by patients.

The Trust was also rated as one of only of 10 to score 'much better than expected' for medical care and one of only eight to be ranked as 'better than expected' for surgery experiences.

This year our charity has continued to play an important role in what we do, supporting the work of the Trust through its fundraising activities and delivers projects, equipment and improvements that are over and above what the NHS funds. The charity has over 50,000 supporters who helped raise £13.9m.

Everything we achieve at The Christie is only possible because of our staff and their hard work and dedication. We continue to perform well in staff surveys, with the majority of employees

saying they would recommend the hospital to family and friends.

The success of our clinicians continues to be celebrated. Professor Ranald Mackay, director of medical physics and engineering at The Christie was named by NHS England as Healthcare Scientist of the Year. The award celebrates 'an exceptional individual who has used their skills and scientific ability for a maximum patient or service user benefit, as recognised by their peers'. Professor Mackay has been instrumental in the development of proton beam therapy at The Christie.

As a foundation trust, we are accountable to the communities we serve, and as such our public members play an essential part in sharing their opinions, shaping our future and making a vital contribution to how our services are developed. We acknowledge their extremely valuable input. This report looks back on the highlights of the last 12 months, but also establishes our plans and aspirations for the year ahead. We are determined to improve and develop still further to ensure that all of our services are truly world-class.

Focusing on the people who count

The Christie is committed to involving and informing both patients and the public about every aspect of our service.

We believe that such involvement helps us provide a service that meets the needs of our patients. By listening to what people think about what we do at The Christie, we understand what is important to our patients.

As part of our commitment, we promised to:

- Provide an extensive range of information to patients.
- Recruit, inform and engage with our members.
- Have a council of governors which has representatives from our public members.
- Hold quarterly council of governors meetings.
- Keep interested members of the public well informed of developments and news through our website, the media and other communication channels.
- Have a Freedom of Information (FOI) lead officer for all enquiries under the FOI Act
- Hold our regular board of directors meetings in public.
- Publicise our complaints procedure on our website and ensure that the investigation of any complaint is thorough and prompt.
- Pursue an open and positive relationship with the media.

Seeing more clearly: Our strategy

We are proud to deliver excellent care to cancer patients from the immediate population of 3.2 million people in the Greater Manchester and Cheshire area, and to a significant number of patients from across the country in need of some highly specialised treatments.

We are able to provide a service based on expert staff and a specialised infrastructure dedicated to the delivery of cancer treatment care, research and education. Our focus and size enable us to uniquely deliver effective and efficient specialist care offering patients the best possible outcomes from our research programmes. This is enhanced by the support that we receive from The Christie charity which enables us to provide a level of care and experience for patients above and beyond what is funded by the NHS.

Our strategy describes where we want to be as an organisation in the coming years. It was developed throughout 2017/18 following extensive consultation with patients, staff, governors and our board of directors. It sets out a clear vision of how we will transform cancer treatments, care & support and improve outcomes for our patients.

Within the strategy, we set ourselves four pledges to prepare for the future. These are:

1. We will continue to lead the development of cancer treatment, research and education so that by 2025 we will be the leading organisation in the UK in reducing the burden of cancer.

2. We will build on the success of the patient and staff experience recognised by the CQC Outstanding rating. We will go further in understanding and acting upon the needs of our patients throughout and after their treatment.

3. We will further expand our networked care model and the breadth of services available in the communities to ensure fewer patients have to travel to receive the best care.

4. We will continue to offer the latest technology and develop new treatments for the future, making our data on outcomes of treatments available to the public.

We have made huge progress so far and through our ambitious strategy, we aim to further improve across these four pledges. Throughout this report, there are tangible examples of projects helping us achieve our goals and making a real difference to patient care.

Sustainability Report

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of the rising cost of natural resources. Demonstrating that we consider the social and environmental impact ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to supersede this target by reducing our carbon emissions by 60% by 2030 using 2013-14 as the baseline year.

Policies

The Trust sustainable credentials/policies are being enhanced using the new NHS sustainable development unit sustainable development assessment tool (SDAT). The SDAT is an online self-assessment tool, which uses four cross cutting themes:

- Governance and policy
- Core responsibilities
- Procurement and supply chain
- Working with staff, patients and communities

The toolkit is being used as a baseline and will allow benchmarking for the Trust. The SDAT will now be used to provide a map (i.e. actions will be derived from the requirements) to aid and support staff in updating policies to meet the new requirements, ensuring all staff move together to ensure sustainable objectives are embedded within the Trust, to meet Government, NHS and local targets/timelines, measure progress and help make plans for the future. The refreshed sustainable development committee (SDC) will drive through the objectives and obligations required.

The previous sustainable Development Management Plan (SDMP), Good Corporate Citizenship (GCC) toolkit actions/progress and the existing sustainable travel plan have already been used as the foundations for detailing progress/scoring and the SDAT will now be monitored by the SDC

Following media programs on the effects of climate change, such as Blue Planet, it is evident, particularly in the last year, that staff want to be more sustainable. The Trust acknowledges its responsibility towards creating a sustainable future for all stakeholders. The Trust will help achieve the objectives by running awareness campaigns across the four themes, promote the benefits of sustainability and embed a culture change via policy update and promotion.

Whilst climate change is at the forefront of sustainability, most recently the Trust has fully recognised its responsibilities to the local village/community, particularly the regeneration of the area. The Trust is now actively supporting the Withington regeneration partnership and has joined its membership. Local businesses such as the swimming baths/leisure centre are participating in the health and wellbeing of staff by attending special events; a real partnership is developing. Policies will be developed to ensure this process is continued and embedded.

Energy

Through 2018 and into 2019 the Trust has progressed with an energy project to identify a suitable partner to support its next phase of energy management. This will be developed through an energy performance contract to commence at the end of the current energy management arrangements in September 2019. The contract the Trust will aim to enter into will provide ambitious targets under a 'guaranteed savings model' and will ensure contract monitoring arrangements are secure for the duration of the agreement. The project will improve site resilience and reduce energy related backlog. The Trust requires an energy partnership that will address both the carbon and energy performance of the site and the potential for financial savings and carbon reduction.

Grid electricity consumption and gas use have risen throughout 2018-19 and CHP electricity generation has dropped by 8%. The increased consumption is mainly due to the addition of the PBT centre and some CHP downtime in June 2018.

Resource		2016-17	2017-18	2018-19
Gas	Use (kWh)	44,960,007	42,452,853	44,988,718
	tCO2e	9,396	8,872	8,276
Oil	Use (kWh)	0	0	0
	tCO2e	0	0	0
Coal	Use (kWh)	0	0	0
	tCO2e	0	0	0
Electricity	Use (kWh)	1,021,976	4,220,901	10,661,428
	tCO2e	528	2,181	3,018
Green Electricity	Use (kWh)	0	10476762	0
	tCO2e	0	0	0
Total energy CO_2e		9,924	11,053	11,294
Total energy spend		£1,135,103	£1,162,987	£1,826,525

Greenhouse gas emissions

The Trust is committed to its obligation to continuously improve energy efficiency and the reduction of greenhouse gas emissions. There has been substantial investment in a variety of energy conservation initiatives over recent years. The Trust's revised energy strategy, managed with the support of the newly appointed partner from September 2019, will ensure we develop strategies that deliver continuous reductions in future years. The Trust has met and continues to exceed the energy reduction objectives set out by the NHS Sustainable Development Unit's Carbon Reduction Strategy. However, the energy strategy will be further developed to meet the strict targets imposed by the Government's Climate Change Act (2008). Our focus will be on replacing the ageing plant and equipment and delivering renewable energy initiatives.

Carbon emissions were up 6% on the previous year which is due to the opening of the PBT which is expected to contribute around 31% of the Trust's overall emissions.

As the Trust qualifies for the Carbon Reduction Commitment (CRC) scheme, its liability and reporting commitments are managed in line with Environment Agency guidance. However, 2018-19 will be the final compliance year in CRC as the scheme is to be replaced by the Streamlined Energy and Carbon Reporting scheme (SECR). The Trust is not required to comply with SECR but increased Climate Change Levy charges will apply.

Designing the built environment

Our designs for new capital developments maximise opportunities to reduce our environmental impact, improve our natural environment and make ready for a change to our climate, helping us create environmentally sustainable care. We recognise the importance of delivering on this agenda through the design and build process with all projects undergoing an environmental, risk and quality assessment. Our

designers are assigned projects from our consultancy framework and have been selected to ensure that they fully develop our sustainability agenda.

Our capital planning team continues to process the capital programme while conforming to the guidelines of the toolkit, developed by the Sustainable Development Unit (SDU) to help cut carbon footprints and improve environmental performance.

Travel

We can improve local air quality and improve the health of our community by promoting active travel choices – to our staff and to the patients and the public that use our services.

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.
The Trust aims to provide methods of travel which do not have a significant adverse impact on the environment or add to problems of congestion, while at the same time aiming to reduce carbon emissions in line with relevant Government legislation and the Trust's agreed sustainable travel plan. The Christie green travel plan (GTP) 2014-2030 was prepared in partnership with Manchester City Council (MCC). The Trust has successfully achieved the modal shift targets from the previous five year plan and is committed to sustainable development. The intention of the GTP is to support Manchester City Council's carbon reduction schemes and address the Trust's commitment to good corporate citizenship.

Data to monitor progress on modal shift is obtained annually through a survey of all site users. At the time this travel plan was written the survey had only been issued to those staff on The Christie payroll, not other site users. This indicated that 34.7% of staff members commute via sustainable travel. These results were used to form the baseline against which this GTP will be measured. The new modal shift target is to aim high with the following targets for staff using sustainable travel:

- Short term (2019) - 48%
- Medium term (2024) - 52%
- Long term (2030) - 60%

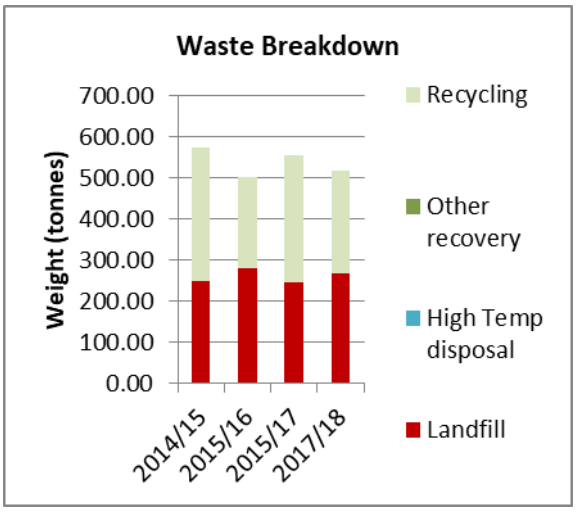
The progress of the GPT plan is monitored through quarterly meetings with an MCC travel policy officer. The survey for 2018 indicated a 41.7% modal shift. The next modal shift target in 2019 is to aim for 48% with a number of actions in place to support this target including:

- All business cases required to consider low carbon travel
- Budget for cycling facilities - £245k for showers/changing facilities
- £100k realised in 2017 to fund sustainable travel
- Weekly walking group (Walking Wednesday).
- Cycle to work scheme through Cyclescheme.
- Bicycle user group – meetings, discussion forum and mailing list
- Free bicycle training
- Secure cycle spaces (176)
- Short stay spaces (149)
- Showers (23)
- Lockers (247)
- Drying areas
- Maintenance points (3)
- Free monthly maintenance
- Free monthly cyclist breakfast
- Cycling services partnership with local supplier
- Free pool bicycle scheme (seven pedal bicycles and three e-bikes)
- Interest free season ticket loans
- Discount weekly, monthly and annual tickets

- Journey planning
- Free to staff - park & ride
- East Didsbury park & ride – free parking for Metrolink customers
- Car share scheme
- EV charge points (free to use)
- Eligibility testing (i.e. permits only issued to those identified as essential motorists)
- Quarterly progress reports presented to internal committees and external stakeholders
- Christie accessibility analysis for all parking permit holders commissioned to identify potential numbers that could switch mode
- Personal travel planning offered to employees
- Travel plan coordinator attends Transport for Greater Manchester travel choices
- Highly commended for Travel and Logistics at Sustainable Health and Care Awards

Waste

Waste		2014-15	2015-16	2016-17	2017-18
Recycling	(tonnes)	326.00	222.00	311.00	248.00
	tCO_2e	6.85	4.66	6.22	5.21
Other recovery	(tonnes)	0.00	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00	0.00
High Temp disposal	(tonnes)	0.00	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00	0.00
Landfill	(tonnes)	250.00	281.00	246.00	269.00
	tCO_2e	61.10	68.68	60.13	83.39
Total Waste (tonnes)		576.00	503.00	557.00	517.00
% Recycled or Re-used		57%	44%	56%	48%
Total Waste tCO_2e		67.95	73.34	66.35	88.60



The Trust complies with waste regulations and obtains assurance to ensure segregating and consigning waste is undertaken with a full commitment to sustainability. Systems are in place to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

Waste stream minimisation and segregation legislation and guidance have been implemented in full across our whole site. External assurers undertake an annual audit, where the Trust is reported to be meeting legislative requirements. The Trust produces data to satisfy the new NHS annual reporting manual for sustainability.

Performance is continually assessed, via key performance indicators, evidence based department surveys, monthly scorecards and key issues reports. Increases in patient and site activity are applied and continually reviewed in the monitoring process to ensure all factors are embraced. Targets are set in line with governmental and trust requirements. Achieving the ongoing targets related to CO2 emissions is crucial in the Trust's endeavour to fully embrace the NHS sustainability objectives. Achievement of the targets is met by adopting

the waste management strategy of prevent, reduce, reuse, recycle and rethink.

In June 2018, the Trust undertook a procurement tender process for clinical waste management and waste minimisation services. Key benefits of the procurement process ensured waste contractors complied with all waste, health and safety, environmental and transport legislation through focussing on the waste hierarchy of eliminating, minimising, recycling and recovery of waste. The procurement process also required contractors to address the carbon impacts related to waste through resource, efficiency, transport impacts, and disposal arrangements.

The growth of our site and patient treatments will ultimately have an overriding effect on the amount of waste generated and our capacity for waste storage. Moving forwards, the Trust will assess waste storage facilities to ensure that the obligations of the Trust to the environment are achieved in full.

Waste minimisation and management metrics are summarised in the financial and non-finance matrix of this report.

Catering and food waste

The catering department has maintained a monthly average of 6.04% food wastage over the last 12 months.

The storage of frozen and chilled provisions has been reviewed and all freestanding fridge and freezers replaced with a walk-in freezer and fridge. The newest technology, such as LED lighting with zonal passive infra-red sensors, has been introduced to ensure lights automatically turn themselves off where there is no activity.

This provides a potential saving on energy and maintenance. The monitoring of the legislative temperature requirements will be enhanced to demonstrate good working practices to our internal and external stakeholders. In addition, the blast chiller has been replaced with an environmentally friendly model using R44-8 gas.

All departmental training details within the catering department are now fully available on ESR via e-lite bites. This provides staff with the opportunity to access the training from any computer or mobile phone with the benefit of a significant reduction in paper and better use of resources.

The catering department continues to apply sustainability criteria to food suppliers and contractors, and these are reviewed when contracts are due for renewal.

The Christie charity and the catering department have worked together for a greener Manchester and launched a reusable cup to be sold for use within our dining room/coffee lounge facilities. This has been a great success and we are looking to expand the range available in the future to include a reusable drinking bottle for cold beverages and boxes for hot/cold food to reduce known recycling wastage.

Finite resource use – water

		2015-16	**2016-17**	2017-18	2018-19
Water	m^3	102248	**100661**	97065	95049
	tCO2e	35	**35**	33	33

The Trust has an obligation to provide a hygienic and safe water system for patients, staff and visitors. Whilst maintaining this system to the highest standard, the efficient use of water is carefully considered on all refurbishments and new developments.

The Trust has continued to invest in the water system to improve safety. Some of these measures will have increased water consumption e.g. Kemper flow systems and Rada thermostatic taps. This has increased general consumption in some areas but measures have been taken in others to control the use of water.

Modelled carbon footprint

The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint.

Using a scaled model, developed by the Sustainable Development Unit (SDU) in 2009-10 (see www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx) results in an estimated total carbon footprint of 28,491 tonnes of carbon dioxide equivalent emissions (tCO_2e). Our carbon intensity per pound is 117 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£); average emissions for acute services is 200 grams per pound.

Biodiversity action planning

The Christie understands that sustainable health requires not only effective medical treatments but also healthy environments.

The value of green space and nature is reflected in the Government's biodiversity strategy reflecting that people intuitively feel nature is good for them, and The Christie believes good environments make us feel better. Therefore our capital projects are designed to provide, wherever possible, accessible green space to help maintain ecosystems and to provide areas for exercise, relaxation and to promote wellbeing. It is our strategy to provide sustainable development which maximises green space to give a feel good factor to as many people as possible.

Sustainable procurement

The Trust's procurement policies and procedures incorporate appropriate sustainability practices. Significant sustainable development aspects, opportunities and risks are identified and addressed when undertaking key procurement projects.

Procurement raises stakeholder awareness of and commitment to sustainable issues emphasising to project teams the importance of considering and taking into account sustainability issues when formulating procurement requirements at pre-qualification stage, when developing specifications and at tender evaluation/award stage. This in turn encourages the adoption of suppliers that are sustainable.

In accordance with the Greening Government commitments the Trust aims to cut paper use year on year.

Year	Number of reams	+/-%
2018-19	13,101	-12.07%
2017-18	14,900	-4.93%
2016-17	15,673	+1.16%
2015-16	15,494	+2.00%

Adaptation

Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change. To ensure that our services continue to meet the needs of our local population during such events we have developed and implemented a number of policies and protocols in partnership with other local agencies these include:

- Major incident plan
  Business continuity plan
  Evacuation plan
  Pandemic influenza plan
  Heatwave plan
  Winter plan

These are all operational plans that comply with the NHS England framework for emergency preparedness, resilience and response. Risk assessments and contingency plans are in place for specific events such as flooding and heatwave.

Awards and Accolades

The Christie is internationally renowned for cancer treatment, research and education, taking pride in providing the very best care for our patients.

Our employees, in whatever type of occupation they hold, consistently work to the highest standards, with individuals, teams and The Christie as a whole often being recognised regionally, nationally and internationally for outstanding work and excellence.

We all work together as one team to deliver the highest possible standards of patient care, research and teaching, and as a result, regularly receive awards, accolades and accreditations. The selection below is just some of the awards we are most proud of during 2018/19.

Healthcare Scientist of the Year

Professor Ranald Mackay, director of medical physics and engineering at The Christie was named by NHS England as Healthcare Scientist of the Year at the prestigious Healthcare Science Awards. He collected the accolade from HRH Princess Anne at the Chief Scientific Officer's Annual Conference at the Royal Society in London. The award celebrates 'an exceptional individual who has used their skills and scientific ability for a maximum patient or service user benefit, as recognised by their peers'. Professor Mackay has been instrumental in the development of proton beam therapy at The Christie.

Patient Safety Awards

Our enhanced supportive care team was shortlisted in the national Patient Safety Awards in the Cancer Care category. 'Enhanced Supportive Care' was developed by specialists at The Christie and has since been nationally recognised and rolled out to 23 other cancer centres across the country, supported by NHS England.

The initiative encourages care teams to address more fully the needs of cancer patients – in particular, preventing and managing the adverse physical and psychological effects of cancer and its treatment. Rather than waiting until patients are in crisis, Enhanced Supportive Care ensures that patients have early access to specialist support where there are pain or symptom problems. This early intervention helps avoid the need for emergency admission to hospital.

RCNi Nurse Awards

Lorraine Turner, an advanced nurse practitioner, was shortlisted for the RCNi Nurse Awards for her work in identifying the holistic needs of patients referred to experimental cancer medicine trials. Lorraine was shortlisted in the Excellence in Cancer Research category. Her work recognises that people living with a cancer diagnosis can be affected in a variety of ways: some will have physical concerns, others may have emotional or spiritual needs, while practical and financial worries can also put significant strain on people. The project encompassed nearly 200 patients who completed a holistic needs assessment to assess their physical, psychological, family, social, religious and spiritual concerns and the effects of their illness and treatment.

North West Charity Awards 2018

The Christie charity was proud to be a finalist in the North West Charity of the year category. Our charity is an extremely important part of what we do. It supports the work of the Trust through its fundraising activities and delivers projects, equipment and improvements that are over and above what the NHS funds. The charity has over 50,000 supporters who helped raise £15.3m last year.

Macmillan Professionals Service Excellence Awards 2018

The Christie secondary breast cancer nursing team was shortlisted for the Macmillan Professionals Service Excellence Awards 2018.

People living with secondary breast cancer often live with perpetual uncertainty and high levels of physical and psychological morbidity. Unlike patients with primary breast cancer, those with metastatic disease may have a limited support structure. The team recognised this disparity in care and established a dedicated service that provides secondary breast cancer patients with a clear pathway of support.

Nursing Times Workforce Awards 2018

A nurse recruitment and retention project at The Christie was shortlisted in the best recruitment experience category in the Nursing Times Workforce Awards. The shortage of candidates with the right skills, abilities and experience in some areas of nursing has created a competitive market. The ability to deliver high quality, compassionate care depends upon recruiting and retaining the right people with the right skills. The nursing workforce is key to the success of the Trust, its values, strategic goals and objectives; therefore an effective recruitment and retention plan that complements the overall workforce plan and the Trust business plans is essential. The recruitment and retention project was established to work collaboratively, take initiative, be creative and challenge the status quo to tackle and prevent recruitment and retention issues at the Trust.

Kate Granger Award for Compassionate Care

Christie nurse Irene Budd won the Kate Granger Award for Compassionate Care in the 1970-79 category. Irene, 80, has been at The Christie since 1979 and was awarded the British Empire Medal for services to nursing in 2014.

The Kate Granger Awards for Compassionate Care are dedicated to Dr Kate Granger who died in July 2016. Kate was the founder of the globally recognised #hellomynameis campaign to encourage all health and care staff, whatever their role, wherever they work, to deliver care with compassion, recognising the individual and their care needs.

Greater Manchester's Building of the Year

The proton beam therapy centre at The Christie was named as Greater Manchester's Building of the Year by the Chamber of Commerce. Judges were impressed by the 'truly staggering' infrastructure needed to enable cancer treatment.

Care Quality Commission: Outstanding

We were delighted to announce in October that we have once again been rated Outstanding by The Care Quality Commission (CQC). The Christie is the first specialist trust to be given the health regulator's highest accolade twice. The Outstanding rating was first awarded to the Trust by the CQC following our inspection in 2016. The report says that The Christie is 'a leader in cancer care' and 'is a pioneer in developing innovative solutions to cancer care'. The rating is the highest we could have been given and is testament to the dedicated, expert staff in every Christie department and site who work tirelessly to give the very best care and treatment to our patients.

St Peter's Medal by the British Association of Urological Surgeons

Urological Cancer Surgeon Professor Noel Clarke was awarded the prestigious St Peter's Medal by the British Association of Urological Surgeons (BAUS). It recognises his sustained contributions to the advancement of urology. The St Peter's medal is the highest honour that the national association can give. It is awarded annually and is the first time in 48 years that it has been awarded to a urologist in the North West.

Royal College of Radiologists (RCR) recognition

Three of our clinicians were recognised at The RCR Fellows Admissions Ceremony. Professor Tim Illidge won the Gold Medal, Professor Neil Burnet won the Exceptional Contribution Award,

and Professor Catherine West was awarded an honorary fellowship.

Greater Manchester Research Awards

Researchers at The Christie won two awards and were shortlisted in six categories at the prestigious Greater Manchester Clinical Research Awards. A team collaboration between The Christie and Wrightington Wigan and Leigh NHS Foundation Trust won the Outstanding Contribution to Research award and research manager Alison Walker won The Debbie and Martin Special award for 'Exceptional Experiences.'

Urology Nurse of the Year

Helen Johnson was named 'Urology Nurse of the Year' at the British Association of Urology Nurses annual conference and awards ceremony in November.

Sustainable Health and Care Awards

Congratulations to our green travel team which was presented with a Highly Commended award at the Sustainable Health and Care Awards in the Travel and Logistics category.

Our generous supporters

The Christie charity provides enhanced services over and above what the NHS funds. With more than 50,000 active supporters, our charity is vital in our quest to improve cancer treatment and research for all our patients.

In the last year, there have been 1,050 community events, 9,393 sporting event participants, 1,300 corporate fundraisers, 261 legators and we had support from 57 charitable trusts. Our supporters have raised £13.9m.

We have once again managed our costs to ensure that as much money as possible goes to our patients - 81p in every £1 will go towards the high standard of treatment and care for patients and their families at The Christie.

From cakes bakes to sky dives, our supporters certainly didn't hold back this year.

This year we introduced a bungee jump at Media City and 53 brave souls jumped from a crane suspended high in the air.

We were once again Manchester City Council's charity partner for the Great Manchester Run and raised a whopping £381,000.

Supporters briskly strolled through Tatton Park at our Walk of Hope event. Just over £38,000 was raised on the night to honour the courage of those battling cancer and of those who have sadly lost their fight.

Night of Neon lit up the sky at Salford Quays when a record breaking 617 neon dressed supporters walked 10k around media city and Salford Quays. Our walkers raised a very impressive £63,000.

Our charity centre in the Oak Road main entrance has gone from strength with many supporters visiting us and purchasing our seasonal retail products.

Our carol concert at Manchester Cathedral in December saw a 678 strong audience enjoy a performance from local singer Jo Farrow and pupils from Beaver Road Primary School. Radio DJ Wes Butters was once again our host for the evening and a good festive sing song was had by all.

Our May Draper tea bar volunteers donned their aprons and served endless amounts of tea and coffee to patients. The tea bar has raised £44,000.

Our Tower Run at Beetham Tower in Manchester was a huge success this year. 217 people took part and raised £58,000, utilising every ounce of energy they had to get to the top of the tower.

Havana nights was the theme of this year's ball. The event started with an Argentinian tango from ex strictly dancers Flavia and Vincent and culminated in a fantastic DJ set from TV presenter Gok Wan. The evening was hosted by Cold Feet's John Thomson and raised £150,000.

Whilst we have achieved a considerable amount thanks to the support of our loyal and committed donors, our charity continues to have exciting and ambitious plans for the future. Work will continue to ensure our patients and their families receive the best care and treatment and that The Christie

remains at the forefront of research advancements. We only exist because of the fantastic support from all of our amazing fundraisers. We really do value everything that our supporters do, whether it's raising funds or giving up their time to volunteer.

Membership: Keeping people involved

Being a member is a way of showing your support for The Christie. Members can be patients, friends, relatives, staff and members of the public. We keep our members informed about the latest Trust news and invite them to special events, giving them a voice via the ability to elect their governor. Through the model of membership, people can influence the way we deliver our services and future strategies.

Recruitment and representation

By the end of March 2019, The Christie's total membership was 19,547 members (including staff and volunteers). Having a large group of supporters providing a wide opinion base helps us to maintain a high profile for the Trust and develop the services we provide.

We use a variety of approaches to recruit members including through our membership newsletter, as a result of community engagement by our public governors and via social media and our website.

As a specialist tertiary centre, we feel our membership should reflect both the size and diversity of the population we serve and the activities we undertake. We monitor the age, gender and ethnic mix of our membership and would like to recruit more members particularly from underrepresented groups.

The council of governors, through its membership and community engagement committee, is responsible for ensuring that we have a representative, active and engaged membership. This is achieved through our three year membership strategy and supporting annual action plan. The next three year strategy will run from April 2019 to March 2022.

Our governors have taken a proactive approach to engagement and go into the community and act as Christie ambassadors, being an open line of communication between the community and the hospital.

We have an established and increasing group of members who have joined our 'patient databank' representing patients and carers. These members are invited to take part in focus groups to give us first hand feedback about our existing services and input into the ways in which we may wish to develop our services in the future. Focus group topics discussed this year included patient fatigue, Equality Delivery System 2, patient engagement, the Goals of Care Initiative, complaints responses, the electronic patient reported outcome measures platform, radiotherapy environment and charity fundraising.

There are two constituencies within the membership, as detailed below:

Public membership

This is open to anyone aged 16 or over, living in England and Wales. There are currently 13 areas within this constituency, 11 based on local government electoral boundaries within our network with the others covering the 'North West' and 'Remainder of England and Wales'. There is one governor for all public areas except Manchester and Cheshire, which each have two. At the end of March 2019 we had 16,417 public members.

Staff membership

Our staff and volunteers automatically become members as they join The Christie. The classes within the constituency are medical staff, nurses, other clinical professional staff, and non-clinical staff and volunteers. At the end of March 2019 we had 2,948 staff members and 182 volunteer members.

Public membership statistics

Public constituencies	Number of members
Bolton	829
Bury	1,020
Cheshire	1,617
Manchester	1,654
North West	1,634
Oldham	788
Rochdale	803
Salford	1,335
Stockport	1,806
Tameside and Glossop	1,015
Trafford	1,499
Wigan	942
Rest of England	1,475
Total public members	**16,417**

Gender	
Male	2,760
Female	2,455
Unspecified	11,202
Total	**16,417**

Figures are correct as at 31st March 2019

Age	
0-16	8
17-21	18
22-49	858
50+	1,804
Unspecified	13,729
Total	**16,417**

Ethnicity	
White	3090
Mixed	36
Asian	230
Black	71
Other	28
Unspecified	12962
Total	**16417**

For further information on membership or to contact your governor, please contact:

Membership Office
The Christie NHS Foundation Trust
Wilmslow Road
Manchester M20 4BX
Tel: 0161 446 8616
Email: members@christie.nhs.uk
Website: www.christie.nhs.uk

Quality report

Part 1: Statement on quality from the Chief Executive

Everything we do at The Christie is aimed at achieving the best quality care and outcomes for our patients. I am pleased to introduce this year's quality report which once again builds on our established foundations of delivering high quality services which we were delighted were once again rated as Outstanding by the Care Quality Commission in their routine and well-led Inspections in July 2018.

Our track record of publishing information on the quality of our services continues, with our integrated quality and performance report published monthly which demonstrates our achievements on each of the three components of quality; patient experience, safety and effectiveness of care. This annual report shows the progress we have made over the past 12 months and our quality improvement plans for the future.

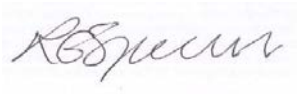
Through the on-going hard work and commitment of all our staff we continued to provide high quality care and services to our patients and their families. We continue to be one of the top scoring trusts for quality of care in the national inpatient survey. During the course of 2018/19 we have continued to work hard on presenting readily available information for our patients about the quality of our services. Information screens outside each ward and department provide live information about safe staffing levels and achievement of safety standards. Feedback from our patients on the Friends and Family Test patients has consistently scored us at over 96% as a recommendation of a place for care. During 2018/19 a quality accreditation programme for the wards continued and all of our wards have been accredited to 'Gold' standard, the best that can be achieved. All three of our radiotherapy centres have achieved The Christie Quality Mark accreditation which means our patients will have the same high standards of care whether they come to the main site at Withington or to the centres in Salford and Oldham.

The board has a quality assurance committee which scrutinises, monitors and provides assurance on our quality programmes and further assurance is given by our governors' quality committee through which our council of governors supports and advises on current quality and priorities for the future.

It is the voices of our patients and their families that really make the difference both in assuring us that we get it right most of the time and more importantly letting us know when we get it wrong and allowing us to make changes. We are extremely grateful to the many people who as health and social care partners, governors, members, patient representatives and our patients take the time to support and advise us.

The board of directors is strongly committed to building on our existing high standards of quality and we aim to maintain our reputation for excellence throughout the coming years, especially at a time when any additional resources available to the NHS remain limited. Our results show that we provide high quality care and we want to maintain this through the implementation of our quality plan for 2017-2020 which is a supporting plan to our five year strategy.

I am pleased to present this report to you and to certify the accuracy of the data it contains.



Roger Spencer
Chief Executive Officer
23rd May 2019

Part 2: Priorities for improvement and statements of assurance from the board

2.1 Quality priorities for 2018/19

1. Delivering the Greater Manchester Cancer Strategy for Living with and Beyond Cancer

The above quality priority was agreed by Greater Manchester Cancer Provider Board as part of the Greater Manchester Cancer Plan.

- The Christie will play its part in delivering the Greater Manchester Cancer Strategy for Living With and Beyond Cancer by ensuring the cancer Recovery Package is implemented for all patients by March 2019.
- The Recovery Package consists of four elements, three of which are hospital based and they are:
- Holistic needs assessment and care planning, at diagnosis and at other significant points in the patient pathway
- Treatment summaries, after significant phases of treatment
- Health and wellbeing events, providing information and support

This quality improvement is part of a two year programme which commenced in 2017/18 and will be monitored and measured quarterly through the Recovery Package Implementation Group and Management Board.

2. Improving Outpatient and Pharmacy Waiting Times for the benefit of our patients

- Through our internal patient experience surveys, review of our performance metrics and review of our Patient Advice and Liaison Service and Complaints themes we know our outpatient and pharmacy waiting times do not meet our patients' expectations or our internal quality standards.
- Therefore by March 2019 we will improve our patients experience by:
  - 80% of outpatient pharmacy prescriptions will be available within one hour
  - 80% of outpatients will have been seen within 20 minutes of their appointment time

This quality improvement will be monitored and measured monthly through the Management Board

3. Ensuring Consultant Review following Emergency Admission to Hospital

- As part of the 7 day hospital services review the Trust has been providing audit data to NHS Improvement. This dataset designed for acute trusts is no longer required for our specialist and triaged admissions. Assurance that we are meeting our standards for our patient population is still required.
- Therefore by March 2019 we will ensure that:
- 95% of patients are seen by a consultant within the first 24 hours of admission
- We have clear clinical protocols for consultant reviews within 14 hours or earlier, and for subsequent senior input
- 95% of patients have documentary evidence of a plan of care agreed with the patient

This quality improvement will be monitored and measured monthly through the Management Board.

Outcomes of our quality improvements for 2018-19

1. Delivering the Greater Manchester Cancer Strategy for Living with and Beyond Cancer

The Recovery Package Implementation project was established to fulfil the Christies ambition to fully implement the Recovery Package in line with the national ambition to ensure "every person with cancer will have access to elements of the Recovery Package by 2020" (Cancer Taskforce – Achieving world-class outcomes, A Strategy For England). To enable this, a Macmillan funded team based at Christie, has been working to implement three of the four elements of the Recovery Package.

Those elements are:

- **Holistic Needs Assessments / Electronic Holistic Needs Assessments**
- **Health and Wellbeing Events**
- **Treatment Summaries**

The fourth element, GP Cancer Care Reviews, does not fall under the remit of secondary care provision and as a result is outside the scope of this project.

Holistic Needs Assessment / eHNA

In 2018 our primary goal was to understand what existing activity was being undertaken by our Clinical Nurse Specialist (CNS) within the Christie. The provision of holistic needs assessments for patients was in itself not a new process as this was being completed on a paper form. As such, the driver here was to recognise and respect the exiting work that is going on within teams in the hospital.

To achieve this, we looked at devising a method to capture this activity via our electronic patient noting system, the Clinical Web Portal (CWP). We identified a form that all CNS's complete following patient contact, therefore being a natural place to pick up on this information. The process, while producing some good results, was not perfect in the first instance and over the course of 6 months this went through a series of iterations to increase the accuracy of the completed CWP form.

Table 1

Initial efforts to formalise data capture, prior to implementing mandatory completion:

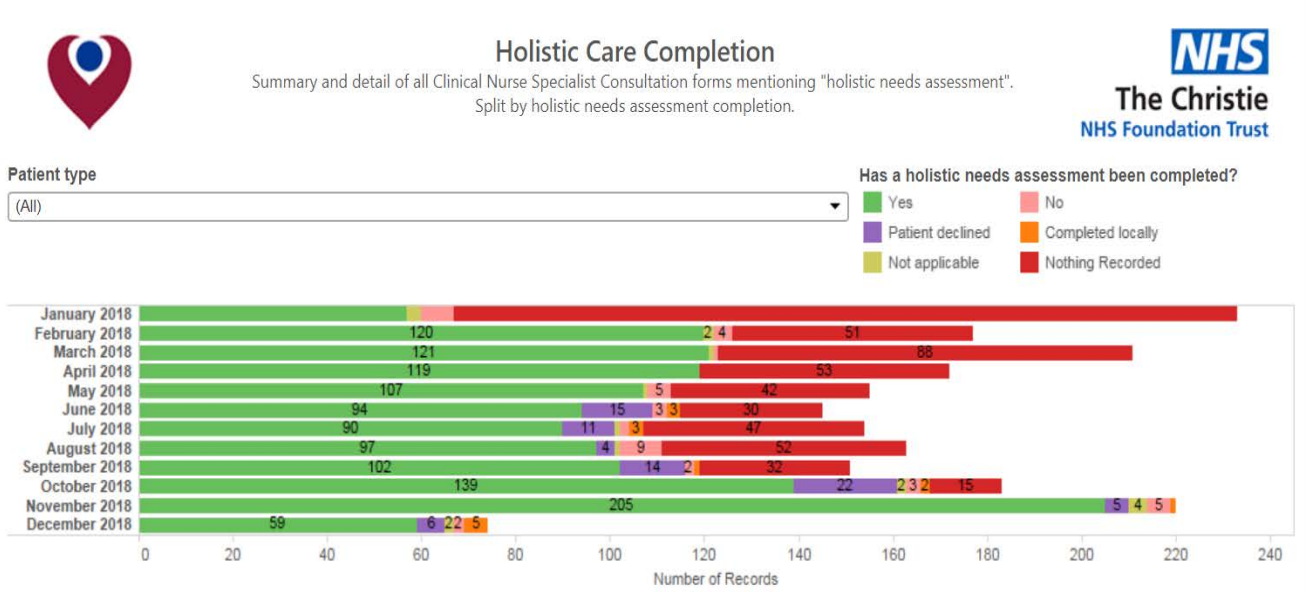
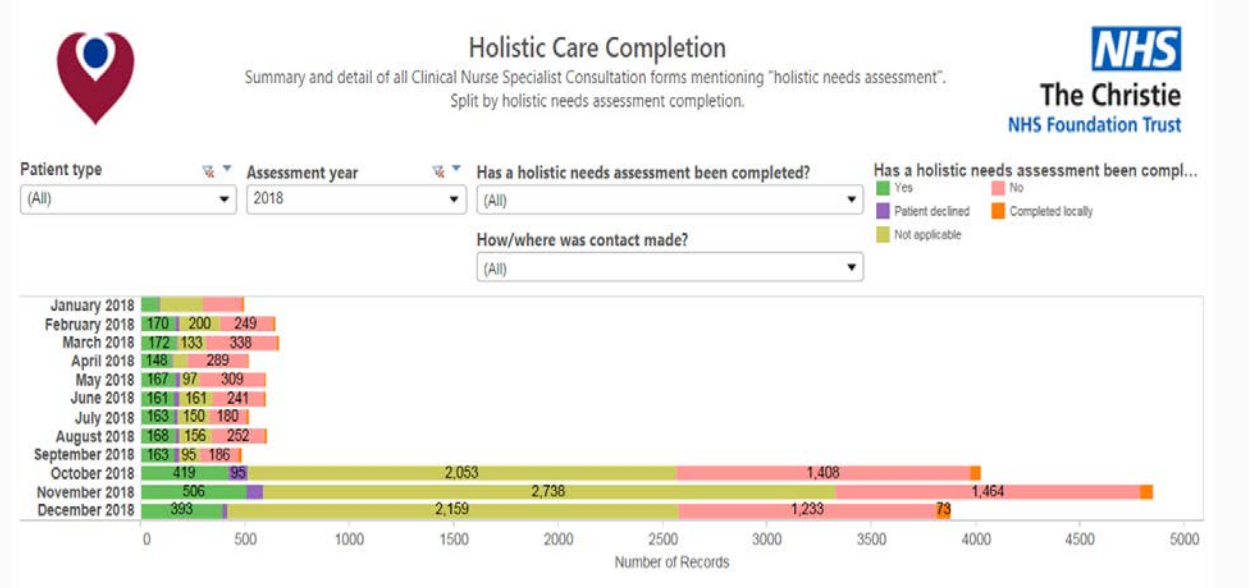


Table 2

Following a change made to how the information was entered and making the field mandatory from October 2018.



To date we have reported twice to Greater Manchester Cancer to report our quarterly results.

The data we were to report on is based from the following question. "How many HNA's have been completed?"

1st July – 30th of September 2018	
Trust:	**The Christie**
Pathway:	
Brain/CNS	1
Breast	41
Colorectal	10
Gynaecology	144
Haematology inc AML	19
Head and neck	1
HPB	0
Lung	10
Sarcoma	6
Skin ex. BCCs	76
Upper GI	0
Urological inc testicular	10
Other/unknown/ undefined	11
Total:	**329**

1st of October – 31st of December 2018			
Disease Group	**No. of HNAs completed**		
		Hepatobiliary and Pancreatic	0
Brain/CNS	133	**Lung**	77
Breast	79	**Sarcoma**	24
Colorectal	48	**Skin ex. BCCs**	112
Gynaecology	280	**Upper GI**	1
Haematology Inc AML	203	**Urological Inc. testicular**	55
Head and neck	2	**Other/unknown /undefined**	189
Total:	**1203**		

This has been achieved via the updates to our clinical noting system as well as regular updates to our CNS teams to ensure they are engaged with this process.

We have been successful in our bid to host 5 band 4 support worker roles from GM Cancer, who are going to be employed specifically to help embed our offer of eHNA's as well as supporting the other elements of the recovery package. During this period of time we are looking to understand the benefits this type of role will bring to the patient, the clinical teams and the organisation.

Health and Wellbeing Events

Since September 2018, there have been a total of 4 generic health and wellbeing events delivered by the organisation. From the outset it was made clear to all disease groups within the hospital that if there were existing disease specific events that were organised during this time, that the generic events would not supersede them.

Our goal was to host 3 generic health and wellbeing events in 2018 with a view of utilising them to shape the future of events offered in 2019 and beyond. At each event, all attendees were given

feedback forms and encouraged to complete them prior to leaving at the end of the event. We also held one event in April 2019.

Attendees were asked to complete a demographic monitoring form and an evaluation form at the end of each session.

Registered attendees: 95

Number attended: 82 (31 patients, of which 17 still undergoing treatment, 9 carers/family members, and 2 who also identified as HCPs.)

Evaluation forms completed: 45

Demographics (n = 45)

Age

Under 24	0
25 – 44	7
45 – 54	12
55 – 64	13
Over 65	13

- Gender Identity: this asked people what gender they identified with and was inclusive of trans and non-binary identities.
  26 people identified as female (including trans women), 18 male (including trans men), only one person preferred not to say.
- Sexual Orientation – 39 attendees identified as straight and only one as gay. Three people preferred not to answer.
- Religion – 21 identify as Christian, 19 reported “No Religion”
- Two people identified as Muslim and one person preferred not to say.
- Ethnicity – 37 people were white British, one was Chinese, one was Pakinstani and one of another Asian background. One person identified as from Eastern European background.
- Language – 41 people had English as their first language and only three didn’t.
- Location- Ten people attended from Manchester and ten from Stockport. Five people came from Oldham, five from Warrington, 2 from Wigan and two from Bolton, one from Staffordshire, two from Cheshire
- Disability – 37 people considered themselves not to be disabled and only 5 people thought of themselves as having a physical disability, one person considered themselves to have another experience of disability that was not physical or a learning disability.

How did people hear about the Health and Wellbeing Events?

It has been difficult encouraging patients and carers to attend the events, so we asked attendees how they heard about the events with a view to improving our marketing activity going forward.

I was asked to attend by a doctor	1
I was asked to attend by a nurse	4
I was asked to attend by a member of my clinical team who is not a nurse or doctor. *Please specify job role if you can remember*	4
I found out about the event from another patient or carer, or a friend	5
I found out about the event from the Cancer Information Centre at The Christie	12
I received a postal invitation	2
I received an email invitation	9
I am attending because my partner/friend/significant other is a Christie patient	4
I can't remember / Don't know / Did not specify	3

The Impact of Health and Wellbeing Events

Whilst numbers of attendees have been small, there is a clear, demonstrable benefit reported by patients who have attended the sessions:

36 out of 45 people said they have started to feel more confident about dealing with life after cancer, as a result of attending a health and wellbeing event, with only three people disagreeing with this statement.

39 out of 45 said that they know where to get reliable help and advice about ongoing concerns or new problems. Two people disagreed with this question.

35 out of 45 people agreed they were more likely to access information online as a result of attending the Health and Wellbeing Event.

34 out of 45 people agreed they are likely to become more physically active after attending this health and wellbeing event

Future plans and innovation

The Trust intends to continue to deliver Health and Wellbeing Events, and continue to innovate around the format, content and delivery, including the potential for "pop-up" events and linking into the recently launched GMHSC prehab and recovery programme.

Our patients voices ….

"Enjoyed this event, gave me some things to think about. I'm going to complete the Life Ahead Plan. Definitely taking up more exercise"

"Thank you for organising this event - it has made me feel a lot more reassured that the thoughts and feelings I have been experiencing are normal. I am also aware of the services available to me after treatment."

"It's been a very useful day, thank you. Patient & carer input was great, physiotherapy interaction very good, mental health sessions generated most discussion & self-help techniques very useful. Very well executed."

Treatment Summaries:
During 2018 we have continued to understand what our current activity for treatment summaries is across all disease groups and treatment modalities.

Initial problems with gathering this information were due in large part to not having a uniform data entry method on a single agreed platform. As it stands there is a mixed economy of the treatment summaries that are in use, though this is not across all disease groups. As with holistic needs assessments however, this is not "new" activity for all teams and there is evidence of some clinical teams already sending out treatment summaries to patients and GP's, though this is not a perfected method.

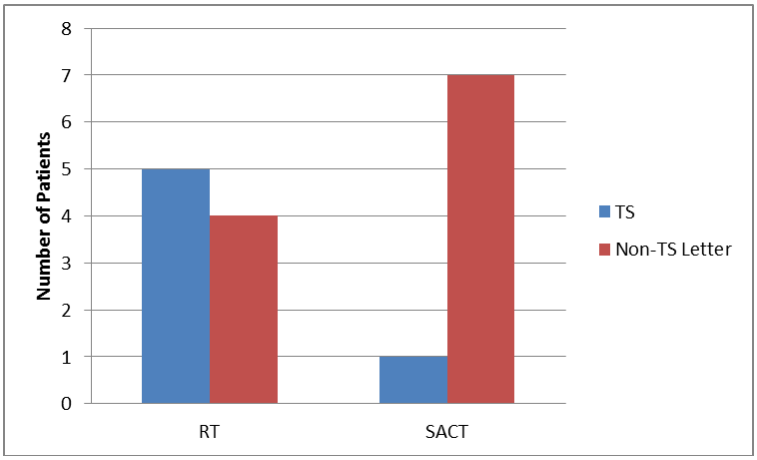
An example of this is a medical secretary typing up a dictation onto a computer template, printing this and sending it via post. Due to this method existing externally to our clinical noting system, we have no record for the volume of treatment summaries created and by which team. We are also unable to monitor the quality of the letters.

A short audit of 20 patients was carried out by our lead clinician for the implementation of treatment summaries (TS), the results are documented below.

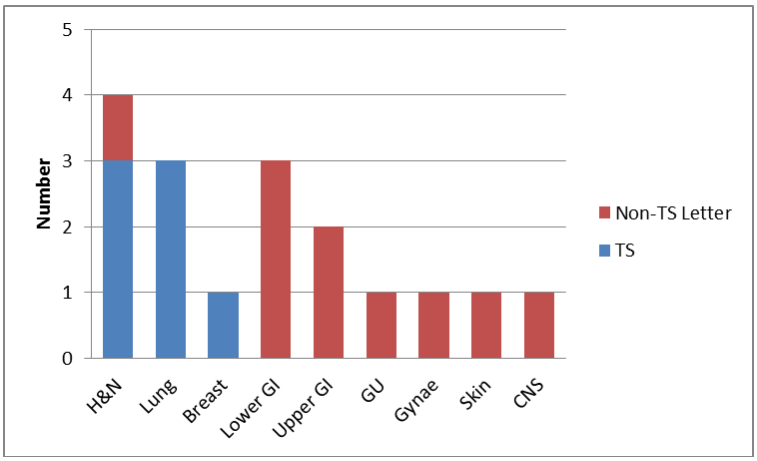
Method:

- Sample: 20 patients completing treatment Nov 2018
- Standards as per MacMillan Treatment Summary How-To Guide
- Treatment summary to be completed within 6 weeks of patient completing treatment
- Treatment summary sent to GP and patient
- Essential and Desirable data fields complete (excluded "READ codes")

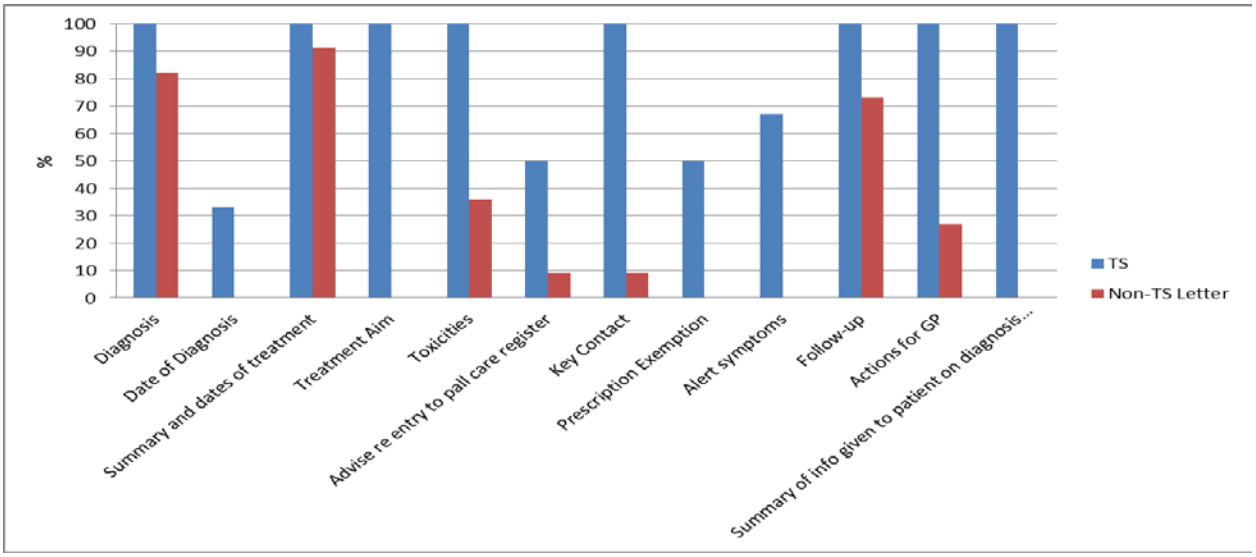
Number of patients where Treatment Summaries are complete:



Treatment Summaries per disease group:



% "Essential" Data Fields Complete:



In Summary:

- Head and Neck and Lung using treatment summary routinely for radical radiotheapy
- Breast using treatment summary for chemotherapy
- Treatment summary more likely to be sent to patient than a non-TS letter at end of treatment
- Treatment summary more likely than a non-treatment summary letter to include the "Essential" data fields set out by MacMillan
- Head and Neck team seem to be leading on this.

Current plan:
Due to the uneven nature of the completion of the treatment summary forms, we are looking toward a digital solution via out in house clinical noting system CWP. In the coming months we are looking to build and trial a form within the lung team and look to then extend this process to other disease groups in the hospital.

The purpose of this form is to ensure the information contained within is written to a patient and not to a clinician, though the goal of this should be also to inform the GP of the patients progress, the primary aim of this is to inform the patient of their progress as well as educate about potential “red flag” symptoms.

Once this is in place, as an organisation we will be able to report accurately on the volume of treatment summaries we are producing as well as monitor the quality of the forms including understanding where in the pathway they should be produced.

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2. Improving Outpatient and Pharmacy Waiting Times for the benefit of our patients

2.1 Pharmacy waiting times

A key quality objective in 2018-19 was to improve the waiting times for patients attending the outpatient pharmacy.

The aim was to consistently achieve the pharmacy waiting time target of more than 80% of patients having their prescriptions dispensed, and ready for collection, within one hour of it being presented.

During the course of 2018-19 the methodology used for calculating the number of patients waiting for their prescriptions was changed, in order that this figure was more reflective of those outpatients attending the pharmacy department, and their overall experience. This change made the target harder to achieve and the decision was taken to ensure there was a focus on the patients experience who were attending our outpatient clinics. The target became more difficult as pre-packaged prescriptions were excluded from the waiting times audit.

The pharmacy team have undertaken a programme of continuous improvement initiatives in order to address the issue of waiting times, and while these actions have made some impact on waiting times they have not delivered the level of improvement required to consistently meet the waiting times target.

The improvements undertaken have included actions to enhance recruitment and retention of staff; the employment of more reception staff; and changes to the skill mix in the department. In March 2019 a new waiting time computer system was introduced. This system provides improved information to patients about the progress of their prescription, and will enable the pharmacy team to change the way work is managed in the department.
It is anticipated that during 2019-20 activity in the pharmacy will increase further, as the pharmacy department takes on more dispensing activity and responds to changes in how chemotherapy treatments are administered.

As the quality improvement was not achieved in 2018/19, work will continue during 2019-20 to address pharmacy waiting times, and in particular concentrating on how prescriptions can be electronically transmitted to the pharmacy with patients only needing to attend the department to collect their dispensed medicine.
The Trust is committed to the development of pharmacy services and in the longer term this will enable further improvements which will see waiting times reduce and patient experience for a more efficient service to be achieved.

2.2 Outpatient waiting times.

A key quality objective in 2018-19 was to improve the waiting times for patients attending the outpatient department.

The aim was to ensure that 80% of patients attending the outpatient department were seen within 20 minutes of their appointment time. Upon analysis of the initial data it was agreed to start by reducing waiting times to less than an hour by identifying the bottlenecks in the process and find the root cause of these. Work was then focused on addressing the root cause of these issues.

During the time of this project the outpatient department moved into a £6.71m purpose built unit incorporating a new patient flow system. The system allows patients to use self-check in kiosks and aids direction of patients to areas for pre outpatients tests and then to their clinic area.

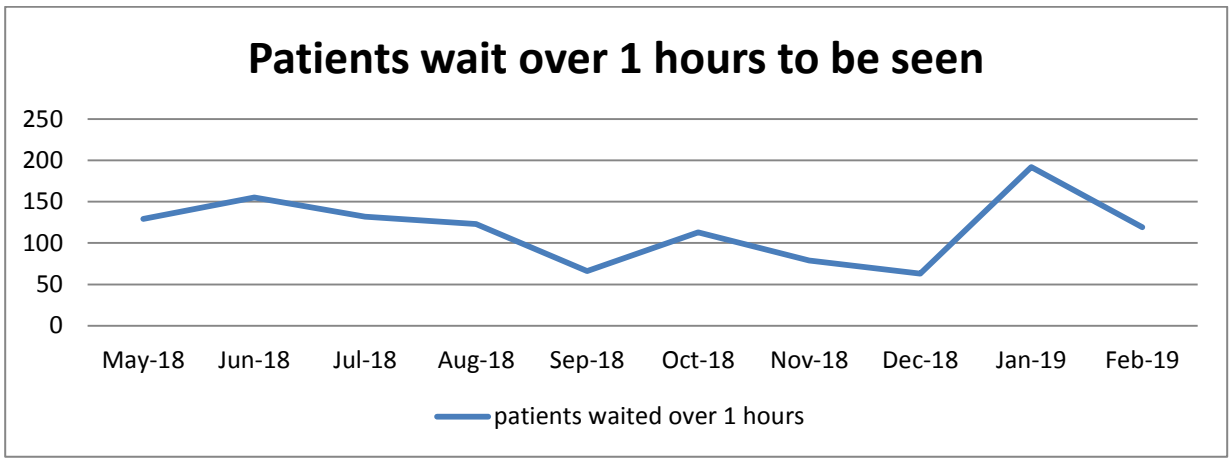
The new facility provides a bright and spacious environment for patients and carers. Within this

facility we have built on the multidisciplinary approach to care with new larger clinical hubs where all members of the multidisciplinary team are based for the duration of the clinic so that the patients have access to the research teams, allied health professionals and pharmacist during their visit.

Findings

Data was collected from the Medway (Patient system) from the time of appointment to the time that the patient was seen. Data on our business intelligence system then showed all patients that had been waiting any minutes after their appointment time. The information demonstrated that too many patients in clinics were seen outside of the 20 minute target for a variety of reasons. It therefore became necessary to focus on a few clinics and start by ensuring all patients were seen within an hour before trying to reach the 20 minute target.

The old department identified a lot of the issues related to the environment and lack of space for clinicians and it was believed these would be addressed when moving into the new outpatient building which took place in February 2019.
Each month at divisional board it was highlighted the top 5 clinics where the most patients had to wait for up to an hour to be seen by a clinician.



Overall we have seen a decrease in the amount of patients having to wait for 60 minutes or more to see a consultant and now aim to look at those waiting 30 minutes or more. We can see from the above data that there was a spike in January and this relates to clinics being cancelled over the Christmas and new year period and having to re-appoint the patients.

Review of the causes for delays in clinics in the "old" outpatient department were identified as the following:

- Skills and training of HCA in clinics - not performing clinical observations in a timely way and not being sure how to refer patients for tests and procedures.

- Lack of a systematic way of identifying over run clinics and ensuring this was escalated to the senior nursing team
- Lack of rooms to see the growing number of referrals
- IT and infrastructure in the old department that required upgrading which has been achieved in the new department Ensuring staff availability when clinics overrun and recognising this impacts on the afternoon clinics
- Delay in blood test results due to clinic preparation not requesting the full suite of blood tests required

The following actions were implemented :

- Computers upgraded, extra phones in clinics and analogue phones replaced with IP phones, some clinics were offered additional rooms following a review of clinic utilisation.
- Service managers, admin managers and front desk staff informed about incorrect clinic prep and letters and reported on each incident were documented.
- Additional staff made available past 5pm for clinics that over ran.
- An extra registered nurse was employed to coordinate all clinics and staffing
- Training guides for the running of each clinic being deployed
- A clinic template redesign project has commenced
- Improved reporting for clinical divisional boards

The Outpatient and transformational team have undertaken a programme of continuous improvement initiatives in order to address the issue of waiting times, and while these actions have made some impact on waiting times they have not delivered the level of improvement required to consistently meet the waiting times target and therefore the quality improvement for 2018/19 was not met and this quality improvement will rollover into 2019/20 so that the ambition can be achieved for the benefit of our patients.

3. Ensuring Consultant Review following Emergency Admission to Hospital

Standards for seven day care

The clinical standards for seven day services in hospitals were developed in 2013 and endorsed by the Academy of Medical Royal Colleges (AoMRC) for consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

The four priority standards

With the support of the AoMRC, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

Standard 2 – Time to first consultant review: patients do not wait more than 14 hours

Standard 5 – Access to diagnostic tests: patients have access to these via a 24 hour turn around (urgent requests, 12 hour and for critical situations, within one hour);

Standard 6 – Access to specialist, consultant-directed interventions

Standard 8 – Ongoing review by consultant twice daily of high dependency patients, daily consultant reviews on other wards unless suitable for delegation to others.

These have been the focus of work undertaken by NHS Improvement with acute trusts with an expectation that these would be in place by 2020. From 2019/20 there is a requirement to include information within Board reports.

The Christie position

The Christie has been working with NHSI to apply the priority standards to support best care in the context of a tertiary cancer centre. There are significant differences in the patients who have unplanned admissions here compared with those that present to an acute medical admissions unit in an acute general hospital:

- All patients are registered and therefore known to The Christie
- All patients are triaged prior to admission either by the clinical team in outpatients clinic or via the Hotline team so that all admissions should be appropriate to care provided here.
- Patients who are experiencing cardiac chest pain, stroke, major bleeds and undiagnosed acute surgical problems would be directed to their nearest acute trust.
- Presentations are therefore of those with acute treatment related or cancer related problems.
- The large majority of these presenting problems fit with established protocols of care for example management of radiation induced mucositis, chemotherapy related nausea and neutropenic sepsis, metabolic/biochemical disturbances, ascites.
- There are comparatively small numbers of admissions after early evening or at week-ends.

The patient pathway once admission has been agreed is through the acute oncology admissions unit. Patients are seen and assessed by their oncology teams, supported by acute physicians (Monday-Friday) and critical care outreach.

Preceding the 7 day standards, the expectation has been a consultant review within 24 hours of admission or sooner if there is a need for urgent escalation; the multidisciplinary models in oncology have established senior advanced nurse practitioners as well as senior oncology trainees, who see and assess patients in addition to consultants. There are fewer admissions at weekends and mortality data has shown fewer deaths among those admitted on these days compared with during the week.

Audits of admission are regularly undertaken. The recent and previous audits have all confirmed that all admissions were appropriate for acceptance for care at the Christie.

The data below describes the self-assessed position February 2018.

Areas of non- compliance and work in progress

Standard 2 – Consultant review within 14 hours (last audit 47%)
All patients were seen by a consultant in clinics prior to admission, following admission but not within 14 hours, or time not documented in some. In this audit there were no escalations of deteriorating patients (which would trigger immediate review). There were no patient safety issues identified where the 14 hour standard was not met.

Issues: Incomplete data capture; limited hours of on site on-call consultants at week-ends (apart from critical care)

Mitigation: Robust escalation policies for any deteriorating patient (confirmed by audits); care protocols for straightforward oncology interventions that do not require consultant supervision (such as drainage of ascites).

Plans: Roll out of electronic noting May 2019; planned extension of acute physician hours when workforce availability permits.

Standard 6 – Access to specialist intervention: only area of non-compliance is lack of an interventional endoscopy service on site: patients would be

deferred to admission at acute trust or transfer arranged as required.

No plans to develop onsite service.

Mitigation: robust triaging to avoid admission here (such as upper GI bleed) or transfer arranged to acute trust if needed. In practice this is required on few occasions and no difficulties have been encountered.

Standard 8 – on going consultant review twice daily for patients on critical care; daily on other areas unless appropriate for delegation.

The trust is fully compliant for twice daily consultant rounds on oncology critical care.

Currently the trust is non-compliant for daily consultant review on other wards.

Issues: data capture; complexity and range of cancer sub-site specialisation and job plans with two or more days at other sites.

Mitigation: there is robust escalation of deteriorating patients to oncology team, on call consultant and critical care outreach; consultant board rounds; reviews by advanced practitioners and specialty trainees; clinical protocols and capture of delegation of review.

Plans: Electronic noting to record required frequency of consultant review plus delegation of reviews where clinically appropriate; recruitment of consultants with acute oncology sessions at main site. This is part of a major inpatient transformation workstream with the aim of improving patient flow and experience.

Further audits will be undertaken and reported to Board Quality Assurance Committee.

Our quality ambitions for 2019/20

In deciding our quality ambitions for 2019/20 we undertook a range of approaches to agree the final three to be taken forward. We reviewed themes from our complaints and concerns through Patient Advice and Liaison Service (PALS). We asked our clinical staff to consider what the quality ambitions should be based on their interactions with the patients and the public and from their professional perspective. We reviewed the contribution required by the Trust to deliver aspects of the national and Greater Manchester cancer strategy. We also hear from our Governors quality committee of any patient and public matters that we should consider.

The Management Board, a board comprising of Executive Directors, Clinical Directors and senior managers agreed the final three quality ambitions and these have been shared with the Council of Governors and with staff across the Trust through the team brief.

Our quality ambitions for 2019/20

1. Improving Outpatient and Pharmacy Waiting Times for the benefit of our patients

In 2018/19 we agreed this quality improvement and it was not achieved. As this is an issue as described by our patients this will be a focus of quality improvement again this year.

Through our internal patient experience surveys, review of our performance metrics and review of our Patient Advice and Liaison Service and Complaints themes we know our outpatient and pharmacy waiting times do not meet our patients' expectations or our internal quality standards.

Therefore by March 2020 we will improve our patients experience by:

- 80% of outpatient pharmacy prescriptions will be available within one hour

- 80% of outpatients will have been seen within 20 minutes of their appointment time

This quality improvement will be monitored and measured monthly through the Outpatient board and the Management Board

2. Learning and making quality improvements from patient feedback

From the outcomes of the one day every patient improvement event in May 2018 we will develop new quality metrics and improvement standards that reflect the quality standards our patients expect. We will triangulate this with our complaints and PALS data and have new quality standards in place for March 2020.

This quality improvement will be monitored and measured monthly through the Patient Experience Committee.

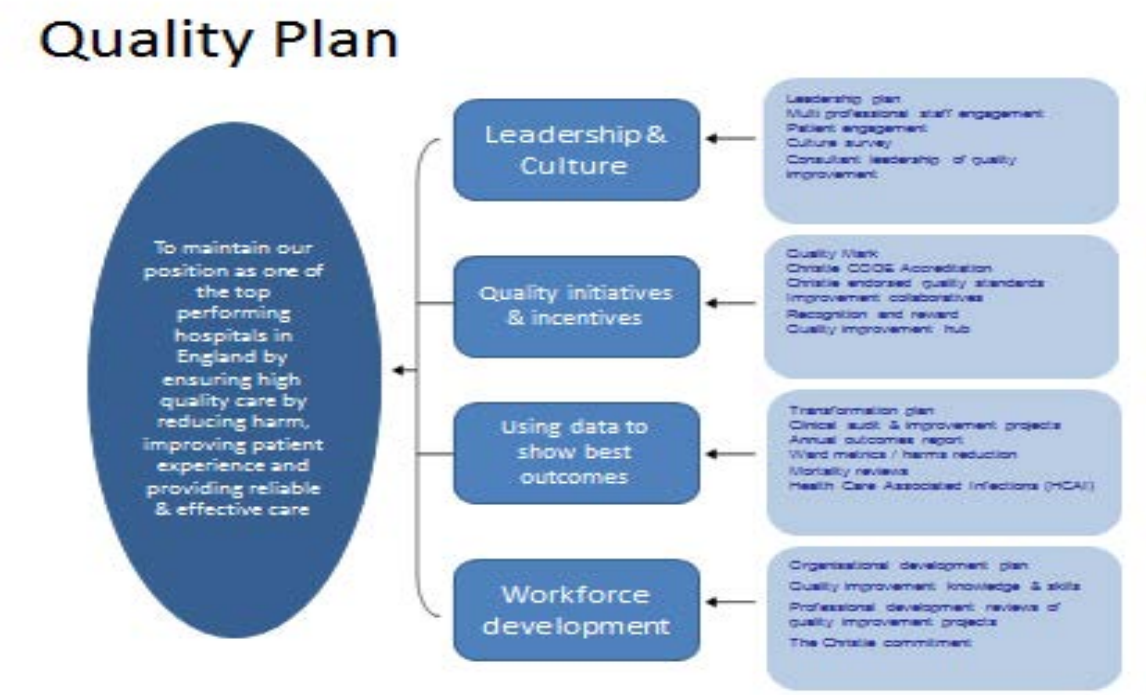
3. Improving Pressure Ulcer Management

By March 2020 in line with NHSI recommendations (2018) we will have baseline data for the number of patients who develop moisture associated skin damage (MASD) during admission. This will inform the development of a quality improvement standard for 2020/21.

- We will maintain our standard of no category 3&4 pressure ulcers developed in the hospital
- There will be no more than 30 Category 2 pressure ulcers, (deep tissue injury and unstageable pressure ulcers) developed in the hospital by March 2020.

This quality improvement will be monitored and measured monthly through the Executive Nursing Panel.

The Quality Improvements in the hospital are underpinned by our Quality Plan 2017/20. The driver diagram below sets out our overarching ambitions



2.2 Statements of assurance from the board

2.2.1 Review of services

During 2018/19 The Christie NHS Foundation Trust provided 14 relevant national health services:

1. Critical care
2. Haematology and transplantation
3. Specialist surgery
4. Endocrinology
5. Clinical oncology
6. Medical oncology
7. Acute oncology
8. Chemotherapy
9. Radiotherapy including intensity modulated radiotherapy (IMRT) and image guided radiotherapy (IGRT)
10. Brachytherapy and molecular imaging
11. Teenage and young oncology
12. Radiology
13. Christie Medical Physics & Engineering
14. Proton Beam Therapy

The Christie has reviewed all the data available to them on the quality of care in all 14 of these relevant services. This takes place through monthly performance reviews, at our Management Board and Risk and Quality Governance committee.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by The Christie for 2018/19.

2.2.2 Participation in clinical audits and national confidential enquiries

During 2018/19 13 national clinical audits and 4 national confidential enquires covered relevant health services that The Christie NHS Foundation Trust provides.

During 2018/19 The Christie participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Christie was eligible to participate in and participated in during 2018/19 are as follows:

The national clinical audits and national confidential enquiries that The Christie participated in during 2018/19 are as follows:

1. Bowel cancer (NBOCAP)
2. Lung cancer (NLCA)
3. National Prostate Cancer Audit (NPCA)
4. Oesophago-gastric cancer (NAOGC)
5. National Cardiac Arrest Audit (NCAA)
6. National Emergency Laparotomy Audit (NELA)
7. ICNARC Intensive Care National Audit and Research Centre Case Mix Programme (CMP)
8. Nephrectomy audit (BAUS)
9. Radical prostatectomy audit (BAUS)
10. Cystectomy audit (BAUS)
11. National Audit of Care at the End of Life (NACEL)
12. Learning Disability Mortality Review Programme (LeDeR)
13. National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)
14. NCEPOD Cancer in Children Teenagers and Young Adults (CiCTaYA)
15. NCEPOD Care of Perioperative diabetes (PD)
16. NCEPOD Pulmonary Embolism (PE)
17. NCEPOD Bowel Obstruction (BO)

The national clinical audits and national confidential enquiries that The Christie participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Name of audits and enquiries	Numbers submitted (eligible)	Percentage of Eligible Submitted
NBOCAP	79/79	100%
NLCA	Treatment data only submitted via COSD data – recorded against trust first seen	100%
NPCA	Data submitted via COSD – recorded against trust first seen	100%
NOGCA	345/345	100%
NCAA	12/12	100%
NELA	15/15	100%
ICNARC (CMP)	651/651	100%
Nephrectomy	67/67	100%
Radical prostatectomy	56/56	Not yet closed
Cystectomy	33/33	100%
NACEL	25/25	100%
LeDeR	1/1	100%
NCABT (TACO)	40/40	100%
NCEPOD (PE)	3/6	50%
NCEPOD (BO)	0/1	Not yet closed

**The PE audit required completion of an 18 page proforma. Despite an extension of the timescale, three proformas were not returned.*

2.2.3 Participation in clinical research

The Christie has a long history of supporting research; this was recognised in 2007 with the creation of the Research and Development Division (R&D). The R&D serves a population of 3.2 million and is the largest cancer research network in the country. The success of research is demonstrated by recruitment of patients on to clinical trials, this includes recruitment of the first patient nationally and globally.

The number of patients receiving health services provided or sub-contracted by The Christie in 2018/19 that were recruited during this period to participate in research approved by a research ethics committee, was 3034. This is a similar level to 2017/18 due to the increased complexity of trials and the greater proportion of early phase trials we now open which recruit low numbers of patients. Since 2015/16 there has been a 30% increase in patients recruited to research studies at The Christie.

2.2.4 Quality goals and the CQUIN framework.

A proportion of The Christie's income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between The Christie and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

The total amount of income in 2018/19 that The Christie received was conditional upon achieving the CQUIN goals was £ 3,664,795. The CQUINs were fully achieved in Q1 – Q3 in 2018/19, we are awaiting confirmation of Q4. In 2017/18 the total amount of income that The Christie NHS Foundation Trust received that was conditional upon achieving the CQUIN goals was £3,595,192

NATIONAL SCHEMES		Reporting Frequency / Implementation	Performance 2018/19 - Q3
INDICATOR	Brief Description		
Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (locally amended)	Year 2 of a national incentive to standardise the doses of SACT in all units across England in order to increase safety, to increase efficiency and to support the parity of care across all NHS providers of SACT in England	Two Years	Achieved
Hospital Pharmacy Transformation and Medicines Optimisation	To support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services	Two Years	Achieved
LOCAL SCHEMES		**Reporting Frequency / Implementation**	**Performance 2018/19 - Q3**
INDICATOR	**Brief Description**		
Adult Critical Care Timely Discharge	To reduce delayed discharges from ACC to ward level care in the same hospital by improving bed management in ward based care, thus removing delays and improving flow. Discharges occurring directly to home will also be included as these are a reflection of a delay in discharge to a ward. 4 Payment triggers: 1. Percentage reduction in the number of patients clinically ready to be discharged within 4 hours 2. Percentage reduction in the number of patients clinically ready to be discharged within 4 to 23 hours 3. Percentage reduction in the number of patients clinically ready to be discharged over 24 hours 4. Percentage reduction in the number of cancelled operations as a result of lack of available critical care beds	Quarterly	Triggers 1, 2 & 4 Achieved. Trigger 3 not achieved but no financial penalty made
Transformation of Chemotherapy	To develop a new model for the prescribing, scheduling, preparation, delivery and coding of chemotherapy. This model will incorporate new technology and new ways of working for the benefit of patients, staff and commissioners.	Quarterly	Achieved
Ambulatory Chemotherapy	To minimise unnecessary overnight stays for patients receiving Systemic anti- cancer therapies by increasing ambulatory care facilities for these patients. To increase the availability of In-patient bed capacity and improve patient experience. The programme focuses on both haematology and Solid Tumour SACT regimens that can be transferred from an In- patient stay to an ambulatory care setting using mobile infusion devices.	Quarterly	Achieved
Sepsis	To build on the previous year's CQuIN to improve the prompt recognition and treatment of established in-patients with suspected sepsis and neutropenic sepsis receiving antibiotics within one hour of recognition. This will improve upon the national CQuIN target of 90 minutes set for patients in 2016/17.	Quarterly	Achieved
Integrated Procedures Unit	This scheme continues to increase productivity and efficiency of the IPU to ensure patients get efficient care with an appropriate length of stay in hospital. In addition to Year 1, performance monitoring of nipple tattoo's and trials without catheters will be introduced.	Quarterly	Achieved

2.2.5 Care Quality Commission

The Christie NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered to provide diagnostic and screening procedures, treatment of disease, disorder or injury and assessment or medical treatment for persons detained under the Mental Health Act 1983. The Christie NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against The Christie NHS Foundation Trust during 2018/19

2.2.6 CQC Responsive Inspection

The Christie NHS Foundation trust has not been part of any responsive inspections during 2018/19

2.2.7 CQC Inspection Programme

The Christie NHS Foundation Trust has been part of an unannounced routine inspection and a well led inspection during 2018/19, where we were rated as outstanding in both areas.

2.2.8 Data Quality

The Christie submitted records during 2018/19 to the secondary uses service (SUS) for inclusion in the hospital episode statistics which are included in the latest published data. The percentage of records in the published data:

	% of records in published data which included the patient's valid NHS number	% of records in published data which included the patient's valid general practitioner registration code
Admitted patient care	99.9%	100%
Outpatient care	99.9%	99.9%
Accident and emergency care	Not applicable	Not applicable

2.2.9 Information Governance

The Christie NHS Foundation Trust's information governance assessment report overall score for 2017/18 standards have been met. Mersey Internal Audit Agency the Trust's internal auditors provided substantial assurance to the evidence provided in the Information Governance Toolkit

2.2.10 Payment by Results / IG Toolkit

The Christie NHS Foundation Trust was not subject to the Payment by Results (PbR) clinical coding audit during the reporting period.

An IG toolkit audit took place in January 2019, by the Health and Social Care Information Centre (HSCIC) the results of this audit are as follows:

	% Correct
Primary diagnosis	95.2%
Secondary diagnosis	93.3%
Primary diagnosis Secondary diagnosis	92.3% 90.2%

2.2.11 Data quality

The Christie NHS Foundation Trust as part of its quality improvements programme will be taking the following actions to improve data quality:

- Implemented the Data Quality Group, a sub-committee of the Information Governance Committee, which meets on a monthly basis;
- Employed an Income and Data Project Manager to undertake specific Data Quality audits and change implementation projects; and
- Worked, and continue to work, collaboratively with commissioners to respond to data challenges.

2.3 Reporting against core indicators

NHS Outcomes Framework	Indicator	The Christie Performance 2017/18	The Christie Performance 2018/19	National average	National Highest/ lowest
The value and banding of the summary hospital-level mortality indicator ("SHMI") The percentage of patient deaths with palliative care coded at either diagnosis or specialty level	Preventing people from dying prematurely. Enhancing quality of life for people with long-term conditions.	This is not applicable to The Christie as we are a specialist cancer hospital.			
The Christie NHS Foundation Trust considers that this indicator is not applicable to the Trust as all our patients have a cancer diagnosis and are not part of the inclusion criteria.					

NHS Outcomes Framework	Indicator	The Christie Performance 2017/18	The Christie Performance 2018/19	National average	National Highest/ lowest
The Trusts patient reported outcome measures scores for: i. groin hernia surgery ii. varicose vein surgery iii. hip replacement surgery iv. knee replacement surgery	Helping people to recover from episodes of ill health or following injury	This is not applicable to The Christie as we are a specialist cancer hospital.			
The Christie NHS Foundation Trust considers that this indicator is not applicable to the Trust as all our patients have a cancer diagnosis and are not part of the inclusion criteria.					

NHS Outcomes Framework	Indicator	The Christie Performance 2017/18	The Christie Performance 2018/19	National average	National Highest/ lowest
The percentage of patients aged: i. 0 to 14 ii. 15 or over Readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the trust.	Helping people to recover from episodes of ill health or following injury	This is not applicable to The Christie as we are a specialist cancer hospital.			
The Christie NHS Foundation Trust considers that this indicator is not applicable to the Trust as all our patients have a cancer diagnosis and are not part of the inclusion criteria.					

NHS Outcomes Framework	Indicator	The Christie Performance 2017/18	The Christie Performance 2018/19	National average 2017/18	National Highest/ Lowest 2017/18
The Trust's responsiveness to the personal needs of its patients	Ensuring that people have a positive experience of care	81.10%	n/a	68.60%	H 85.0% L – 65.0%
The Christie NHS Foundation Trust considers that this data is as described for the following reasons: to show the percentage of patients receiving a good experience of care whilst under the care of The Christie. The Christie NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by continuing to monitor compliance to the above target and to take any remedial action if required: This will be reviewed through monthly Board level scrutiny of patient satisfaction surveys and the National Friends and Family test.					

NHS Outcomes Framework	Indicator	The Christie Performance 2017/18	The Christie Performance 2018/19	National average 2017/18	National Highest/ Lowest 2017/18
The percentage of staff employed by, or under contract to, the Trust who would recommend the trust as a provider of care to their family or friends.	Ensuring that people have a positive experience of care.	96.8 %	95.0 %	80.7%	H – 100% L – 54.5 %
The Christie NHS Foundation Trust considers that this data is as described for the following reasons: to show the percentage of staff who would recommend The Christie as an organisation that provides good quality care for their family or friends. The Christie NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by continuing to monitor compliance to the above target and to take any remedial action if required: This will be reviewed through quarterly Board level scrutiny of the outcomes of the National Staff Friends and Family Test.					

NHS Outcomes Framework	Indicator	The Christie Performance 2017/18	The Christie Performance 2018/19	National average 2017/18	National Highest/ Lowest 2017/18
The percentage of patients admitted as an inpatient to the Trust who would recommend the trust as a provider of care to their family or friends.	Ensuring that people have a positive experience of care.	97.42%	96.0%	95.8%	H - 100% L – 54.5%
The Christie NHS Foundation Trust considers that this data is as described for the following reasons: to show the percentage of patients admitted to the Trust who would recommend The Christie as an organisation that provides good quality care for their family or friends. The Christie NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by continuing to monitor compliance to the above target and to take any remedial action if required: This will be reviewed through monthly Board level scrutiny of the National Friends and Family test.					

NHS Outcomes Framework	Indicator	The Christie Performance 2017/18	The Christie Performance 2018/19	National average 2017/18	National Highest/ lowest 2017/18
Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism	Treating and caring for people in a safe environment and protecting them from avoidable harm.	97.4%	95.2%	95.2 %	H –100% L – 76.6
The Christie NHS Foundation Trust considers that this data is as described for the following reasons: to show the percentage of patients admitted to The Christie that have had a full risk assessment of venous thromboembolism. The Christie NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by continuing to monitor compliance to the above target and to take any remedial action if required: This will be reviewed through monthly Board level scrutiny of the results of the venous thromboembolism assessments on admission.					

NHS Outcomes Framework	Indicator	The Christie Performance 2017/18	The Christie Performance 2018/19	National average 2017/18	National Highest/ Lowest 2017/18
Rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over.	Treating and caring for people in a safe environment and protecting them from avoidable harm.	31.4	25.2	13.7	H 91–0 L 0–0
During the course of the year we have seen a reduction in post-72 hour C.difficile cases by 22% from 18 cases to 14, which is lower than the threshold set of no more than 19. We have also seen a small increase in pre-72 hour cases of C.difficile. Whilst The Christie performance is at the higher end of the national average it was disappointing that there have been five lapses in care of the C.difficile standards (four cases were on one ward during a period of increased incidence). Remedial action plans were put in place and monitored to conclusion and there have been no further incidences of lapses in care. The Christie NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by continuing to monitor compliance to the above target and to take any remedial action if required: This will be reviewed through monthly Board level scrutiny of the results of the C.difficile numbers and through the monthly review with our commissioners.					

NHS Outcomes Framework	Indicator	The Christie Performance 2017/18	The Christie Performance 2018/19	National average 2017/18	National Highest/ Lowest 2017/18
The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	Treating and caring for people in a safe environment and protecting them from avoidable harm.	2442 12 0.49%	2510 5 0.20%	49327 100 0.20%	H - 6396 L - 859 H -25 L- 0 H – 0.59% L – 0.0%
The Christie NHS Foundation Trust considers that this data is as described for the following reasons: to record the incidences of patient safety, the rate of incidences and the percentage of severe harm or death of patient safety incidences within The Christie. The Christie NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by continuing to monitor compliance to the above target and to take any remedial action if required This will be reviewed through the quarterly Patient Safety and Experience report.					

2.4 Staff who "Speak Up"

The Christie is fully committed to promoting an open and transparent culture across the organisation to ensure that all members of staff feel safe and confident to speak out. When staff feel confident and safe to speak up the following benefits are achieved:

- The Trust is made aware of situations that could potentially impact on patient care
- The Trust has the opportunity to take action so that any detrimental consequence is avoided
- The Trust has the opportunity to learn
- Staff are able to share their anxiety about a situation and therefore reduce their stress
- Staff feel a greater sense of engagement, inclusion and support for Trust values

Every opportunity is taken to raise the profile of the importance of raising concerns and the support available. This includes a Schwarz round where staff are able to discuss the emotional aspects of raising concerns, the provision of reflective reports by staff available on the intranet, articles in the staff magazine, displays in corridors and presentations at department meetings.

It is important that staff are able to choose a way to raise their concerns in a way that is right for them and that they are confident they will be supported both during and after raising their concern. The message that they will not suffer any detriment as a result of raising their concern is of equal importance.

Staff are encouraged to speak with whoever they feel is most appropriate for them, this could be their manager, the Freedom to Speak Up Guardian, the HR team, any member of the Senior team or the non-executive director with a responsibility for Freedom to Speak Up. Those who receive the concern have a clear responsibility to listen, thank the person raising the concern and keep them updated with progress in a manner that is right for them. This could be by phone, email or face to face. In addition to the Speaking Up policy, The Christie, in partnership with trade union colleagues have developed a positive working relationships policy including a self-assessment tool which enables managers and members of staff to identify and tackle negative behaviours through a range of informal and formal mechanisms with the aim of tackling any issues or concerns at the earliest opportunity. The organisation's approach to supporting staff through this policy and subsequent breakfast seminar and educational events has been recognised nationally and shortlisted for a 2019 HPMA Social Partnership Forum award for partnership working between trade unions and employers.

Those who raise concerns are asked for their views on their experience of raising a concern, including any detriment so that any shortcomings are identified and addressed. In addition to learning from staff feedback, as a direct result of feedback as part of the national staff survey, an anti-bullying and harassment listening project has taken place across the organisation to identify how the organisation can learn from staff experience in order to continually improve mechanisms to support staff at work and tackling issues at the earliest opportunity.

Part 3: Other Information
Review of quality performance in 2018/19

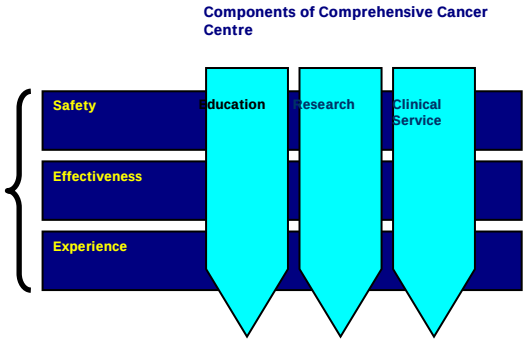
Introduction

In February 2009, The Christie adopted a framework for quality reporting (see diagram) which provides the framework for monthly quality accounts reporting as part of our regular performance reports and this annual document. The board of directors believes that quality of care should where possible be reported and scrutinised frequently so that adverse trends can be identified early.

The monthly quality accounts for the Trust as a whole are reviewed at the management board with key senior clinical leaders, as well as the directors of research and education. Quality metrics for individual divisions are reviewed as part of the regular performance review meetings with the executive team. Any matters of concern are followed up either through the divisional meetings or through the risk and quality governance committee.

The board's Quality Assurance Committee is responsible for providing board assurance on these issues. Reports on quality of care are made to the council of governors meetings and a governor sub-committee on quality receives reports and assurance of the quality work of the Trust. The executive team regularly reviews the quality of care within the hospital through visits to clinical areas, through a programme of Executive walk rounds. Non-executives and governors also undertake regular visits to clinical areas to see at first hand the quality of care and environment and to hear directly from patients about their experience of the hospital.

This section of our quality accounts draws on monthly performance reports and includes additional annual indicators for which annual reporting is appropriate. The data is drawn from regular surveys, audits or routine data systems that have been established to provide a focus on and assurance about quality of care.



Patient experience

Satisfaction levels with care provided at The Christie are extremely high and all our efforts are directed towards ensuring the best possible experience for patients at a time of enormous stress and worry for them and their families

PLACE Assessment

The quality of healthcare premises has been captured in the latest patient-led assessments. Annual patient-led assessments of non-clinical elements of care such as food and waiting areas have been published by NHS Digital on the 16 August 2018.

This is the sixth year; Patient-Led Assessments of the Care Environment (PLACE) involve teams going into NHS and private/independent hospitals to assess how the environment supports the provision of clinical care.

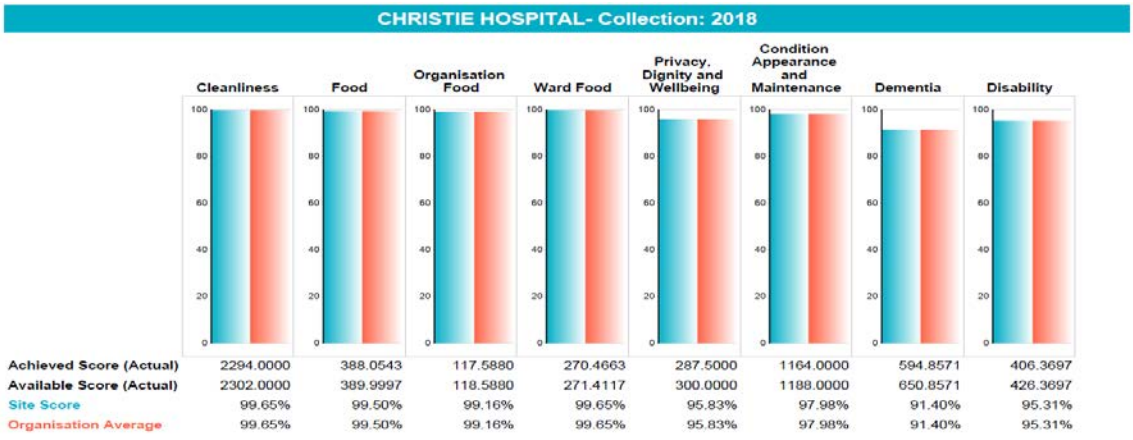
PLACE assessments are undertaken by teams of healthcare staff and members of the public. The public members of the team, who comprise at least half of the assessing team, are known as patient assessors.

At the Christie the assessment was carried out on the 23rd April 2018. The patient assessors were recruited from the Christie membership and included an independent external assessor from Cheshire and Wirral partnership NHS Trust. Their assessments looked at areas such as privacy and dignity, food, hydration, cleanliness and general building maintenance, as well as the extent to which the environment is able to support the care of those with dementia.

An additional assessment of how well healthcare environments support the provision of care to those with a disability was introduced in 2016. This assessment focused particularly on issues of access such as wheelchairs, mobility (e.g. handrails) and signage, as well as provision of visual/audible appointment alert systems and hearing loops.

The report published on the 16th August 2018 "Patient-Led Assessments of the Care Environment (PLACE) 2018 – England" covers the assessments for 2018, with comparable historical data where available.

2018 PLACE Scores for the Trust



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2294.0000	388.0543	117.5880	270.4663	287.5000	1164.0000	594.8571	406.3697
Available Score (Actual)	2302.0000	389.9997	118.5880	271.4117	300.0000	1188.0000	650.8571	426.3697
Site Score	99.65%	99.50%	99.16%	99.65%	95.83%	97.98%	91.40%	95.31%
Organisation Average	99.65%	99.50%	99.16%	99.65%	95.83%	97.98%	91.40%	95.31%

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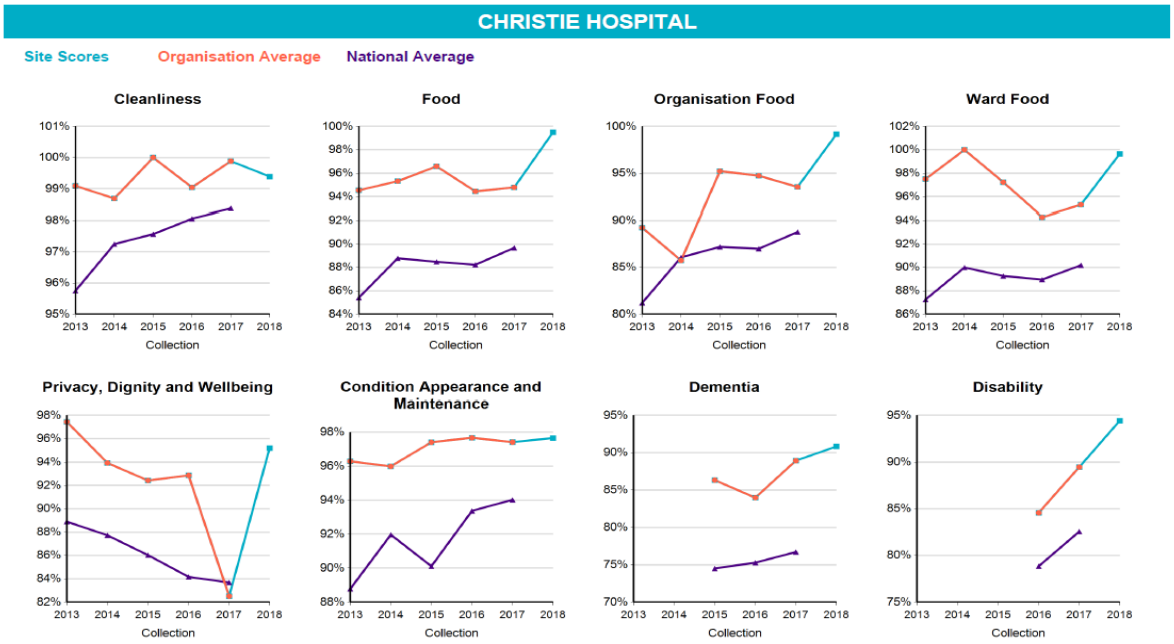
All inpatient wards, except Oncology Critical Care Unit (OCCU), were assessed along with outpatient areas and oak road treatment centre. All general circulation areas were covered, including oak road foyer, lifts, corridors, public toilets, external areas, car parks C and D and the main entrances. The lunch service on three wards was also assessed.

The trust continues to perform very well and all scores are well above the national average.



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Patient experience stories to the board

Board meetings are held on the last Thursday of the month at 12.45pm except for the May meeting which was held on Thursday 24th May 2018 (due to financial year end). There are no meetings in February, July, August or December.

Date	Presenter	Topic
2018		
Thursday 26th April 2018	Dr Matt Krebs, Clinical Senior Lecturer and Honorary Consultant in Medical Oncology	The TARGET Trial – Precision Medicine Impacting Patient Outcomes
Thursday 24th May 2018	Dr Anita Ghosh & Dr Tania Hawthorn	Psycho-Oncology – A service overview and mental health promotion
Thursday 28th June 2018	Prof Nick Slevin	Improving outcomes through the Paterson redesign
July	**No meeting**	
August	**No meeting**	
Thursday 27th September 2018	Joanne Fitzpatrick & Jason Dawson	Patient access
Thursday 25th October 2018	Jackie Bird, Olivia Samuel, Was Mansoor	Working in partnership with our patients in the development of the new outpatient department
Thursday 29th November 2018	John Radford	CAR-T – a game changer for cancer patients
December	**No meeting**	
2019		
Thursday 31st January 2019	Dr Ed Smith	What proton treatment offers patients in the context of advanced radiotherapy
February	**No meeting**	
Thursday 28th March 2019	Dr Fabio Gomes , Clinical Research Fellow, Medical Oncology	Improving Care for Patients Living with Clinical Frailty – From QIP to Clinic at The Christie

The Christie CODE

The Christie CODE is our framework for measuring the quality of care provided to patients through observation, clear documentation and patient and staff experience.

The CODE has enabled ward leaders and their teams to adopt quality assurance and improvement as the underpinning foundations of their everyday practice in a coherent, focused and systematic way, whilst supporting our culture of openness and candour.

This framework strengthens professional leadership, empowers doctors, nurses, allied health professionals and other team members to lead and deliver quality improvements at ward level for patient benefit.

There are 14 standards covering the fundamentals of nursing care, plus management and leadership. Each standard is based on current evidence of best practice, national legislation, and regulatory guidance.
The aim of the Scheme is:

- To put patients at the centre of everything we do
- To celebrate excellence
- To demonstrate commitment to quality improvement
- To have methodological rigour and draw on the evidence base in the development of standards and in the process used to assess levels of performance
- To share best practice
- To be inclusive of all multi-disciplinary staff who make a substantial contribution to the delivery of clinical care

All seven of our wards have now been accredited with 'gold' status and 4 of these have demonstrated maintenance of the CODE standards through annual re-accreditation. The remaining three wards will seek re-accreditation between May and August 2019

Work is currently underway to develop The CODE for clinical teams

More information on The Christie CODE can be found at http://www.christie.nhs.uk/about-us/about-the-christie/christie-quality/the-christie-code-quality-scheme/

Quality Strategy 2017 – 2020

Everything we do at The Christie is directed at achieving the best quality care and outcomes for our patients and The Care Quality Commission rating of 'outstanding' was underpinned by our five year strategy which is underpinned by our plans for quality and workforce. Our plans affirm the organisation's commitment to improving quality and delivering safe, effective and personal care, within a culture of learning and continuous service improvement. Having delivered against the objectives at completion of the three year tenure of the 2014 – 2017 strategy and following consultation across the organisation, in September 2017 we launched the next three year plan for 2017 – 2020.

Aimed at staff, patients' carers and stakeholders this plan sets out how we will govern, measure, recognise, transform and improve quality in care, acknowledging the significant impact that excellent leadership, collaboration and the culture within our organisation has on the experience and outcomes for patients and the experience and empowerment of our staff.

We will continue to strengthen professional leadership, empowering doctors, nurses, allied health professionals and all our other clinical and non-clinical staff to lead and deliver quality improvements. This builds on the positive and proactive work that has already been undertaken to maintain patient safety, deliver effective treatments and enhance the patient experience. We will continue in our drive to improve the quality of care for our patients by ensuring cost effectiveness and efficiency through the creative use of finite resources. And as with everything we do at The Christie our service is underpinned by meaningful communication and the provision of care by compassionate, committed, and competent staff.

The plan is constructed around 4 broad objectives which will drive achievement of the trust's five year strategy and continued delivery of patient safety, effective treatment and a positive patient experience.

Outcome 1 – To ensure a trust culture where high quality care and outstanding leadership are fundamental in all that we do.

Outcome 2 – To promote and support quality initiatives and develop quality improvement incentives

Outcome 3 – To use data to demonstrate best outcomes and achievement of established standards

Outcome 4 - To ensure that the delivery of quality standards is inherent in the attitudes, behaviours and performance of the trust workforce

Within this refreshed plan we have strengthened the need for collaboration across all our services but in particular we have highlighted the synergy between quality, leadership, workforce, transformation and informatics. The joint working between these strands of the organisation will be evident in the joint function of the newly introduced 'Improvement Hub, established to support staff and align improvement initiatives.

The Christie Quality Mark

Through the five year strategy the Trust set out its ambition to deliver its services to a Christie quality mark standard that would be recognised by patients. With this ambition in mind, a patient focus group developed and agreed what the "Christie experience" meant to them in the form of 5 statements.

- We want to experience the same standard of care as if we were in The Christie@ Withington

when we have chemotherapy and radiotherapy services;
- We want the same safe, clean environment with standards of pride as The Christie@ Withington;
- We want to be greeted with a warm welcome and where we are a returning patient to be recognised by staff;
- We want continuity of care by our doctors and nurses and to know that we are partners in all care and decision making
- We want to recognise The Christie team in "The Christie@" sites

The quality mark accreditation scheme was launched at the September 2014 annual members meeting. Through the steering group which included patients, Governors, consultants and nurses the quality mark accreditation scheme was developed, piloted and implemented. Since its launch the quality mark accreditations have been achieved for the following chemotherapy units: The Christie NHS Foundation Trust, Pennine Acute NHS Trust, Stockport NHS Foundation Trust, East Cheshire NHS Trust, Wrightington, Wigan & Leigh NHS Foundation Trust and The Christie Mobile Chemotherapy Unit.

During 2017, the Quality Mark was developed further to include our Radiotherapy Services; and during 2018 all three of our units at Withington, Oldham and Salford achieved quality mark accreditation

The Quality Mark inspection was undertaken at two more units delivering chemotherapy to our patients. Mid-Cheshire NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust. These hospitals and we were delighted that they achieved accreditation in September 2018 and March 2019 respectively.

Of the six chemotherapy units in the original group; The Christie NHS Foundation Trust, Pennine Acute NHS Trust, Stockport NHS Foundation Trust and East Cheshire NHS Trust successfully achieved their 3 yearly re-accreditation during 2018 and 2019, with the others scheduled to do so during 2019.

Friends and Family Test

The NHS Friends and Family Test (FFT) is an important tool whereby The Christie receives direct, regular and real time feedback from our patients. This feedback is used to help shape and further improve our services for our patients.

Following their most recent experience at the Christie, patients are invited to answer the question: "How likely are you to recommend our service to friends and family if they needed similar treatment". Patients can respond via text message (free of charge) or on a paper form. Text messages are sent to patients within 48 hours of their inpatient stay. As an alternative, nursing staff ensure paper forms are available for patients to complete and return on the day of discharge. Patients can opt out of responding at any time.

Given the number of patients who are regular patients for treatment, the text message is sent to the patient's mobile number once per month only, even if they have attended more frequently, and asks them to think about their most recent experience.
Patients are asked to respond on a 1-5 point scale from extremely likely to recommend, to extremely unlikely to recommend.

Following the patient's response a second, follow up question is asked which reminds them that their comments will help us improve our services, and asks them to state in their own words, what the best/worst parts of the service were. Specific comments are anonymised, though patients are encouraged to contact our Patient Advice and Liaison Service should they wish their comments to be handled directly.

The response rate for FFT and individual ward/department results is collated monthly and high level results published in the performance report as well as at ward level on the ward screens, where specific quotes from patients are also displayed.

During the year April 2018 to March 2019 response rates for the inpatient ward areas ranged from 29.3% to 42.0% (average of 36.6%)

The FFT scores, measured as percentage of positive scores ranged from 95.7% to 99.4% (average 97.8%) for the inpatient ward areas and from 94.7% to 96.8% (average 96.0%) for the outpatient areas.

Examples of feedback received:

Staff have been amazing, supportive & understanding! Brilliant team.

I have been treated with respect and kindness throughout my stay. The building and treatment are first class, but the staff are fantastic.

The staff are very caring, approachable, very helpful and kind. The ward is very clean and tidy. Food is great. You are all fabulous and a credit to the institution.

The staff are very helpful and have been very caring. The only downside to the ward is that there are no windows

National inpatient survey 2017

The Christie has again received excellent results in the annual inpatient survey by the Care Quality Commission (CQC) and the Trust performed better than most other trusts in all the eligible section scores. This continues the theme we have seen over the last number of years.

1249 patients of The Christie who had a stay of at least one night and were discharged between April and July 2017 were sent a questionnaire. The response rate was 52% when those who are ineligible are discounted.

Of the 60 questions, 18 results were better than last year, 29 had shown a small fall and 6 remained the same.
There was one result that showed a change upwards that was significant

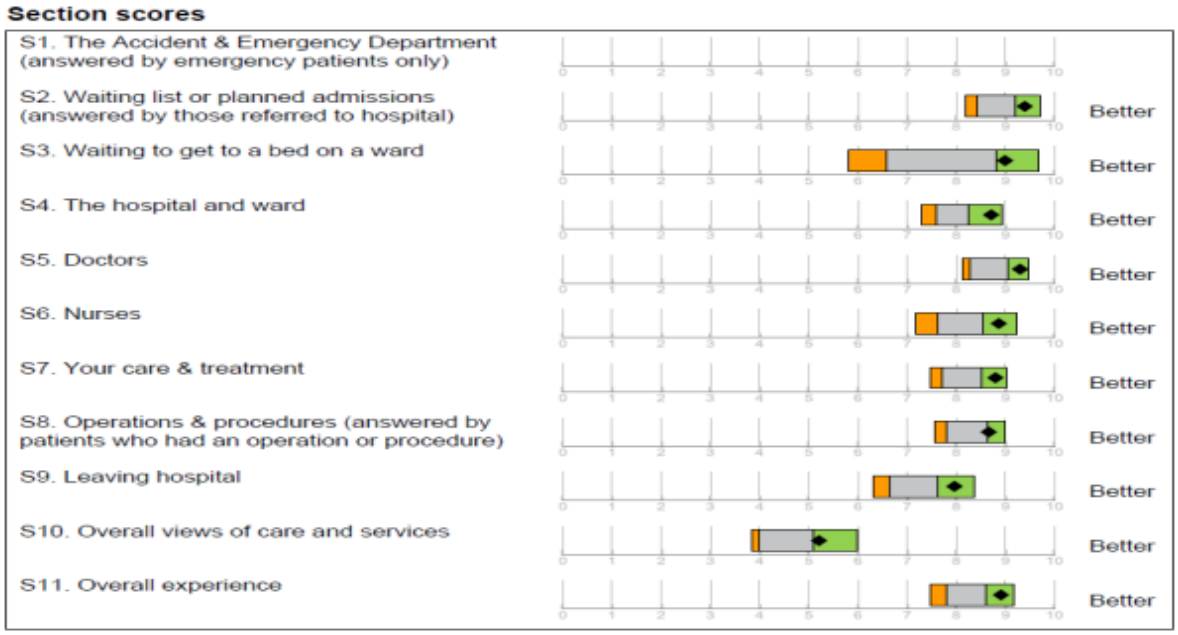
- Being given enough notice of discharge.

Whilst the Trust had an excellent set of results, four questions showed a change downwards from last year's survey that was significant;

- Patients finding someone on hospital staff to talk to about worries and fears
- Enough nurses on duty to care for patient
- Having enough emotional support from staff during stay
- Overall treated with respect and dignity while in hospital.

There were no questions where our performance was worse than most other trusts. Patients were asked to rate their overall experience of care and the Trust scored a high score of 8.9. The lowest score by any trust was 7.5 and the highest achieved was 9.2

(The black diamond is the Trust score, if it lies in the green section then it is better than most other trusts, the orange indicates the same as most other trusts and the red is worse compared to most other trusts).



Following the 2017 survey an action plan was developed, discussed at Nurse Leaders Forum and monitored through the Patient Experience Committee.

The outcome of the 2018 inpatient survey is expected in May 2019.

Safer Staffing

The Safe Staffing levels indicator is a national quality measure that was introduced in 2014. It looks to measure and ensure that a hospital's nursing staffing requirements are being met. The measure focuses on two distinct groups of staff, registered nurses and non-registered care staff. The data collected each day for both Day & Night shifts allows a member of the public to see whether the actual number of staff on duty met what was planned on a ward. This data is then submitted at ward & trust level nationally and is made visible on the NHS choices website as well as the Trust's internet site. The data is also made visible to patients and visitors in real-time on each ward.

For 2018/19, 95.1% of the required hours were filled with the planned numbers of registered nurses and care staff. The monthly data on our safe staffing levels and the six monthly reports can be seen in the public Board papers which can be seen at: _ or https://www.christie.nhs.uk/about-us/the-foundation-trust/about-the-trust/board-of-directors-meetings/

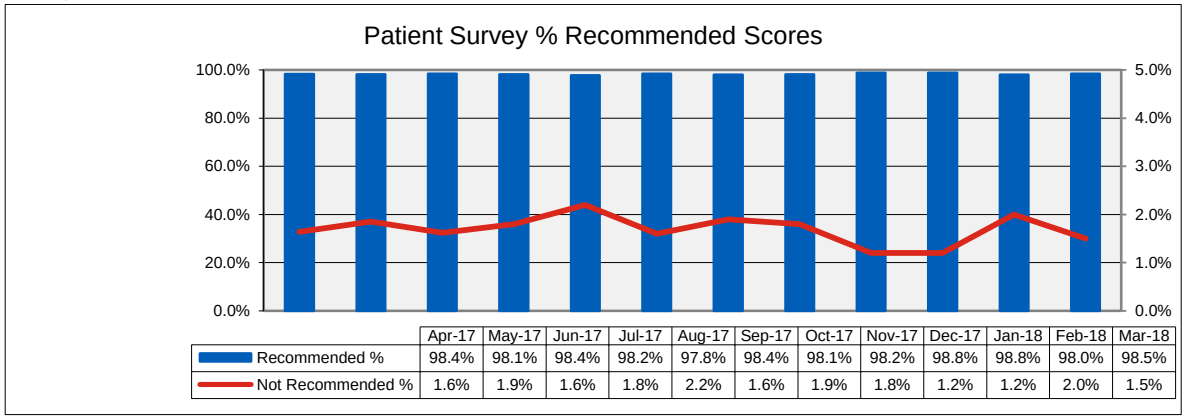
From May 2016, all acute trusts with inpatient wards/units began reporting monthly care hours per patient day (CHPPD) data to NHS Improvement. CHPPD is calculated by adding the hours of registered nurses and the hours of healthcare support workers and dividing the total number of patients at midnight. CHPPD is reported as a total and split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix. CHPPD data is now being used for peer comparison to act as a 'sense check' on professional judgements concerning nursing requirement; and is reported to the board bi-annually.

3.1. Clinical Indicators - Patient Experience

3.1.1 Patient survey

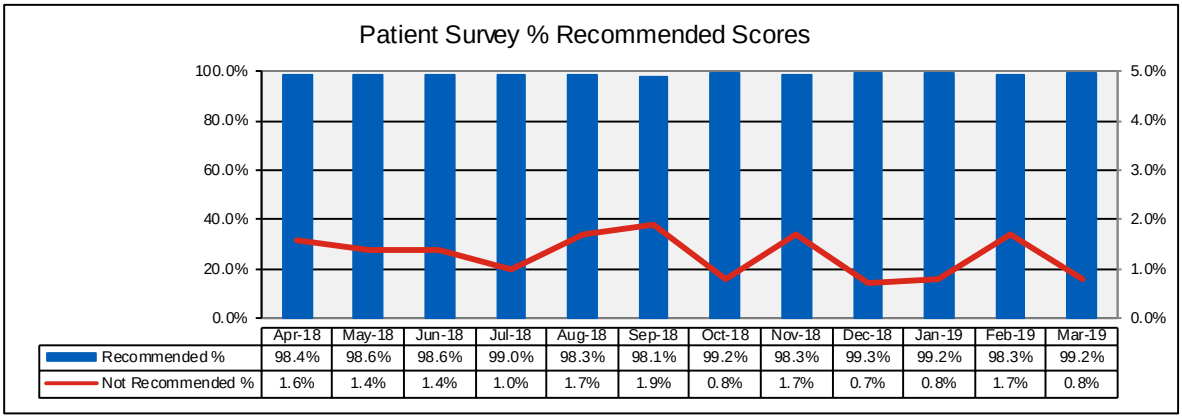
Where available, comparative and benchmark data has been included and unless otherwise stated the indicators are not governed by standard national definitions and the source of the data is the Trusts local systems. Our internal surveys below show that there has an improvement in patient satisfaction in 2018/19.

2017/18



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Recommended %	98.4%	98.1%	98.4%	98.2%	97.8%	98.4%	98.1%	98.2%	98.8%	98.8%	98.0%	98.5%
Not Recommended %	1.6%	1.9%	1.6%	1.8%	2.2%	1.6%	1.9%	1.8%	1.2%	1.2%	2.0%	1.5%

2018/19



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Recommended %	98.4%	98.6%	98.6%	99.0%	98.3%	98.1%	99.2%	98.3%	99.3%	99.2%	98.3%	99.2%
Not Recommended %	1.6%	1.4%	1.4%	1.0%	1.7%	1.9%	0.8%	1.7%	0.7%	0.8%	1.7%	0.8%

3.1.2 Complaints

The grading system captures complaints into grades 1 – 5 as demonstrated below

1	2	3	4	5
►Query/suggestion ►Verbal concerns resolved by the end of the next working day ►Anonymous comment forms raising concerns	►Allegation that service received substandard ►Simple complaints which can be resolved quickly	►Single issue complaints with allegation of lack of appropriate care ►Serious complaints containing one issue ►Simple complaint where more than one complaint has been received regarding the same subject from different complainants	►Multiple issue complaints with allegations of lack of care ►Serious complaints containing more than one issue	►Multiple issue, complex complaints ►Serious complaint where more than one complaint has been received regarding the same subject from different complainants ►Risk to organisational reputation

Complaints by division

2017/18

In 2017/18 The Christie received 73 complaints. The table below shows the number of complaints received by each division. It depicts the grading of complaints at the time they are received into the Trust. The grades are reviewed as part of the investigation process and some may be regraded either up or down at the end of the investigation

	Grade 2	Grade 3	Grade 4	Grade 5	Total
Network Services	13	13	27	0	53
Cancer Centre Services	7	3	8	0	18
Estates and Facilities	1	0	0	0	1
Research & Development	0	0	0	0	0
Other	1	0	0	0	1
Total	22	16	35	0	73

2018/19

In 2018/19 The Christie had 99 complaints. The table below shows the number of complaints by each division. It depicts the grading of complaints at the time they are received into the Trust. The grades are reviewed as part of the investigation process and some may be regraded either up or down at the end of the investigation

	Grade 2	Grade 3	Grade 4	Grade 5	Total
Networked Services	16	28	19	0	63
Clinical Support & Specialist Surgery	10	14	9	0	33
Estates and Facilities	2	0	0	0	2
Christie Medical Physics & Engineering	1	0	0	0	1
Research & Development	0	0	0	0	0
Total	29	42	28	0	99

The 99 complaints for 2018/19 are 26 more than were received in 2017/18.

We continue to resolve complaints at source; our clinicians, matrons, ward sisters and charge nurses have a high profile on the wards and in clinical departments where they focus on the patient experience and ensuring continual improvement in care and service delivery on a day by day basis. All complaints are reviewed weekly by the executive directors and all new complaints are triaged through an executive review process so that there is a triangulation between incidents, claims and complaints

83% of written complaint responses were sent within a timescale of 25 working days

Two complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) between April 2018 and March 2019. Five complaints investigations were concluded by the Ombudsman with four concluded as not upheld and one partially upheld

Complaints survey

The Christie has routinely sent complainants a questionnaire since August 2013 asking their views on how their complaint was handled and their opinion of the complaint response. The questionnaire was redesigned in August 2015 in line with The CQC report 'Complaints Matter' and Parliamentary Health Service Ombudsman 'My Expectations' 2015.

The respondents all felt confident to speak up when initially considering raising a complaint and

felt that the person to whom they initially raised the complaint to was overwhelmingly supportive and helpful.

The majority of responses indicated that making the complaint was simple. The behaviour of the Complaints Team was on the found to be helpful and supportive and respondents said that they found that in general that their case was treated with respect and understanding.

In regards to their complaint making a difference, it was split between those who maybe thought it made a difference and those who felt it hadn't, however, the majority would feel comfortable in making a complaint in the future or encouraging someone else to so.

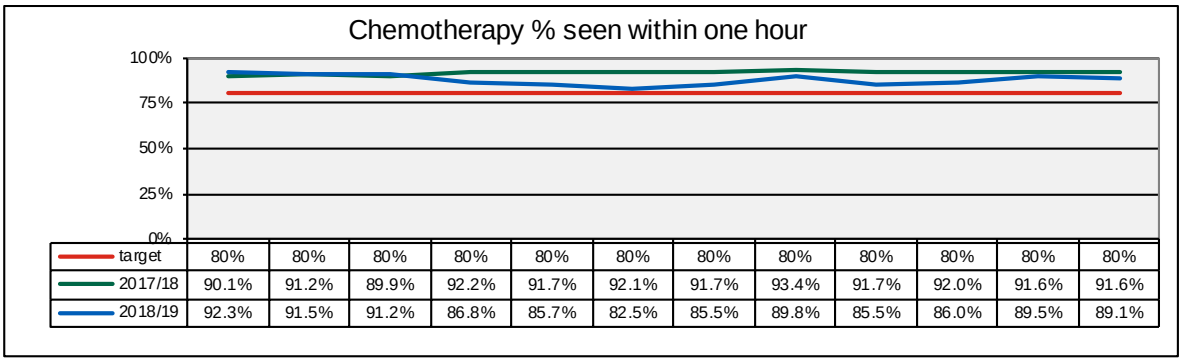
Learning from Complaints 2018/19

- Review of the pharmacy service in relation to patient waiting times resulting in recruitment of more reception staff, increased retention of staff, new staff training, and new waiting time system
- Screening of chemotherapy prescriptions by outreach team
- Alterations made to appointment times process for patients to prevent requirement for bloods
- Patient Experience Focus Group convened to discuss complaints process and the response letters content with a view to improving their quality and detail from the patients perspective
- Training of reception staff to deal more empathically with patients with attendance on the Positive Patient Experience course
- Education and update for medical staff on timely signing of death certificates and coroners referrals
- Provision and promotion of advanced communication skills training for healthcare professionals
- Review of process for second opinions to ensure it is meeting the need of patients and referrers
- Amendment of clinic templates to better reflect the work streams within clinics
- New process ensuring updated patient lists get to outreach clinics
- Process reviewed for communicating required medication changes with patients
- Review of the process for providing ward visiting times to visitors, including per-op assessment

3.1.3 On-the-day waiting times

We have continued to set ourselves the challenging target of ensuring that 80% of patients would wait no longer than one hour for their chemotherapy treatment

The graph below show the performance of this target for 2018/19 and we continue to monitor this target.



target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
2017/18	90.1%	91.2%	89.9%	92.2%	91.7%	92.1%	91.7%	93.4%	91.7%	92.0%	91.6%	91.6%
2018/19	92.3%	91.5%	91.2%	86.8%	85.7%	82.5%	85.5%	89.8%	85.5%	86.0%	89.5%	89.1%

3.2 Clinical indicators - Clinical Effectiveness.

National and local clinical audits show that the care provided by The Christie is effective in prolonging life and reducing the pain and distress associated with cancer and its treatment.
As described in our 2018/19 quality accounts outcomes such as mortality and complication rates after highly specialised, urological, gynaecological and colorectal surgery at The Christie have been reported to the board of directors and when published have set international benchmarks for standards of care. Similarly, outcomes of radiotherapy and chemotherapy for specific cancer types have shown care at The Christie to be of international standard. These results are published in professional journals and discussed at the Trust's regular mortality and morbidity meetings.

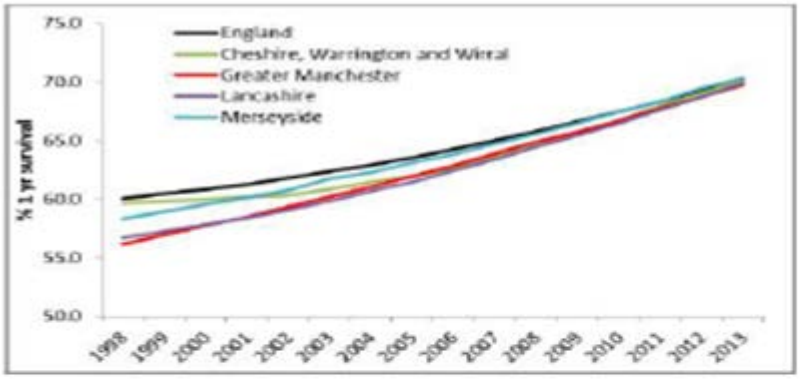
The board of directors receives a monthly presentation from a clinician describing a patient's story including the outcomes and effectiveness of the care that they provide. The board of directors also receives summary reports on the outcome measures. Reports are discussed at the quarterly morbidity and mortality meetings with the technical reports available to board members if required.

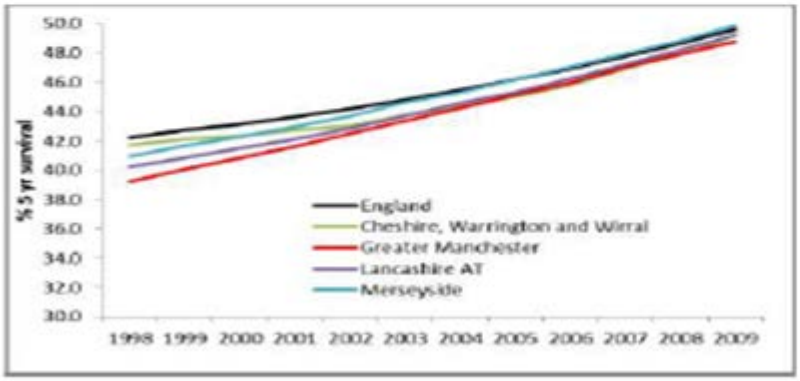
Cancer survival is dependent upon the type of disease, some cancers have worse prognosis than others e.g. lung cancer and therefore geographical differences in survival are often related to the relative incidence of poor prognosis cancers in that region. In the North West there is a particularly high rate of lifestyle related cancers in particular smoking related cancers that have poor prognosis. These lifestyle factors also influence how well a patient will respond to treatment. Nevertheless national published data (Figs 1) show Greater Manchester as having made the greatest improvements in all cancer survival in the North West over the past 15 years and that GM has almost equivocal one year (proxy for stage at presentation) and five year (proxy for treatment quality) survival rates to those achieved across England as a whole, the gap having now almost completely closed.

As a specialist cancer centre The Christie only sees patients in specific parts of the patient pathway following diagnosis rather than at the point of diagnosis and may not see some patients at all depending on their type of cancer and the stage of their cancer at diagnosis. For some cancer types only the most advanced patients are referred to The Christie. For others none of the most severe cancer patients are referred here. These differences need to be accounted for when benchmarking survival outcomes for Christie patients against national figures. Where national survival data are available by stage at diagnosis we are able to show comparable if not better 1 year survival for our patients compared to the national average (Table 1). We also publish our own outcomes reports available for each cancer type at http://www.christie.nhs.uk/about-us/our-standards/clinical-outcomes-unit/the-christie-outcomes/,

3.2.1 Five year cancer survival

Figure 1: Trends in one and five year all cancer survival for the areas in the North West of England and for England as a whole.



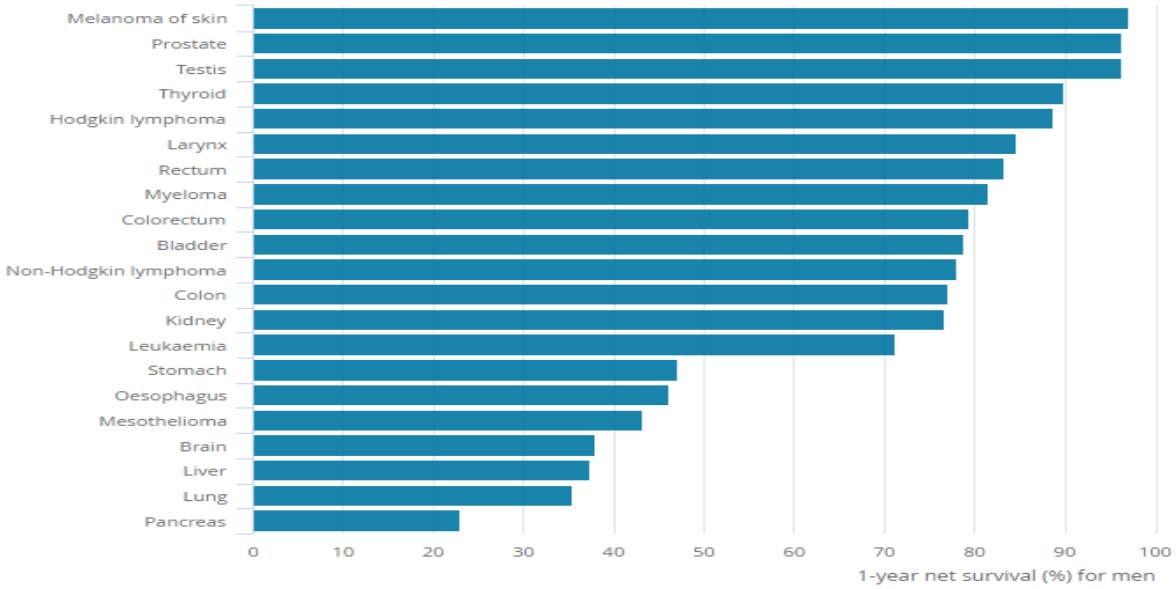


Data from Office for National statistics
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/cancersurvivalratescancersurvivalinenglandadultsdiagnosed

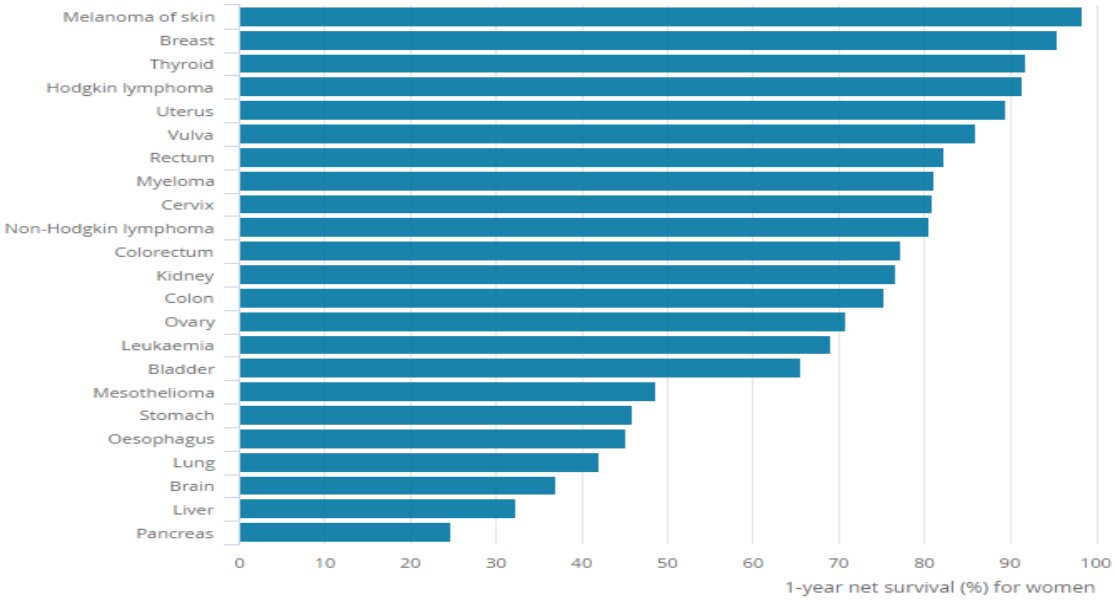
		All Stage		Stage 1		Stage 2		Stage 3		Stage 4	
Colorectal	England	80.0%		96.0%		93.0%		88.0%		46.0%	
	Confidence Interval	80.0%	81.0%	96.0%	97.0%	93.0%	94.0%	87.0%	89.0%	45.0%	47.0%
	Christie Patients	79.0%		100.0%		93.7%		94.3%		57.3%	
	Confidence Interval	76.6%	81.6%	100.0%	100.0%	90.3%	97.2%	92.1%	96.6%	52.7%	62.2%
Lung	England	39.0%		84.0%		68.0%		46.0%		19.0%	
	Confidence Interval	38.0%	40.0%	83.0%	86.0%	66.0%	70.0%	45.0%	48.0%	18.0%	20.0%
	Christie Patients	46.1%		83.2%		64.6%		51.0%		23.1%	
	Confidence Interval	44.5%	47.7%	80.6%	85.9%	59.4%	70.3%	47.6%	54.6%	21.1%	25.2%
Prostate	England	97.0%		100.0%		99.0%		99.0%		85.0%	
	Confidence Interval	97.0%	97.0%			97.0%	100.0%	98.0%	100.0%	84.0%	87.0%
	Christie Patients	97.9%		99.4%		98.7%		98.6%		91.5%	
	Confidence Interval	97.3%	98.4%	99.0%	99.8%	97.6%	99.8%	97.7%	99.7%	89.1%	94.0%
Ovary	England	72.0%		94.0%		78.0%		69.0%		50.0%	
	Confidence Interval	71.0%	73.0%	91.0%	96.0%	72.0%	83.0%	67.0%	71.0%	47.0%	53.0%
	Christie Patients	83.7%		97.6%		91.9%		80.2%		74.7%	
	Confidence Interval	80.2%	87.2%	94.4%	100.0%	83.3%	100.0%	74.8%	86.0%	67.0%	83.4%

Table 1: One year survival by cancer type for The Christie and England as a whole. England data are based on patients diagnosed in 2012 (http://www.ncin.org.uk/publications/survival_by_stage). *Data for the Christie are for patients diagnosed between 2012 and 2015 (time periods vary between cancer types).*

3.2.2 Age-standardised 1-year survival (%) for men (aged 15 – 99 years) diagnosed with a common cancer between 2011 and 2015 and followed up to 2016, England



Age-standardised 1-year survival (%) for women (aged 15 – 99 years) diagnosed with a common cancer between 2011 and 2015 and followed up to 2016, England



Source: Office for National Statistics (ONS)

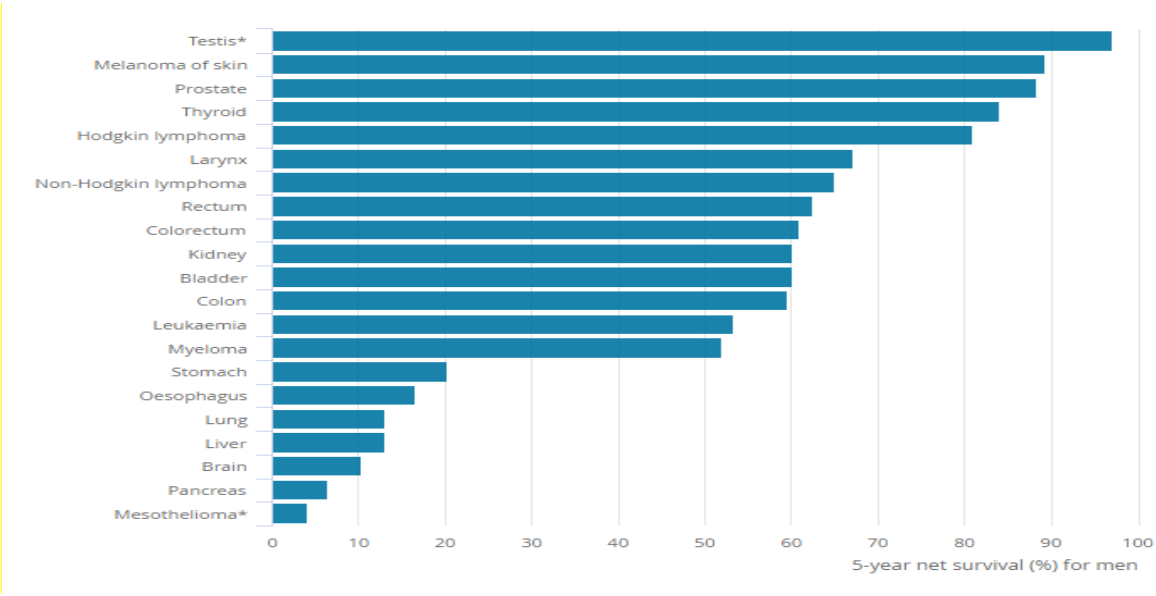
Our aim is to provide leadership within Greater Manchester and Cheshire to improve awareness of cancer symptoms and to support earlier local diagnosis, for example through supporting screening programmes. We aim to work with the providers in Greater Manchester and Cheshire to ensure effective diagnostic, treatment and referral pathways to The Christie and to ensure, through our clinical audit and other mechanisms that the treatment we provide meets best evidence based practice guidelines. As the cancer centre we have a responsibility to lead improvements in cancer services across Greater Manchester and Cheshire and whilst both one year and five year survival rates are the result of many factors other than the services provided by The Christie they are influenced by our services. We have the opportunity to support efforts at cancer prevention and earlier detection, as well as ensuring rapid diagnosis and referral when needed.

The table shows that for all cancer types the five year survival figures in Greater Manchester are similar to those for England as a whole. Differences between the figures do not reach statistical significance.

Demonstrating that our treatments are effective is very important as is demonstrating our contribution to improvements in cancer care across Greater Manchester and Cheshire. We have selected three indicators: the coverage of our clinical audit programme, examples of outcome data available and patient safety.

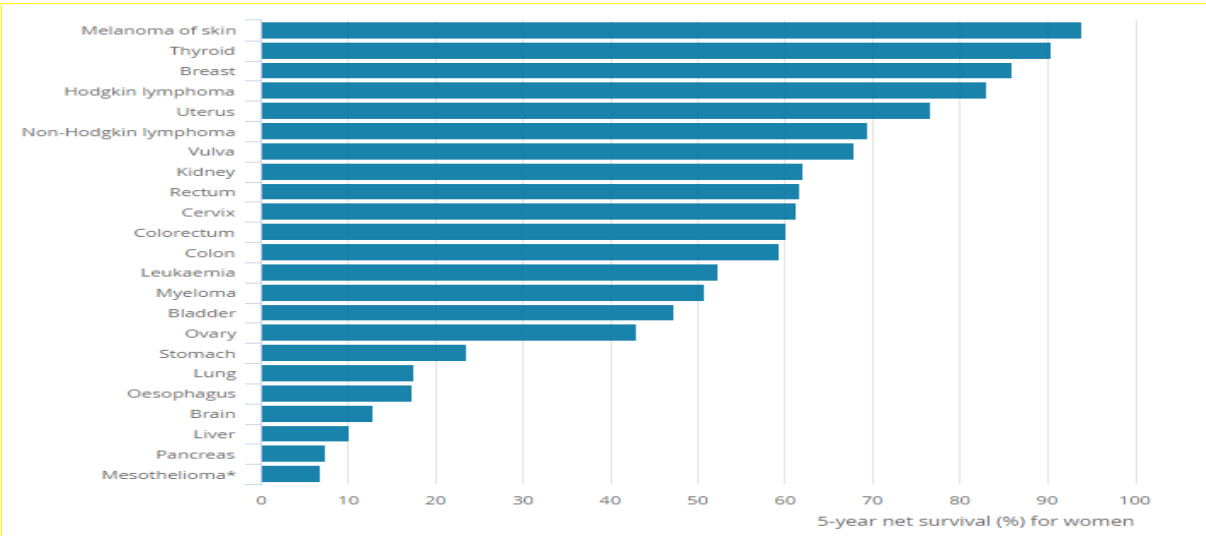
Clinical audit of our services provides data on the effectiveness and outcomes of care directly provided by The Christie. The audit programme is approved by the Board of directors and the outcomes of individual audits monitored by the clinical audit committee.

3.2.3 Age-standardised 5-year net survival (%) for men (aged 15 to 99 years) diagnosed with a common cancer between 2011 and 2015 and followed up to 2016, England



* denotes that the age-standardised estimate is not available and the unstandardised estimate has been presented.

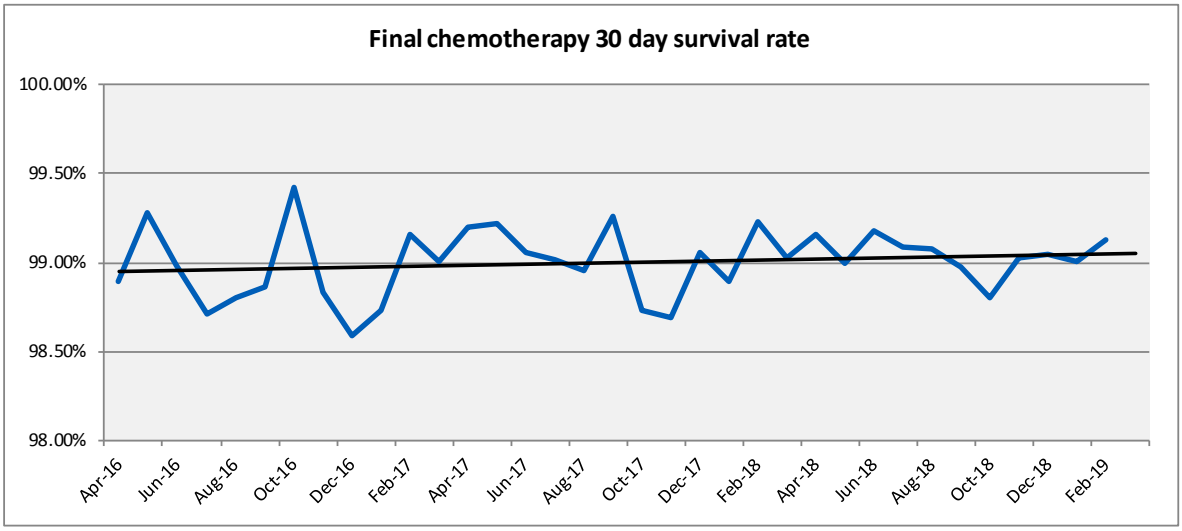
Age-standardised 5-year net survival (%) for women (aged 15 to 99 years) diagnosed with a common cancer between 2011 and 2015 and followed up to 2016, England

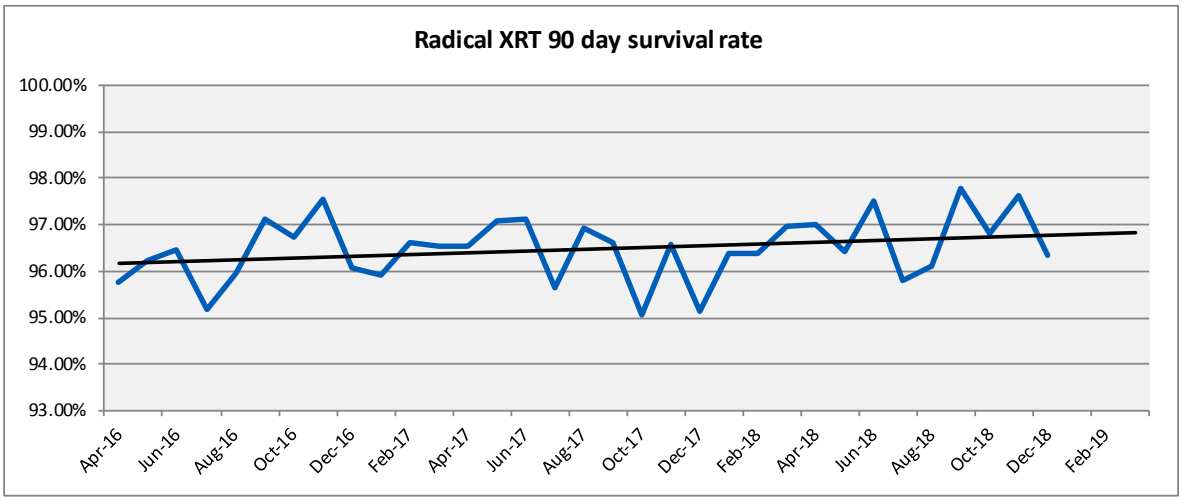


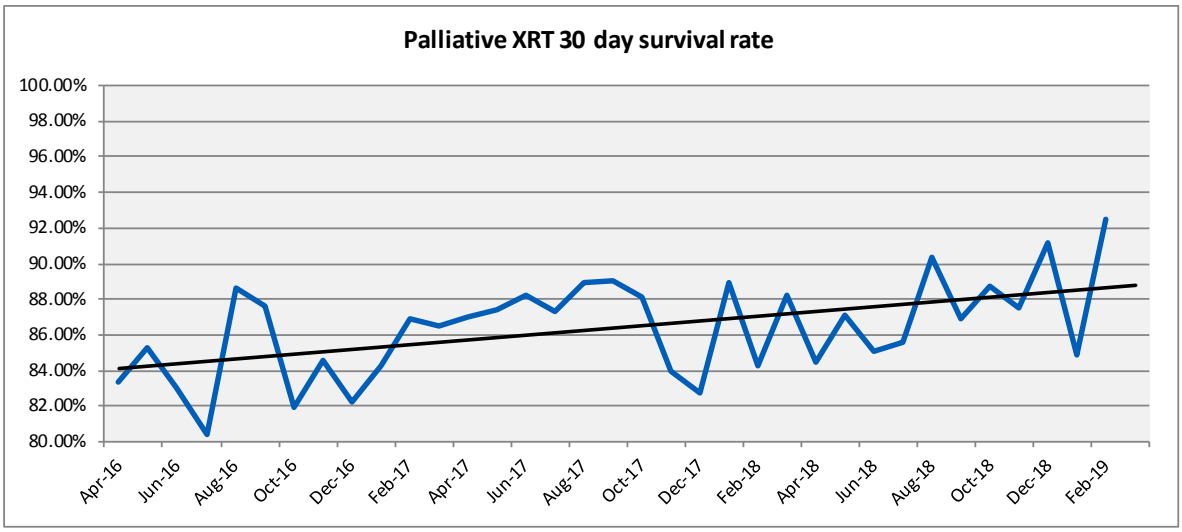
* denotes that the age-standardised estimate is not available and the unstandardised estimate has been presented.

Data from Office for National statistics
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/cancersurvivalratescancersurvivalinenglandadultsdiagnosed

3.2.4 Survival rates for 30 days post chemotherapy treatment, 90 days post radical radiotherapy treatment and 30 days post palliative radiotherapy treatment.







3.3 Clinical indicators - Patient safety

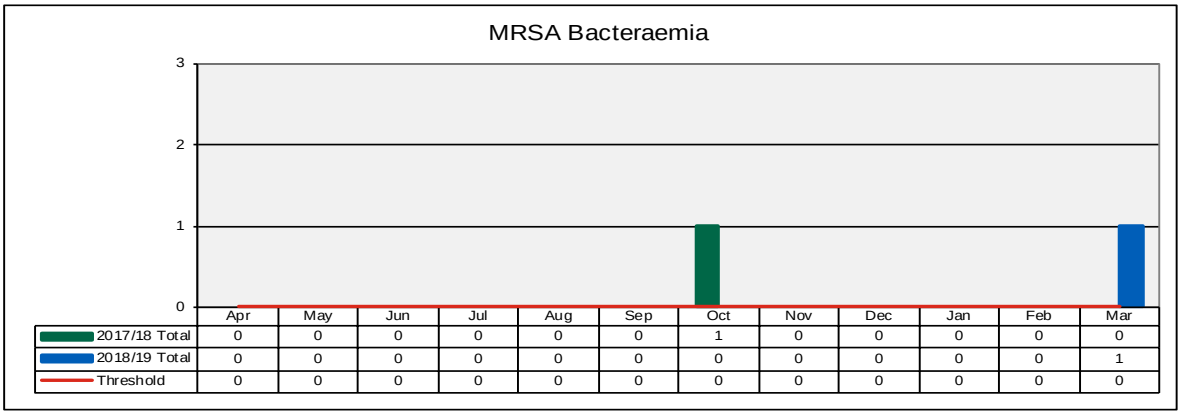
3.3.1 Healthcare acquired infections

We have low levels of healthcare acquired infections despite the particular vulnerability of many of our patients to infections as a result of their disease and treatment. Low rates of healthcare acquired infections indicate high standards of cleanliness, hygiene, antibiotic use and other measures to prevent cross-infection.

- **MRSA bacteraemia**

In 2017/18 we have had one case of MRSA bacteraemia, against a threshold of 0.

In 2018/19 we have had one case of MRSA bacteraemia, against a threshold of 0.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18 Total	0	0	0	0	0	0	1	0	0	0	0	0
2018/19 Total	0	0	0	0	0	0	0	0	0	0	0	1
Threshold	0	0	0	0	0	0	0	0	0	0	0	0

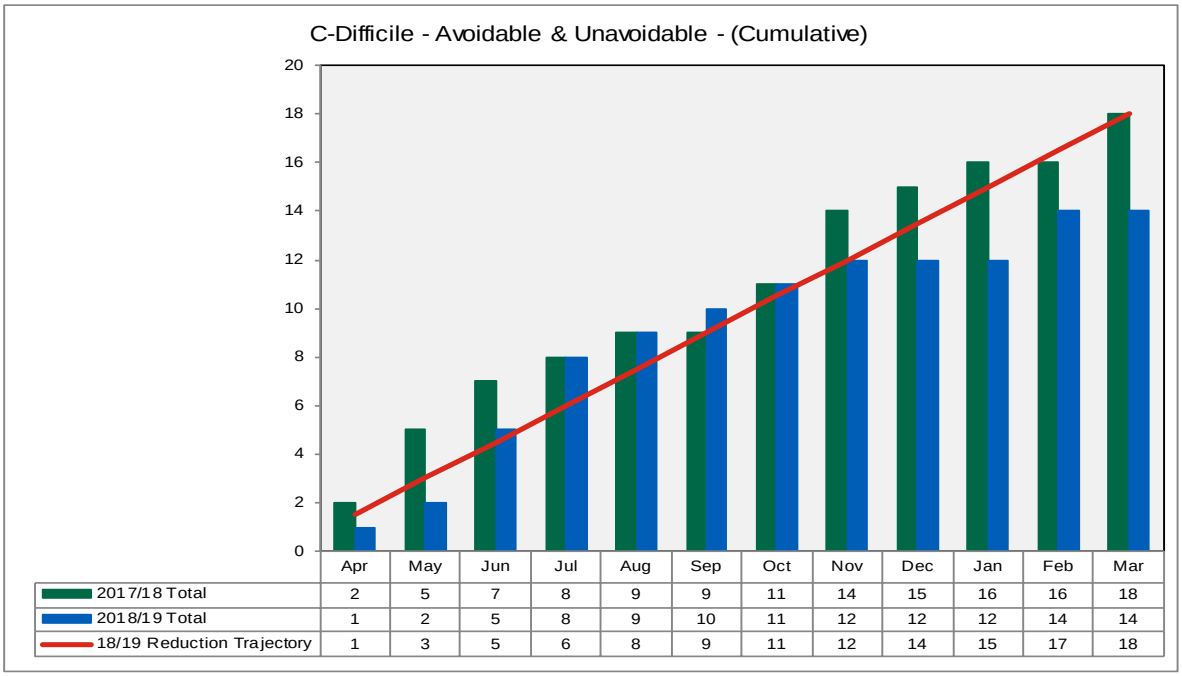
- **MRSA % appropriate elective patients screened**

In 2018/19 The Christie screened 100% of eligible elective patients.

3.3.2 Healthcare acquired infections - Clostridium Difficile

There were 14 cases of Clostridium Difficile infections (CDI) in 2018/19 against an agreed threshold of no more than 18. Upon full root cause analysis 5 of these cases were deemed avoidable by our commissioners. There were 26 cases that were identified on admission or pre 72 hours of admission and are therefore not attributable. The maximum impact of infection is a period of increased incidence of clostridium difficile of which the Trust has had one on ward 4 where four patients had clostridium difficile in a defined time period and two of the cases were found to be cross infection between two patients.

Each case of CDI is subjected to a rigorous review and multi-disciplinary root cause analysis. This has demonstrated that each attributable case of CDI was induced by the specialist treatment provided at The Christie. The treatments we provide make our patients more susceptible to CDI and this is balanced against the importance of delivering effective cancer treatments.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18 Total	2	5	7	8	9	9	11	14	15	16	16	18
2018/19 Total	1	2	5	8	9	10	11	12	12	12	14	14
18/19 Reduction Trajectory	1	3	5	6	8	9	11	12	14	15	17	18

3.3.3 Incidents Management

We have a strong system of incident reporting and review which enables us to identify underlying problems and to learn from events, thereby preventing recurrence.

We upload patient safety incidents from our internal system to the National Reporting and Learning System (NRLS). Comparison of our reporting practices with those of trusts in the same cluster of specialist trusts shows that we have good levels of reporting and low levels of patient harm, indicating an appropriate culture of reporting and learning within the organisation.

Our reporting rate for patient harm incidents occurring in 2018/19 was on average 0.11% of activity (all patient episodes).

All reported incidents are investigated, with the level of investigation commensurate with the incident grade. All incidents with an impact grade of 3 (moderate) and above, out of a maximum of 5, are reported on a weekly basis to the executive team. These incidents are triaged by an executive review team consisting of the Chief Nurse and Executive Director of Quality, the Medical Director, the Associate Chief Nurse and Deputy Director of Quality, the Associate Medical Director. The outcome of the root cause analysis is then presented to this review group. The same process is followed for complaints and claims and any concerning on-going trend of incidents of any grade.

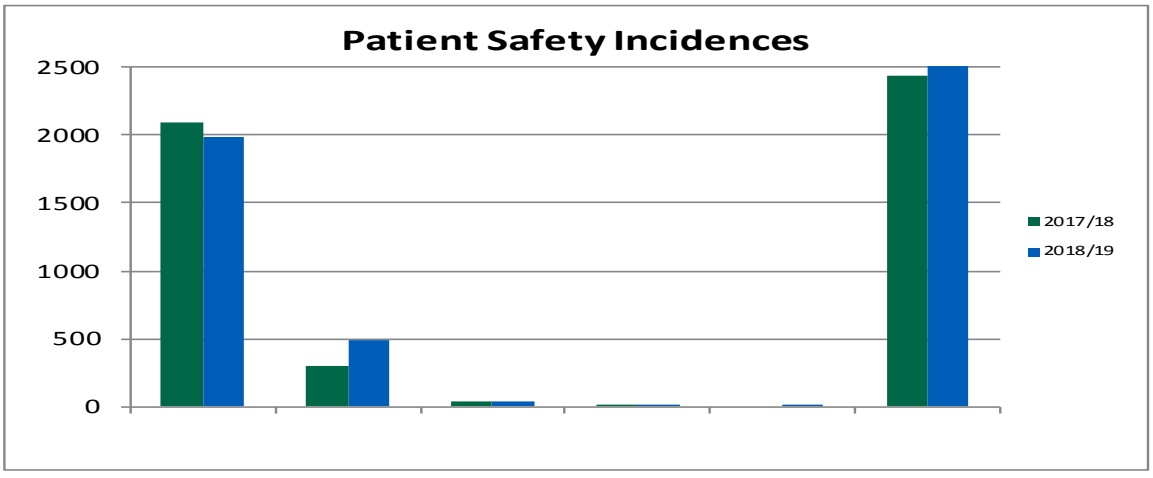
We also review our systems and processes in the light of national reports in order to ensure that similar incidents will not happen at The Christie.

The data for the second half of 2018/19 is not formally closed down until the end of May 2019, therefore the data contained within these accounts is subject to further validation

Patient Safety Incidences.

The Christie is regarded nationally as a high reporting, low harm organisation. The Trust uploads information about its patient safety incidents into the National Reporting and Learning System (NRLS) on a monthly basis. Twice yearly reports are published and made available into the public domain by the NRLS, based on the incidents submitted by the Trust. In addition, monthly updates are published on the NHS Improvement website

The Christie has a small number of in-patient beds, compared with other hospitals, and over 95% of its activity is ambulatory care (out patients and day cases).



An increase in the number of patient safety incidents from 2017/18 to 2018/19 is mainly attributable to the fact that since September 2018 reactions to medication and blood transfusions have been reported as clinical incidents rather than clinical events, in line with NRLS guidance.

3.3.4 Serious Incidents

There were three serious incidents reported this year. These related to:

- Administration of a contra-indicated medication
- Unexpected death following complications of elective gastrostomy insertion
- Safeguarding incident regarding allegation against nurse

*the Serious Incident panel concluded that the death was multifactorial and not directly related to the care received following the procedure and downgraded this from a Serious Incident.

Serious incident panels are chaired by a Non-Executive Director and also comprise of two Executive Directors. The panel reviewed each of these incidents, for which lessons learned were identified and implemented.

3.3.5 Duty of Candour.

We have a Duty of Candour policy which is based on the requirements of regulation 20 of the Health and Social Care Act and evidence gained from national data regarding recommendations from major inquiry reports, government initiatives and the experience of other countries.

Each incident handler is asked to ensure that a Duty of Candour conversation happens within ten working days for each patient safety incident graded 3, 4 or 5. The handler may arrange for a more appropriate person to talk with the patient or their family, for example the consultant or a senior nurse.

Information from this initial discussion is taken account of within the incident investigation and the person undertaking the Duty of Candour keeps in touch with the patient or their family as appropriate during the investigation. At the end of the investigation, feedback is given on the outcome which will include any learning that has been identified.

3.3.6 Never Event.

There have been 0 (zero) never events in 2018/19

3.3.7 Pressure Ulcers

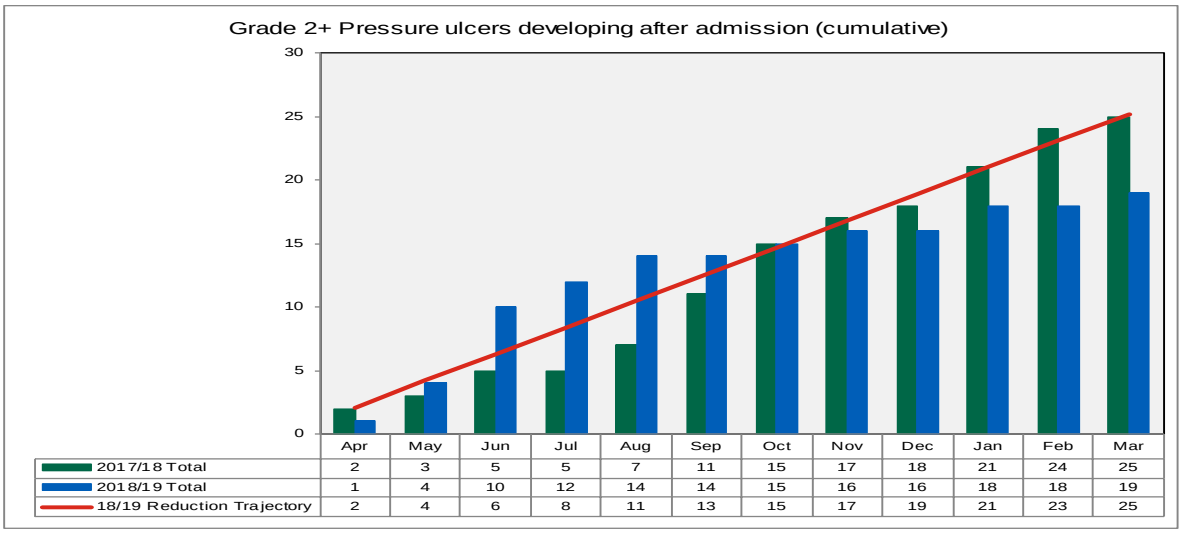
We aimed for no more than 25 category 2 or above hospital acquired pressure ulcers in 2018/19. This target remained consistent with the target in 2017/18. No category 3 & 4 hospital acquired pressure ulcers were reported. The chart below demonstrates that we have achieved the target; there have been 16 pressure ulcers category 2 and no category 3& 4 pressure ulcers that developed after admission in this financial year.

An Executive Nursing Panel is undertaken to review all category 2 pressure ulcers and above. Recent NHSI guidance advises that NHS Trust's should no longer use the definition of avoidable or unavoidable.

This has therefore not been included in this report.

Themes arising from RCA investigations have been identified as:

- Inaccurate calculation of pressure ulcer risk factors.
- Failure to reassess risk on change of condition and change of care setting
- Failure to conduct a head to toe skin inspection
- Failure to initiate a repositioning regime for patients at risk of pressure ulcers
- Failure to use pressure relieving mattress pump or other pressure redistribution equipment

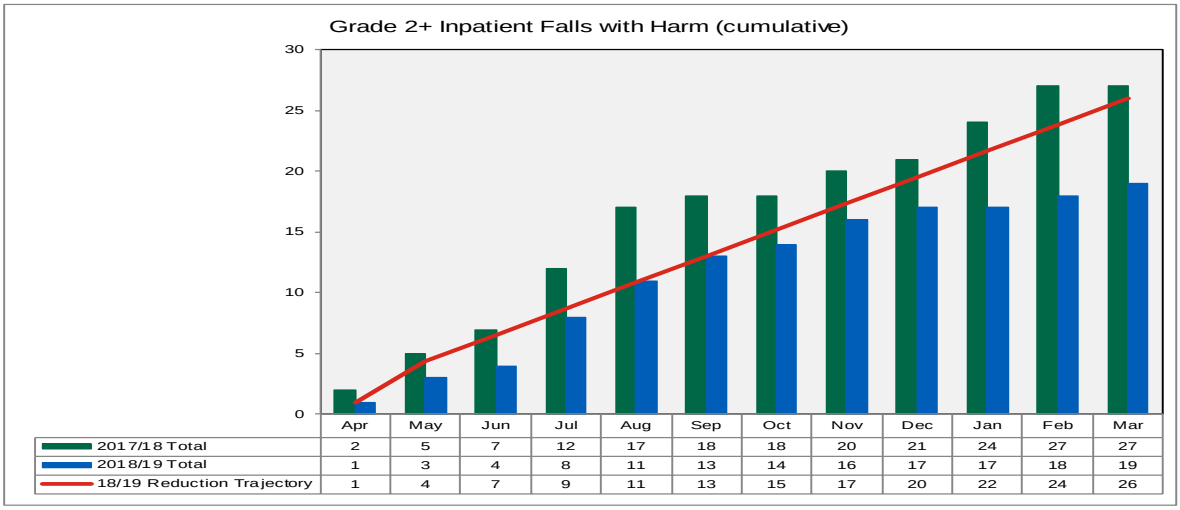


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18 Total	2	3	5	5	7	11	15	17	18	21	24	25
2018/19 Total	1	4	10	12	14	14	15	16	16	18	18	19
18/19 Reduction Trajectory	2	4	6	8	11	13	15	17	19	21	23	25

3.3.8 Patient Falls.

We aimed to maintain the 2016/17 outturn of no more than 26 falls with harm.

The chart below demonstrates that we have achieved the target; there have been 19 inpatient falls with harm in 2019/20.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18 Total	2	5	7	12	17	18	18	20	21	24	27	27
2018/19 Total	1	3	4	8	11	13	14	16	17	17	18	19
18/19 Reduction Trajectory	1	4	7	9	11	13	15	17	20	22	24	26

3.3.9 Local Clinical Audits

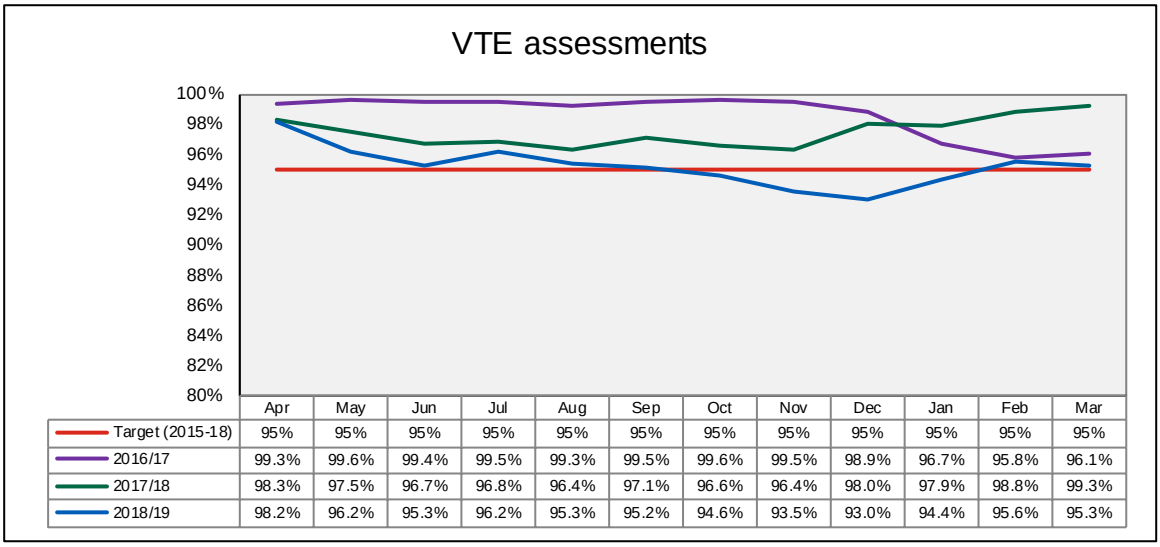
In 2018/19 187 audits were completed across the divisions as shown in the table:

Division	Number of completed audits in 2013/14	Number of completed audits in 2014/15	Number of completed audits in 2015/16	Number of completed audits in 2016/17	Number of completed audits in 2017/18	Number of completed audits in 2018/19
Clinical Support and Specialist Surgery (formerly Cancer Centre services)	60	78	80	78	88	95
Networked Services	62	68	76	90	82	69
Other (Quality & standards, School of oncology, Research)	11	14	20	20	17	18
Total	**133**	**160**	**176**	**188**	**187**	**185**

The results of these audits are described in the annual clinical audit report with data from some of these audits being reported to the board of directors.

3.3.10 Venous thrombo-embolism assessment

Our aim is to increase the number of patients receiving a thromboprophylaxis assessment on admission to over 95%. This is presented monthly in the integrated performance report and is also uploaded nationally.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target (2015-18)	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
2016/17	99.3%	99.6%	99.4%	99.5%	99.3%	99.5%	99.6%	99.5%	98.9%	96.7%	95.8%	96.1%
2017/18	98.3%	97.5%	96.7%	96.8%	96.4%	97.1%	96.6%	96.4%	98.0%	97.9%	98.8%	99.3%
2018/19	98.2%	96.2%	95.3%	96.2%	95.3%	95.2%	94.6%	93.5%	93.0%	94.4%	95.6%	95.3%

4. NHS Staff Survey

Indicator	2016/17	National Average (specialist trusts only)
Q13c - % of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	15.7%	18.8%
Q14 - % of staff believing that the trust provides equal opportunities for career progression or promotion regardless of ethnic background, gender, religion, sexual orientation, disability, age	91.0%	86.1%

5. Inpatient mortality reviews at the Christie 2017/18

The Christie as a specialist trust does not participate in the HSMR reporting framework. The process for mortality reviews was established in 2011. From April 2017, mortality reviews for deaths occurring on site have been undertaken in accordance with the recommendations from the National Quality Board (National Guidance on Learning from Deaths, March 2017). The process is overseen by the Board Quality Assurance Committee and the Patient Safety Committee receives information on findings and actions form the reviews.

In January 2018 Merseyside Internal Audit undertook a review of the new process and reported this had significant assurance. Areas for improvement did identify the need to improve

timeliness of screening completion, and follow up of learning.

All on-site deaths are screened using a set of triggers for further review. This is undertaken by the mortuary team, who also ask families about any concerns; the ward nursing team and the responsible medical team are asked to complete a brief on-line screening questionnaire. The triggers include deaths reported to the coroner, deaths within 30 days of chemotherapy, indicators of acute deterioration, planned interventions and any significant incident during the last admission.

These reviews are allocated to one or more trained independent reviewers and discussed at regular Mortality Surveillance Group meetings. The RCP Structured Case Review tool is used to define the outcome in terms of care and avoidability of the death. Concerns identified are reported to the weekly executive review group who will oversee further investigation if indicated. From Q3, mortality outcomes are included in Board performance reports.

Monitoring of deaths

Deaths each week are monitored by the Executive review group to identify any exceptional trends. During 2018/19 293 Christie patients died at the Withington site (as of 25th March 2019). There has been an increase over the last three years, the majority of which followed a non-elective admission. These are all Christie-registered patients, triaged prior to admission. No other factors have been identified. A comparison with the previous two year is shown below:

	2016 -2017	2017 - 2018	2018 - 2019
Total deaths in year	237	271	293
Deaths following emergency admission	212 (90%)	222 (82%)	266 (91%)
Emergency admissions in year	5081	6212	5921
% deaths /total emergency admissions	4.17%	3.57%	4.49%
Total admissions (excluding day cases)	10, 079	10,768	10,154
% deaths /total admissions	2.35%	2.51%	2.88%

By 25th March 2019 115 cases have been referred for structured- judgement case reviews (SCR) of which 91 have been completed. 84 cases have been further reviewed by the MSG. In 13 cases a death was subjected to both a case record review and further investigation.

During 2018/19, 292 of The Christie NHS Foundation Trusts patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

2018/19	No. deaths onsite	Triggered mortality review (number process completed to date)
Q1	74	29 (86%)
Q2	79	34 (100%)
Q3	78	29 (83%)
Q4	61	23 (35%)

39% of the deaths 'triggered' for a more detailed review by one or more of the categories below (one patient may have activated more than one trigger):

Mortuary triggers activated	Frequency
Death reported to coroner	60
Death on CCU	22
Death following cardiac / respiratory resuscitation attempt	7
Death < 24 hours after admission	6
Age < 18 years	-

Nursing triggers	Frequency
DoLS in place during this admission	5
Significant mental health issue e.g. psychosis:	4
Family raised a significant concern about care in this last admission	3
Staff raised a significant concern about care in this last admission	2
A grade 3 or 4 incident OR 2 or more grade 2 incidents last admission	-

Clinical trigger(s)	Frequency
Death substantially related to or as a direct consequence of sepsis	32
Death was unexpected this admission (excluding cancer related events)	27
<30 days SACT (day 1 of any given cycle) where death may be treatment related	23
Death substantially related to or as a consequence of Stage 3 AKI	15
Other concerns where clinical team felt case review was indicated	14
Death of this patient, on this admission, is considered by you to be possibly or probably avoidable	6
Death linked to planned procedure or surgery at The Christie in last admission	5

To date, 84 (92%) reviews have been undertaken and discussed at Mortality Surveillance Group meetings (not all reviews and any subsequent process will be fully completed until the close of Quarter 1 2019-20).

No deaths in year to date have involved a patient with a learning disability. Concerns were raised by 3 bereaved families through the Mortuary screening question and reviews were triggered for each of these. These families are supported by the PALS team, with subsequent feedback offered by PALS or clinical team.

Outcomes of reviews

Tables below show the final outcomes of the review process year to date (validated data to end of Q3.

Note these are the validated scores for avoidability of the death and overall care once any additional investigation has been completed.
13 deaths since April have been referred to the executive review group (ERG) for further investigation. Following this a final rating for care and avoidability is agreed.

Avoidability
Key:
RCP 1 = definitely avoidable; RCP 2 = strongly avoidable; RCP 3 = > 50% avoidable; RCP 4 = <50% avoidable; RCP 5 = strongly unavoidable; RCP 6 = unavoidable and LD = learning disability
The ratings for **overall avoidability of death** confirmed by the Mortality Surveillance Group are shown in the next table:

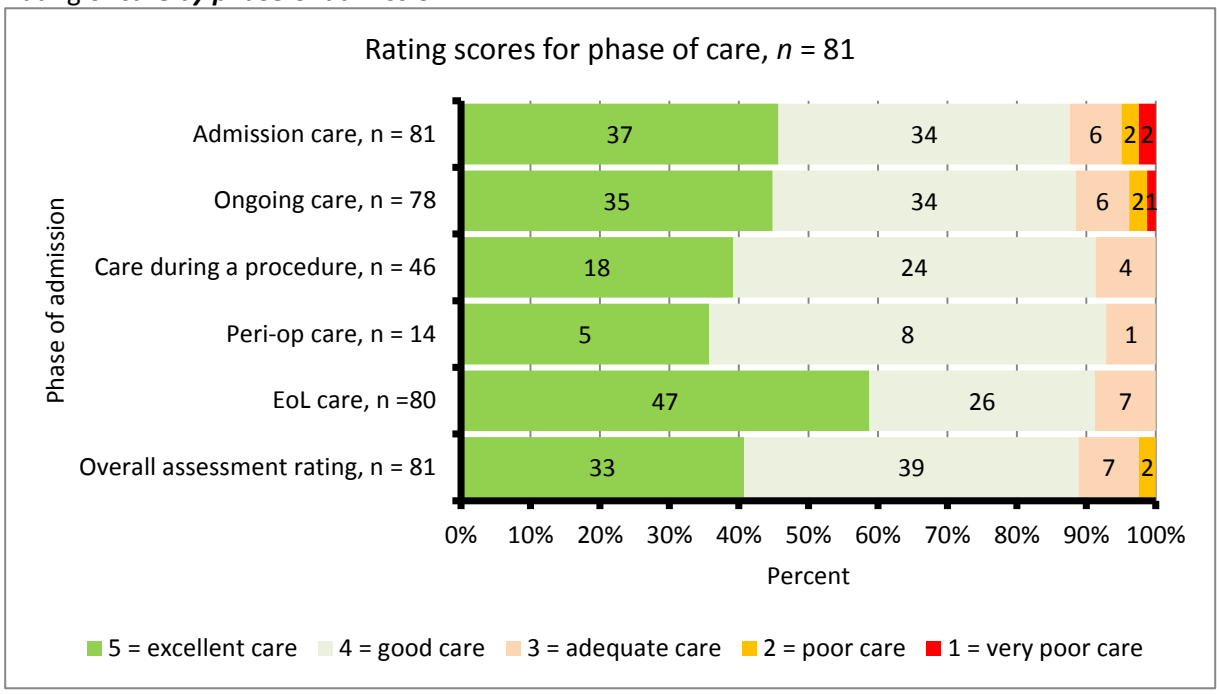
Month (2018-19)	Total Deaths (not LD)	SCR final (not LD)	Deaths Avoidable > 50% (not LD)	RCP 1	RCP 2	RCP 3	RCP 4	RCP 5	RCP 6	LD Deaths	LD Deaths Reviewed	LD Deaths Avoidable > 50%
Apr	25	8	-	-	-	-	-	-	**8**	-	-	-
May	24	8	-	-	-	**1**	-	-	**7**	-	-	-
Jun	25	9	-	-	-	-	-	**1**	**8**	-	-	-
Jul	33	15	-	-	-	**1**	**1**	**1**	**12**	-	-	-
Aug	25	10	-	-	-	-	**1**	**2**	**7**	-	-	-
Sep	21	8	-	-	-	-	-	-	**8**	-	-	-
Oct	38	16	-	-	-	-	**2**	-	**14**	-	-	-
Nov	19	3	-	-	-	-	-	**1**	**2**	-	-	-
Dec	21	4	-	-	-	-	-	-	**4**	-	-	-
Jan	24	3	-	-	-	-	-	-	**3**	-	-	-
Feb	19	-	-	-	-	-	-	-	-	-	-	-
Mar	19	-	-	-	-	-	-	-	-	-	-	-
Total	293	84	-	-	-	2	4	5	73	-	-	-
Sub Total to Q3	**231**	**81**	**-**	**-**	**-**	**2**	**4**	**5**	**70**	**-**	**-**	**-**

Assessment of care provided

The final ratings for *overall care* in 81 reviews completed and validated to end of Q3 are shown below. Reviewers rate each phase of care and overall care for the admission was good or excellent in 81 / 91 (89 %).

	Overall care rating					
Month (2018)	1 = very poor care	2 = poor care	3 = adequate care	4 = good care	5 = excellent care	Total
April	-	-	2	3	3	8
May	-	-	-	6	2	8
June	-	-	-	2	7	9
July	-	-	3	6	6	15
August	-	1	-	7	2	10
September	-	-	-	5	3	8
October	-	1	1	8	6	16
November	-	-	-	1	2	3
December	-	-	1	1	2	4
Grand Total	**-**	**2 (<2%)**	**7 (9%)**	**39 (48%)**	**33 (41%)**	**81 (100%)**

Rating of **care *by phase* of admission**:



13 deaths since April have been referred to the executive review group (ERG) for further investigation. One death was investigated as a Serious Incident (subsequently down- graded); two underwent a formal root-cause analysis, and 10 required a second review led by either the Executive Medical Director or Associate Medical Director for Quality. As part of this process, learning is identified and a final rating for care and avoidability is agreed.

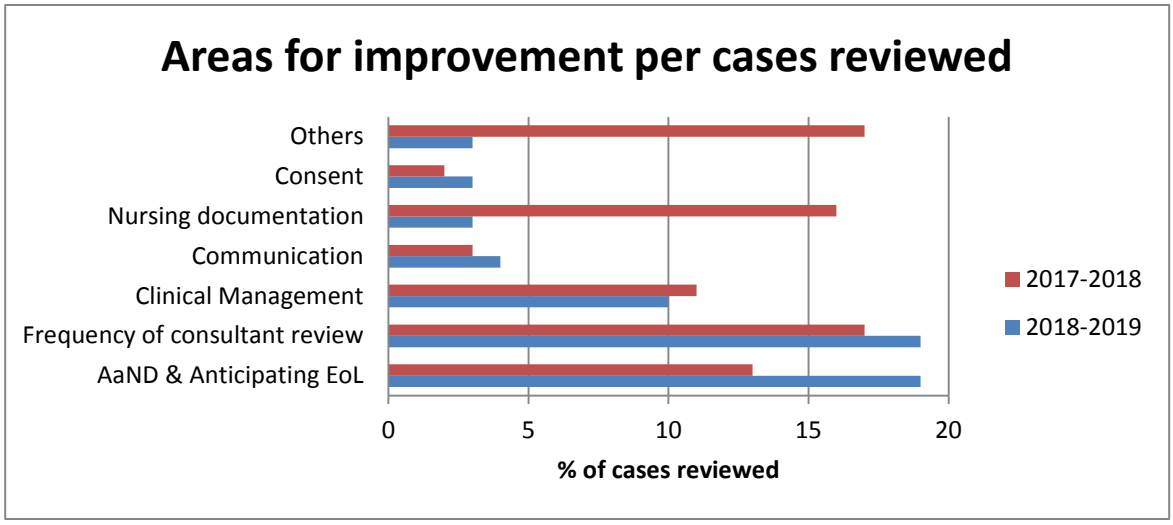
In some instances, further investigation provided assurance. For example, a second review of a death relating to management of a patient with sepsis conducted by the Associate Medical Director and the trust sepsis nurse, who concluded that the clinical management was appropriate and consistent with local and national guidance. An investigation into to a missed opportunity for earlier escalation to outreach in an unwell patient identified learning relating to management of the deteriorating patient, but concluded that the death was unavoidable and earlier intervention from outreach/oncology consultant would not have changed the outcome.

The serious incident investigation related to a death following a planned procedure. On hearing the outcome of the investigation, the Serious Incident panel concluded that the death was multifactorial and not directly related to the care received following the procedure and downgraded from a Serious Incident. The final overall care rating was 4 (good care) and avoidability score 4 (possibly avoidable but less than 50:50).

An investigation concerned a death due to a complication of chemotherapy, caused by a rare enzyme deficiency (DPD) present in <1% of the population. The review identified no lapse in care although had routine screening for DPD deficiency been part of standard care, the enzyme deficiency could have been detectable and the chemotherapy drug avoided. It was noted that there are currently no national guidelines or recommendations regarding screening patient for DPD deficiency prior to chemotherapy. NHS England has proposed an intention to commission screening for DPD deficiency through Genomic Hubs from April 2020. A working group is reviewing how this could be established earlier at The Christie while raising awareness in patients who are at risk.

Learning from deaths

Reviewers also comment on low level concerns (felt not to have had an impact on care outcome). A trend analysis of these has been undertaken for all reviews in year and the top themes among the low level concerns compared to the previous year. The top themes that did not adversely affect outcome but where reviewers felt there could be improvement are shown below.



Actions from the reviews have included:

- the development of a Quality Improvement Programme in interventional radiology to improve post-procedure care
- improving documentation and handover of Allow a Natural Death status
- Formation of a working group at The Christie to explore is a role for DPD deficiency screening in appropriate patients
- SACT delivery group introducing a pop-up to the electronic prescribing system reminding prescribers to consider stopping nephrotoxic medication when nephrotoxic chemotherapy prescribed
- Educating ward teams regarding process for escalating to outreach
- Formalising team-based consultant cover arrangements for in-patient care
- Grand Round event on Anticipating end of life and earlier 'Allow a natural death' discussions

Findings from the mortality reviews have informed many of the Trust work programmes, including End of Life Care, 7-day services and in-patient care, and ReSPECT (a communication tool to capture aims of care including resuscitation status and levels of intervention for a deteriorating patient).
This information is reported 6 monthly to the Board Quality Assurance Committee.

Summary

A rigorous and on-going process for mortality review has been established in accordance with national requirements. This demonstrates a low level of deaths which were potentially avoidable and overall care provided was good or excellent.

6. Performance against key national priorities

The Christie aims to meet all national targets and priorities. We have provided an overview of the national targets and minimum standards including those set out within Monitor's Compliance Framework below.

The indicators "18 Week Targets - 18 week incomplete pathways" and "Cancer Targets - % of cancer patients waiting a maximum 62 days from GP referral to first definitive treatment including rare and testicular cancers (based on the GM&C reallocated position, and also on the new national allocation position)" in the table below have been subject to external assurance from our auditors

based on the annual out-turn performance, and are marked below with:

National targets and minimum standards	Target	Threshold 2018/19	Q1	Q2	Q3	Q4	Yearly position
Infection control	Number of Attributable C-Diff cases	18	5	5	2	2	**14**
	Number of MRSA Bacteraemia	0	0	0	0	1	**1**
	MRSA Screening	100%	100%	100%	100%	100%	**100%**
Cancer Targets	% of cancer patients waiting a maximum of 31 days for diagnosis to first definitive treatment	96%	97.1%	96.1%	96.4%	97.0%	**96.6%**
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti- cancer drugs)	98%	99.8%	99.7%	99.6%	99.9%	**99.7%**
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	94%	98.0%	96.2%	98.7%	98.9%	**98.0%**
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (radiotherapy)	94%	99.6%	99.7%	99.9%	99.6%	**99.7%**
	% of cancer patients waiting a maximum of 62 days from GP referral to first definitive treatment including rare and testicular cancers (based on GM&C reallocated position).	85%	86.3%	86.1%	82.8%	78.1%	**83.4%**
	% of cancer patients waiting a maximum of 62 days from GP referral to first definitive treatment including rare and testicular cancers (based on national allocated position).	85%	83.3%	80.3%	74.6%	77.5%	**79.1%**
	% of cancer patients waiting a maximum of 62 days from screening referral to first definitive treatment (based on GM&C reallocated position)	90%	100.0%	100.0%	88.2%	100.0%	**95.6%**
	% of cancer patients waiting a maximum of 62 days from screening referral to first definitive treatment (based on national allocated position)	90%	77.8%	91.3%	88.9%	77.8%	**86.4%**
18 Weeks	18 week incomplete pathways	92%	98.7%	98.4%	98.5%	98.6%	**98.5%**
6 Weeks diagnostic waits	Maximum 6 week wait for diagnostic procedures	no value	100.0%	100.0%	100.0%	100.0%	**100.0%**

*Following a national policy change the 62 day standard has shown a decline in performance throughout 2018/19, along with the rest of the Country. Full action plans are in place to ensure that this standard will to be back on trajectory throughout 2019/20.

Independent Review of Quality Reports:

An assurance opinion on data quality within the Quality Report is also provided by our External Auditors, Grant Thornton who are required to perform audit work on two nationally mandated performance indicators and one local indicator mandated this year by NHSI. The performance indicators and their criteria are as follows:

Mandatory Performance Indicators

The reported indicators performance has been calculated based on all patients recorded as having been referred to the Christie NHS Foundation Trust for consultant led services, against the 62 day standard and for patients who are on incomplete pathways at the end of the period.

i) <u>Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers</u>

Where the numerator is the number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05) and the

Denominator is the total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).

Reallocation of breaches between Trusts are made depending on when the referral has been transferred to a secondary Trust for further treatment, with referrals made before day 42 resulting in breaches being allocated to the treating Trust but referrals after day 42 resulting in breaches being reallocated to the referring Trust.

ii) Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

Where the numerator is the number of patients on an incomplete pathway at the end of the reporting period (monthly) who have been waiting no more than 18 weeks and the denominator is the total number of patients on an incomplete pathway at the end of the reporting period.

Outlined below are the verbatim statements on the feedback of our quality accounts from:

- NHS England Specialist Commissioning
- The Christie Governors
- Statement of the Directors
- Independent Auditors

1. NHS England Specialised Commissioning

The Christie NHS Foundation Trust Quality Account 2018/19

NHS England, Specialised Commissioning team wishes to thank The Christie NHS Foundation Trust for the opportunity to comment on their Quality Account for 2018/19. As lead commissioner, we are committed to working in partnership with The Christie to provide safe, high quality care and services. The Quality Account clearly sets out the progress against priority areas for the last 12 months and details the priorities for 2019/20. The rationale for the forthcoming years priorities are well documented. The account sets out how each priority is measured and monitored and there is clear evidence of good governance from 'ward to Board'. The Quality Account gives a thorough and detailed account of Quality at The Christie NHS Foundation Trust.

Commissioners wish to highlight notable achievements of the Trust, firstly in gaining 'Outstanding' for the second consecutive CQC inspection in both the routine inspection and well led, this is a testament to the hard work of the staff and Board. The report also sets out achievements in patient experience including being in the top scoring Trusts for quality of care in the National Inpatient Survey and consistently achieving high scores in the Friends and Family test. It is evident that patient experience and engagement is at the heart of the Trust.

The Quality Account demonstrates a real focus on quality and outcomes and there is strong evidence of patient engagement and learning from patient experience, notably utilising the lessons learnt from complaints and mortality reviews to change practice to ensure continuous improvement in patient experience and care. It is evident that the Trust have used patient experience outcomes to develop 19/20 priority areas.

There is a clear commitment to patient recruitment to clinical research with number of patients recruited increasing year on year. Commissioners have seen commitment to CQUIN over the last year and the Quality Account demonstrates the achievements to Quarter 3 milestones. The account also provides assurance regarding the robust governance within the Trust. There is an open and honest culture of reporting, the account details serious incidents that have occurred and shows how the learning is disseminated and changes in practice embedded within the organisation.

The Christie has provided high levels of quality assurance throughout 2018/19 through regular contract, quality and performance meetings with Commissioners, achieving significant achievements against the National Specialised Commissioning quality dashboards.

Specialised Commissioners would like to take this opportunity to congratulate all staff on their hard work in ensuring high quality care is delivered and consistently maintained throughout the year.

We look forward to continuing to work in partnership with The Christie during 2019/20.

ANDREW BIBBY
Assistant Regional Director of Specialised Commissioning (North)

2. The Christie Governors

Governors Quality Statement for Quality Accounts April 2018-March 2019

Continuing Open Relationship between the Council of Governors and Board of Directors

The relationship between the Council of Governors and The Christie NHS Foundation Trust has enabled us to continue to work together throughout 2018-2019 and to learn from and understand the quality of the patients' experience across the Trust and see continuous improvements.

The joint board of directors and council of governors' time outs continue to offer protected time for board members and governors to jointly work on quality improvements and ensure a good working knowledge of each other's remits. Our last time out was on Friday 7th December 2018.

Access to Appropriate Information

All Governors receive the chief executive's report and the summary integrated performance report following each board meeting with comments and questions readily invited. There are three subcommittees of the Council of Governors and executive and non-executive members continue to attend meetings. They provide regular updates and discuss issues with governors to keep them involved and proactively engaged.

The Quality Committee

The quality committee is provided with information about the quality of care. In addition, they regularly invite local managers and front line staff to give presentations, discuss specific issues so that the committee is kept informed of quality improvements and respond to any queries raised by the committee.

Members of the quality committee are also actively supported and encouraged to meet with patients and obtain their feedback regarding the care they received and the environment at The Christie. This feedback is valued by the board of directors and the council of governors. Governors have also been involved in the Quality Mark reaccreditations and will continue to be involved when these arise. The Trust and its managers actively provide feedback to members on any issues raised and where necessary provide proactive feedback together with the efforts being made to resolve outstanding issues.

Governors Evidence Based Summary Statement

The above approach enables the quality committee to triangulate feedback and provide valued reassurance to the Council of Governors on key matters relating to patient experience.

Having reflected on the comments and discussions raised at their meetings during 2018-19 the Council of Governors believes that the Trust continues to provide a high quality and safe service for patients as evidenced by:

- Integrated performance reports: this document includes information on waiting times, infection rates, responses from patient surveys, serious untoward incident reports, details about the number and types of complaints received and financial information.
- A monthly summary from the Chief Executive: this gives information on all issues affecting the Trust and the contact details for the relevant executive staff member in case further information is required about a specific item. The report also includes regular updates on the Trust's 2025 strategy.
- Feedback demonstrates the proactive patient centred progress being made and the clear focus on staff development and support to provide high quality care and services. This is also clearly articulated in the Trust's draft annual plan which has been discussed with the Council of Governors and relevant subcommittee.

- Feedback following the 2018 CQC inspection where the Trust was again rated 'Outstanding' by the health regulator becoming the first specialist trust in the country to be given their highest accolade twice. This followed the feedback from the 2016 CQC inspection which included factors which influenced the 'Outstanding' award and the resulting improvement plan.
- The annual quality report, which includes information on complaints and incident, is presented to the quality committee. This gives governors information about all the complaints that have been received; further evidence of the learning has once again been taken from complaints over the year. We are also assured that the outcomes of the complaint investigations are used to inform staff training.
- Information from the Patient Led Assessments of the Care Environment (PLACE)
- Through 2018-19 the committee has sought and obtained detailed insight into the following fundamental aspects of care and communications and reports from clinical areas on initiatives and new developments to improve the patient experience. These include presentations on:
    - Reducing the incidents of Healthcare Acquired Infections
    - The reduction of harm to patients who have, or are at risk of, developing diabetes
    - The patient meal service
    - Trust systems for managing incidents
    - NHS target to reduce e-coli blood stream infections by 10% in the first year and by 50% by 2024

The above has enabled governors to understand the mechanisms in place to address these important areas. This has provided reassurance to the quality committee and the council of governors regarding these important issues for patients and the wider community and this focus has provided valuable insight for the governors.

In addition to the above the governors have access to the following:

- Regular communication with the Chairman of the Trust who is the Chair of the Council of Governors.
- Provision of the governors newsletter and lunch meetings with the Chair (attended by the non-executive directors).
- Freedom for all governors to attend the monthly board of directors meetings which normally include a presentation from a member of the clinical staff on the latest developments.
- At least one non-executive director attends the quality meetings. This practice provides a flow of information to and from the board of directors.
- Quality assurance committee updates are received from the non-executive chair of the committee / chief nurse & executive director of quality. Members of the quality committee are provided with answers to any queries they may have and more detailed explanations as required.
- Participation in the "Talking to patients and carers" initiative – this is an exercise undertaken before each quality committee meeting where governors go out into the hospital and talk to patients and their families about the experience they have had. The total freedom to speak to whoever they choose (subject to advice on the patient's wellbeing on the day) gives governors the reassurance that the feedback given is a true and honest reflection of the experience patients have had. Any issues raised from the interviews are proactively reviewed by the manager and feedback is provided illustrating that all issues are taken seriously and responded to. The experience of the governors concerned,

without exception, is predominantly positive and it is almost impossible to obtain any constructive comment to help us improve our service. The committee continues to produce an annual report giving details of feedback received and action taken.

- Minutes from all council of governor sub committees.
- Each year the governors, in liaison with the Chief Nurse & Executive Director of Quality and the External Auditors, choose an indicator to monitor throughout the year. The indicator can be anything from the Trust's annual external audit work programme. Updates from the relevant department are given to the quality committee in the form of presentations / reports to allow the indicator to be monitored. This year the committee has chosen complaints recording.

Effectiveness

The Council of Governors monitors the Trust effectiveness and efficiency through the key targets agreed for the Trust and the Trust continues to stretch itself to identify further improvements. The quality committee has been in existence since the Trust gained Foundation Trust status and this continuity means that members have a high level of awareness of the quality agenda and hence the ability to request presentations and information they feel is beneficial. The link between this committee and the Quality Assurance Committee cannot be over-emphasised and shows how seriously The Christie takes quality in all aspects of care and treatment of patients.

Experience

The Trust has an experienced and highly committed group of governors. There are some excellent examples of community and member engagement across the areas we serve. Information gained from community engagement offers another opportunity to ensure the patient and public voice is heard and utilised to inform quality initiatives at The Christie. Together this enables us to actively contribute to ensuring high quality patient centred care and services across The Christie NHS Foundation Trust. A presentation for governors to use for engagement purposes has been developed by the Trust and can be modified to suit the engagement situation.

Based on the evidence above, the Council of Governors has confidence that the trust continues to demonstrate proactive commitment to delivering safe and high quality patient centred services to meet the needs of patients cared for by The Christie NHS Foundation Trust now and in the future. In the past year the Chair of governors has been able to guide and reassure governors that they are continuing to help keep quality and overall performance to a high standard.

Ann Gavin Daley
On Behalf of the COG Quality Committee
April 2019

3. Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

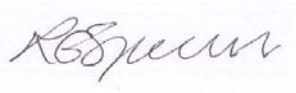
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes for the period April 2018 to March 2019
  - Papers relating to quality report reported to the Board over the period April 2018 to April 2019;
  - CQC inspection reports;
  - Feedback from the Commissioners, Northwest Specialised Commissioning Hub dated May 2019
  - Feedback from Governors dated May 2019
  - The Trust's 2018/19 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009; dated May 2018
  - The 2017 national inpatient survey;
  - The 2018 national staff survey;
  - The Head of Internal Audit's 2018/19 annual opinion over the Trust's control environment
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Chairman Date 23rd May 2019



Chief Executive Date 23rd May 2019

4. Independent Practitioner's Limited Assurance Report to the Council of Governors of The Christie NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Governors of The Christie NHS Foundation Trust to perform an independent limited assurance engagement in respect of The Christie NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

We refer to these national priority indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2018 to March 2019;
- papers relating to quality reported to the Board over the period April 2018 to March 2019;
- feedback from commissioners, Northwest Specialised Commissioning Hub, dated May 2019;
- feedback from Governors dated May 2019;

- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated May 2018;
- the 2017 national patient survey;
- the 2018 national staff survey;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated March 2019; and
- the Care Quality Commission's inspection report dated 12 October 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of The Christie NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Christie NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and The Christie NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by The Christie NHS Foundation Trust.

Our audit work on the financial statements of The Christie NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as The Christie NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to The Christie NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to The Christie NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of The Christie NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than The Christie NHS Foundation Trust and The Christie NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP

Chartered Accountants

4 Hardman Square
Spinningfields
MANCHESTER
M3 3EB

24 May 2019

Appendix 1
Summary Outcomes for Completed Projects

Clinical Support & Specialist Surgery				
Clinical Pharmacy	8	Summary of Findings	Core Recommendations	
16/1736 Re-audit Emergency use of oxygen 2016	1. Poor	The average prescribing rate across the Trust remains at 90%. The average for the percentage of patients where every ward round has been accounted for is at 40%. This is considerably lower than expected, in spite of interventions.	Continue to collect data monthly to demonstrate improvements following intervention and Report quarterly to SMPC. Review Kardex to re-locate the Oxygen section to front page. Address nursing concerns around non-administration. Distribute Oxygen prescribing poster to raise awareness. A QIP collaborative was advised for attempting to take this project forward.	Risk and Quality Governance Committee, May 2018
16/1781 Outpatient prescribing 2016	3. Partial	Modest improvements noted in many aspects of this audit, notably for documentation of allergy status. This is most likely due to the roll out of electronic prescribing (iQemo) in the outpatient setting. Weight documentation is not mandatory and compliance reduced unexpectedly.	Continue the development of e prescribing of all medication within all outpatient areas. Liaise with the clinical trials teams to review their data and maximise e prescribing, for example by returning paper prescriptions. Emails and newsletter to remind prescribers of importance of recording allergy status and weight where required. Review the audit questions in particular around electronic prescribing and re-audit in 12 months.	SMPC, Jun 2018
17/1882 Annual re-audit of Intrathecal Chemotherapy 2017	3. Partial	The audit demonstrated worsening areas of non-compliance with the required intrathecal documentation of doctor administering the chemotherapy and the time of administration. Drugs were collected within working hours in all but one case but unable to verify others were given in hours.	Remind staff on the intrathecal register of the need to complete all details (i.e. signature and time of issue or administration). Repeat audit for 2018.	SACT delivery group & DTC, Nov 2018
17/1891 Annual Safe Medicines Practice Audit: prescribing administration and storage 2017	3. Partial	Areas of good compliance included demographics, allergies, prescribing. Weak areas to address included assessment of patients own medications, documentation of self-administration, printed name, designation and contact, omitted medicines (some critical medicines).	Re-deploy poster highlighting how to obtain medicines & consider screen saver. Continue regular data collection and QI project approach within teams/areas.	SMPC, Apr 2018
18/2189 Annual re-audit of Intrathecal Chemotherapy 2018	4. Significant	Full compliance for 4 of 6 measures; nurse checking the ITC is authorised dropped to 92% and administering doctor authorised/supervised to administer ITC measure improved to 96%.	Remind staff of the need for clear recording and completion of the required details. Request staff to document the reason if not administered. Repeat audit in Oct.	SACT delivery group, Dec 2018
18/2276 Incidence of Hypomagnesaemia in Gynaecological Cancer Patients treated with	3. Partial	The audit demonstrates that magnesium levels are not currently being tested routinely. Only one patient on a	All Gynae med onc treatment protocols now include monitoring serum magnesium levels and a	Results shared with Consultant Pharmacist / Oncologists, Oct 2018

Platinum-based Chemotherapy		clinical trial had magnesium levels taken for each cycle of chemotherapy. Hypomagnesemia is not routinely recorded on CWP. Only 3 of the 7 patients who had hypomagnesemia were treated according to the Acute Oncology Handbook.	request has been made to Biochemistry to consider adding magnesium to the Christie profile (may be financial implications).	
18/2289 An audit on current unlicensed prescribing practices within the Trust	3. Partial	76 patients were identified to have received an unlicensed medicine across 11 different schemes over a 2 year period to 2018. The process of prescribing an unlicensed medication needs to be standardised and streamlined across all departments. Results showed that the process of requesting authorisation of an unlicensed medicine by DTC was not being followed and when DTC gives authorisation the communication of this was not well documented.	The protocol work should actually formalise the ULM process a bit more that currently; but still needs further work and development under the DTC. Informatics need to add an extra option on JAC under special instructions, 'unlicensed SACT.' A database should be developed by pharmacy. A new proforma to be developed on CWP, eventually to include SACT and non-SACT medication. Medicines with an off label use should also be reviewed. Benchmark processes with other cancer trusts.	DTC 2018
SE18/2137 Patient Group Directions (PGDs) Audit 2018	4. Significant	This audit provides assurance that the governance processes for staff training, documentation and record keeping set out in the PGD policy are being followed appropriately in the majority of wards/departments/areas/teams in which they are being used.	Reiterate the requirement for key workers to ensure that the most up to date copy of the PGD is available in the departmental PGD folders.	SMPC, Oct 2018
Complementary Therapies	1	Summary of Findings	Core Recommendations	
18/2270 Epidural Wound Dressings at The Christie	3. Partial	In this study of 37 patients who underwent the placement of an epidural and developed a skin break under the dressing or tapes in 2017, no obvious themes within the possible risk factors were identified. There is no identified national guidance for epidural dressings.	All lesions as a consequence of epidural dressings now being recorded in Datix as a clinical incident and photographs taken. An SOP is being written to standardise application and removal of dressings, including application of barrier film. Develop data collection tool for ongoing collation of information of potentially relevant risk factors and discuss initial data with the Anaesthetist. To re-audit once the SOP has been used for a year. If no improvement within the year, consider further analysis of data set through cross tabulation of possible risk factors.	Dissemination through pain team, 2018
Dietetics	4	Summary of Findings	Core Recommendations	
17/1826 Enteral Feed Documentation Re-audit 2017	3. Partial	Improvements for referrals. However, bloods not being checked daily.	Remind nursing staff about checklist completion Address blood monitoring - approach junior doctors	TBA
17/2056 Allergen/Food intolerance/Coeliac Disease Awareness Audit	3. Partial	Allergies recorded well and compliant. Food intolerances not so well recorded in this small sample. .	Improve the recording of allergies/intolerances on CWP and nursing handover sheets. To review training including session for ward/kitchen staff. To re look at questions that were difficult to obtain information for and identify ways to capture this information for further audits.	Nutrition Steering Group, early 2019 (TBA)

18/2219 Re-audit protected mealtimes 2018	3. Partial	All ward areas were well organised and meal service was timely, with all wards ensuring doors were closed. Poor compliance with interruptions, patients not aware of PMT, lack of menu files.	Address unnecessary disruption of meal time by medics via senior staff. Communicate findings, encouraging continuation of good practice and promote the benefits of patient involvement. Review audit process to minimise subjectivity and repeat in 6 months.	Nutrition Steering Group, Apr 2019
SE17/1868 Evaluation of TPN usage within The Christie	2. Weak	Median length of time on TPN is 12.9 days. 20 (4%) patients on TPN over the year audited were considered by the dietitians to be on it inappropriately. In most cases TPN was stopped soon after initiation.	Business case for multi-disciplinary Nutrition Support Team (NST) for specialist management of PN as recommended by NCEPOD and NICE. Review the cases considered inappropriate to develop checklist for appropriateness of TPN and inform further plans. Re-audit.	Nutrition Steering Group, Dec 2018
Health Records	1	Summary of Findings	Core Recommendations	
18/2171 Annual record keeping 2018	3. Partial	There were good results for black ink and date in this re-audit; it also showed improvement in recording the timing of entries, but more to do. Author designation and overall legibility were weak.	To develop and move towards systems for electronic record keeping across the Trust; the aim is for the trust to be paperless in 2 years. A letter has been sent from the medical director to medical staff following escalation to R&QGC. Re-audit in Mar 2019.	PSC, Nov 2018; R&QGC, Dec 2018
Infection Control	3	Summary of Findings	Core Recommendations	
17/2033 Re-audit prophylactic MRSA eradication treatment and prescription 2017	3. Partial	Baseline results provide good assurance that prophylactic MRSA products are being administered on OAU. Documentation around prescribing is not as good, but the newly devised drug chart does not have sufficient area for a prescriber signature. Staff survey results indicate that MRSA screening is being explained and patients reminded to use. Patient survey results showed the leaflet is not being given, the nurses are explaining the screening but were less positive about being reminded to use. 75% patients said they were using the products as prescribed.	Weekly data collection to continue just for patients who have been inpatients for more than 24 hours. The date will be added to allow run charts to be produced to support regular feedback. Ward manager is pursuing possibility of a patient group direction for nurses to prescribe the MRSA prophylaxis.	Infection control and ward manager, Nov 2018
18/2176 Frontline Ownership Tool (Infection Prevention and Control)2018	3. Partial	The FLO audit represents a key indicator in the IPC compliance for local areas. It's used as evidence for RCAs and in the Christie Code. It gives matrons and ward managers an overview of the infection prevention 'health' of wards and departments. Compliance has improved in the last year. 9 of 28 areas were reported as not submitting an audit in January including W11 & 12. 6 areas had no remedial actions, 13 others had between 1 and 11 actions recorded, some of which were regarding full completion of the audit.	Added in some new areas to cover the new Saving Lives. The IPC team ensures actions are followed up in the areas and assist wards to do these. Examples include reminding staff to engage the temporary closure mechanism on sharps bin, not overfill sharps bins, BP cuffs to be cleaned between patients, clean indicator tape to be used, food to be stored appropriately, the ANTT trolley to be cleaned, and making hand gel available at every bed space. Urgent rectification of unclean rooms on OAU was sought. To continue audit.	Ward results distributed regularly, Jan 2019
18/2177 Sharps Bin Audit 2018	3. Partial	20 of 23 standards have full or high compliance and 22/28 NHS areas scored 90 or higher overall. Labelling of sharps bins has fallen to 73%. Use of the temporary closure mechanism remains poor at 71% although in	Review wording of the audit questions to reflect a more accurate position of the practice within the hospital. Distribute newly designed labels to prompt staff to use temporary closure and add non-	Link workers, ward managers and matron, Jun 2018; Infection prevention control committee, Jul 2018

		some areas this isn't appropriate as they are constantly in use. Availability of the policy/poster has fallen slightly.	compliances to the risk register. Use Bugbrief to promote the policy and poster. Request and distribute brackets for bins. Re-audit six months after this audit as per policy.	
Integrated Procedures Unit	2	Summary of Findings	Core Recommendations	
18/2118 Central Venous Access Device (CVAD) care and maintenance re-audit	4. Significant	Overall improvement in adhering to our four standards. There is some room for improvement, especially when it comes down to standard 1 (dressing change 24 hours post insertion).	Anonymous central line care, survey to be disseminated around the different wards to establish staff level of knowledge/confidence when looking after central lines. To identify any areas for training or support. Non-compliant cases were reviewed, and the proforma changed for 2019.	PSC, July 2018
SE17/2041 Prospective Audit to Study Syner-KINASE use to restore Patency in Occluded Central Venous Catheters	4. Significant	In this prospective audit treatment of occluded CVAD with Syner-KINASE was safe and effective in restoring patency of CVAD. Catheter occlusion clearance rates for PWO and TO combined were 84.5% and 84% after first and subsequent interventions respectively, with no adverse effects reported.	This prospective audit shows promising results to assist clinicians in reaching consensus on thrombolytic protocols for the use of Syner-KINASE for occluded CVADs. The Christie input two cases to a non-renal use protocol.	Poster and presentation, World Congress on Vascular Access, Jun 2018
Interventional Radiology	10	Summary of Findings	Core Recommendations	
15/1540 RCR Audit of prevention and detection of Acute Kidney Injury in Adult Patients undergoing iodinated contrast media injections (CI- AKI)	7. Not Applicable	80 sets of data were submitted to this Royal College audit in 2015 but in June 2018 there is still no report forthcoming. Decision taken to close it.	New guidance has been introduced locally for iv contrast and a follow up audit on this is planned.	Radiology team, Jun 2018
18/2194 Audit of morbidity mortality and length of stay for nephrostomy insertions	3. Partial	Our findings demonstrated that major complication rates appear in the peri-procedural setting or within 4 hours of procedure. This is similar to a day case biopsy procedure. Hence, there is sufficient evidence to perform PCN as day case procedures with appropriate post procedural nursing care in patients who are otherwise well. The group that would particularly benefit from this service are those diagnosed with malignant obstruction of the urinary tract by review of cancer surveillance scans. There would need to be provision for a more robust care service pre and post procedure, including informing patients on what to expect on the day, basic understanding of the management of the tubes and drain bags and an established pathway for patients who may encounter issues once they have been discharged home. Complication rates are in line with published literature.	Consider the feasibility of provision of a day case service for otherwise clinically well patients via presentation of results, assessing logistical provisions for the service, resources needed and further steps.	Radiology department interventional meeting, Jan 2019
18/2197 Audit of morbidity and mortality from CT guided lung biopsy	1. Poor	Our mortality rate is higher than the national average. Although not part of the audit brief, we note that both patients who had died had not been consented for death, and the death rate had not been discussed or documented. ? The technical success rate of our chest	Present findings to all operators performing chest biopsies to increase awareness of the results with a view to encourage operators to review their techniques and patient selection criteria. Present findings at the Radiology department interventional	Interventional Radiology Departmental Meeting, Jan 2019

		biopsies was above the international, but below the national standard, proposed by the ACR and RCR respectively. This could in part be explained by our sample population which has a higher morbidity rate than the general population evaluated to establish the guidelines. Increased number of adverse events could be related to the demanding biopsy requirements of clinical trials (i.e. increased size, number and depth of biopsies), but there was insufficient evidence to support this.	meeting to debate the pros and cons of use of devices for the treatment of pneumothoraxes as well as cost effectiveness. Encourage all operators to discuss and document morbidity and mortality rates clearly and to consider pre-printed consent forms. Re-audit in 6 months.	
18/2215 Audit of the Value of Abdominal Radiographs at The Christie	4. Significant	Review of a random sample of 100 AXR referrals found low (17%) yield of positive findings including small bowel dilatation and bowel obstruction. A small subsection (6%) of requests featuring non-guideline indications exclusively, such as vomiting and abdominal distension, were all reported normal, suggesting unwarranted referral. 31% of patients underwent further scanning by CT, which revealed patients who were reported normal on AXR but had positive CT findings.	The use of AXR in favour of selective CT referral may offer greater outcomes for abdominal symptoms where diagnosis cannot be made by clinical examination alone and avoid potentially unnecessary AXR-induced radiation exposure. However, this was acceptable practice in a small sample, so no action proposed.	Radiology, Feb 2019
18/2307 An audit of the patient consent process for image-guided biopsies in Radiology.	2. Weak	Results from this small student observational study with patient survey, showed that although patient satisfaction was high, there are areas in which the consent process can be improved with respect to national standards. This included initial discussion; how patients are told; content of the initial discussion; readability of patient information leaflets; asking the patient if they have questions; prepare the patient for the procedure only after consent is gained.	There are plans to design a radiology-specific consent form to mandate adherence to national guidelines. The process needs to be adapted to ensure that there is sufficient time for patients to reach a decision; initial discussions about a quality improvement project to take this forward have started.	TBA
CE15/1486 Venting Gastrostomy in the management of Malignant Bowel Obstruction	2. Weak	100 patients with inoperable MBO referred for Radiological Inserted Venting Gastrostomy (RIVG) were identified and 85 Gastro-jejunostomy (GJ) tubes were placed. There was 99% technical success but 1 procedure related fatality in a patient who was of a poor performance status, and a life expectancy of less than 2 weeks. Peristomal leakage, minor irritation, peristomal infection blockages, tube migration, tube degradation or balloon rupture were among the complications. In 6 patients a venting procedure could not be performed. Symptomatic benefit was noted in the majority of patients however GJ drainage may be more beneficial for symptom control. The procedure is not risk free and should be reserved for those with a life expectancy of more than 2 weeks. Leaks are a significant cause of psychological and quality of life morbidity and provoked one patient complaint. Ability to manage predictable complications is required.	Present findings to all operators performing chest biopsies to increase awareness of the results with a view to encourage operators to review their techniques and patient selection criteria, and to debate the pros and cons of use of IR devices for treatment of pneumothoraces as well as cost effectiveness. Encourage all operators to discuss and document morbidity and mortality rates clearly. Consider use of pre-populated consent forms to increase informed consent.	Interventional Radiology departmental meeting, TBC Jun 2019
SE17/1979 Service evaluation of the Gastrostomy	3. Partial	Good compliance was shown with the standards for	No action was planned as the situation has	

drop in clinic		2016, although the report was not fully completed due to changed circumstances.	changed due to co-location of consultants and nurses and reduced availability of nutritional nurses. A further audit may be carried out in the future.	
SE17/2092 Audit of initial success patency rates stent replacement and secondary nephrostomy rates of both antegrade and retrograde ureteric stents.	3. Partial	Antegrade ureteric stenting in radiology found to have moderate success rate; 5 (23%) failed. Of these, 3 were not possible and 2 failed to function so nephrostomies remained in situ.	To compare radiology stenting with retrograde stenting in surgery as a secondary project.	To be decided
SE18/2116 Length of hospital admission following radiology drainage	1. Poor	Just over a quarter of chest drains requested in 2017 were reviewed; three quarters had a chest drain inserted for pleural effusion with an average time in-situ of 4.8 days. Output was documented only for 1/25 and only 5/13 patients discharged less than 2 days after removal. It is usual practice to obtain post removal chest x-ray, which does not add value and may further increase length of stay	Obtain discharge dates for all patients. Action required to address potential to halve length of drain duration and related bed days, with financial savings.	Radiology, Mar 2019
SE18/2206 Evaluation of MRI imaging post treatment of neck malignancies	3. Partial	Around 80% of MR reports gave a definitive answer. False positive rate increased amongst MR equivocal & suspicious reports. Although the numbers for PET CT were small the results mirrored the MR reports.	Considering a follow up to this baseline, with additional data for PET CT and if there is a need to implement NI RADS type reporting criteria to aid follow up imaging decisions.	H&N DG, 2018
Oncology Critical Care	18	Summary of Findings	Core Recommendations	
16/1683 NAP6 Perioperative Anaphylaxis	4. Significant	National report highlights antibiotic allergy as an increasing problem suggesting that optimising preoperative allergy history could reduce the number of perioperative anaphylactic reactions. Administering antibiotics before induction of anaesthesia if practicable is recommended. Immediate management was judged good in half and a third of patients experienced harm in some form.	Data not provided but no local action required.	National report published May 2018 reviewed within anaesthetic team
17/1940 Cardiac arrest audit (NCAA) 2017	4. Significant	A report for the year to end March 2018 was received from NCAA covering 13 cardiac arrests, the lowest of all hospitals; the small numbers make comparisons difficult. 3 patients survived to hospital discharge. Data completeness to NCAA was 100%. The non-risk adjusted rate of arrests is low compared to other hospitals. The age of patients is much lower due to being an oncology centre. For 3 patients an outpatient appointment was the reason for attendance was higher, the mean number of days from admission to arrest is lower, the proportion of patients who were deteriorating (not yet arrested) was higher than NCAA.	Internal review of all cardiac arrests is carried out to determine learning; no particular learning or action identified from the NCAA report.	Resuscitation team, Mar 2019
17/2047 Re-audit intra-hospital critical care transfers: how are we documenting them.	2. Weak	Some improvement noted in 6 of 8 standards in this re-audit, most significantly in documenting a note on return. However, overall we continue to fail to meet the	New intra-hospital transfer checklist and SOP designed and being implemented formally with the new transfer bag and monitoring system.	Acute & Critical Care Departmental Meeting, Jul 2018

		agreed standards in our documentation and from this it could be inferred that the quality of our transfers themselves also falls well below standards. Useful observations on possible causes and factors have been noted including availability of the transfer checklist, awareness of features of and processes for Metavision, restricted access to new monitoring system, poor introduction of the new transfer bag and numbers of new staff requiring transfer training.	Metavision being updated with the new transfer checklist. Re-audit.	
17/2099 Sepsis CWP Infection Care Plan Re-audit	3. Partial	Since the last audit in 2016 there has been an increase in the use of infection care plans for patients meeting the criteria. However education and training does need to continue for nursing staff to ensure its proper use and completion.	Continue to monitor the number of proformas for each ward via the dashboard Continue education and training of the infection care plan, explaining the rationale of why and how it is completed. Re-audit in one year making an adaption to If NO did the patient receive appropriate treatment and was this within the hour?' to consider those patients that may not have received antibiotics but in mitigating circumstances.	Sepsis Steering Group 8th May 2018 by Leah Morgan, Sepsis Nurse Specialist
17/2112 Documenting consent for anaesthesia	1. Poor	The pre-operative assessment section of the anaesthetic chart was completed by an anaesthetic consultant in most cases. In nearly 60% there was some documentation of a discussion had that might constitute elements of a consent process (either an explanation of the plan, listing some possible risks etc.). In no cases was a full consent process (explanation, risks, benefits and alternatives) documented. A full consent process was not documented for any elective insertion of arterial or central lines. There was some component of consent documented in 50% cases. Accidental awareness under general anaesthesia was never documented as a risk of undergoing general anaesthesia; it was agreed that this was a serious adverse outcome that should probably be mentioned in the consent process, despite its low incidence. Although the majority of patients received a nurse-led pre-operative assessment clinic visit, there are concerns of information overload for patients.	Address concerns that time limitations on the day of surgery do not enable a proper discussion to obtain consent and need to wait until after the team brief due to an increasing frequency of surgical uncertainty in the listing of operations by carrying out a survey of the anaesthetic medical team to produce a majority consensus on what we should consent patients for in our consent process. To update the existing guidance and information in line with the consensus agreed following the survey. Re-audit in 1 year (or sooner once change has been implemented)	Critical care lunchtime meeting, Apr 2018
17/2129 Annual re-audit AAND (DNAR) 2017	4. Significant	Involvement of patients and/or relatives in AaND discussions has improved to 100% overall, and just over 80% for each group individually. Recording of time, date and signature on the AaND form and related documentation in the medical notes remain fairly static as shown by run charts over the last few years.	ReSPECT group meeting to oversee its introduction via a quality improvement initiative; the timing of further data collection to be planned around this. Spot checks carried out and an SpR survey completed to investigate barriers.	Resuscitation & Deteriorating Patient Committee, July 2018
17/2144 Annual review of cardiac arrests (RCAs) 2017	3. Partial	There were 10 cardiac arrests in 2017 of which 5 had a successful resuscitation with return of spontaneous circulation Two of those patients had an AaND form initiated after the crash call and died soon afterwards.	Implementation of RESPECT in ongoing. To try to implement advanced care planning including resuscitation discussion for all patients with advanced disease.	Resuscitation & Deteriorating Patient Committee, Oct 2018

		Root cause analysis of all of them found 2 further cases where AaND form should have been in place.		
18/2136 MEWS Re-Audit 2018	3. Partial	Results varied from ward to ward but generally the MEWS audit results were not as good as they have been in previous years. There has been a fall in a number of key measures notably patients with score of >=2 having 4 hourly observations and observations carried out as per set monitoring frequency.	Discussion with ward nurses around understanding MEWS policy and process Agree leeway on timings, for the purpose of future electronic auditing. Amend policy. Attend nurse induction talk. Assign outreach nurse to a link ward to provide smaller group teaching.	R&DP committee, June 2018 (TBA)
18/2152 Preoperative airway assessment	4. Significant	From this sample looks that our team is very skilled in prediction of difficult airways and treating them correctly.	Improve awareness about importance of proper documentation. Develop new anaesthetic chart with tick boxes for key information about airways to improve documentation. Re-audit 6 months after the new chart is introduced.	Departmental meeting, Jan 2019
18/2153 ICNARC Case Mix Programme (CMP) 2018	5. Full	All results across the indicators in the ongoing ICNARC reports are better than comparable units and the national average.	Continue to participate; no other action required.	Acute and Critical Care Directorate, 2018
18/2190 Cardiac arrest equipment (crash trolleys) re-audit 2018	4. Significant	Trolleys checks met desired standards in 2018 for all but HTU OPD. Spot checks of Inpatient areas indicated non compliances in all but one area.	Spot check content of trolleys to continue; results provided to areas.	Resuscitation and Deteriorating Patient Committee, Oct 2018
18/2229 An Audit of the Supportive Care Team Referral Forms	3. Partial	Completion of sections of the forms very good with the medications section most likely to be missed, although this is still completed in the majority of referrals. However for more than a third of referrals the information was too short to be adequate. Two thirds of referrals were for pain but the site of pain was not indicated for a third of these. There was variation in when patients are referred for 'end of life' care suggesting definitions are unclear to staff. It highlighted wider issues in regards to late referral of patients. Overall the audit has prompted discussion around late referrals and inappropriate referral, highlighting potential need to consider new ways of working.	To redesign the Supportive Care Team referral form. Liaise with other team members working on triage of referrals. To discuss potential new ways of working, such as attending board rounds on the wards in order to try and pick up patients that require SCT input earlier. Consider re-audit in 12 months, dependent on whether new changes from ongoing inpatient work render this unnecessary.	Supportive Care Team weekly education meeting, Jun 2018
18/2249 Documenting consent for anaesthesia re-audit	3. Partial	With a limited sample in this re-audit, the proposed new chart appears to allow us to better meet the minimum standards for documentation of consent to anaesthesia and related procedures; documentation of discussion on the chart, including risks and verbal consent all achieved good compliance and documentation of alternatives and awareness as a risk improved.	To review, revise and formally implement a new anaesthetic chart. To review, revise and consolidate current pre-operative information provided to patients. To produce online information resources that patients can access prior to attending for surgery. Re-audit in 1 year.	Lunchtime departmental meeting, Jul 2018
18/2279 Trust Wide Fluid Balance Audit	3. Partial	Although there is still room for improvement, since introducing the new chart improvements in fluid balance recording have been made in the pilot areas. Staff feedback influenced chart amendments which led to improvement at each iteration and resulted in a chart	New fluid balance chart to be ratified by Patient Safety Committee and printed to overcome resource issues on wards. Commence education and training on new chart in all remaining inpatient areas and launch the chart in these, followed by	Patient Safety Committee, Feb 2019

		that is beneficial to all areas within the trust.	the same for outpatients. Weekly audits to be carried out by ward staff with support from the AKI nurses and a dashboard to communicate results.	
18/2293 Re-audit intra-hospital critical care transfers 2	1. Poor	Improvements were observed in 6 out of 8 standards, the best of these being documenting a note on return. Overall we continue to fail to meet the agreed standards in our documentation and from this it could be inferred that the quality of our transfers themselves also falls well below standards. Reasons for this are believed to include large volume of new staff, restrictions for use of new monitoring system and transfer bag to OCCU nurses only, awareness of the transfer tab in Metavision and no more paper copies of the transfer checklist.	To design and introduce a new intra-hospital transfer checklist. Update SOP and Metavision with the new intra-hospital transfer checklist. Investigate whether data can be retrospectively uploaded to Metavision from the new monitoring system. Formally introduce the new transfer checklist along with the new regional transfer bag and new monitoring system. Identify person to lead data collection for re-audit.	Acute & Critical Care Departmental Meeting, Jul 2018
S18/2238 Patient and Family Satisfaction Survey (Critical Care)	4. Significant	Very good levels of patient satisfaction were received with no negative responses and some very positive comments. There were some suggestions including improvements to relatives facilities and a wider range of aprons.	In 2018 OCCU has completed a programme of works to improve both the waiting area for OCCU relatives and the accommodation area. The OCCU Relatives accommodation can cater for up to two families utilising the facilities overnight with access to other Christie accommodation if required. At each bedside OCCU now uses different coloured aprons for each bed space for Christie staff to utilise.	Peer Review Report; ACCD staff meeting August 2018; Patient Safety Committee, 2018
SE17/2046 Surveillance of Blood Stream Infections in Patients Attending ICUs in England (ICCQIP) 2017/18	3. Partial	On-going project. 2017/18 data gathering demonstrated an increase in blood stream infection which is being investigated thoroughly by CCU Nursing team and Infection Control team.		Critical care, 2018
SE18/2368 Re-audit evaluation of outcomes of unplanned medical admissions to the Christie critical care unit	2. Weak	There were fewer emergency referrals in 2018 compared to 2016, with almost the same number of admissions. There was more agreement between CCU consultants and the clinical teams about the ceiling of care for patients. However there were still 5 patients who received level 3 care when the admitting CCU consultant thought it should be level 2; there was 80% mortality on the unit for these patients. 3 month mortality overall is similar to 2016 at 42%, though worse for haematology patients; APACHE mortality risk scoring where possible to obtain, matched this well.	Need to improve CCU confidence and communication between teams, involving the parent consultant including out of hours. Consider joining handovers and increasing outreach engagement. Obtain a second opinion where there is disagreement and increase communication with patients and relatives.	CCU teaching meeting, Jan 2019
Patient Flow	2	Summary of Findings	Core Recommendations	
SE18/2126 Clinical effectiveness audit of patient flow policy	3. Partial	Data from this challenging week, showed an average of 25 daily unplanned admission requests, reducing to 12 at weekend due to lack of outpatient clinics and radiotherapy treatments. Findings showed 77% of unplanned requests allocated a bed within four hours, but excluded an error, average time for bed allocation was 1 hour 20 mins. All the diverted patients due to lack of a bed were escalated to DCCO's in hours and	A full audit is planned once the new Admissions policy has been embedded. This should include ; level of staff knowledge to target for future training, planned discharges from wards before midday to PATS or home, infection control updates and side room occupancy and risk by 10.30 am, patient flow manager working seven days a week, identified OCCU step downs within 4 hours and core	Risk & Quality Governance Committee, Mar 2018

		EOC out of hours as per policy. An incident and timeline was recorded for the 3 days when required.	attendance at 10.30 PF daily meeting. Incident reporting and root cause analysis may be safely replaced by an IRF timeline completed by patient flow team and submitted through Datix for monitoring and reporting. A wider audit of the patient flow, including delays and escalation of patients medically fit for discharge may be added within future the patient flow work streams.	
SE18/2205 Patient Experience attending elsewhere	3. Partial	Data from various sources reviewed. The proportion of patients not admitted with reason recorded as no bed reduced month on month to Mar 2018. The proportion of beds allocated with 4 hours rose to 94% in March with unplanned admissions more likely to wait longer. Policy was followed for diverted patients.	UKONS 24 hour triage tool needs to be implemented on CWP as soon as possible. Patient flow admissions operational policy updated. A full re-audit planned after implementation.	June 2018
Physio and OT	4	Summary of Findings	Core Recommendations	
17/1998 Service evaluation of the occupational therapy role on the Oncology Assessment Unit re-audit	4. Significant	Since the previous audit in 2017, the profile of the occupational therapist on OAU and collaboration between OAU and therapy team has improved substantially. The significantly increased workload generated by the greater number of referrals to the service indicates the need for a full time therapist in post on OAU. The goal of maintaining referral to treatment times within 24hrs remains high (96%). 20% of the patients referred on whilst on OAU have a full assessment and 67% of patients referred have some form of occupational therapy input.	Reflect on the most appropriate and effective way to raise awareness of occupational therapy in the treatment of acute oncological patients on OAU and the valid contribution to early discharge planning. Liaise with the OAU manager and improve the clarity of referrals to the service.	Occupational Therapy and Physiotherapy teams team meeting/in-service training, 2018
SE18/2244 Review of quality of implementation Fatigue group management as a new service at The Christie NHS Foundation Trust	5. Full	96 patients attended this new service on 4 wards in 14 months. Almost all patients rated the group as good or very good overall and all but one found it useful and would recommend it. According to the patient's feedback, advice regarding energy management was most useful, followed by exercise.	Occupational therapy team to liaise with clinical audit team to structure the questions to produce more specific and measurable feedback. To pilot the fatigue group as an out patient service, which would extend the occupational therapy service to outpatient clinics. To educate CNS's on importance of fatigue management via the CNS meeting. To book a slot for fatigue management at the health and wellbeing event at The Christie. To discuss staffing levels and time constraints with rehab unit manager to increase the service. Re-audit in a year.	Occupational Therapy and Physiotherapy teams at their staff team meeting, Oct 2018
SE18/2277 A Review of Frailty Assessments and Discharge Destinations of patients referred to occupational therapy at the Christie NHS Foundation Trust.	3. Partial	Three quarters of patients met the national standard that the majority of frail patients referred to hospital occupational therapists should be discharged home. No definitive correlation found between age increase and higher levels of frailty in this patient cohort. Increased length of stay was not directly correlated with age. The Rockwood Frailty Score, though effective for	To review the range of frailty assessments and identify a holistic tool that will measure the impact of Occupational Therapy input. To review a standardised functional assessment that can be utilised alongside the frailty assessment chosen.	Later life interest group, tbc 2018

		retrospective data and gaining a basic understanding of a patient's dependency level, does not seem to be an appropriate tool to define frailty within this setting. It also does not effectively reflect the impact of Occupational Therapy input on levels of frailty.		
SE18/2278 Evaluate the referral system from palatine ward to therapy team (Occupational therapy & Physiotherapy).	2. Weak	Only a third of 50 referrals were received with the correct paper form; this was consistent over 3 months. 9 patients were discharged before they could be seen by the therapy team and more were close to discharge, some patients were too unwell, and consent from the patient was not always sought.	Educate staff about referral criteria and roles of Physiotherapy and Occupational Therapy within the Haematology ward. Meet with transplant CNS's to discuss need of therapy input from admission. Therapist to attend ward x2 per week to have handover from co-ordinator. Develop referral criteria and provide as a visual aid on the ward. Re-audit.	Rehabilitation Department and Palatine Ward department meetings, March 2019; Haematology study day, TBC 2019.
Psycho Oncology	2	Summary of Findings	Core Recommendations	
18/2353 Mental Capacity Assessment Best Interest Decision Making and Deprivation of Liberty re-audit 2018	3. Partial	This trial of CWP forms has shown a marked improvement in the quality of documentation of the online mental capacity assessment , with 100% meeting standards. The introduction of an online best interests meetings proforma has been utilised more than the online capacity assessments; 2 of 27 had a concurrent online capacity assessment form.	Continue to educate clinicians about the availability of these electronic patient forms on CWP, particularly targeting those who are not completing them. To consider adding a reminder at the top of the best interests meeting form. To re-audit.	
SE17/2064 Pilot implementation: psychological screening and psychological interventions for distress and depression in the Head & Neck and Haematology clinics	4. Significant	Results from this pilot indicated that it is possible for clinical teams to screen for depression and suicidal ideation in clinic and that an oncology nurse can be trained with support from a psychiatric service to deliver collaborative care for depression. For all patients, the oncology nurse liaised directly with the GP to request a review of the patient's mood and medication; GPs responded very positively. The most frequent other interventions included medication changes, safeguarding and psychiatric review.	There is a case for recommending this model of depression screening and management in disease groups with high levels of depression and at high risk of suicide- i.e. lung, stomach, oesophagus and pancreatic cancers. In addition, the pilot makes a strong case for all clinicians to assess psychiatric co-morbidities in new patients.	Head and neck and haematology teams, Aug 2018
Speech Therapy	2	Summary of Findings	Core Recommendations	
18/2275 Benefits of SLT Swallowing Therapy on H&N Patients	3. Partial	This data set provides evidence to support the vital role of speech and language therapy in improving the lives of this patient group. Dysphagia for head and neck cancer patients has a huge impact on the quality of life as evidenced by several patients wishing to continue with oral intake despite aspiration risks. Over two thirds had a positive change from therapy input and a quarter had psychological issues relating to their cancer.	Data used to support business case to address need for speech therapy resources to improve quality of life in survivorship.	Speech and Language Therapy department, Feb 2015
SE19/2441 An approach to risk stratification model for patients with Head and Neck cancer in order to effectively target Speech and Language Therapy support through and beyond chemo / radiotherapy treatment	4. Significant	Results of Macmillan Innovation supported pilot to assess the feasibility and effectiveness of increased and systematic speech and language interventions in patients with head and neck cancer receiving radiotherapy demonstrated the benefit of pro-active support before, during and after radiotherapy to help	Subject to further funding, on-going modifications to improve the pathway, and ongoing review of the enhanced risk stratification tool to improve accuracy, the new preventative model is now becoming embedded in our practice.	Quality Assurance Committee, Feb 2019; GM Pathway Board, Head and Neck Cancer, Jan 2019

		optimise swallow recovery for patients. At the 3 month endpoint of the project, 50% of patients had already achieved their therapy goals for swallowing and could be discharged eg could eat and drink out in public again and did not require texture modified food. High risk patients were identified and transferred to Community Speech therapy services for ongoing rehabilitation more promptly. Swallow function improvements and positive patient experience, alongside a sense of greater fulfilment for the Speech therapists are leading to change. Issues to address include a greater workload for SLTs within shorter timescales and in limited physical outpatient or radiotherapy clinic environments.		
Surgery - Colorectal & PTS	16	Summary of Findings	Core Recommendations	
15/1592 Splenectomy as part of Cytoreductive Surgery for PMP patients	4. Significant	Splenectomy is necessary in almost 40% of patients undergoing cytoreductive surgery (CRS) for Pseudomyxoma peritonei (PMP). This can be performed safely with minimal early complications. Recurrence following CRS and HIPEC is low and rates are similar with or without splenectomy. Prospective data collection also showed that all patients were discussed at a Multidisciplinary team (MDT) meeting, vaccinated at least three weeks before elective surgery where appropriate and received long-term antibiotic prophylaxis to reduce the risk of post splenectomy related infections.	The data collected has supported reports regarding the need for splenectomy and where there can be preservation during cytoreductive surgery.	Abstract submitted and presented in Amsterdam 2016
16/1827 National Emergency Laparotomy Audit (NELA) patient audit (year 4)	4. Significant	Fully compliant with 7 standards, including reporting of CT before surgery, the documentation of which is now better captured. Risk documented before surgery improved to 67% cases. All surgery is consultant led. There is no MCOP (Medical Crises in Older People) specialist at the Christie so assessment of patients >70 years not considered applicable.	P-POSSUM scoring pre-op implementation in progress. Due to change in inclusion criteria there are fewer cases included than anticipated. Continue to participate in NELA audits.	Colorectal team, Mar 2019
17/1980 Bowel cancer (NBOCAP) 2017	4. Significant	The Christie was identified as an outlier when looking at 18 month stoma rates in the NBOCA 16-17 report. In all other areas we are above average in the performance indicators. The stoma rate is a consequence of our practice; 56/62 patients were given permanent stomas due to the extent of their disease. The Christie T4 staging rate for those with stomas was 53% (26% T3) against the NBOCA data set T4 rate of around 7%. On review of cases considered possible to reverse there is only 1 outstanding patient decision which is due following a forthcoming CT scan.	Continue the good practice; reason no action required for 18m stoma rate advised to national team and CQC.	Colorectal and Peritoneal Oncology team, Feb 2019

18/2060 NPSA Oral Bowel Cleansing 2018	4. Significant	The re-audit has shown stable compliance for completing the indication, medical history and medications however there has been a further decline in compliance for the completion of contra-indications. Results across 8 other standards were good.	Actions continue to re-audit annually and ensure renal profiles are undertaken for those patients having Picolax including eGFR. Implementation of nurse led endoscopy clinic to assess/screen patients prior to colonoscopy.	Safe Medicines Practice Committee, Colorectal Business Meeting, Endoscopy Users Group, date TBC
18/2151 Pre-operative blood transfusion requests	4. Significant	An initial study found 50% compliance with the blood transfusion protocol for surgical units. 89 units were requested but only 8 were used.	Teaching session held for all current and new junior staff; to be included in future induction programmes. The colorectal surgical consultants agreed revised blood transfusion guidelines and practice was re-audited at above 90%.	Colorectal Research Group, 2018
18/2348 Pre-operative blood transfusion requests re-audit	3. Partial	Compliance with local guidelines fell but is still above that measured in the first audit. The number of units requested is lower than the first audit. Transfusion was needed in 5 of 18 cases.	Implementation of re-education programme for junior staff. Revise blood transfusion guidelines after discussion with colorectal, Urology & Gynaecology consultants. Pilot and re-audit within a month of implementation.	Colorectal Research Group, 2018
CE15/1541 Temporal pattern of PMCR referrals	4. Significant	Study indicates low complication rates and survival advantages compared with traditional non-surgical treatments. NCI CTAE grade 3/4 complication rates were 9.4%; 30-day mortality was 0.85%. Median OS following CRS/HIPEC was 46.0 months: patients not receiving CRS/HIPEC survived 13.2 months.	Increasing awareness of the potential benefits and low risks of CRS/HIPEC for CRPM should promote an increase in referrals. An experienced MDT should mentor new providers reducing the learning curve for selecting patients for potentially curative treatment of PM of colorectal origin.	Peritoneal Surgical Oncology team; submitted to the JCO, Jul 2018
CE16/1731 Changing patterns of referral and treatment in Psuedomyxoma peritonei	4. Significant	Over the 14 years the Christie Colorectal and Peritoneal Oncology Centre (CPOC) has been operating, there has been year on year increases in the number of patients referred with pseudomyxoma peritonei. Patients are increasingly being referred in the early stages of this disease, when the likelihood of successful treatment is much higher. Earlier referral of patients with precursor lesions allows an increasing number of patients to be managed either by risk reducing surgery or active surveillance. The impact on long term survival is being monitored over time.	No further action identified.	Poster submitted to ACPGBI 2016 (awarded distinction rosette); RSM, Dec 2016 (awarded the Norman Tanner Prize); accepted for publication in the Journal of Colorectal Disease, May 2018
QIP18/2248 Colorectal Ward Round Audit	3. Partial	Following the introduction of a new colorectal notes booklet, “skinny files” (a current admission slim set of notes) and use of a notes trolley) results improved across all measures for notes quality, which was statistically significant for 8 measures out of 14. Non significant improvements in 5 measures. Patient Labels although not on every page were in every booklet.	Continue to use the skinny files, notes trolley and colorectal notes booklet to improve case not quality. Room for improvement : ID stickers on each page of the booklet. Ensure staff wear gloves when examining wounds. Engage staff in the ward round to close the curtains, check the obs and drugs charts, fluid balance and drain output. Re-audit.	Colorectal team, Nov 2018
SE17/1951 Total Pelvic Exenteration (TPE) for Primary and Locally Recurrent Rectal Cancer	4. Significant	Overall, this study has shown that pelvic exenteration can be performed with good oncological outcome and low rates of mortality. This study supports current evidence that R0 resection is fundamental to favourable survival outcomes. In all of the key quality standards, the reported outcomes for the Christie fell	Maintain current standard of care; no action required.	Colorectal research team meetings between Nov 2017 and Mar 2018; also being submitted to a journal.

		within the 95% CI reported or was higher.		
SE18/2127 Treatment options and outcomes for patients with Low grade appendiceal mucinous neoplasm type II	3. Partial	A significant proportion of LAMN II patients with normal CT scans having L-CRS/HIPEC were found to have EALD, with good mid-term survival outcomes. The risk of these patients developing PMP without surgery needs to be further quantified. L-CRS/HIPEC can be safely performed in well-selected LAMN II patients and results in a significantly shorter post-operative stay, justifying the increased operative time.	No action identified	Peritoneal Surface Oncology Group International (PSOGI) conference, Sep 2018
SE18/2149 Central line care in colorectal patients	4. Significant	We identified that the colorectal surgical team were 100% compliant with the Local Christie Guidelines for the removal of central lines. An infection rate of 4% was noted which is within the acceptable parameters. We have not observed a direct association between length of time central line is in place versus infection rates.	Continue with current practice.	Colorectal Research Meeting, 2018
SE18/2150 Post-operative blood testing for colorectal patients	3. Partial	32 patients studied over 4 weeks and their blood investigation frequency monitored from postop Day 1 to the last day of data collection. All patients met standards for blood investigations sent, surgical treatment received and frequency of blood monitoring.	To standardise the timings of specific blood tests as set out in the recommendations. Discussions are currently being held with the surgical consultants. New colorectal surgical guidelines for post-operative blood testings to be created.	Colorectal Research meeting, Apr 2018
SE18/2213 Goblet cell carcinoid tumour of appendix: outcomes following CRS & HIPEC	4. Significant	Right hemicolectomy showed no statistical significance on patient outcomes although a high rate of malignancy within the removed tissue demonstrated the benefit of this procedure. These results may also be a result of selection bias as this is a retrospective study. Tang C advanced T and N stage and PCI score of 4 or more were all significantly associated with less favourable patient outcomes. The standard of a minimum of one scan (post-surgery) was met in all but one case. Despite not having significant data in relation to right hemicolectomy we would still advise and recommend its use with all patients as per current guidelines.	Consider feasibility/timescale of a prospective study to add additional knowledge and information to this little reviewed area to help improve understand and develop decisive treatment management of patients if necessary.	APEP student presentation, Jun 2018; dissemination to senior surgical leads
SE18/2214 Surgical outcomes of the patient undergoing Redo Cytoreductive and HIPEC surgery	5. Full	Advanced PMP, recurrent appendiceal & peritoneal metastasis of colorectal origin have poor prognosis. This study demonstrates in selected group of patients redo CRS and HIPEC is safe and feasible option which may improve survival. Standards re PCI and CC scores, date/duration of surgery and <5% morbidity and mortality were fully met. All patients are alive with median surgical follow up of 12 months.	Results disseminated; no action required.	Colorectal Research Meeting, Mar 2018; Abstract submitted for international meeting on Peritoneal oncology (PSOGI)
SE18/2333 Central line care in colorectal patients re-audit	5. Full	Adherence to local guidelines set following the last audit on duration of CV line stay in post operative patients is 100% in our patients and there is no specific	Continue with current practice.	Colorectal research meeting, Apr 2018

		relationship with rate of infection within this time period in our patients. It is safe to leave CV line for 7-10 days following insertion in post operative colorectal and peritoneal cancer patients.		
Surgery - Gynaecology	7	Summary of Findings	Core Recommendations	
17/2072 How Does The Christie's Outcomes for Gynaecological Pelvic Exenteration Compare Against National and International Standards.	4. Significant	Overall good compliance and practice. Interval time from MDT to surgery could be improved.	Streamline pathway to improve MDT decision to Surgery time	M62 Gynaecological Oncology Meeting, May 2018
18/2034 Mortality and Morbidity in gynaecological cancer 2017	5. Full	546 cases were reviewed in 2017 and all comparisons against nationally reported post-operative morbidity and mortality were significantly better. Year upon year case workload, complexity, comorbidities and surgically radicality increases. Morbidity is low and stable.	Gynae Onc fellow is completing CWP morbidity form following weekly Gynae Oncology Clinical Governance Meeting.	Gynaecological Oncology Clinical Governance Meeting, Apr 2017; Gynae Onc study day
18/2035 Robotic Surgery in gynaecological oncology (2017)	4. Significant	Overall, 88% of patients had no complication and unplanned readmission rate was 2.5%, significantly exceeding target compliance. Median length of hospital stay was 2.5 days excluding 4 complex joint robotic procedures. The caseload was significantly morbid and complex; 30% patients were morbidly obese. Pre-operative assessment, high quality surgical training & experience and thorough post-operative care can ensure low morbidity in a high risk population undergoing major and complex robotic surgery.	All consultants trained for Advanced Laparoscopic / Robotic Surgery. Maintain the excellent outcomes and continue annual review.	Gynaecological Oncology Clinical Governance Meeting, Robotic users group, Jun 2019
18/2317 How the Christie compares to LACC trial in managing cervical cancer stage 1b1 by minimal access surgery?	4. Significant	UK data were broadly representative of the LACC dataset in terms of demographics and tumour types. Rates of mortality and recurrence were lower. With a median follow up of 23 months there was no statistical difference in survival between patients treated with open and minimal access surgery.	These results provide confidence that minimal access surgery remains a safe option. The Christie Gynae Onc Surgery has achieved accredited training centre status for Robotic Surgery in Gynaecology by DaVinci Surgery. There is >95% gynae oncology recruitment to ERAS pathways. Further analysis of the LACC data, when published, is required.	BGCS annual scientific meeting, London, Jul 2018; BJOG publication
CE15/1558 Extremity lymphedema in gynaecological patients after Sentinel lymph node biopsy	4. Significant	There was a 50% response rate to the patient survey. Reported symptoms related to lymphoedema following WLE with primary closure and SLND for all patients identified in 22 month period to Mar 2017 slightly better than published data at 8.3% (1/12). 2 of 3 women that have undergone plastic flap reconstruction on the vulva have reported symptoms related to lymphoedema.	Specialised plastic clinic with lymph node transplant special interest follow-up at 1 year post op to assess possibility of lymphedema and further management.	Plastic surgery, Aug 2018
SE18/2232 Evaluation of Albumin levels pre and post-surgery in relation to nutritional status following laparotomy for ovarian /FT/PP cancer.	4. Significant	There is a beneficial effect of enteral nutrition, which has been shown to improve albumin levels, as a method to provide nutritional support both preoperatively and postoperatively. Patients who were hypoalbuminemic preoperatively were more likely to have a longer length of stay, and slower mobilisation. Patients on TPN post op had a significant higher mean LOS and were slower to achieve independent	Continue adherence to ERAS pathways.	APEP presentations, Jun 2018; Gynaecological Oncology Clinical Governance meeting, Jun 2018; BGCS, July 2018;

		mobilisation in comparison to patients on oral feeding.		
SE18/2233 Association of Elevated Pre-operative HbA1c and Post-operative Complications in Non-diabetic Patients undergoing gynaecological oncology surgery.	3. Partial	Incidence of infection was highest amongst patients with: Diagnosed diabetes and / or A borderline pre-operative HbA1c (42-47mmol/mol). Diabetic patients with borderline HbA1c (not well controlled) were over twice as likely to present with a post-operative infection compared to the non-diabetic patients. Monitoring HbA1c pre-operatively is important as it can lead to health and well-being interventions, address dietary advice and initiation of treatment for undiagnosed pre-diabetic and diabetic patients.	Continue adherence to ERAS pathways. Referrals to GP to be done in every case in order to act further and investigate in primary care setting.	APEP presentations, Jun 2018; Gynaecological Oncology Clinical Governance meeting, Jun 2018; BGCS, July 2018;
Surgery - Plastics	5	Summary of Findings	Core Recommendations	
15/1402 Audit Of Melanoma Curetted In Primary Care	3. Partial	The audit results show that patients diagnosed with melanoma via shave biopsies are being misdiagnosed/understaged and are at a higher risk of developing earlier loco-regional and distant metastasis. All suspicious lesions should be marginally excised rather than shaved. Shaved melanomas should be treated as a higher stage .	Update all the primary care centres and dermatology centres to follow the national guidelines and perform 2mm excision biopsies with a cuff of fat for any suspicious lesions. Update all the tertiary care centres to offer sentinel lymph node biopsy where possible, for all malignant melanoma diagnoses via shave biopsy. To submit for publication in BMJ and to all tertiary centres across the UK.	BULAPRAS annual scientific meeting, Bulgaria, Jun 2018
SE16/1842 What is the best surgical management for patients with angiosarcoma of the breast?	7. Not Applicable	Median survival from presentation of all patients 2y 6m reducing to 15 months from presentation of metastases.	Recommend careful consideration of the individual patient and a period of at least 2 and a half years disease free prior to consideration of secondary breast reconstruction with careful counselling of the patient of ongoing risk of recurrence and metastases. No further action.	American Society for Reconstructive Microsurgery, Jan, Phoenix, Arizona, BAPRAS; Winter Meeting in London in Dec 2017; Italian Society for Plastic Surgery (SICPRE), Modena, Sep 2017
SE18/2163 Perineal Complications after Total Pelvic Exenteration	3. Partial	72 patients underwent TPE with perineal resection. The numbers are to small to be conclusive but the risk of perineal hernia is higher in patients who had a primary closure of perineum. In the flap group only one patient had a breakdown of perineal wound in the post-operative period. In the group of patients who had a primary closure of perineum with or without the omentoplasty, five patients had perineal complications including dehiscence (2 cases) and infection (3 cases). In terms of long term complications, there were 4 cases of uncomplicated perineal hernia. Three patients had a primary closure and one a flap.	Further prospective studies and randomised controlled trials are necessary to assess the benefit of flap closure after TPE. Plastic and colorectal team to consider prospective intra-operative assessment and measurement of pelvic-perineal defect to choose the ideal reconstruction.	No presentation
SE18/2288 Microsurgery in the elderly. How safe is it? A review of the literature and comparison with the Plastic Surgery Department experience.	4. Significant	Of 32 free flaps performed in patients over 65, 94% Successful microsurgical anastomosis, 100% salvage rate, 97% overall flap survival, zero mortality rate and return to CCU. Limitations acknowledged around elective skin cancer related cases only. Microsurgery in	No action identified but considerations based on literature and experience were presented.	Plastic surgery M&M meeting, Oct 2018

		elderly is safe provided careful assessment and patient selection.		
SE18/2298 Evaluation of the management and outcomes of patients with Radiation Induced Angiosarcoma of the breast in our institution.	3. Partial	More than 95% patients were discussed in Sarcoma MDT, all had a biopsy, diagnosis and imaging prior to treatment in line with NCCN standards. Half the patients had an adequate oncological margin and just under a quarter received palliative or neo-adjuvant chemotherapy.	Recommendations included consideration of surgical re-section to obtain negative margins if impact on functionality is not to great and careful consideration of the individual patient and a period of at least 2 and a half years disease free prior to consideration of secondary breast reconstruction with careful counselling of the patient of ongoing risk of recurrence and metastases.	Morbidity and Mortality meeting of Plastic Surgery, Feb 2019; National Audit of Management and Outcomes of Angiosarcoma of the Breast and Chest Wall (Breast Angiosarcoma Surveillance Study, BRASS
Surgery - Theatres	5	Summary of Findings	Core Recommendations	
17/1994 Theatres Controlled Drug Record Re-Audit	4. Significant	This re-audit has shown an overall increased level of compliance for all standards measured. - There has been a significant increase in compliance in signature recording for both the Responsible Person and Witness. Radiotherapy theatre, although improved, has a lower compliance than theatres 1 to 5 or recovery. - The recording of dose has also increased and is at or near 100% across all areas. - The recording of time has increased to a lesser extent with the times for administered and destroyed remaining lower.	Continue to raise awareness of all anaesthetic and recovery staff.	Disseminated to anaesthetic and recovery staff, 2018
17/2093 ANTT Audit for all Clinical staff	3. Partial	Correct ANTT procedures were followed to a very high standard in the preparation zone and during the anaesthetic procedure but require improvement during the care of lines. This includes glove usage, hand washing and use of the cannula port for non-emergency drug administration.	Continue monitoring hand washing and improve hand washing awareness by use of the ultraviolet machines. Improve Glove awareness campaign. Review non-compliance cases and the audit tool and provide guidance to auditors.	Ward Manager/band 7s/Band 6s and Anaesthetists, 2018
18/2255 Theatres Controlled Drug Record Re-Audit 2018	4. Significant	100% compliance has been achieved in all areas for the responsible person and witness signature. There has been a significant increase in times entered, and while still not 100% in all sections, it was observed that the times missing were often relating to the destroyed section, where the value was zero. Radiotherapy compliance has increased significantly over all sections. Recovery compliance excellent, recording 100% in 11 sections out of 12.	Remind all staff the importance of entering drug dose in all sections, as this is the only area where compliance has dropped, albeit only 1%.	
18/2286 Re-audit of MEWS in Theatre 2018	4. Significant	This year there were improvements in 11/12 standards measured and generally good results. Run charts initiated make it clear that improvements in the various standards have been erratic and un-sustained over the past 5 years.	Selected staff are being provided with extra support or supervision to increase knowledge or awareness. Monitoring via run charts is to continue with spot checks at regular intervals. Results of the audit to be pinned to the Recovery room notice board to raise awareness and serve as a reminder.	Recovery staff meeting, Aug 2018
18/2321 WHO Checklist – Observational Re-Audit IV	4. Significant	Overall, good compliance but non-compliance noted for Endoscopy patients for documenting specific instructions. Staff were using the audit tool incorrectly.	Ask IPU managers to remind staff that where specific instructions are not applicable then staff tick 'NA' instead of 'NO. The audit will become part of the Surgical Theatres WHO Checklist annual	Brachytherapy and Surgical Theatre staff, 2018

			audit.	
Surgery - Urology	3	Summary of Findings	Core Recommendations	
17/1843 Flexible cystoscopy follow up for bladder cancer patients re-audit	4. Significant	All 4 patients who were able to have their risk categorised as low based on the clinico-pathological data for the follow up of NMIBC had compliance to the NICE guidelines, which represented a significant improvement on the previous audit. For those patients who lacked the clinico-pathological data to categorise their risk, 2 were discharged as soon as it was safe and the other 2 will be followed up until it is felt safe to discharge to primary care. The majority of patients had intermediate and high risk and they are also meeting NICE guidance for follow up.	To record the risk category of the NMIBC in the case records to support care as NICE guidance.	Urology team, April 2018
S17/2032 Questionnaire to establish patient support needs of men diagnosed with penile cancer attending the Christie NHS Foundation Trust.	3. Partial	20% of men who completed a survey without prejudice in the clinic expressed an interest in a support group, with the expressed mode preference for frequency being monthly and bi-annually. The main anticipated benefits indicated was educational and friendship/support. A tailored website was popular with over a third of patients.	To approach Maggie's re the venue and support for setting up a group and Orchid for funding and support with the aim to do this within 12 months. Identify team members to ensure the smooth facilitation of the support group. Obtain feedback.	Penile Cancer AGM, May 2018
SE18/2222 Assessment of outcomes for men under the age of 55 with penile cancer	3. Partial	Findings from this student presentation indicated that there was no correlation between age and survival. Although it was found that recurrence reduced chances of survival, this disagrees with the current literature.	Further research considered crucial as there are a limited amount of studies performed in developed countries. No action identified.	APEP student presentations, Jul 2018
Surgery (Overall)	3	Summary of Findings	Core Recommendations	
17/2004 Perioperative Diabetes (NCEPOD)	2. Weak	Following data submitted, 3 lengthy two-part questionnaires were requested and 2 were returned to NCEPOD by the recipients. 10 of 13 NCEPOD recommendations are partially compliant and 3 need to be addressed in full. The trust has been carrying out quality improvement work as part of the its Sugar Matters initiative which is extending into surgery.	Continue working closely with the nursing teams to improve systems for patients with diabetes around peri-operative care and liaise with aneasthetics/surgeons to include them. A new diabetes specialist nurse will be in post soon addressing reduced staffing levels and making it easier to progress revisions to the policy.	Diabetes and surgical teams, Dec 2018
17/2059 Clinical record keeping re-audit (surgery)	3. Partial	The overall average scores in this re-audit have improved from 63% to 79% with the scores for all but one standard increased. The proportion of records in the sample where the overall documentation score was poor has reduced by half. Documentation of bleep number, printing name in block capitals and alterations requires improvement.	Plan to raise awareness of the findings, to educate on the GMC guidelines and continue with unplanned checks of medical notes against the guidelines.	Plastic and Skin surgical team meeting, Aug 2018
18/2117 Annual Re-audit of informed consent 2018	3. Partial	Competency to consent consistent at 68%.Appropriate information provided to 67% (to be confirmed)	To be advised	PSC, Oct 2018

Network Services				
Chemotherapy Services	1	Summary of Findings	Core Recommendations	
S18/2300 Annual chemotherapy outreach nurse led clinic patient satisfaction survey – Re audit 2018	4. Significant	There were high levels of patient satisfaction across the 6 questions. 91% of patients rated the standard of care as 'Excellent' and the remaining 9% reported that it was 'Very good'.	Schedulers and Nursing staff reminded of processes for alterations and allocation of appointments before leaving clinic to ensure patients are informed of treatment times in advance. Review scheduling for Bury and options for alternative locations as the lack of lack can compromise privacy.	SACT delivery group, Jan 2019
Clinical Oncology	17	Summary of Findings	Core Recommendations	
17/1848 Stage 1 NSCLC Northwest sector	3. Partial	Whilst the majority of patients recommended for radical treatment received it as recommended by the MDT, there were delays for 19 patients (18%), recommended for surgery, but found medically inoperable. These patients were re-referred for radiotherapy but median treatment times were nearly doubled. Improved decision making within the MDT, particularly with regards to selecting patients for surgery, could be achieved with more careful consideration of patient age, PS, comorbidities, and lung function. Accurate estimation of PS and comorbidity score at time of patient presentation is imperative.	A business case has been raised for a joint surgery-oncology clinic in Greater Manchester which could reduce waiting times for treatment in a proportion of patients, however further studies are needed to determine the effect on treatment outcomes and patient survival.	APEP presentations, Jul 2017; BTOG, Jan 2018
17/2016 In patient admission of Head and Neck patients receiving concurrent radiotherapy	3. Partial	56 (55%) patients treated with concurrent chemo-radiotherapy for head and neck cancers developed Acute Kidney Injury (AKI) of whom 91% were admitted. 10/14 patients taking ACE-I were advised to stop. 53% patients had more than 10% of weight loss after treatment. Nearly two thirds of all patients were admitted during the course of treatment overall with mean length of stay 8.1 days.	Statistical analysis is to be undertaken to identify risk factors for AKI in this cohort. Aim for early identification of those at higher risk of AKI in order to optimise their management and reduce emergency admissions. Reviewing recent article indicating that a score-based model created by using the patient's age, cisplatin dose, hypertension, and serum albumin is predictive of C-AKI.	H&N team meeting, Jan 2018; Trust M&M meeting, Jun 2018
18/2143 re-audit outcome of Solitary Plasmacytoma treated with radical radiotherapy	4. Significant	In one of the largest recent series in the literature, outcomes were at least as good as published data.	To continue current practice but ensure full completion of the clinical outcomes forms for plasmacytoma to allow longer follow up and increase ability to monitor survival.	HaemOncology education meeting, May 2018
18/2193 An audit of osteonecrosis in oral cancer treated with radical radiotherapy	3. Partial	ORN rates were 5.3% (ORN20) and 8.5% (ORN30) respectively. The ORN20 is acceptable, but the ORN30 is higher than we would like, but reflects the change in planning with IMRT.	Changes to CTV planning guidelines will reduce the overall treatment volume and reduce the incidence of ORN30	H&N RTQA meeting, 2018
18/2236 National Small Cell Bladder Cancer Audit	7. Not Applicable	Participated in national audit but awaiting national report; local results presented. Median survival for those who have died was 14 months.	No action identified.	Clinical oncology urology team, 2018
18/2264 NLCA pleural mesothelioma audit 2016	5. Full	As a tertiary referral centre we should have none or very few patients in this national audit, but 4 were	Review of the cases found that only 1 was truly eligible and had been discussed at the MDT. 1 did	Lung DG (by email), Jul 2018

		allocated to us.	not have a definite diagnosis, 1 was wrongly allocated and 1 was for pathology review only and never seen at the Christie. The national team added a statement into the report indicating that allocation of cases may be inaccurate for us as the tertiary provider.	
19/2389 Further re-audit outcome of Solitary Plasmacytoma treated with radical radiotherapy	5. Full	The standard primary treatment is radiotherapy and we have achieved 100% rate for all 4 patients in 2018. All patients were considered into current available trial however 2 were ineligible.	Continue to follow current local guidelines and fill in plasmacytoma CWP outcome forms to ensure patients with rare cancers such as this are considered for trials.	Haematology Oncology Education meeting, May 2018
CE15/1521 Adherence to the radical chemo-radiotherapy schedule in HIV positive anal cancer patients: a retrospective case-matched study	3. Partial	Slightly more HIV positive patients than HIV negative patients completed chemo-radiotherapy without radiotherapy treatment gaps. A quarter of gaps were due to Bank holidays. HIV positive patients received similar radiotherapy, but less chemotherapy treatment as compared with the HIV negative patients. HIV positive patients were twice as likely to be admitted overnight as HIV negative patients.	The CD4 count of HIV positive patients is measured, either by The Christie or another healthcare institute, and formally documented and dated in the patient notes. Review these cohorts for a prolonged follow up period to establish long term tumour outcomes.	GI away day, Sep 2015; APEP student presentations
CE16/1747 Long-term Swallowing Outcomes after Chemoradiotherapy for Oropharyngeal Cancer	3. Partial	This study highlights that long term swallowing dysfunction is prevalent amongst a large cohort of oropharyngeal cancer patients, treated with chemoradiotherapy across two centres. Amongst our patients, 32% reported composite MDADI scores below 60, which would suggest poor swallowing function. Altered pre-treatment diet, poorer performance status and requirement for enteral feeding during treatment were all significantly associated with poorer MDADI outcomes on multivariate analysis. Although each centre in this study used differing treatment techniques and radiotherapy dose fractionation schedules, there was no significant difference in long term MDADI outcomes between Leeds and The Christie.	In view of the significant impact of long term swallowing dysfunction on quality of life, it is important not only to counsel patients appropriately prior to treatment, but it remains a priority to develop treatment strategies which may reduce this toxicity.	Accepted for publication by Radiotherapy & Oncology (the Green Journal), Jun 2018
QIP17/2057 Improving safe Cisplatin delivery and compliance in patients receiving concurrent chemoradiation for locally advanced Cervical cancer	3. Partial	Completion of all planned Cisplatin chemotherapy is relatively low in this sample compared to published data (27% patients completing all five cycles, 57% completing four or more). Hospital admission was required for 12 (27%) patients with non-neutropenic infection the main cause. Total treatment times were acceptable with the majority of patients completing treatment within 50days. Those with longer treatment times tended to be those in whom brachytherapy was not possible who went on to have an external beam boost.	Aim to increase the proportion of patients safely completing all cycles to above 35% through development and pilot of a checklist for ore-chemotherapy assessment, prophylactic G-CSF from week 2 onwards. Chemotherapy omissions will be recorded prospectively; also to check overall treatment time and thrombocytopenia does not increase with G-CSF. If successful to implement checklist on CWP.	Gynaecological clinical oncology away day, Apr 2018
SE17/1866 Assessment of time from biopsy to surgery histology result and commencement of	3. Partial	Time from surgery to commencing radiotherapy improved over the two time periods audited. In 2014	Continue to work towards reducing the time from surgery to treatment to < 6 weeks for the majority	Head and Neck QA meeting

radiotherapy		treatment started an average of 6.8 weeks after surgery, by 2016 this has fallen to 6.3 weeks. The reduction was achieved largely through shorter times from initial oncology review to starting RT, falling from an average of 25.9 days to 22.3 days. The period of time from surgery to clinical oncology consultation remained relatively static at 21.5 and 21.7 days respectively. The time from surgical specimen being available until review also remained static at 10 and 10.7 days over the two periods. In 2014 25% of patients commenced radiotherapy within 6 weeks of surgery, as recommended by NICE compared with 42% in 2016. The figure commencing radiotherapy within 8 weeks also rose, from 85% to 92%.	of patients. Liaise with surgical and histopathology departments to attempt to reduce time from biopsy sample being processed to being discussed. Review radiotherapy planning pathway to attempt to get average time from oncology assessment to commencing treatment to < 20 days. Re-audit outcomes in 24 months.	
SE18/2119 Head and Neck patient satisfaction survey	3. Partial	Results of this patient pathway survey at the start and post completion of radiotherapy were generally very positive with all patients strongly agreeing they would recommend the Christie.	To consider possible improvement in online resources, ensuring understanding during consent, access to dietitian and speech therapist at MRI, pre-treatment and in the community, specialist dressing station, notice for appointments and 6 week follow up phone call.	H&N QA meeting, Dec 2018
SE18/2217 Audit of the use of Radiotherapy in Manchester lymphoma practice	3. Partial	Overall 94% of patients with bulk>10cm were correctly attributed an X-modifier. At the MDT 82% were recommended or considered for radiotherapy and 67% of patients with bulk disease received radiotherapy. In addition 94% of all patients with DLBCL were given radiotherapy within 4 weeks of the treatment recommendation.	Actions are being confirmed re adoption of the Lugano classification system as the use of the X-modifier to record bulk disease is outdated. Instead a single dimension and site should be recorded and those with bulk >7.5cm should be considered for radiotherapy. If bulk disease is documented and radiotherapy is not proposed, then the reason for not doing so should be recorded at MDT.	Lymphoma DG, planned 2018
SE18/2225 Knowledge of e-cigarettes in Lung cancer patients	7. Not Applicable	Overall e-cigarette usage was low in this group of Lung cancer patients. Their knowledge was also poor but this may have been due to the age and frailty of this group of patients and the small number of patients (7) who had tried e-cigarettes. This was in big contrast to young people (year 7/8 and year 11) whose knowledge was much better in our other survey.	No action identified.	Lung DG, 2018
SE18/2281 Audit of local recurrence following partial breast radiotherapy	4. Significant	The rate of local recurrence following partial breast radiotherapy is low, when appropriately used in the low risk patient cohort, and should be considered in this cohort routinely.	No action required.	National meeting (unnamed), Nov 2018
SE18/2303 Re-audit blood transfusions for patients with an anal cancer diagnosis undergoing chemo-radiotherapy	4. Significant	Fewer patients required a blood transfusion during their radical chemo-radiotherapy compared to the previous audit. Patients who required transfusion did not have abnormal HCT levels prior to commencing radical chemo-radiotherapy, as compared with the previous data. It can be inferred that there has been a significant reduction in the patient's requiring transfusion during radical treatment for anal cancer, since the implementation of VMAT radiotherapy.	In the future consider studying whether changes in the provision of treatment has any further effect on the myelosuppressive nature of concurrent chemo-radiotherapy.	Colorectal clinical oncology group, Nov 2018

SE18/2349 Identify incidence of disease recurrence after radiotherapy and residual disease in the cohort of patients treated with anal VMAT	3. Partial	Findings from this student project suggest that patients with more advanced tumours, in particular those with nodal involvement, may benefit from further systemic therapy, such as adjuvant chemotherapy.	No action identified beyond updating the data to reinforce the suggestion that male gender and younger age may be predictive of poorer treatment response.	APEP presentation and LGI team, Jul 2018
Endocrinology	1	Summary of Findings	Core Recommendations	
SE17/2068 Assessing the prevalence of steroid use and other fracture risk factors in an unselected neuro-oncology patient population to inform a policy for DXA scan requirements and bone health management in this high risk group.	2. Weak	The neuro-oncology outpatient setting includes a group of patients with high frequency of glucocorticoid (GC) use and thus at risk. The audit demonstrates low rates (4/25 indicated) of assessment of bone health and anti-resorptive treatment in this high risk group.	The results will inform a Quality Improvement bone initiative to determine best methods for incorporating bone health and bone mineral density assessment within this setting.	Poster to World Congress International Osteoporosis Foundation, Krakow 2018
Haematology	4	Summary of Findings	Core Recommendations	
16/1823 Quality of Bone Marrow Biopsy Samples	2. Weak	Just under 60% samples during May met the quality standard required. It wasn't possible to determine any effect on the sample from the regimen or disease due to the variability and there were no clear effects from the other variables reviewed.	All practitioners to be retrained to ensure that the target of 75% good quality samples is met. Re-audit in 6 months.	Haematology Quality meeting, Jul 2018
18/2260 Haematology Capacity re-audit 2018: Chemotherapy peer review measure 14-3S-408	4. Significant	The number of new cases for higher intensity treatment has increased from 70 to 81 (16%). The number of emergency admissions has decreased from 46 to 24 (48%). No deaths are attributable to infection or complication of treatment. All admissions to the Christie were appropriate and the numbers have reduced from two thirds to less than a third of patients.	The hotline plays an essential role in the management of this patient group providing the opportunity for early assessment and management of symptoms which on some occasions could be managed in the community with the assistance of the GP. Further analysis of the 5 patients admitted for nausea & vomiting is required to assess if these admissions resulted from omission of anti-emetics on discharge and could have been managed in the community.	Haematology Quality meeting, Oct 2018
SE18/2240 Haematology Clinical nurse specialist support services	4. Significant	Good awareness and support from the CNS. Only 29% engage with other services.	Promote outside support through introduction of welcome pack and networking with charities	TBA
SE18/2274 Acute Kidney Injury in Haematology	4. Significant	This review following an incident shows good practice and compliance with policy within haematology. All patients had observations, biochemistry and signs and symptoms of sepsis assessed. All 4 inpatients had fluid balance assessed. Urine dip was performed by nursing staff, however not commented on in medical notes. No patient had USS KUB however in many cases this was probably not clinically indicated as another cause of the AKI was found and corrected. Although a small sample, the team felt it was representative.	Educate medical staff on management of AKI, in particular to consider USS KUB and where to find information on urine dip. Re-audit in 24 months.	Haematology Quality Management meeting, Dec 2018
Medical Oncology	25	Summary of Findings	Core Recommendations	
14/1330 Evaluation of first line treatment for HER2 positive metastatic breast cancer	4. Significant	Compliance against 8 CDF eligibility criteria was high overall with 4 fully compliant.	No recommendations or actions received; the team are carrying out ongoing analysis of the dataset.	No information

16/1649 National Oesophago-gastric Cancer Audit (NOGCA) 2016	3. Partial	The Christie submitted 513 treatment records in the 2 year period to end March 2016. Because results are attributed to the diagnosing trust not all can be interpreted here.	No areas for improvement were identified. The National OG Cancer Audit will be re-commissioned in 2018, together with the current National Bowel Cancer Audit, as the three-year National Gastrointestinal Cancer (Oesophago-gastric and Bowel) Audit Programme.	Apr 2018
16/1727 Evaluating the effectiveness and safety of Raltitrexed as a single agent and in combination with Oxaliplatin in colorectal cancer	4. Significant	Within the context of its use at the Christie and recommendations in NICE guidance the use of Raltitrexed appears to be safe and demonstrates useful levels of effectiveness in selected patients. The current practice can be continued.	Given the small number of patients treated and assessed re-audit after an interval may provide further information on safety of individual regimens, but only worthwhile if sufficient patients available.	GI Research meeting, Jun 2016
16/1812 Effects of glucose control during treatment on outcomes of patients with pancreatic adenocarcinoma - a single centre experience.	3. Partial	This study demonstrated for the first time that baseline Glucose above thresholds and the absolute minimum random Glucose confers worse outcomes for patients with pancreatic ductal adenocarcinoma (PDAC). Whether this risk is modifiable is subject to further research.	No action yet identified.	Submitted to ESMO, 2018
17/1906 Audit of (Neo)Adjuvant Carboplatin-Based Chemotherapy in the Treatment of Triple Negative or BRCA-mutated Early Breast Cancer	4. Significant	Findings indicate that the addition of carboplatin to standard chemotherapy for triple negative breast cancer is deliverable in a real world setting and achieves comparable outcomes to that seen in published phase II trials2,3. Data shows dose reductions and treatment deferrals were most commonly seen during those receiving carboplatin chemotherapy. Neoadjuvant patients had more dose reductions and consequently had a dose intensity of <85%. Unable to assess all standards.	No actions available yet; auditor now on mat leave.	Breast DG, 2018
17/2009 HATRCA 2017/18	4. Significant	52 instances of Hospital Acquired Thrombosis were identified for the year to Mar 2018. Root cause analysis was carried out for 78% of them by Oct 2018. For all but two, the root cause was considered to be disease or treatment related. There were no deaths related to the VTE and only 3 said more could have been done to prevent the VTE.	An audit of line related thrombosis is planned. Improving communication about the risks and benefits of having LWMH to be considered at Thrombosis committee.	Thrombosis Committee, Oct 2018
17/2088 Enhanced Supportive Care Outcomes Project - extension	3. Partial	This Masters dissertation reported a statistically significant increase in symptom burden between baseline and follow up. The most common symptom was pain, and this was the most common reason for referral to the SCT. Patients reported a significantly higher symptom burden than clinicians at both baseline and follow up. There was no statistically significant difference in change in symptom burden from baseline to follow up between patients who were and weren't referred to the SCT.	Use of the IPOS form to facilitate a proactive referral pattern to the SCT for patients entering a phase I trial is feasible. Both clinician and patient reported symptoms may be useful in assessing adverse event burden of phase I patients. Future work with a larger cohort of patients may better demonstrate the benefit of ESC for phase I trial patients, or help identify subgroups of patients who benefit in particular.	MSc presentation, 2019
18/2045 Factors governing mortality from Febrile neutropenia in cancer patients re-audit	3. Partial	The study found that factors that could predict mortality from febrile neutropenia at the start of a line of chemotherapy were: age, Charlson comorbidity score	These results should be validated in a larger study and could form the basis of a prognostic tool for predicting mortality from febrile neutropenia in	APEP presentations, Jul 2018

		>5, presence of liver metastases, pre-existing renal impairment, ECOG PS >0, steroid use >2weeks and use of topoisomerase inhibitors. Biomarkers that could be predictive at the start of a line of chemotherapy or at each cycle were raised levels of ALP and LDH. It also found that risk factors for developing febrile neutropenia included early cycles of the patients first line chemotherapy and lymphopenia at the start of treatment.	cancer patients at the start of treatment.	
18/2161 Cancer of Unknown Primary (CUP): Audit of management and outcomes since introduction of CUP MDT at The Christie Hospital	4. Significant	66 new patients were referred in the financial year, an 24% increase of CUP referrals. The number of patients seen by the CUP CNS at their first consultation remains stable; this would have been appropriate for 4 patients, but there is a lack of cover for the post. Where patients are not seen on their initial visit they are reviewed by the CNS on subsequent visits. The percentage of patients referred to palliative care services has reduced slightly to 78% of applicable patients. The number of patients seen within in 2 weeks of referral has improved however increasing demand on the service may make this standard more difficult to attain in the future. The number of patients receiving chemotherapy or other treatment modalities has increased with a reduction in the number of patients receiving best supportive care than in the previous 12 months.	Areas for improvement identified as CNS review at initial consultation, specialist palliative care referral offered and timely patient appointments, ideally by the next clinic available following referral. Feedback will be provided to the network to emphasise the need for early referral to ensure that patients are well enough for treatment and that patients whose performance score is >3 would not be suitable candidates for systemic anti-cancer therapy. Annual audit to be carried out.	CUP team, 2018
18/2173 Impact on prognosis and management of bone metastases in patients diagnosed with neuroendocrine neoplasms.	3. Partial	Rate of bone metastases in patients with NENs seems to be lower than previously expected with just over half at the time of diagnosis of other distant metastases. Most patients will develop some degree of symptomatology from bone metastases (pain 61%). Radiotherapy use was adequate, despite being reported to be below standards (limited to use in patients with refractory pain). Use of bisphosphonates was below standards for other tumour types with a longer prognosis probably due to lack of guidelines for patients with NENs.	Guidelines to standardise practice and management of bone metastases in patients with neuroendocrine tumours being developed. Re-audit in 2 years.	NCRI (poster presentation), abstract to European Society of Neuroendocrine Tumours (ENETS) and UK and Ireland Neuroendocrine Tumour Society (UKINETS).
18/2191 30 day mortality following SACT 2018	3. Partial	Treatment related deaths reduced against an increasing number of patients treated with SACT.	Promote compliance with Trust target of 90% proforma completion rate. Promote compliance of 90% of all treatment related mortality cases discussed at a Morbidity and Mortality meeting. Promote compliance of 100% of all Christie death cases to be discussed at a Morbidity and Mortality meeting.	Patient Safety Committee OCT 2018 SACT Delivery Group OCT 2018

18/2224 The Management of Nausea and Vomiting in Patients with Advanced Cancer	3. Partial	Good compliance with nausea and vomiting symptom response to antiemetic medication, follow-up with supportive care team and appropriate health professional. However only a third of patients' symptoms resolved with antiemetic medication.	The audit data highlight the complex nature of nausea and vomiting in cancer patients and its management and the need for future research in this area. The supportive care team provide excellent support for symptomatic patients but are limited by available antiemetics. No changes recommended based on this data.	APEP student presentations, Jun 2018
18/2282 Re-audit of The Neuroendocrine (NET) service - your views	3. Partial	Communication between health professionals considered adequate for majority of patients. The number of patients feeling they had enough time with the health care professional has fallen slightly. Around a quarter of patients indicated partial understanding of information given.	Patients who are attending for scan results only will have blood test performed on the day of the scan, rather than when they attend clinic. Review clinic flow for possibility of further improvements. Re-survey in 2 years.	HPB business meeting, Oct 2018
CE16/1784 Outcomes following docetaxel chemotherapy in patients with previously treated advanced oesophagogastric cancer	3. Partial	97 patients identified with OG cancers who received docetaxel in the general oncology setting 2012-17 had an OS comparable to that in randomised trials, but experienced significant toxicity. Grade 3 or worse toxicity was experienced by half the patients. Dose reduction was required for more than a third, and a quarter stopped therapy due to toxicity. The median OS for all patients was 5.8months.	No action identified.	Oesophageal cancer team, Mar 2019
S18/2299 Homecare pilot scheme re-audit 2018	5. Full	100% patients completing the survey rated the standard of care received as excellent. All patients preferred Christie at Home location for care, were adequately informed of treatment times and felt staff dealt with their anxieties.	Expansion of the service to include medications for patients treated for renal, lung and melanoma in 2019. Further drugs being reviewed to check those that are suitable for delivery at home. The SACT outreach clinic will be the second option for location if Christie at Home is declined.	SACT delivery Group, Jan 2019
SE17/1857 Neoadjuvant chemotherapy in locally advanced inoperable colorectal cancers	7. Not Applicable	Neoadjuvant chemotherapy (NACT) achieves a high resectability rate in patients with locally advanced colon adenocarcinoma (LACA) deemed unresectable at diagnosis. However, this patient group still has a relatively poor prognosis; median OS was 42 months.	Mature data will be presented at the meeting. No action identified.	Abstract submitted, ESMO, 2019
SE17/2065 Effect of nodal status and yield on survival after curative resection of gastroenteropancreatic neuroendocrine tumours	3. Partial	Removal of LNs (Lymph Nodes) is associated with greater risk of relapse in G1 & G2 GEP NETs; localisation also has a significant association with RFS (relapse-free survival), necessitating stricter surveillance. Median follow up times for all patients were 41 months and 71 months for RFS and Overall Survival respectively.	Larger prospective studies are required to validate these findings. No further action identified.	Submitted to ESMO, 2018
SE17/2108 Assessment of weight change after one cycle of palliative chemotherapy as a predictive marker of survival in metastatic Oesophagogastric patients.	3. Partial	Patients who had a weight reduction of =3% of baseline had statistically significant shorter median OS compared to those who did not have such weight reduction (7.2 vs. 14.2 months, log-rank p=0.011). A multivariate Cox proportional regression model including age, gender, histology, weight loss, PS and radiological response indicated that a weight loss of =3% were independently and statistically associated	To ensure staff are aware of the results and reminded to assess and document nutritional parameters at the initial consultation and each subsequent outpatient attendance. To increase the cohort and validity of results and consider prospective intervention study to examine if early nutrition interventions to support weight maintenance from cycle 1 to cycle 4 and beyond.	UGI team meeting, Nov 2018; dietetic team, 2018; ESMO Oct 2018.

		with OS. 47% (n=54) of patients completed six cycles of first line palliative chemotherapy. Of the 68 patients who had stable disease or a treatment response after cycle 3, 38% (n=26) had weight loss of =3% from baseline and are a target for nutrition interventions at the start of chemotherapy.		
SE18/2124 Survival and clinical impact of pembrolizumab for pretreated advanced non-small cell lung cancer (NSCLC)	4. Significant	Our cohort demonstrated similar survival outcomes to KEYNOTE-010. Baseline Derived Elevated neutrophil-lymphocyte ratio dNLR <3 and good/intermediate Lung Immune Prognostic Index (LIPI) score was associated with significantly improved OS (overall survival) compared to dNLR =3 and poor LIPI score respectively. In contrast, baseline NLR, dNLR, LDH (lactate dehydrogenase), PD-L1 and LIPI score were not significantly prognostic of PFS (progression free survival).	No action identified	Poster, European Society of Medical Oncology, Dec 2018
SE18/2160 Second primary malignancies in patients with non-pulmonary neuroendocrine tumours	7. Not Applicable	Non-pulmonary well-differentiated neuroendocrine tumours (wdNETs) are associated with high rates of Second primary malignancies (SPMs). Most SPMs are diagnosed pre-NET, potentially indicating treatment-induced selection of neuroendocrine differentiation clones. A high proportion of NETs are diagnosed incidentally. The association between colorectal cancer and SB-NETs supports previous propositions of colonoscopy use in the work up to NET diagnosis, and association of breast cancer and pNET diagnosis may suggest a possible common pathway alteration in phosphoinositide-3-kinase (PI3K)/protein kinase-B (AkT)/mTOR pathway. Tumourigenic peptides secreted by functional NETs do not appear to have an impact on SPM development.	No action identified.	Submitted to the NCRI conference, Glasgow 2018
SE18/2234 The use of 2nd generation ALK inhibitors in lung cancer	4. Significant	As part of this active project and expanding network, a multicentre retrospective analysis across 23 active NHS trusts was conducted. The ALK+ UK Patient Group has been supporting the expansion of this network. Median overall survival from diagnosis of advanced/metastatic disease was 6.2 years. A nationwide collaboration is possible and should be promoted, particularly with rare cancer subtypes. The involvement of patient groups helps shaping projects' aims and identify further unmet needs. The remarkable survival of ALK+ patients mirrors the revolution in the treatment landscape.	All efforts should be done to exclude ALK rearrangement, particularly in never smokers due to the significant prognostic implications.	Poster presented, Jan 2019
SE18/2245 Identification of risk factors for Malignant bowel obstruction in ovarian cancer and validation of the Manchester bowel obstructions	7. Not Applicable	In this QEPEP project cohort, the MBOS was unable to stratify patients with MBO according to prognosis. Further application of the MBOS to a larger cohort	The Manchester Bowel Obstruction Score (MBOS) requires further validation in a larger cohort. No direct action identified, though improved recording	Student presentations, Jul 2018

core		could contradict these findings, particularly if more variables such as distribution of serosal disease, age, albumin levels, Ca125 at diagnosis, concurrent presence of ascites, and previous treatment strategies were accounted for.	of date of admission in discharge summaries and diagnosis in the CWP summary record was encouraged.	
SE18/2256 Acute Kidney Injury risk and prevention in patients undergoing treatment for lung cancer	3. Partial	The tool had a low sensitivity of 14.52% and a high specificity of 96.39%. However, it does identify that patients with higher body mass, poorer performance status and diabetes represent a high proportion of AKI cases and special care is warranted when starting these patients on therapy for lung cancer. The high incidence of diabetes in the AKI population would infer greater case should be given in the treatment of patients in this population. Dehydration was identified to be the cause of AKI in majority of the population. This study also identified hypertension, COPD, osteoarthritis and PPI use as factors with high incidence.	Once changes are made to the tool and the sensitivity is increased, to implement pre-emptive hydration of high risk patients. In the meantime, to take special care when starting patients with the higher risk factors on therapy for lung cancer.	Lung Cancer breakfast meeting, Jun 2018
SE18/2312 Survival and clinical impact of pembrolizumab in first line NSCLC	4. Significant	80% received treatment within 62 days of diagnosis. There were 7 (13%) grade 3-5 adverse events considered treatment-related and 7% pneumonitis overall.	The results are positive and in line with trial data, with a good chance that patients will tolerate and benefit from Pembrolizumab; no action required.	Lung DG, June 2018
SE18/2331 The first 12 months of PD-L1 testing in non-small cell lung cancer (NSCLC)	5. Full	Results from 2017 showed that 70% of the PD-L1 test results were positive (1% positivity or above) and therefore patients would be eligible for treatment with pembrolizumab. However only 35% had PD-L1 =50% and therefore eligible for pembrolizumab in the 1st line of treatment for advanced/metastatic NSCLC. The remaining were only eligible for pembrolizumab in subsequent treatment lines. There were 12% of inappropriate samples for PD-L1 testing at the first round and therefore 20% had to be repeated (new biopsies for PD-L1 testing).	Results shared with the lung cancer pathway in order to promote all peripheral centres to request this new test (PD-L1) to all patients as part of standard of care, particularly before any systemic treatment considering that in 35% of cases such result may have a positive impact in the first line treatment options.	Results shared with Lung cancer pathway in Greater Manchester and lung DG, Jan 2018
Nursing - NS	5	Summary of Findings	Core Recommendations	
17/2061 Upper GI Cancer Nurse Specialist Service - Patient Survey re-audit	3. Partial	The re-audit has shown some improvement, however it is clear from patient responses that the demand for the GI specialist nurse is ever increasing. VOH is part time, and the need for the service is full time at least.	There are plans in place to appoint another CNS and this is expected to occur in July 2018. The audit will be repeated in 2019/20 to show whether this additional resources has enhanced the patient experience further.	Upper GI team meeting, 2018
CE16/1611 Evaluating the effectiveness of a pilot nurse led clinic to support patients newly diagnosed with secondary breast cancer	4. Significant	79% of 121 patients invited attended the Secondary Breast Cancer (SBC) nurse-led clinics; evaluations were extremely positive, with clear benefits to patients demonstrated in terms of diagnosis/treatment understanding and support. Assessing patients' psychological distress using the HADS and Concerns Checklist appears to be useful, easy to complete and clinically informative, including detecting potential	Continue the planned weekly SBC-led clinics. Disseminate findings.	Breast team; Macmillan; The Christie board of governors; 2018.

		changes over time.		
QIP17/1982 Christie CODE: OAU re-assessment	5. Full	OAU was successfully re-accredited.		OUA, April 2018
QIP17/1985 Christie CODE: Palatine Ward re-assessment	5. Full	Palatine ward was successfully re-accredited.		Palatine Ward, Jan 2018
S16/1787 Lymphoma patient satisfaction survey 2017	5. Full	Positive patient experience in clinic. Information on trials not being offered frequently. Some patients did not get CNS support.	Investigate feasibility of extra CNS support	Lymphoma meeting, Dec 2018
Oldham	1	Summary of Findings	Core Recommendations	
SE18/2489 BCON radiotherapy in bladder cancer	3. Partial	Patients receiving BCON radiotherapy with Nicotinamide for muscle invasive bladder cancer need close monitoring during treatment with bloods and clinical review regarding tolerability of Nicotinamide and radiotherapy toxicity. Early detection of worsening renal function can be proactively investigated and managed with the discontinuation of Nicotinamide if necessary, allowing the patient to continue with Carbogen alone. Patients with an eGFR of <40 mL/min should not receive Nicotinamide.	Patients to have their U&Es checked in the 4 weeks prior to prescription of Nicotinamide and to have these repeated weekly during treatment in order to assess for any deterioration. Patients to be seen weekly and receive as required pre-emptive anti-emetics and advised to seek early review if not effective. To re-audit in 6 months.	GU team, Mar 2019
Radiotherapy	4	Summary of Findings	Core Recommendations	
SE18/2130 The knowledge of therapy radiographers on sepsis and its management	2. Weak	The audit results demonstrated staff in the radiotherapy department had minimal and inconsistent knowledge regarding sepsis recognition and management; suggesting additional training is required. The preferred format was classroom based.	Mandatory E-lite bite learning has been developed for all clinical staff and will be linked to the acute oncology module. Classroom based training will be offered to radiotherapy staff adapting information for the radiotherapy referral pathway. Survey learners after using the initial questionnaire at the end of each classroom session.	Education and training committee, Mar 2018
SE18/2135 An audit of Radiotherapy related calls received by The Hotline: Are we meeting the information needs of our patients?	3. Partial	Overall, the Trust generally is meeting the information needs of the Radiotherapy patients. Some of the calls received by the Hotline were unavoidable due to the patient becoming acutely unwell and requiring a clinician review and/or admission to hospital. However some of the calls may have been avoided with greater information provision, particularly calls during the post Radiotherapy period.	Reiterate the importance of the treatment review and reminding patients about side effects on the first day to radiographers. Encourage staff to ensure the patient has enough medication. Discuss the need for written Radiotherapy information. Address the accuracy of the data completed by the hotline staff if possible to allow accuracy in the number of calls affecting radiotherapy.	Radiotherapy team, 2018
SE18/2209 Training post-graduate therapy radiographers to deliver radiotherapy treatment to sarcoma tumours in the extremities: evaluating the use of treatment simulations.	4. Significant	All 9 participants reported an increase in self-efficacy after receiving the simulated training session.	Recommend continued use and exploration of this training platform, and indicates its application in teaching of other radiotherapy techniques.	Radiotherapy department and academic report, 2018.
SE18/2247 Rapid Access Palliative Radiotherapy Clinic at The Christie at Oldham – first 19 months of	4. Significant	244 patients were referred for 270 episodes in 19 month period. More than half the patients (and the	Further developments include radiographer-led practice, enhanced supportive care clinic, MDT	British Institute of Radiology (BIR) meeting, Mar 2018

operation		majority actually seen) were referred by the radiotherapy (XRT) booking form and seen by the clinical oncology team before referral. 69 (28%) patients alive. 20 (8%) died within 30 days of XRT start. Median survival was just over 6 months. Implementation of the rapid access palliative XRT clinic has achieved its intended benefit of providing timely and efficient access to palliative radiotherapy.	'fast track route', PROMs, 30 day mortality after palliative XRT, complex bone metastases clinic and SpR-led palliative XRT clinic.	
Stem Cell Transplant	4	Summary of Findings	Core Recommendations	
17/2111 Evaluation of post transplant CNS role	7. Not Applicable	The post CNS transplant nurse carried out this piece of work in collaboration with the Anthony Nolan Trust, but has since left. Anthony Nolan produced a written report, and their website indicates they hope to expand the service.	No local action identified.	Haematology team, 2018
SE18/2364 Analysis of Inappropriate SFLC Requests and Cost Implications	1. Poor	This review found that 1 in 3 of the 1538 Serum Free Light Chain (SFLC) tests requested in 2017 were inappropriate (cost over £11,000). Inappropriate use was defined as requests in non-myeloma patients (non-PCD) or requests outside the defined time frame.	Change the timing of the lab not carrying out the request from 4 to 3 weeks. Change the timing of tests to Serum Paraprotein estimation as well (to 3 weeks). To consider an outcome column for test at next clinic and HTDU visits. Re-audit in 6 months to evaluate the impact of current change in policy on the appropriateness of SFLC ordering, timing and missed or asynchronous test results on patient management.	Haematology/TYA QMM, Dec 2018
SE18/2366 Results of Auto-PBSCT in patients above the age of 70 yr.	4. Significant	Engraftment times are within expected range. Lymphoma patients take longer for platelet recovery. Treatment Related Mortality is within quoted range for AutoPBSCT. Probability of ICU transfer, serious complications leading to prolonged convalescence and longer hospital stay is higher in lymphoma patients above the age of 70yr. Re-admission rates are similar. Rate of second AutoPBSCT is similar for both groups and the outcomes are comparable.	Continue the current practice of individual case selection in patients above 70yr age. Safe to increase the age limit to 75yr in select group of cases if the transplant physicians perceive that the benefit outweighs the individualized risks, risk of morbidity and expected survival benefit.	Haematology/TYA QMM, Dec 2018
SE18/2367 Retrospective analysis of Autograft for GCT	3. Partial	The numbers in this study over nearly 7 years are too small to identify valid predictors of response. However, it is possible to use Sirolimus without toxicity. Hypertriglyceridemia is common but rarely requires discontinuation of therapy. Responses observed with any organ involvement and also with established scleroderma. Flare ups and need for steroid escalation is common (67%). Steroids could be discontinued in a minority of cases (3/18 cases, 17%). Results are comparable to published studies.	Re-analyse after extended recruitment of patients. To use Statins for prevention of hypertriglyceridemia. Consider use early in the therapy of GVHD in combination with steroids and possibly CNI.	Haematology/TYA Quality Meeting, Nov 2018
Surgery - Gynaecology	1	Summary of Findings	Core Recommendations	
19/2427 Robotic Surgery in gynaecological oncology (2018)	4. Significant	Significantly morbid patients and complex caseload. 28% were morbidly obese. Overall 85% patients had no complication. The overall and major complication	All consultants trained for Advanced Laparoscopic / Robotic Surgery. Gynae Onc fellow completing CWP morbidity form following weekly Gynae	Gynaecological Oncology Clinical Governance Meeting, Jun 2019; Robotic users group, Jun 2019

		rates and unplanned readmission rate was much lower than published data. The minor complication rate is slightly lower.	Oncology Clinical Governance Meeting. Pay attention to minor complication rate. Re audit on annual basis.	
Teenage & Young Adult Services	1	Summary of Findings	Core Recommendations	
16/1753 NCEPOD Cancer in Children Teenagers and Young Adults	4. Significant	The NCEPOD recommendations have been reviewed by the Paediatric Governance Committee; they identified areas of partial compliance but CREC agreed that these are not fully applicable to the patient group at The Christie. There are in general equivalent systems in place via Specialist Commissioning.	No further action required.	Paediatric Governance Committee, Jan 2019; CREC, Feb 2019
Transfusion	8	Summary of Findings	Core Recommendations	
16/1679 Annual re-audit Massive Blood Loss 2016	4. Significant	Delay in identifying that the patient was having a massive haemorrhage/blood loss, this would hopefully be quicker as blood loss would be more visible in an acute situation. Confusion with laboratory not releasing the O negative blood products.	Remove old Massive Blood Loss algorithm from the clinical area arrest trolley. Provide teaching sessions to clinical areas.	HTC Aug 2018
17/1875 2017 Audit of the management of patients at risk of Transfusion Associated Circulatory Overload (TACO)	3. Partial	Results for inpatients having their weight recorded at an appropriate time and receiving single unit transfusion were above the national average. Indication for transfusion documentation, evidence of discussion regarding benefits and risks and closer monitoring of outpatient weight require improvement.	A number of national recommendations are being added to the trust policy, including pre-transfusion risk assessment and a checklist for risk factors.	HTC, Aug 2018
18/2157 Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme 2017	7. Not Applicable	49 recommendations applicable to The Christie. Action plan or comment recorded for each learning point.	Actions are largely to include recommendations in trust policy and training. They will be progressed via the Hospital Transfusion Committee.	HTC, Aug 2018
18/2183 Patient information leaflets re-audit 2018	3. Partial	Compliance has remained at similar levels to the previous audit. Evidence that patients are receiving information leaflets prior to transfusion is the weakest area at 65%.	Remind the porters and security staff to take the information leaflets to the clinical areas with the unit. Remind medical staff and practitioners to provide the information to the patients prior to receiving a transfusion. Remind nursing staff to ask the patient if they have any questions prior to starting their transfusion. Re-audit in 6 months.	HTC Aug 2018
18/2184 Bedside Transfusion Re-Audit 2018	4. Significant	53/64 audits questions reached 95% or above compliance. The reason for request and practitioner details continue to have the poorest compliance. 84% patients received information as part of consent, which is a significant increase on last year.	Electronic prescribing being implemented. Promotional campaign for the importance and availability of transfusion information for patients to support informed consent.	HTC, Nov 2018
18/2185 Blood Prescription Re-Audit 2018	4. Significant	Legibility improved from the previous audit. There was good compliance across 38 standards with only 4 being below 95%.	Electronic prescribing is to be introduced in 2018. The audit tool will be revised and there will be an audit 3 months after implementation.	HTC, Nov 2018
18/2186 Collection of Blood Products re-audit 2018	4. Significant	20/25 standards were fully compliant. The weakest area that requires improvement notably is identification	New electronic prescribing implemented trust wide. This will address the areas needing improvement;	HTC, Feb 2019

		of the doctor.	also to educate collection staff to wait for checks to be completed. The audit proforma will be amended and a further audit carried out as part of the Clinical Transfusion Process audit later in 2019.	
18/2228 Second sample audit	3. Partial	Process of second sample is embedded into the trust however the specific details on when to take the second sample requires further education.	Education on specific details of process ie when to take the second sample. Re-send the policy to ward managers and link nurses. RE-audit in 18 months.	HTC, Nov 2018
Other Division				
Christie Pathology Partnership (CPP)	2	Summary of Findings	Core Recommendations	
18/2175 Audit of biochemical monitoring for adult male patients with androgen deficiency syndrome receiving testosterone replacement therapy.	3. Partial	Patients on T therapy are usually monitored frequently enough to be safe. Patients are often monitored more frequently than is necessary because clinical staff are ordering extra monitoring investigations every time they come to the Endocrinology Department. When patients were not investigated often enough this was usually because they missed an appointment. When patients have abnormal results for their T therapy monitoring, these are noticed and acted upon appropriately by clinicians.	Consider process for patients who miss appointments. To agree options to improve rate of serum T measurement being taken at the same time, including provide teaching to clinicians. To agree options to reduce unnecessary monitoring investigations including identifying someone to have responsibility, educated and a reminder to check the previous timing in the protocol. Endocrinology team to discuss changing guidance in line with the evidence base reported in this study.	Biochemistry and endocrinology teams, Aug 2018
SE18/2174 Monitoring of Patients with Multiple Myeloma on treatment with Daratumumab by Protein Electrophoresis	3. Partial	Daratumumab can be detected on an electrophoresis trace from 1 month of commencing on the drug. Unless the laboratory is informed that a patient had been commenced on daratumumab, the appearance of a second band will be reported by the laboratory as a second paraprotein band. This band will be quantified by densitometry. This may impact upon assessment of remission status of patients. Clinical use will increase following NICE approval via Cancer Drugs Fund. Patients may also be referred to The Christie having been treated with daratumumab at other hospitals. Therefore, it is really important that in conjunction with Haematology the laboratory works to improve the reporting of electrophoresis results of patients on daratumumab	Notifications are now being sent to the Specialist Biochemistry department. Maintain records of patients on daratumumab to ensure the electrophoresis reports on these patients adds value and are not detrimental to the patient's clinical assessment. Formalise a set of comments from the audit findings based on the different presentations of suspected daratumumab interference. This list will evolve over time depending of the electrophoresis patterns observed. Send the reports and costing information to Haematology for consideration of implementing the Sebia Daratumumab assay into the patient pathway for myeloma patients.	Association of Clinical Biochemistry annual meeting, FOCUS, Jun 2018 (won the ACB Medal Award) ; lab staff, 2018; Regional North West ACB meeting, 2018
CPCR	3	Summary of Findings	Core Recommendations	
17/1931 Unplanned admissions for older people with cancer: factors influencing length of stay	3. Partial	In this small sample, all patients were assessed for falls, psychological distress/worries on admission and social circumstances. 2/25 were not assessed for co-morbidities, performance status, medication on admission. Two thirds of patients were undergoing chemotherapy and 88% of these were experiencing SACT toxicity. Length of stay had a positive association with stage of cancer, urea and number of medications	Given the lack of clarity regarding optimal assessment tools in geriatric oncology, further research in this field is required. Incorporated into Later Life group strategy. Funding application in preparation for further research.	APEP student presentation, June 2017; Later Life interest group.

		on admission. It was negatively associated with GCSF, haemoglobin and neutrophil count.		
SE17/2011 Qualitative analysis of the Macmillan Cancer Improvement Partnership (MCIP) project: Improving care coordination for patients with advanced breast cancer	3. Partial	Semi-structured interviews were conducted with 19 patients who had advanced breast cancer, and 13 health professionals (7 Christie and 6 Pennine Acute Health Trust. The main benefits noted by staff were improved communication, joined-up working and coordination of care across primary, secondary and tertiary care. There was a lack of consensus regarding HNAs and uncertainty about handing over the key worker role across care boundaries and the 'Support for You' cards. Patients generally felt involved in their care and well supported, although highlighted some gaps in communication at the outset, including difficulties in obtaining appointments. Some patients were not familiar with the terminology, but confirmed that they had a HNA after it was explained to them; others did not think they had a HNA assessment. Christie staff demonstrated a high level of engagement and joint working across the multidisciplinary team, with commitment to improve the pathway for people with SBC.	It is early to evaluate sustainability, particularly for Pennine who were later to implement the pathway. No action identified in report.	MCIP committee meeting, Feb 2018
SE19/2436 Evaluation of the safety and effectiveness of PSA monitoring in primary care after discharge from hospital based follow-up following prostate cancer treatment	2. Weak	This project was funded by Manchester University and The Urology Foundation. In 39% of 300 cases, no PSA re-referral level was provided to GPs; and in those letters where the information was provided there was huge disparity in discharge letter instructions. 36% of patients were monitored as the oncologists' discharge letter instructed leaving 46% not tested frequently enough and 19% with no PSA testing recorded post-discharge. Time between treatment completion and discharge into primary care differs greatly across both geographic areas (4months to 16 years). Findings denote disparity between oncologists, GPs and patients regarding approach, procedure and quality of PSA monitoring. Instructions are unclear and arbitrary and testing is inconsistent.	Service improvement is required. Findings will be fed back to oncologists and GP's so to develop a strategy to improve the service and ultimately to create an evidence-based, uniform Greater Manchester PSA monitoring service which is safe, acceptable and effective for all. To carry out semi-structured interviews with patients, GPs and oncologists for thematic analysis to inform the improvement.	Urology team meeting, Nov 2018; Greater Manchester Cancer Conference, Nov 2018; CRUK early Diagnosis Conference, Feb 2019; Manchester University and The Urology Foundation, Mar 2019
Education	5	Summary of Findings	Core Recommendations	
17/1893 Patient Handling Risk Assessment - Inpatients - Re-audit 2017	3. Partial	The re-audit showed that 100% of patients admitted in the audit period had a manual handling risk assessment undertaken. There was some improvement to risk assessments being reviewed every 7 days. All patients had been assessed on CWP in detail and also identified as requiring moving and handling assistance on handover, however only 22%	Meet with in patient managers to discuss the need for specific moving and handling information on hand over sheet as well as CWP – refer to data that was collected for audit to observe and discuss Managers to forward evidence of compliance with action to MH Advisor by end of May	

		(5/23) had detailed information on hand over sheet.		
18/2079 Moving and handling Inanimate loads risk assessment re-audit 2018	4. Significant	The re-audit showed an increased level of compliance for most standards. Hard facilities have introduced the RAPP tool and they do not complete specific MH risk assessments (bespoke forms HSE). The rehabilitation unit is completing risk assessments and protocols separately.	Rehabilitation unit to link risk assessments to protocols	Quality and Safety Committee - Feb 2019
18/2080 Patient Handling Assessment – out patients & day case Re-audit 2018	4. Significant	All seven standards were met with above 90% compliance.	Review policy and ensure that all standards are adequately reflected in the CWP form. If not consider changes to the CWP form. To encourage all OP & DC areas to complete the assessments electronically so that a care plan would always be completed. Consider audit of the care plans.	Health & Safety Committee, Feb 2019
18/2200 Clinical supervision for nurses & allied health professionals audit 2018	3. Partial	All clinical supervisors received appropriate training for their role in this sample. The proportion actively providing supervision fell from half in 2016 to under a third with 35 staff being actively supervised.	Policy and database updated. Additional clinical supervision training workshops arranged throughout 2018 with promotion of the role to staff. Presentations given to staff groups to raise the profile of the role and training. Key staff are reviewing alternative support provided to staff including mentoring, coaching, and Schwartz rounds. Considering how outcome benefits can be collected and shared with staff.	Education & Training Committee, 2018
18/2218 Re-audit of Peripheral Cannulation 2018	4. Significant	All 20 practical standards were fully compliant; compliance with 4/6 documentation standards was good, but weaker for the number of attempts and the cannula size.	Continue to remind staff in training and at updates about requirements. To liaise with the departments where documentation needs improvement. To liaise with Clinical Web Portal regarding capturing all the information for cannulation as it is missing the option to record VIP score and size of cannula. Re-audit in 12 months in line with the Peripheral Cannulation Policy.	Patient Safety Committee, May 2018
Nursing - Other	1	Summary of Findings	Core Recommendations	
17/2078 The Christie One Day Every Patient - Outpatient survey November 2017	3. Partial	The Christie continues to perform well in terms of patient experience measures from the national outpatient survey; all have increased compliance. Additional questions were included this time around waiting times. 84% of patients had to wait at some point during their visit although there much better information given about waiting times than previous audits. Patients reported the most dissatisfaction with the waits in pharmacy.	Radiotherapy “Pre-scheduling project" which aims to deliver the patient’s full treatment schedule from day 1 of treatment completed. Data on radiotherapy waiting times and causes of delay are being analysed. ORTC Ground floor redesigned in Dec 2017. Pharmacy waiting times to be the main focus; progress on actions are being reported to the Trust Board. Making changes to how procedures are allocated to staff in the outpatients department; plan to issue staff nurses with a bleep to be able to locate staff and respond quicker. New patient flow electronic system coming in Sep. To display delays on patient information screen.	PEC, Apr 2018
Quality	1	Summary of Findings	Core Recommendations	

S18/2095 Re-audit speaking Up at The Christie - Staff raising concerns	3. Partial	Overall the results and positive comments indicate that respondents believe they could raise concerns and that they would be supported to do so. The response rate was lower this year a number of different methods of encouraging staff to complete.	In order to raise awareness of the importance of speaking up and how to do this, an e-learning tool on FTSU and a managers' guide on roles and responsibilities will be developed which include sources of support. Develop Schwarz round session on raising concerns.	Workforce committee, Nov 2018
R&D	1	Summary of Findings	Core Recommendations	
S18/2058 Sarcoma Patient survey (Greater Manchester and Oswestry Sarcoma Service (GMOSS)) 2018	3. Partial	Survey findings indicate good support service to sarcoma patients across the GMOSS network.	A disease specific Health and Wellbeing event was undertaken in April which is hoped will reflect a further improvement in satisfaction on next year's survey results. No further actions indicated.	Sarcoma team, date not indicated
Trustwide	4	Summary of Findings	Core Recommendations	
16/1698 Learning Disabilities Mortality Review (LeDeR)	5. Full	There was 1 qualifying death during the year and a full review was carried out. 3 national recommendations were applicable to The Christie and there is already an embedded process for each.	Training on learning disabilities is provided in the Trust Mental Capacity training. Safeguarding Nurse to investigate if specific Learning disability training is available to consider introduction. Learning from mortality reviews have led to actions to improve service provision, including strengthening discharge planning processes, and the provision of reasonable adjustments for people with learning disabilities.	Grand Round, June 2018
17/1895 Inpatient Mortality 2017	4. Significant	There were 271 onsite deaths of which 43% triggered a full review from screening by responsible consultant, bereavement suite and ward staff. The main reasons for triggering were for deaths reported to the coroner and occurring on CCU. At the time of the annual report, there was just one review outstanding, awaiting information from the coroner. Reviewers rated the overall care as good or excellent in 91%. 12 deaths were discussed by the Executive Review Group. 2 cases were considered to have a greater 50% chance of the death having been avoidable, both related to missed opportunities to identify patients at high risk of AKI. Themes for improvement included documentation, frequency of consultant review and anticipation of end of life.	A detailed action plan to act on learning from the reviews is being undertaken. It includes medical teaching, feedback to doctors, recruitment of 2 AKI specialist nurses, development of care plans for high risk interventional radiology procedures, agreement of identification and escalation processes for more frequent consultant review and informing 7 day service work programme.	Trust wide M&M meetings, Nov 2017 and Apr 2018
18/2148 7 day hospital services survey 2018	2. Weak	Only 1 of 9 eligible met the standard for the patient to be seen by a consultant within 14 hours of admission in the national review in Jun 2018. A new process was completed in Feb 2019. A sample of non-elective admissions found (14/30) were seen within 14 hours. All were on active cancer treatment at The Christie, triaged before admission, with known complications of treatment or cancer related problems managed through	Revise data collection tool and re-audit key standards May 2019. Plan audit programme to support quarterly data. Implement 7 day Board Round to improve standard for consultant review within 14 hours of admission. Improve data capture through implementation of electronic noting. Agree criteria for twice daily and daily consultant reviews and formalise access to endoscopy off site with	Acute & Critical Care Directorate, Divisional Board, Divisional governance, Risk & Quality Governance Committee, Jun 2019

		care protocols. No clinical concerns identified even where review not documented in 14 hours. None required critical care input.	another trust.	
S17/2105 National inpatient survey 2017	4. Significant	52% response rate is similar to previous years and other specialist trusts. The results remain excellent with all eligible section scores being better than most other trusts. Of the 60 questions, 18 results were better than last year, 29 had shown a small fall and 6 remained the same. 6 new questions were added. Five questions received a highest score from our patients, 1 significantly improved (being given enough notice of discharge) and four scores declined.	Actions are in place and being monitored via the Patient Experience Committee. Specific improvement projects are being considered.	Patient Experience Committee, Aug 2018

Directors' Report

Our board of directors'

The role of our board of directors is to govern The Christie NHS Foundation Trust effectively so that our patients, public and stakeholders have confidence that their care is in safe hands.

Our board is collectively responsible for ensuring the Trust is compliant with its terms of authorisation, its constitution, mandatory guidance, relevant statutory requirements and contractual obligations.

The quality and safety of our services are of paramount importance; the board ensures that it applies all the relevant principles and standards of clinical governance.

All members of the board meet the 'fit and proper' person test as described in the provider licence.

Our authorisation from our regulator and constitution govern the operation of the Trust. The schedule of reservation and delegation of powers sets out the types of decisions that must be taken by the board of directors and those which can be delegated to management. As required under Schedule A of the NHS Foundation Trust Code of Governance (A.1.1), the Trust's constitution (Annex 7, 10.3) defines which decisions must be taken by the council of governors and how disagreements between the board and the council should be resolved. Annex 6 paragraph 2 describes how the chairman or a non-executive director may be terminated. Further detail can be obtained from our Constitution which is accessible via our website.

Our board considers that it has complied with the requirements of the constitution relating to board composition. The board is satisfied that it has acted appropriately, been balanced and

complete and has contained a suitable range of appropriate and complementary skills and experience.

The board considers that all the non-executive directors are independent and the Chairman was independent on appointment (as required by the NHS Foundation Trust Code of Governance provision B.1.1).

Kathryn Riddle is the senior non-executive director and the designated link to the governors in case they have concerns they feel they cannot raise with the chairman or any of the executive directors. She also leads the appraisal process for the Chairman.

During 2018/19 there were no changes to the membership of the board of directors.

Process for evaluation of performance

In line with the NHS Foundation Trust Code of Governance (provision B.6), all directors have an annual performance appraisal and a personal development plan. The Chief Executive is responsible for the performance appraisal of the executive directors. The performance of the Chief Executive is reviewed by the Chairman. The results of these appraisals are reported to the remuneration committee.

The performance of the non-executive directors is reviewed by the Chairman and reported to the council of governors, using a process agreed by the council of governors. The performance of the Chairman is reviewed by the non-executive directors led by the senior independent director in a process agreed by the council of governors.

The board of directors and the audit and quality assurance committees undertake an annual self-assessment exercise to ascertain their effectiveness. The responses are collated and discussion is held on the key points arising from the review. The focus of the discussion is on those areas which clearly need improvement or where there is great variation in answers.

Board appointments

All non-executive director appointments made since 1st April 2007, including the Chairman, were made by the nominations committee and were approved by the council of governors.

The Chairman and non-executive directors are appointed for an initial period of 3 years and may be removed by the council of governors in accordance with Annex 6, paragraph 2, of our constitution.

Our executive directors are appointed through an open competition panel; their contracts of employment do not contain an expiry date.

Board meetings and committees

The board supports the Nolan principles and makes the majority of its decisions in meetings open to the public. The board met in public and in private eight times during 2018-19. It also held four informal board time outs one of which was a joint board and governor time out; this afforded the opportunity for our governors to input into discussions around the Trust's future plans.

The board delegates some of its work to sub committees and there is a standing item at each board meeting to receive a copy of the full minutes of these meetings. This helps the assurance committees to demonstrate a stronger audit trail of the work of their committee as well as steering their agenda in line with key risks (as identified in the Board Assurance Framework and divisional risks).

Attendance by directors at board and subcommittee meetings is shown on page 175.

Register of Interests

Details of company directorships and other significant interests held by directors which may

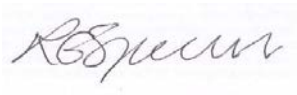
conflict with their management responsibilities are held in the register of interests of directors. This may be viewed at board of directors

Accounting policies for pensions and other retirement benefits are set out in the notes to the accounts and details of senior employees' remuneration can be found in the remuneration report on page 194.

There are 13 board members (seven non-executive and six executive directors; the executive medical directors share a vote on the board).

Gender	Non-executive directors	Executive directors	Total number of directors (substantive)
Female	3	4	7
Male	4	2	6
Total			**13**

The directors are responsible for preparing the annual report and accounts. The directors consider the annual report and accounts taken as a whole to be fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.



Roger Spencer
Chief Executive
23rd May 2019

Our board members

Non-executive directors

Christine Outram
Chairman

Christine was appointed Chairman of The Christie in October 2014. Her first job in the NHS in 1985 was as a patient advocate, and she continues to be passionate about working with clinical staff and with patients to provide excellent services and outcomes, and to further the Christie's internationally leading role in cancer research. As a chief executive in the NHS in London and Yorkshire for over 20 years, she championed many improvements and innovations in services, and also led major national programmes at the Department of Health and NHS England. She has expertise in professional education and research, and in maximising the benefit for health from digital technology.

Christine is also Board Trustee and Vice Chair of NHS Providers, which represents all Trusts providing services for patients within the NHS in England. Alongside her role at The Christie, she is a non-executive director of the Yorkshire & Humber Academic Health Science Network. A modern languages graduate, she holds a Master of Business Administration degree from the London Business School.

Neil Large MBE
Non-executive director

Neil was appointed as an interim non-executive director in July 2014 and as a substantive non-executive from July 2015; he is chair of the Trust's Audit Committee and Remuneration Committee and member of the proton beam therapy programme board.

Neil is currently Chairman of the Liverpool Heart and Chest Hospital NHS Foundation Trust (also rated as 'Outstanding' by the CQC) appointed in December 2009 and was previously a Non-Executive Director for two years at that Trust. Neil is an accountant by profession and has spent most of his career in the NHS holding board level appointments both Chief Executive / Executive and non-executive director positions for over 25 years. His last executive appointment prior to retirement was as Director of Finance & ICT of the former Cheshire & Merseyside Strategic Health Authority and he was a member of the National Finance Staff Development Committee.

Neil also supports local charitable /voluntary causes and is a member of the Chester University Audit & Risk Management Committee.

Neil was awarded an MBE in the 2017 New Year's honours list for services to healthcare.

Kathryn Riddle OBE JP DL
Non-executive director

Kathryn was appointed as an interim non-executive director in May 2014 and as a substantive non-executive director from May 2015. Kathryn is the senior independent Non-Executive Director. She also chairs the Charitable Funds Committee and is a member of the audit committee.

Kathryn is a patron of Weston Park Hospital, Sheffield and a patron of St Luke's Hospice, Sheffield. A former High Sheriff of South Yorkshire, Kathryn is a Deputy Lieutenant of South Yorkshire. She has been involved in health services since 1994 chairing the Community Health Trust in Sheffield, the Strategic Health Authority in Yorkshire and the Humber and from 2011-2013 she chaired NHS North of England.

Kathryn, a former lecturer in law, was the first woman to be appointed a Pro-Chancellor at the University of Sheffield and the first female Chair of Council at the University from 2007-2013. Kathryn remains connected with the University as a member of the alumni board.

Kathryn was Honorary Colonel of the Sheffield Universities Officer Training Corps from 2008-2014. A Magistrate since 1975 she chaired the Family Panel at Sheffield and the South Yorkshire Panel of Guardians ad Litem for eight years. Kathryn retired from the bench in 2015. Kathryn has had associations with a number of charities including Scope, Victim Support and Birthright.

Professor Kieran Walshe
Non-executive director

Kieran was appointed from July 2015 and chairs the Trust's Quality Assurance Committee.

Kieran is Professor of Health Policy and Management at Alliance Manchester Business School. He is a board member of Health Services Research UK. He was associate director of the National Institute of Health Research health services and delivery research programme from 2012 to 2015, and directed the NIHR service delivery and organisation research programme from 2008 to 2011. From 2003 to 2006 he directed the Centre for Public Policy and Management in Manchester Business School, and from 2009 to 2011 he directed the University's Institute of Health Sciences.

He has thirty years' experience in health policy, health management and health services research. He has particular interests in quality and performance in healthcare organisations; the governance, accountability and performance of public services; and the use of evidence in policy evaluation and learning. He has led research projects funded by the ESRC, Department of Health, NIHR, Health Foundation, European Union and other funders. He has advised many government agencies and organisations, in the UK and internationally, including acting as an advisor on health reforms to the House of Commons health select committee. His current research is mainly focused on reforms to health professions regulation; the use of inspection and rating in the regulation of healthcare organisations and services; organisational

capabilities and processes for improvement; and health and social care devolution.

Professor Jane Maher
Non-executive director
Jane was appointed from September 2015. She is the non-executive director safeguarding lead and is a member of the Quality Assurance Committee.

Jane was Chief Medical Officer of Macmillan Cancer Support from 1999-2018 and remains a clinical advisor to the charity. She has worked as a consultant clinical oncologist at Mount Vernon Cancer Centre for nearly 30 years and over this period focussed on a range of different cancers, including lymphoma, head and neck cancer and lung cancer, most recently with a particular interest in breast and advanced prostate cancer, with a research interest in understanding what happens to patients after their initial cancer treatment, as well as the influence of cultural differences on cancer management. She has also advised national NHS and international bodies on aftercare and survivorship.

Jane chaired the Maher Committee for the Department of Health in 1995, led the UK National Audit of Late Effects Pelvic Radiotherapy for the Royal College of Radiologists in 2000 and chaired the National Cancer Survivorship Initiative Consequences of Treatment workstream. She co-founded one of the first cancer support and Information services in the UK, winning the Nye Bevan award in 1992 and more than 60 support and information units have been established based on this model. She is a member of the Older People and Cancer Clinical Advisory Group.

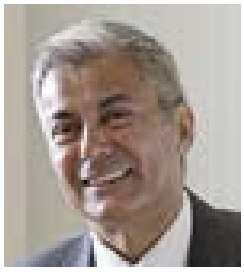
She has published widely and is a UK representative for cancer survivorship in Europe and advises on cancer survivorship programmes in Denmark and Canada.

Robert Ainsworth
Non-executive director
Robert was appointed on 7th March 2016**.** He is a member of the Audit Committee and is the independent Chairman of The Christie Pharmacy Limited. Robert was previously a non-executive director of Pennine Care NHS Foundation Trust having been appointed in 2008, and served as deputy chairman and senior independent director from 2011 until 2016**.** He is also a director of HF Holidays Ltd.

Prior to taking up the role of non-executive director, Robert held several senior management and director positions in the private sector, most recently in Premier Farnell plc, where he was Finance Director of the Europe & Asia Pacific division. This consisted of over twenty businesses across Europe and Asia with a turnover in excess of £400 million.

He was previously Finance Director and Company Secretary of National Tyres and Autocare Ltd and was Executive Director of Finance of GUS Catalogue Order Ltd. He has also been employed by The Co-operative Bank plc, and Price Waterhouse & Co. He has wide experience of general and financial management and much of

his career has been spent in competitive industries with a focus on customer service. He has a degree from Leeds University and he is a Fellow of the Institute of Chartered Accountants in England and Wales.



Tarun Kapur CBE
Non-executive director
Tarun was appointed from 1st June 2016 and is a member of the quality assurance committee.

Tarun is the CEO of The Dean Trust, comprising 10 schools across four local authorities. He was appointed as the first national leader of education (NLE) in the North West and since 2005 has led on many significant school to school support commissions. He has been an advisor to the Department of Education and speaks regularly on educational issues.

Tarun, as the headteacher at Ashton on Mersey School, won secondary headteacher of the year 2007. He is chairman of the Football Foundation facilities panel (FA and Premier League), which is the largest sports charity in the country. He is a director of the Manchester United Foundation Board that is dedicated to community provision in sport, education and employability.

Tarun was awarded a CBE in 2008 for services to education and in 2015 was nominated as one of 250 of the most influential people in Greater Manchester.

Executive directors

Roger Spencer
Chief executive
Roger has been undertaking the role of Chief Executive at The Christie since December 2013.

He has managed significant service developments including networked radiotherapy and chemotherapy centres across Greater Manchester, transforming the delivery of Christie services to an outpatient model. He directed the establishment of Christie partnerships for pathology, specialist diagnostic services and private patients, academic investment plan and the establishment of the first national proton therapy service in the UK.

In 2016 he led the Trust to a CQC Outstanding rating, repeated again in 2018.

Roger led for Greater Manchester on the National Cancer Vanguard developing and testing new models of care and was a member of the long term plan working group. He is the executive lead for Greater Manchester Cancer Alliance.

In December 2018 Roger was appointed to the Healthcare UK Advisory Board. The Advisory Board is accountable to the Department for International Trade (DIT) and the Department of Health & Social Care (DHSC) ministers.

Roger holds an MBA, an honours degree in Nursing Studies and is a Registered Nurse.

Jackie Bird
Chief nurse & executive director of quality
Jackie was appointed in June 2011, joining from The Rotherham NHS Foundation Trust where she was chief of quality and standards and chief nurse. Prior to this, she was the deputy director of nursing and governance at Salford Royal NHS Foundation Trust. Jackie is responsible for the professional leadership of nursing and allied health professionals. Her director role allows her to develop her long standing interest in cancer while addressing improvements in patient safety, patient experience and clinical outcomes.

Jackie was awarded a Florence Nightingale Leadership Scholarship in 2013 and has used her scholarship to develop and introduce a quality mark for patients undergoing chemotherapy, which was awarded the North West Leadership academy award for innovator of the year. Jackie is a board member on Manchester Health and Care Commissioning and is a member of the Health Education England (North)board. A registered general and mental health nurse, she holds an honours degree in nursing studies and a Masters in management and leadership.

Joanne Fitzpatrick
Executive director of finance & business development
Joanne was appointed on 1st April 2013 and is the former deputy director of finance and business development, a post which she held from 2001 to 2013. Prior to that Joanne was the assistant director of finance at The Christie NHS Foundation Trust from 1992 to 2001.

Joanne is responsible for the finance, business development, capital planning, estates and digital teams within the Trust and is also a Director of The Christie Clinic and The Christie Pathology Partnership. Joanne is also executive lead for The Christie charity.

In 2011, Joanne was recognised as being one of the top deputy directors of finance in the NHS through the successful attainment of the HFMA Deputy Director of Finance Award.

She is a qualified accountant and holds an ACMA.

Fiona Noden
Chief operating officer
Fiona was appointed chief operating officer from 1st August 2015. She was previously director of operations & performance at Wrightington, Wigan & Leigh NHS Foundation Trust, where she was part of the team that collected the HSJ Award for staff engagement in November 2013, and one of the executive management team at WWL that received the HSJ Award for 'Best Provider Trust of the Year' in November 2014.

Prior to this, she was the deputy director of operations, Wrightington, Wigan & Leigh NHS Foundation Trust, and the director of operations - diagnostics and clinical support services, Salford Royal NHS Foundation Trust.

Fiona qualified as a radiographer and has held a variety of clinical radiography posts before moving into operational management. Fiona is responsible for the performance and the delivery of clinical services at the Trust. Fiona is passionate about service improvement, staff development and whole system working to improve patient outcomes and experience.

Fiona is also a Director of The Christie Clinic LLP and The Christie Pathology Partnership.

Professor Christopher Harrison
Executive medical director (strategy)
Chris was appointed as executive medical director from 1st February 2016 and combined this role with that of National Clinical Director for Cancer at NHS England, a post he held until September 2018. Chris holds an honorary clinical professor position at the Manchester Academic Health Sciences Centre and continues to hold an honorary professor position at Imperial College, London

Chris was the medical director and responsible officer at Imperial College Healthcare NHS Trust from 2013 until 2016 during which period he was also the vice chairman of the London Clinical Senate. As medical director he was responsible for all aspects of the clinical strategy, clinical governance and medical professional leadership for a London teaching hospital with over 1000 doctors. He was also the executive director with responsibility for research and medical education.

Before moving to London, Chris was medical director at The Christie between 2005 and 2013. During this time he led the work leading to the development of the networked radiotherapy satellite facilities in Salford and Oldham and established the long term clinical strategy for the Christie. He established Manchester Cancer an integrated cancer system which has since evolved into the Greater Manchester Cancer programme and designated as part of the national cancer vanguard. Between 2010 and 2012 he was seconded part time to NHS London to lead the development of cancer services across the

capital, establishing the arrangements for the two London based integrated cancer systems which are also part of the national cancer vanguard.

He had previously held posts as head of the regional cancer team at North West Regional Office, deputy regional director of public health at North West Regional Office, director of the Greater Manchester Health Protection Unit and medical director and director of public health at Greater Manchester Strategic Health Authority. From 1992 he was the director of public health for The South Lancashire Health Authority (Ormskirk, Chorley, South Ribble) and in 1996 director of public health and commissioning for North West Lancashire Health Authority (Preston and Blackpool). During this period he was the executive director responsible for overseeing the development of the new radiotherapy service in Preston.

He has been involved in numerous national and international committees relating to cancer care, quality of care and standards of clinical practice. He led the first region wide cancer peer review programme and later chaired the accreditation committee of the Organisation of European Cancer Institutes which oversaw the peer review programme for cancer centres in Europe. He is frequently invited to lecture on cancer care policy in the UK and abroad.

Dr Wendy Makin
Executive medical director & responsible officer
Wendy was appointed from 1st November 2016.

Wendy initially trained as a clinical oncologist at The Christie. Following this, she decided to work in palliative care and worked as a consultant based at St Oswald's Hospice in Newcastle upon Tyne. She returned to Manchester in 1995 as Macmillan consultant in palliative care and oncology at The Christie, with sessions at St Ann's Hospice. She led the development of the multidisciplinary palliative care service at The Christie and helped to establish higher specialist training in palliative medicine in Greater Manchester. Wendy led a cross-College working party into the urgent care needs of people with cancer in 2012-13 and chaired the Palliative Medicine specialty committee at the Royal College of Physicians from 2013-16 and was a member of the Joint Collegiate Council for Oncology during that period.

For several years she has been engaged in the development of support and information for cancer survivors and was appointed as the new Manchester Cancer pathway director for Living With and Beyond Cancer (LWBC) in 2014. Wendy has continued to support areas of this work and is now a member of a national steering committee to develop models of 'Prehabilitation' for patients who undergo both surgical and non-surgical treatments.

Wendy is a member of the Macmillan consultant advisory group, working closely with the Macmillan GP network and a member of the Macmillan clinical advisory board. In 2017 she received a 'Lifetime achievement award' from Macmillan Cancer Support in recognition of her work.

Wendy was Deputy Medical Director for several years before her appointment as Executive Medical Director for governance and performance in 2016; she combines this role with that of Responsible Officer and is a regional RO appraiser.

Committees of the board

Audit committee

The audit committee uses the work of the auditors to provide the board of directors with an independent and objective review of how the foundation trust manages its finances, how it is structured to deliver its strategy and how it manages its risks. The committee was chaired throughout the year by Neil Large, non-executive director. Non-executive attendance at assurance committees is split between the audit and quality assurance committees (the Chairman of the Trust cannot be a member of the audit committee so attends the quality assurance committee). The other members of the audit committee are Kathryn Riddle and Robert Ainsworth.

The committee receives reports, scrutinises the findings, makes recommendations on requirements and follows up on actions taken.

Key activities during the year were:

- reviewing the Trust's annual report, financial statements, quality of costing & coding and quality accounts
- receiving and acting upon the annual governance report from the external auditor
- monitoring the board assurance framework
- approving the corporate governance documents of the Trust
- receiving reports from the internal auditor including counter fraud

Internal audit – internal audit is a cornerstone of good governance. Boards need timely and relevant assurance and look to internal audit to support that objective. Our internal auditor, Mersey Internal Audit Agency (MIAA), produces a plan of audits to be undertaken during the year. These are reviewed by the audit committee; additional audits can be added to the plan if required. Where further assurance is needed the relevant manager attends the committee and reports on actions to address the risks identified.

MIAA has a programme of follow-up audits which ensure recommendations to address identified risks are implemented.

External audit - an external audit is an examination of the annual financial statements of the foundation trust in accordance with specific rules by someone who is independent of the foundation trust. The external auditor performs the audit by examining and testing the information prepared by the foundation trust to support the figures and information it includes in its financial statements. The external auditor is appointed by the council of governors. Grant Thornton was appointed as our external audit provider in September 2017 for an initial period of 3 years. The effectiveness of the external audit process is assessed through regular reports to the committee as well as regular contact with the senior finance team.

The annual financial statements are presented to the committee. Areas of significance are accounting for the trust joint ventures, fixed asset transactions, adherence to IFRS15 accounting standard and the presentation of the group accounts to include The Christie Pharmacy and The Christie Charity.

The audit committee annual report is available on our website https://www.christie.nhs.uk/

Quality assurance committee

The role of the quality assurance committee is to provide independent assurance to the board of directors that The Christie NHS Foundation Trust is properly governed and well managed across the full range of activities and to provide internal and external assurance relating to quality by reviewing the establishment and maintenance of effective systems of governance, risk management and internal control. The committee is chaired by Professor Kieran Walshe, non-executive director, and comprises 3 other

non-executive directors; Professor Jane Maher, Christine Outram and Tarun Kapur.

Key activities during the year were:

- Maintaining registration with the CQC and full compliance with CQC essential standards of quality and safety, along with all other regulatory requirements.
- receiving reports and action plans from internal and external reviews
- monitoring the board assurance framework
- receiving internal audit reports relating to quality
- reviewing the terms of reference of the committee

The quality committee annual report is available on our website.

Charitable funds committee

The role of our charitable funds committee is to oversee the management of the affairs of The Christie Charitable Fund. The committee is chaired by Kathryn Riddle, non-executive director. The other members of the board are trustees.

Remuneration committee

The Remuneration Committee determines the pay of the executive directors. The committee is a non-executive committee of the board of directors comprising the independent non-executive directors. The committee is chaired by Neil Large who is also the chair of the audit committee.

The remuneration committee ensures that appropriate procedures are in place for the nomination, selection, training, development, monitoring, evaluation and remuneration of the chief executive and executive directors, having proper regard to the financial and commercial health of the organisation and for the provision of any national arrangements for such staff.

The committee evaluates and considers the recommendations of the chairman on the performance of the chief executive and evaluates and considers the recommendations of the chief executive on the performance of the executive directors. The committee determines the appropriate remuneration and terms of service for the chief executive and executive directors including all aspects of salary, provisions for other benefits (including pensions) and arrangements for the termination of employment and other contractual terms. Any decision must be based on individual contributions to the trust, having proper regard to the trust's circumstances and performance and to the provisions of any national arrangements for such staff (where appropriate).

The committee advises on and oversees appropriate contractual arrangements for executive directors including the proper calculation and scrutiny of termination payments taking into account such national guidance as is appropriate.

The committee evaluates its own membership and performance on a regular basis and is authorised to obtain reasonable external legal or other independent professional advice if it considers this to be necessary.

Management board

The role of the management board is to formulate recommendations on strategic and operational matters for referral to the board of directors for approval. The committee also monitors the effective and efficient financial, performance, risk, quality and safety management of The Christie. Meetings are held monthly and are chaired by the Chief Executive and comprise the executive directors, divisional directors, divisional medical directors, clinical

directors and general managers. The terms of reference including its membership were reviewed during the year.

Board members attendance at meetings

Name of committee	Board of directors	Board time out	Audit	Quality assurance***	Joint audit & quality assurance	Charitable funds	Remuneration	Council of governors	Joint board of directors/council of governors
Number of meetings	8	3	5	5	1	4	2	4 *	1
Christine Outram (Chairman)	8	3	N/A	5	1	3	2	4	1
Kathryn Riddle (NED)	5	3	2	N/A	1	3	1	3	1
Neil Large (NED)	8	3	5	N/A	1	2	2	4	1
Prof Kieran Walshe (NED)	7	2	N/A	4	1	4	2	1	1
Prof Jane Maher (NED)	7	3	N/A	4	1	4	1	0	1
Robert Ainsworth (NED)	8	3	5	N/A	1	3	2	4	1
Tarun Kapur (NED)	6	2	N/A	4	1	4	2	3	1
Roger Spencer (Chief Executive)	8	3	N/A	N/A	1	4	**	4	1
Jackie Bird (Executive Director of Nursing & Quality)	8	3	5	5	1	4	N/A	1	1
Joanne Fitzpatrick (Executive Director of Finance & Business Development)	8	3	5	N/A	1	4	N/A	4	1
Prof Christopher Harrison (Executive Medical Director)	7	3	N/A	-	1	3	N/A	3	1
Fiona Noden (Chief Operating Officer)	8	3	N/A	N/A	1	1	N/A	3	1
Dr Wendy Makin (Executive Medical Director)	8	3	N/A	5	1	4	N/A	3	1

* With the exception of the Chairman, there is no requirement for board members to attend council meetings unless governors' request attendance to gain information about the Trust's performance or the directors' performance of their duties. Governors have not exercised this power during this financial year.

** In attendance for part of the meeting

*** Meeting attended by one of the executive medical directors

Our council of governors

Governors play an important role in making us publicly accountable for the services we provide and they bring a valuable perspective and contribution to our activities. Importantly, governors hold the non-executive directors to account for the performance of the board.

The council of governors is made up of both elected and partner governors who act on behalf of their members or partner organisations, working closely with us to support future plans and ensuring we keep pushing our standards for the benefit of our patients.

Our council is made up of 28 governors: 15 representing the public, patients and carers; 4 representing our staff and volunteers and 9 appointed by partner organisations (we currently have vacancies in this group).

Elections in 2018

There were 4 constituencies up for election in 2018; the results of the election are as follow:

Public constituencies:

Cheshire
Maurice Gubbins
Rochdale
Craig Wellens
Stockport
Jackie Collins (re-elected uncontested)
Wigan
Nick Coghlan (re-elected uncontested)

We would like to thank two of our outgoing governors, Alex Davidson and Christine Mathewson, for their considerable contribution to The Christie over many years. Alex was public governor for Cheshire and Christine for Rochdale and both stepped down after completing the maximum 9 years of service. Alex and Christine were both members of the governor quality committee and played a valuable role in helping to promote the work of The Christie.

We would also like to extend our thanks to Damian Heron. Damian had been our public governor for the Remainder of England & Wales since 2013 but stepped down from this role in September 2018.

We would also like to welcome our two new governors, Maurice Gubbins and Craig Wellens, to The Christie.

Staff constituencies

During the year there were no changes to our staff governors.

Partner governors

During the year there were no changes to our partner governors.

Working with our governors

Our governors have a number of statutory responsibilities which are reflected in the Trust's Constitution. These responsibilities include, but are not limited to:

- the appointment or removal of Non-Executive Directors
- deciding the remuneration for Non-Executive Directors
- the appointment or removal of the Trust's external auditor
- receiving the annual report, accounts and auditors report

In addition, the Health and Social Care Act 2012 introduced two new legal duties:

- Hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board
- Represent the interests of the members of the Trust and public in general

In order for Governors to fulfil their statutory duties and responsibilities, it is important to ensure that they can connect with the Board of Directors. Therefore the chair of the board is also the chair of the council of governors. It is the chair's responsibility to ensure that the board and council work effectively together and that they receive the information they need to undertake their respective duties. To this end, the Council of Governors meeting is attended by Executive Directors. The Senior Independent Director (who is the designated link between the Council of Governors and the Board of Directors) also attends. The other non-executive directors are invited to the meetings but attendance is not mandatory unless requested to do so by the council of governors; this power has not been exercised during the course of this financial year.

Non-executive directors are also assigned to sit on one of the governor sub-committees. Governors have a rota for attendance at board meetings where they can observe the Non-Executive Directors carrying out their duties. The rota is a guide only with governors able to attend as many board meetings as they wish. Governors receive a copy of the agenda prior to the meeting and also receive copies of the Chief Executive's report and summary performance report following each Board meeting; they also have access to all board minutes.

We hold an annual joint time out session with the full council of governors and the board of directors. This half day event focuses on the strategy of the organisation and is a great opportunity for both groups to work together on the future direction of the Trust.

This interaction is invaluable and enables the governors to review how well the board is working, challenge the board in respect to its effectiveness and ask the board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the trust.

During the year we held an externally led development session which was attended by both our existing and new governors. The session included an introduction to The Christie, how we fit into the wider health system and a section on governor statutory responsibilities.

The governors also receive regular newsletters which keep them informed and updated on items of interest. The Chairman also hosts a number of Chairman's lunches which are attended by our non-executive directors to offer governors a more informal opportunity for interaction.

In situations where any conflict arises between the Board of Directors and the Council of Governors, the Trust's internal processes will be followed (*Annex 7 paragraph 10 of the Trust's Constitution*). The constitution states that the council of governors has three main roles:

- Strategic – to use the breadth of experience of the governors to help determine the trust's future direction and support it in delivering its plans.
- Advisory – to act as a critical friend providing support, feedback and advice.
- Representative – to use the views of their electorate or organisation to enhance and inform the work of the trust.

The board of directors, however, has overall responsibility for running the affairs of the trust. In circumstances where a conflict cannot be resolved the Chair can initiate an independent review (normally led by the Senior Independent Director) to investigate the concerns and make any recommendations.

Governors have an important role to play in making an NHS foundation trust publicly accountable for the services it provides. It is their responsibility to maintain and review membership numbers and the membership strategy. The board of directors consults with governors when the annual plan is being prepared and also on other issues such as revisions to our constitution and our declaration for the Care Quality Commission's 'essential standards of quality and safety'.

Our governors canvass the opinion of our members via newsletters and events and welcome any feedback. The Christie membership team also holds a series of focus groups each year to help gather members' views. The council met formally 5 times during 2018/19 (one of these was a joint time out session with the Board of Directors). The council of governors has four subcommittees focusing support into the areas of nominations, membership & community engagement, quality and development & sustainability.

Our governors have supported the board as well as providing an appropriate degree of challenge. They have contributed to our strategic plans via their involvement in council meetings, subcommittees, time-out sessions and working groups.

Governors are not paid but the Trust ensures that they are appropriately reimbursed for reasonable expenses incurred in the course of their duties.

- In 2017/18 5 governors submitted travel claims and for the year ended 31st March 2018 the total amount claimed was £1,491.70.

- In 2018/19 5 governors submitted travel claims and for the year ended 31st March 2019, the total amount claimed was £1783.12.

Governor sub-committees

Nominations committee

The nominations committee makes recommendations to the council of governors on the appointment and remuneration of the chairman and non-executive directors. The committee may work with an external organisation recognised as an expert at appointments to identify the skills and experience required; they will also take into account the views of the Board of Directors.

The nominations committee comprises the chairman of the foundation trust (or when the chairman is being appointed by another non-executive director), two elected governors and one appointed governor. The chair of another foundation trust will be invited to act as an independent assessor to the nominations committee.

The committee is chaired by the trust's Chairman and the following governors are members:

- Richard Hubner (staff governor for registered medical practitioners)
- David Makin (patient representative partner governor)
- Lisa Wylie (public governor for Bolton and lead governor)

The Director of Workforce may also be asked to attend as an advisor to the committee.

The committee met once during 2018-19 to discuss the remuneration of the chairman and the non-executive directors. The committee reviewed all available benchmarking data and concluded that non-executive director pay is in

line with comparative data and recommended to the council of governors that there should be no increase to non-executive pay and that they should remain on their current pay level. In regard to the chairman, the benchmarking data showed that our rate of pay fell below the national and peer average. The committee proposed an increase of 3% to bring the rate of pay of the chairman in line with that of similar size trusts.

The council of governors approved these recommendations at its meeting on 14th February 2019.

Membership and community engagement committee

This committee directs and monitors recruitment and engagement activity, manages communication with members through newsletters and letters and has overseen the organisation of a governor led programme of community engagement. The committee also advises on our target membership level and have supported the process to comply with the new General Data Protection Regulation in respect of the membership database.

Members are invited to regular supporters' seminars and major events such as Trust open days. Through the membership and community engagement committee, we are encouraging and developing increased participation of members by building a 'databank' of people who are readily available to give their views on our services and offering additional engagement opportunities. In particular, this group of members are invited to take part in our programme of patient focus groups which are run by the membership and voluntary services team.

Quality committee

The Council of Governors' Quality Committee monitors, reports and comments on patient experience and quality and standards of service. This involves both formal feedback reports and a range of presentations to the committee meetings combined with direct engagement with patients, carers and front line staff.

Priorities this year have been: understanding and learning from complaints, surveys and incidents; monitoring progress on the implementation of The Christie quality accreditation schemes (The Christie Quality Mark and The Christie CODE) including being actively involved in the Christie Quality Mark accreditation; speaking directly with patients and carers in outpatient and inpatient areas about their experiences.

Development and sustainability committee

This committee reviews the Trust's annual plan and strategy on behalf of the council of governors and makes suggestions and recommendations to the Board. It also receives presentations from senior executives on major capital projects and provides input into these on behalf of the council of governors.

Governor register of interests

The register of interests of our governors is available on our website https://www.christie.nhs.uk/

Our current governors

Name	Note	Elected public/ Elected staff/ Appointed	Representing	Council meetings (incl joint meeting with the board) x5	Member of committee (see key)	Year term ends	Terms remaining
Public							
BOWMAN Roger		Elected public	Trafford	4	D&SC	**2019**	**0**
CHOI Alice		Elected public	Cheshire	3	D&SC	**2020**	**1**
COGHLAN Nick		Elected public	Wigan	1	M&CE	**2021**	**1**
COLLINS Jackie		Elected public	Stockport	5	D&SC	**2021**	**1**
GAVIN-DALEY Ann		Elected public	Salford	4	QC	**2020**	**0**
GBBINS Maurice		Elected public	Cheshire	1 out of 3	QC	**2021**	**2**
HARRISON Derek		Elected public	North West	0	D&SC	**2019**	**2**
MADEN Mary		Elected public	Tameside & Glossop	0	M&CE	**2020**	**1**
MANSFIELD Madeleine		Elected public	Manchester	3	M&CE	**2019**	**2**
MEE Susan		Elected public	Oldham	3	QC	**2020**	**2**
QURESHI Mohammad		Elected public	Bury	2	QC	**2020**	**1**
WELLENS Craig		Elected public	Rochdale	3 out of 3	D&SC	**2021**	**2**
WOLSTENHOLME Fiona		Elected public	Manchester	1	M&CE	**2019**	**2**
WYLIE Lisa	[1]	Elected public	Bolton	4	M&CE & Nomco	**2020**	**1**
The Remainder of England & Wales				Vacant			

Name	Note	Elected public/ Elected staff/ Appointed	Representing	Council meetings (incl joint meeting with the board) x5	Member of committee (see key)	Year term ends	Terms remaining
Staff							
ARMSTRONG Alison		Elected Staff	Other clinical professional	2	D&SC	**2020**	**2**
KENDAL Rachel		Elected staff	Non-clinical staff	5	D&SC	**2020**	**1**
HUBNER Richard		Elected staff	Registered medical practitioner	2	Nomco	**2020**	**2**
Matt Bilney		Elected staff	Registered nurses	3	QC	**2019**	**2**

Name	Note	Elected public/ Elected staff/ Appointed	Representing	Council meetings (incl joint meeting with the board) x5	Member of committee (see key)	Year term ends
Partner						
MAKIN David		Appointed	Patient rep	5	Nomco / QC	**TBR**
MEYER Stefan		Appointed	The University of Manchester	1	QC	**2021**
MOORES Cllr Eddie		Appointed	Local authority - GMCA	4	M&CE	**2025**
MOSS Janice		Appointed	The Christie Charity	4	M&CE	**2025**
SIMCOCK Cllr Andrew		Appointed	Local authority – Manchester City Council	1	D&SC	**2022**
TURNER Marcella		Appointed	Nominated - BME (Can-Survive)	2	M&CE	2025

Key:

1	Lead governor	D&SC	Development & sustainability committee
QC	Quality committee	Nomco	Nominations Committee
M&CE	Membership & Community Engagement committee	TBR	To be reviewed

Staff Report

Our patients are at the heart of everything we do and our workforce makes the difference by achieving the highest possible patient support and care. We are committed to attracting, retaining and developing our staff and aim to support them by engaging with them and valuing their individual contributions to the work that we deliver.

Our approach to staff engagement

At The Christie, we recognise the link between staff engagement and the quality of services we provide to our patients. Our principles, behaviours and staff pledges assure our patients, carers and families that the treatment and care they receive will be high quality and compassionate, but they also reflect the way in which we commit to treat and care for our workforce.

We frequently seek staff feedback and use a number of different approaches, including the NHS Staff Survey, the quarterly Friends and Family Test and executive team walkabouts.

Our Christie staff pledges demonstrate our commitment to communicating and engaging with our staff to support their learning and development, to recognise their contribution and to provide a healthy working environment.

Healthy Workplace

As a result of staff feedback, in 2018-19 we have developed our health and wellbeing plan to support staff to maintain their health and well-being and encourage them to lead healthy lifestyles. We have invested in initiatives to support health and well-being including the introduction of Mental Health First Aid Champions and mindfulness sessions. The organisation has participated in national campaigns linked to health and wellbeing such as mental health awareness week which has enabled staff to be signposted to a range of support. We continue to provide our staff with support mechanisms through occupational health, staff physiotherapy services and employee assistance programmes which provide advice, guidance and counselling for those who require it.

Communication & Engagement

A significant focus this year has been to promote a positive working environment. We have launched our positive working relations policy and introduced a staff mediation service. We have also held a number of listening events to gather feedback from staff about their experience of working at the Christie. This feedback will help us develop further action plans in 2019-20 to improve staff experience.

Learning & Development

In 2018-19 we have continued to invest in learning and development opportunities for staff. We have introduced staff mentors and promoted coaching opportunities. We continue to ensure that we equip our managers, team leaders and supervisors with the skills needed to enable our staff to be the best they can be and to support them to promote a positive working environment.

Achievement & Recognition

We continue to recognise the efforts and achievement of our staff. Our monthly staff recognition scheme 'You made a difference' has continued. In June 2018 we held our annual staff awards where we celebrated the outstanding achievements of staff and recognised the long and valued service of some of our long standing employees.

NHS Staff Survey

The NHS staff survey is conducted annually. From 2018 onwards the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2018 survey among our staff was 46% (2017: 47%). Scores for each indicator together with that of the survey benchmarking group (Acute Specialist Trusts) are presented below.

In 2018 our key findings continued to be extremely positive. When compared with other Acute Specialist Trusts we performed best in 2 thematic areas and better than average in 7, with only the quality of appraisals lower than the national average. However, our improvement in this area since last year is significant.

There is strong evidence to show that employee engagement is intrinsically linked to high performance and good quality care, so it is particularly pleasing that the Trust's staff engagement score remains significantly better than the national average.

There was a significant improvement in this year's scores in relation to relationships with immediate managers with the scores being the best in the benchmarking group.

Actions to address the key development areas will now be drawn up.

Key Theme	2018/9		2017/8		2016/7	
	The Christie	Benchmarking Group	The Christie	Benchmarking Group	The Christie	Benchmarking Group
Equality Diversity and Inclusion	9.4	9.3	9.3	9.3	9.5	9.3
Health and Wellbeing	6.5	6.3	6.4	6.3	6.6	6.3
Immediate Managers	7.3	7.0	7.1	6.9	7.1	6.9
Morale	6.6	6.3				
Quality of appraisals	5.6	5.7	5.2	5.5	5.5	5.5
Quality of care	7.9	7.8	7.7	7.7	7.9	7.8
Safe environment – bullying and harassment	8.7	8.2	8.8	8.4	8.9	8.3
Safe environment – violence	9.9	9.7	9.9	9.7	9.9	9.7
Safety culture	7.3	6.9	7.2	6.9	7.3	6.9
Staff engagement	7.6	7.4	7.5	7.4	7.6	7.5

Staff Policies

During 2018-19 the following employment policies were updated: Facility Time, Professional Registration & Revalidation, Management of Stress, Organisational Change, Management of attendance, Work Experience, Raising Concerns at Work, Annual Leave, Retention / Management of Personnel Files and Positive Working Relationships.

In addition, we have a number of policies in operation that support our workforce. The equality and diversity policy provides our commitment to treat everyone with compassion, dignity and respect, and to ensure that we promote a fair culture. Each person is an individual, whether they are a patient, a visitor or a colleague, and each has their own different needs from the services we provide or from their employment. This includes employment, training, promotion, and general treatment. All policies are assessed to establish the equality impact, to ensure all groups are treated fairly and consistently, and where appropriate reasonable adjustments are considered. For example, our recruitment and selection policy is underpinned by the achievement of the Disability Confident Scheme (Level 2) which provides our commitment to employing and retaining disabled people and ensuring this commitment is reflected in all recruitment practices.

We work in collaboration with our staff and consult where decisions are likely to have an impact on individuals. Our organisational change policy, in particular, provides mechanisms for consultation with recognised trade union and professional association representatives as well as our staff. We work in partnership with our staff-side representatives which include a number of recognised trade unions. Regular staff forums are held to engage with our union partners to share information about the direction of the organisation and to gain feedback and support. If there is a concern in relation to an employee who has potentially undertaken a fraudulent act this would be investigated through the Trust disciplinary policy. Concerns can also be dealt with by our counter fraud team.

Our sickness absence data

Figures Converted by DH to Best Estimates of Required Data Items		
Average full time equivalent (FTE) 2018	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE
2650	21,349	8.1

To ensure our staff feel able and confident to raise concerns they can access the Trust's Freedom To Speak Up Guardian. The Freedom to Speak Up Guardian provides confidential support and advice to any member of staff thinking about raising a concern. In addition, we have a network of staff advisers, who are independent sources of advice and support for any employee who wishes to raise a concern about the manner in which they have been treated.

We encourage our workforce to be involved in our performance, and frequently gain their opinion and feedback through our annual staff survey, through regular engagement events and our quarterly friends and family test which indicated on average in 2018-19 that 72% of our workforce would recommend The Christie to their friends and family as a place to work and 97% would recommend it as a place for care and treatment. Also, our monthly board of directors and council of governors meetings are public, and staff are welcome to attend.

Our staff quarterly magazine and our monthly team brief, which is delivered face to face by the Chief Executive, cascade key information and messages about the Trust's performance, plans

and developments, changes to services and information that is of interest to our staff.

Our process for welcoming staff includes a trust induction, which provides the opportunity to meet our Chief Executive and learn more about the Trust. In addition to the trust induction, nursing colleagues have the opportunity to meet with the Chief Nurse during their first six weeks within the organisation.

The trust recognises its legal duty to protect patients, staff and visitors from the risk of injury or work-related ill health. There is an effective executive-led approach to managing health and safety with close co-operation between management and staff side representatives. Managers have access to specialist trained advisers in health and safety, moving and handling, fire and security. In addition, advice and support are available from radiation protection, infection control, occupational health and waste management.

Our staff (headcount at year end 2018 including non-executive Directors)

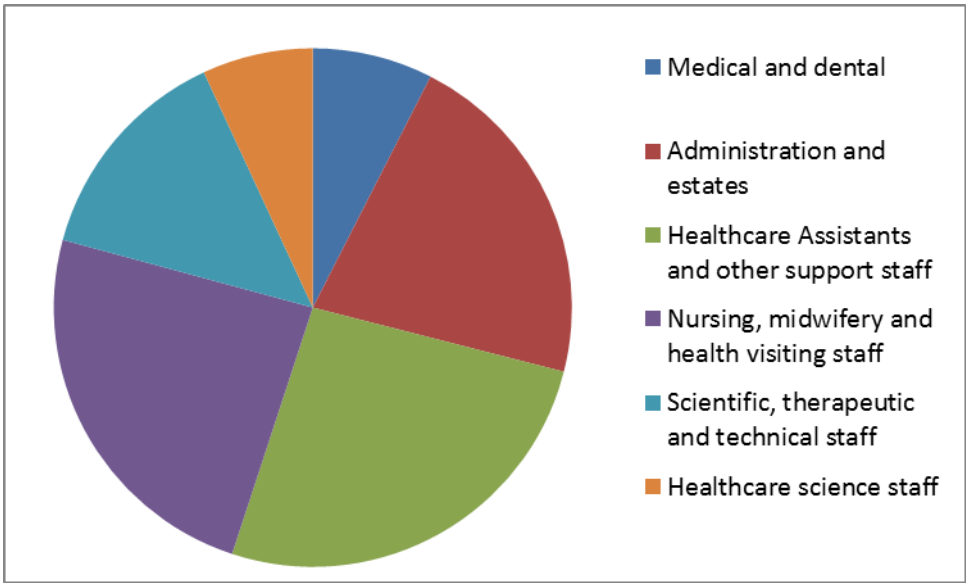
	Male	Female
Directors	6	7
Other senior managers	8	17
Employees	803	2117

	Male	Female
Directors	46%	54%
Other senior managers	32%	68%
Employees	28%	73%

Our staff (headcount at year end 2018 including non-executive Directors) continued

	Fixed Term Temp	Non-Exec Director/ Chair	Permanent	Grand Total
Administration and estates	56	7	588	651
Healthcare assistants and other support staff	184	0	572	756
Healthcare science staff	15	0	181	196
Medical and dental	57	0	165	222
Nursing, midwifery and health visiting learners	0	0	0	0
Nursing, midwifery and health visiting staff	101	0	611	712
Scientific, therapeutic and technical staff	37	0	384	421
Grand Total	**450**	**7**	**2501**	**2958**

Average numbers of persons employed (WTE) in 2018-19



Average numbers of persons employed (WTE) in 2018-19 (subject to audit)

Group 2018-2019			
	Total	Permanently employed	Other
	WTE	WTE	WTE
Medical and dental	201	149	52
Administration and estates	574	525	49
Healthcare assistants and other support staff	696	509	187
Nursing, midwifery and health visiting staff	645	551	95
Scientific, therapeutic and technical staff	371	339	32
Healthcare science staff	185	172	13
Total	**2671**	**2244**	**427**

Staff exit packages (subject to audit)

Group 2018-2019			
Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	17	18
£10,000 - £25,000	0	9	9
£25,001 - £50,000	2	6	8
£50,001 - £100,000	0	2	2
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
Total number of exit packages by type	**3**	**34**	**37**
Total resource cost (£000's)	**75**	**547**	**622**

Exit packages: non-compulsory departure payments

	Agreements number	Total value of Agreements £000
Voluntary redundancies including early retirement contractual costs	0	
Mutually agreed resignations (MARS) contractual costs	19	£486,260.80
Early retirements in the efficiency of the service contractual costs	0	
Contractual payments in lieu of notice	2	£3447.30
Exit payments following Employment Tribunals or court orders	0	
Non- contractual payments requiring HMT approval	1	£4000
Total		£493,798.10
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	

Employee expenses (the following table has been subject to audit)

Group 2018-19			
	Total	Permanently employed	Other
	£000	£000	£000
Salaries and wages	108,762	107,127	1,635
Social security costs	9,592	9,592	
Apprenticeship levy	479	479	
Employers' contribution to NHS pensions	12,583	12,583	
Pension costs - other contributions	58	58	
Termination benefits	54	54	
Agency/ contract staff	1,070		1,070
Total	132,598	129,893	2,705

Capitalised staff costs are excluded from this note and total £550k (2017-18 £1,009k)

Off payroll engagements

The Trust has a robust recruitment process that has been developed for individuals and agencies where IR35 rules may be relevant. Engagements and any associated staffing agencies have been contacted requesting them to provide assurance that they agree to the HMRC IR35 ruling terms and that their responsibilities in line with this have been met. The off payroll arrangements are outlined in the 3 tables below:

For all off-payroll engagements as of 31st March 2019, for more than £245 per day and that last for longer than six months	2018-19 Number of engagements
No. of existing engagements as of 31 March 2019	2
Of which:	
Number that have existed for less than one year at the time of reporting	1
Number that have existed for between one and two years at the time of reporting	
Number that have existed for between two and three years at the time of reporting	1
Number that have existed for between three and four years at the time of reporting	
Number that have existed for four or more years at the time of reporting	
Confirmation:	
Please confirm that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	Yes

For all new off-payroll engagements, or those that reached six months in duration, between 1st April 2018 and 31st March 2019, for more than £245 per day and that last for longer than six months	2018-19 Number of engagements
Number of new engagements, or those that reached six months in duration between 1st April 2018 and 31st March 2019	1
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
Number for whom assurance has been received	0
Number for whom assurance has not been received	
Number that have been terminated as a result of assurance not being received	

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1st April 2018 and 31st March 2019	2018-19 Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	8

Trade Union Facility Time

Table 1
Relevant Union Officials

Number of employees who were relevant Union officials during the relevant period (April 2018 – March 2019)	Full time equivalent employee number
12	2958

Table 2
Percentage of time spent on facility time

Percentage of working hours spent by employees who were relevant union officials employed during the relevant period on facility time	Number of employees
0%	2
1-50%	8
51-99%	1
100%	1

Table 3
Percentage of pay bill spent on facility time

Percentage of total pay bill spent on paying employees who were relevant union officials for facility time (during the relevant period)	
Total Cost of Facility Time	£51,364.72
Total Pay Bill	£129,439,000.00
Percentage of total pay bill spent on facility time calculated as: (total cost of facility time ÷ total pay bill) x 100	(51,364.72 ÷ 129,439,000.00) x 100 =**0.040%**

Table 4
Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (Total hours spent on paid trade union activities by relevant union officials ÷ total paid facility time hours) x100	(713.55 ÷ 2700.50) x 100 = **26.42%**

Equality and diversity: an inclusive culture

Creating an inclusive culture for our patients and staff is vital to what we do at The Christie. Our approach to equality and diversity is to ensure our care is individual and patient-centred, and that patients, visitors and colleagues are treated with dignity and respect at all times.

We are determined to ensure that we offer equal access to healthcare and employment opportunities to everyone in the communities we serve. We are committed to actively promoting equality across all our activities with the intention of achieving and maintaining a fully inclusive organisation.

Recognising our responsibilities, there is an effective executive-led approach to promoting inclusion activities in respect of service delivery and the workforce. We regularly discuss workforce equality issues with trade union colleagues through our staff forum and our senior managers through workforce committee.

Key achievements in 2018-19 include:

- We were proud to maintain our Disability Confident Status level 1 meaning that we are committed to making a difference for disabled people from a workforce and patient perspective.

- In line with the Equality Act duties, we published our annual patient and workforce equality monitoring reports.

- Our published patient services equality objectives (to continue to enhance the experience of vulnerable patients with the provision of accessible information) have been progressed.

- Similarly, our plans to progress our published workforce equality objectives (to continue to embed mechanisms for staff to confidently raise concerns at work, to continue to demonstrate progress against indicators within Workforce Race Equality Standard and to develop plans to implement Workforce Disability Equality Standard and to commit to decreasing the gender pay gap) have been achieved.

- Our equality performance was assessed using the NHS Equality Delivery System 2. We published this assessment following engagement with key stakeholders, including patients. We continue to use this as a platform to develop and promote inclusion.

- Our fourth published NHS Workforce Race Equality Standard annual report indicated some improvements on the previous year, including a percentage difference in our black and minority ethnic members of staff being appointed from shortlisting across all posts. We continue to use the standard as a platform to take further action on the causes of ethnic disparities.

- In the NHS Staff Survey 2018, our male/female, disabled / not disabled, white/black and minority ethnic staff all consistently scored 72% recommending the Trust as a place to work and 97% recommending the Trust as a place to receive treatment.

- As a result of our first published gender pay gap report as mandated by national government, we are progressing plans to decrease our gender pay gap within the organisation.

- We have developed an equality, diversity and inclusion interest group in partnership with members of staff and staff side colleagues to develop a programme of events and activity which will be developed in the coming years.

Workforce statistics - diversity

We have a predominantly female workforce (approximately 72% female). With regard to ethnicity, approximately 12% of our workforce comprises staff from black and minority ethnic backgrounds.

In 2018-19 we have continued to encourage the reporting of equality data in respect of protected characteristics, although disclosure remains at the individual's discretion.

Further details of our workforce composition are provided in the following tables.

Gender	%
Female	72
Male	28

Age	%
16-20	<1
21-30	24
31-40	27
41-50	23
51-60	21
60+	5

Religion or belief	%
Atheism	17
Buddhism	1
Christianity	47
Hinduism	1
Islam	4
Jainism	<1
Judaism	<1
Sikhism	<1
Other	7
Undefined/undeclared	20

Ethnicity	%
Asian/Asian British	7
Black/Black British	3
Mixed	2
Other	2
White	84
Undefined/undeclared	2

Sexual orientation	%
Lesbian, gay, bisexual	4
Heterosexual	80
Undefined/undeclared	16

Disability	%
Yes	4
No	83
Undefined/undeclared	13

Future priorities

We continue to develop our equality objectives and work plans in relation to our patient services and workforce based on data from our Equality Delivery System 2 and Workforce Race Equality Standard reports. In line with national developments, we will be implementing the Workforce Disability Equality Standard and roll out the capturing of sexual orientation monitoring information to ensure that we are meeting the needs of all of our patients, staff and volunteers. We will continue to develop opportunities for work experience within our organisation for individuals with additional needs or requirements and will continue to develop plans, activities and events in partnership with our staff through the equality, diversity and inclusion group. Our approach to equality, diversity and inclusion is in partnership and through effective engagement with our stakeholders including patients, staff and staff side representatives which will continue into 2019-20.

Remuneration report

The Remuneration Report describes how the Trust has applied the principles of good corporate governance in relation to Directors' remuneration as required by the Companies Act 2006, Regulation 11 and the NHS Foundation Trust Code of Governance.

Annual statement on remuneration

The remuneration committee is a non-executive committee of the board of directors comprising all of the independent non-executive directors. It has no executive powers other than those specifically delegated in its terms of reference. The role of the Committee is to ensure that appropriate procedures are in place for the nomination, selection, training, development, monitoring, evaluation and remuneration of the chief executive, executive directors and other senior employees, having proper regard to the financial and commercial health of the organisation and for the provision of any national arrangements for such staff where appropriate. The committee can call on advisors to support their decisions such as the Director of Workforce and the Chief Executive. The chair of the Audit Committee also chairs the remuneration committee.

The remuneration committee met twice during 2018-19 to discuss executive director pay. At its December 2018 meeting, the committee deferred a decision until further guidance was available. The committee met again in February 2019 and looked at national benchmarking information for executive pay. They agreed a 2% pay award for eligible executive directors and agreed to an increase in the pay scale for one executive director to bring the salary for the post in line with the median national benchmarking.

Non-executive directors

The chair of the foundation trust is expected to devote 3 days a week to his/her duties which may include some time commitment during the evening or weekend.

Non-executive directors are expected to devote sufficient time to ensure satisfactory discharge of his/her duties. This will be no less than 2.5 days per month and will comprise a mixture of set commitments with more flexible arrangements for ad-hoc events. Non-executive directors are not entitled to any payment for loss of office.

Non-Executive Directors are not employees of the Trust. They receive no additional benefits or entitlements other than reasonable expenses which are paid in accordance with the approach set out initially by the Trust Development Authority (TDA) and then endorsed by the then 'Monitor' for foundation trusts. Non-executive directors are not entitled to any termination payments.

In 2016-17 four non-executive directors received expenses. The aggregate sum of expenses paid was £3,730.30.

In 2017-18 four non-executive directors received expenses. The aggregate sum of expenses paid was £3,757.99.

In 2018-19 four non-executive directors received expenses. The aggregate sum of expenses paid was £4,015.89

Terms of Office

The term of office for Non-Executive Directors at the Trust is 3 years (to a maximum of 9 consecutive years). Non-Executive Director re-appointments are managed in accordance with NHS Improvement's Code of Governance, i.e. any term beyond six years (two three-year terms) will be subject to rigorous review and subject to annual reappointment. The term of each non-executive director is included in the table below.

Termination

The process for the removal of the chairman or non-executive director will be in accordance with the trust's constitution. Any proposal for removal must be proposed by a governor and seconded by not less than ten governors including at least two elected governors and two appointed governors. If any proposal to remove the chair or other non-executive director is not approved at a meeting of the Council of Governors (failing to achieve the support required pursuant to paragraph 25.2 of the constitution), no further proposal can be put forward to remove the chair or such non-executive director based upon the same reasons within 12 months of the meeting.

Remuneration

The Trust does not make any contribution to the pension arrangements of Non-Executive Directors.

The governor nominations committee met on the 22nd January 2019 to discuss the remuneration of the chairman and the non-executive directors. Please see page 178 for further details.

Non-executive director payments

	Fee payable	Additional fee payable	Start of term	Term of office	End of current term
Christine Outram	£43,981	A 3% uplift was approved by the council of governors in 2018/19	01/10/2014	Second	30/09/2020
Kathryn Riddle *	£12,850	£3,000 to chair the Charitable Funds Committee	13/05/2015	Second	12/05/2020
Neil Large *	£12,850	£3,000 to chair the Audit Committee	15/07/2015	Second	14/07/2020
Kieran Walshe	£12,850	£3,000 to chair the Quality Assurance Committee	01/07/2015	Second	30/06/2021
Jane Maher	£12,850	N/A	01/09/2015	Second	31/08/2021
Robert Ainsworth	£12,850	From December 2017 £3,000 to chair The Christie Pharmacy (recharged)	07/03/2016	Second	06/03/2022
Tarun Kapur	£12,850	N/A	01/06/2016	Second	31/05/2022

* Held interim non-executive director posts from May and July 2014 respectively

Senior managers' remuneration

Senior manager is defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS foundation trust.

The Christie is committed to the overarching principles of value for money and high performance. In making its decisions on remuneration the Committee considers the responsibilities and requirements of each of the executive director roles, how long individuals have been in post and the performance of the Trust. We do not have a separate senior managers' remuneration policy.

All Executive Directors work within the NHS National Terms and Conditions. All service contracts have a 6 month notice period set within them. Executive Directors are only entitled to payment for loss of office if a redundancy situation has arisen. Redundancy is calculated within clearly defined parameters as per legislative and NHS terms and conditions.

Any overpayments will be managed in accordance with the Standing Financial Instructions. There is no additional benefit that will become receivable by a director in the event that that senior manager retires early. No exit packages or non-compulsory departure payments were agreed for any of the senior managers in year.

Executive Directors are expected to devote sufficient time to ensure satisfactory discharge of their duties in accordance with agreed responsibilities and rotas as determined by their manager.

The performance of the executive directors is assessed through regular appraisal against pre-determined objectives. Comparative remuneration data is used to determine market rates of similar acute NHS Foundation Trusts. The executive directors are all employed on a permanent contract basis with set salaries that do not include any other components.

We have reviewed our policies in relation to executive remuneration and they ensure that we have all the necessary governance in place and use appropriate benchmarking to ensure that our pay levels are reasonable and publicly justifiable. Where executive directors are paid more than £150,000 this is a reflection of market rates.

Details of senior employees' remuneration and pension benefits can be found in the two tables in this remuneration report and are subject to audit

	2018/19						2017/18					
Name and title	**Salary and fees (bands of £5,000)**	**Taxable benefits (total to nearest £100)**	**Annual performance related bonuses (bands of £5,000)**	**Long term performance related bonuses (bands of £5,000)**	**Pension related benefits (bands of £2,500)**	**Total (bands of £5,000)**	**Salary and fees (bands of £5,000)**	**Taxable benefits (total to nearest £100)**	**Annual performance related bonuses (bands of £5,000)**	**Long term performance related bonuses (bands of £5,000)**	**Pension related benefits (bands of £2,500)**	**Total (bands of £5,000)**
R Spencer Chief Executive	190 - 195	0	0	0	17.5 - 20	205 - 210	185-190	0	0	0	25 - 27.5	210-215
J Fitzpatrick Director of Finance & Business Development	135 - 140	0	0	0	105 - 107.5	240 - 245	125 - 130	0	0	0	0	125 - 130
J Bird Chief Nurse & Executive Director of Quality	125 - 130	0	0	0	5 - 7.5	130 - 135	125-130	0	0	0	17.5 - 20	140 - 145
W Makin * Medical Director (Internal)	180 - 185	0	0	0	0	180-185	180 - 185	0	0	0	310-312.5	490-495
Prof C Harrison** Medical Director (External)	190 - 195	0	0	0	0	190 - 195	140-145	0	0	0	0	140-145
F Noden Chief Operating Officer	130 - 135	0	0	0	7 - 7.25	140 - 145	130 - 135	0	0	0	0	130-135

	2018/19						2017/18					
Name and title	**Salary and fees (bands of £5,000)**	**Taxable benefits (total to nearest £100)**	**Annual performance related bonuses (bands of £5,000)**	**Long term performance related bonuses (bands of £5,000)**	**Pension related benefits (bands of £2,500)**	**Total (bands of £5,000)**	**Salary and fees (bands of £5,000)**	**Taxable benefits (total to nearest £100)**	**Annual performance related bonuses (bands of £5,000)**	**Long term performance related bonuses (bands of £5,000)**	**Pension related benefits (bands of £2,500)**	**Total (bands of £5,000)**
C Outram Chairman	40 - 45	0	0	0	0	40 - 45	40 - 45	0	0	0	0	40 - 45
K Riddle Non-Executive	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
N Large Non-Executive	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
K Walshe Non-Executive	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
E Maher Non-Executive	10 - 15	0	0	0	0	10 -1 5	10 - 15	0	0	0	0	10 - 15
R Ainsworth*** Non-Executive	15 - 20	0	0	0	0	15 - 20	10 - 15	0	0	0	0	10 - 15
T Kapur Non-Executive	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Band of highest paid director's total remuneration (£'000)	190 - 95						185-190					
Median total remuneration	29,177						28,747					
Ratio	6.5						6.5					

* The remuneration for Dr Makin disclosed above is the total remuneration package.

**The remuneration for Professor Chris Harrison disclosed above is the total remuneration package for his role as Executive Medical Director (Strategy) at The Christie NHS Foundation Trust.

*** Mr Ainsworth receives £3,000 per annum for his role as Chair of The Christie Pharmacy Limited, a wholly owned subsidiary of The Christie NHS Foundation Trust. Remuneration for the year ending 31st March 2019 was £3,000 (period ending 31st March 2018 - £920).

The Executive Directors of The Christie Pharmacy Limited are Senior Managers employed by The Christie NHS Foundation Trust and are not included in the table above. Neither of the Executive Directors of the subsidiary company receive additional remuneration for these roles.

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in The Christie in the financial year 2018-19 was £190,000 - £195,000 (2017-18 £185,000 - £190,000). This was 6.5 times (2017-18 6.5 times) the median remuneration of the workforce, which was £29,177 (2017-18 £28,747).

In both 2017 -18 and 2018-19 no employee received remuneration in excess of the highest paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Salary and pension entitlements of senior managers

Pension benefits

Name and title	Real increase in pension at pension age (bands of £2500) £000	Real increase in pension lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age at 31 March 2019 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2018 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Employers Contribution to Stakeholder Pension £000
R Spencer	0 - 2.5	0 – 2.5	75 - 80	230 - 235	1,514	167	1,754	0
J Fitzpatrick	5 - 10	7.5 - 10	60 - 65	165 - 170	1,032	201	1,285	0
J Bird	0 - 2.5	0 - 2.5	60 - 65	180 - 185	1,162	128	1,344	0
W Makin	0 - 2.5	0 - 2.5	90 - 95	275 - 280	0	0	0	0
F Noden	0 - 2.5	0	50 - 55	130 - 135	939	106	1,092	0

C Harrison left the pension scheme on 1 February 2016 and is therefore not included in the above table.

W Makin is over the National Retirement Age in the existing scheme and therefore a CETV calculation is not applicable.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

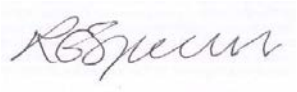
Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Last year there was a calculation error in the CETV factors used by NHS Pensions for individuals with benefits in the 2015 scheme. The CETV as at 1 April 2018 have been amended prior to this exercise to reflect the transfer value at 31 March 2018 using the correct CETV factor.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.



Roger Spencer
Chief Executive
23rd May 2019

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for identifying the potential support needs of healthcare providers. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

We have been segmented as a 1 (maximum autonomy). This is the best possible assessment and reflects high performance across the 5 themes.

This segmentation information is the Trust's position as at 31st March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the assessment of five appropriate financial performance measures. These are given a 'score' from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2018-19 Q4 score	2017-18 Q4 score
Financial sustainability	Capital service capacity	1	1
	Liquidity	1	1
Financial efficiency	I&E Margin	1	1
Financial controls	Distance from financial plan	1	1
	Agency spend	2	1
Overall Scoring		**1**	**1**

The Trust's finance and use of resources score for 2018-19 is 1, as it has been since the Single Oversight Framework was introduced in 2016-17. This score represents the strongest performance possible.

As recorded in the finance score calculation, agency spend against the £997k ceiling set by NHSI stands at £1,031k for 2019-20, which includes £43k of agency spend on services hosted by The Christie.

Statement of compliance: NHS Foundation Trust Code of Governance

Corporate governance is the means by which a board of directors leads and directs their organisation so that decision-making is effective and the right outcomes are delivered. In the NHS this means delivering safe, effective services in a caring and compassionate environment in a way that is responsive to the changing needs of patients and service users.

The NHS Foundation Trust code of governance sets out best practice principles and processes to assist NHS foundation trusts to achieve this goal. The main areas are:

Leadership
Every NHS foundation trust should be headed by an effective board of directors. The board is collectively responsible for the performance of the NHS foundation trust.

The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.

Effectiveness
The board of directors and its committees should have the appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.

Accountability
The board of directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.

The board of directors is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management systems.

Relations with stakeholders
The board of directors should appropriately consult and involve members, patients and the local community and the council of governors must represent the interests of trust members and the public.

Details regarding how the Trust has applied the Code principles and complied with its provisions are set out throughout the annual report. The disclosures required by the NHS FT Code of Governance in relation to the Board of Directors, Council of Governors, Membership, Nominations Committee, Risk and Audit Committee are also included within the Annual Report. The disclosures required by the Code in relation to the Remuneration Committee are contained in the remuneration report on page 194.

During 2018-19 The Christie NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Statement of the Chief Executive's responsibilities as the accounting officer of The Christie NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

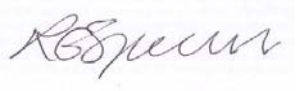
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require The Christie NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Christie NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.



Roger Spencer
Chief Executive
Date: 23rd May 2019

Annual governance statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Christie NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Christie NHS Foundation Trust for the year ended 31st March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Board of Directors pay close attention to the risk management processes of the Trust. The Board has approved a three year Risk Management Strategy and Policy and annually in September they receive an outcome report against the achievement of the milestones within the strategy. On a monthly basis, the Board of Directors reviews the corporate risk register and the Board Assurance Framework in the public meeting. At each of the formal Board sub committees, which are the Audit and Quality assurance Committees and which are wholly Non-Executive Director led, they carry out a review of the Board Assurance Framework and they escalate any concerns directly to the Board of Directors.

The reporting of incidents and near misses is encouraged and the Trust is viewed as being a high reporting low harm organisation.

The Trust has a training needs analysis that is reviewed annually and sets out the training requirements for risk management training. All staff during corporate induction have an introduction to risk management and health and safety. With regards to more advanced training in Root Cause Analysis following incidents, the clinical staff trained include, for example, medical consultants, senior nursing staff from ward managers and above and for non-clinical staff the training is for service managers and above.

The training to all staff is delivered in a range of ways from face to face training to specific e-learning modules.

Learnings from incidents, complaints and claims are shared throughout the Trust through the action plans developed following root cause analyses. Lessons learned are also discussed at the monthly Risk and Quality Governance Committee, through patient safety newsletters and at Grand Rounds. A quarterly report on patient safety and experience pulls through all the themes for learning and is discussed in detail at the patient safety and the patient experience committees.

The outcomes and recommendations from Serious Incidents are presented to an impartial panel chaired by a Non-executive director and two executive directors before being presented to the Board of Directors and submitted to our commissioners and the Care Quality Commission.

In the last CQC inspection in 2018 the risk management and governance systems in the well led domain were tested and the Trust was rated as Outstanding.

As accounting officer, I have overall responsibility for risk management processes across the organisation. I have delegated responsibility for the coordination of risk management systems and processes to the chief nurse & executive director of quality. She discharges her responsibilities through the quality & standards team, which includes lead officers for the Care Quality Commission (CQC), the National Health Service Litigation Authority (NHSLA) rating for claims, the corporate risk register and the incident reporting management system. She coordinates the governance and risk management arrangements undertaken within the organisation through performance review meetings with all operational divisions and through the risk & quality governance committee.

The board assurance framework is delegated to the company secretary thereby ensuring impartiality from the operational management of the Trust. The Board assurance framework is reviewed at all of the Audit and Quality Assurance committee meetings and at all of the Board of Directors meetings. Internal Audit presented the annual assurance framework opinion in February and concluded that 'the organisation's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board'

Risks associated with information systems and processes are the responsibility of the executive director of finance & business development who acts as the senior information risk owner. The risk management strategy & policy (2017-2020) provides a framework for managing risks across the organisation, which is consistent with best practice and Department of Health guidance. The strategy provides a clear, structured and systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes at all levels across the organisation. The strategy sets out the role of the board of directors' and standing committees together with individual

responsibilities of the Chief Executive, executive directors, managers and all staff in managing risk. In particular, the risk and quality governance committee through its sub-committees of patient safety, patient experience and clinical & research effectiveness, provides the mechanism for managing and monitoring risk throughout the Trust and reporting through to the board of directors'. The risk management system was thoroughly tested during the CQC comprehensive inspection in May 2016.

The board receives its assurances on the risk management and governance arrangements in place through its quality assurance and audit committees. Both of these are non-executive board committees and each is chaired by a non-executive director. All non-executive directors have independent access to internal and external auditors.

Our staff are well trained and equipped to manage risk in a number of ways appropriate to their authority and duties. Risk management training is provided for all staff through our comprehensive induction programme. In addition, there is specifically tailored training for individual roles and these are agreed with staff through personal development plans. Regular risk management awareness training continues for all staff through our corporate essential training programme. This includes key risk areas such as incident reporting and investigation, Root Cause Analysis training, human factors training, complaints handling, infection prevention & control, health and safety, moving and handling and counter fraud and prevention.

The organisation aims to ensure that it learns from internal and external incidents and shares good practice through a range of mechanisms including governance meetings, team briefings, action plans arising from external reviews such as National Inquiries, publications of the Royal Colleges, peer review and PLACE inspections. The board of directors also reviews the outcomes and action plans of relevant corporate reports.

The risk and control framework

The 2017-2020 Risk Management Strategy has five elements, based on the Health Foundation 2014 Policy for monitoring and measuring safety. Each element has key milestones in place in order to:

a) Ascertain whether it has been safe for patients, staff and others in the past
b) Identify whether our systems and processes are reliable
c) Ensure sensitivity to operations so that we are safe in the present
d) Anticipate and prepare to ensure that we will be safe in the future
e) Integration and learning to ensure we are responding and learning as appropriate

The work is prioritised over the three years of the strategy and links with and is complementary to the quality improvement plan, the operational plan and the Trust's five year strategy. The operational delivery of the incident reporting and risk register system, electronic patient record and prescribing systems across the in-patient and outpatient

setting will all assist and support the delivery of safer care and practice.

The high level committee structure for the management of safety and risk is effective in ensuring that the Trust's systems and processes are as safe as possible. Membership of these committees is multi-disciplinary and is chaired by medical leaders and includes representation by other key members of Trust staff. There is an annual review of the effectiveness of the terms of reference and any issues are managed at that point. There are mature risk management policies and procedures in place, with an underpinning process to ensure that these policies consider all aspects of risk when in development or review. These policies and procedures were tested by the CQC during their comprehensive inspection in 2018. There is a mature system of clinical audit across the Trust, on occasion the learning identified following these audits is not always acted upon and there are audits that do not progress to completion. This is being addressed in the clinical audit and improvement plan for 2019-20.

The Board on an annual basis reviews its Risk appetite and this is shown in the public board papers. The risk appetite statement is taken into account when considering strategic decisions, business cases and quality matters.

The Board, In order to be assured that it is meeting the outcomes required by the Care Quality Commission, has engaged the internal auditors to carry out quality spot checks and also to review elements of the well led outcomes. The outcome of the audits and compliance reviews are presented to the Board on an annual basis in April to show adherence with the CQC standards and the 2018 CQC inspection outcome showed the Trust to be Outstanding in the key lines of enquiry and well led for the well led domain.

The information below sets out the current top corporate risks to the organisation and their risk score.

The Trust top risk relates to the challenges in meeting the 24/62 day national cancer waiting time standards. If the standards are not met this could impact patients by causing delays to their care and treatment. There could also be a potential reputational risk of non-compliance with national cancer standards at Trust and Cancer Network level. This risk is currently scored at a 20 on our risk register and there are a range of mitigating actions with a small number of clinical service lines within the organisation and also work on cancer pathways across Greater Manchester to ensure delivery of these key cancer standards.

The Trust like most other organisations in the NHS has an overarching risk with regards to staffing gaps due to national shortages in some occupations such as nursing, radiology, rotational junior medical staff and radiotherapy staff. We have identified this could lead to a negative impact on engagement levels and the delivery of services. The risk is currently scored as a 16 on our risk register and there are a range of actions in place to ensure recruitment and

retention work programmes are in place. The Trust is also part of the NHSI recruitment and retention collaborative.

There has been a significant increase in chemotherapy referrals and activity over the last few months which has seen a potential risk to delays in receiving and delivery of chemotherapy treatment. The risk is currently scored at 15. There are many mitigating actions in place including looking to open extra capacity away from the main Withington site, increasing capacity on the Withington site outside of the dedicated chemotherapy unit and looking to further extend hours at the weekend.

The Trust has identified a potential risk of cyber-attack due to not modernising our IT system and being compliant with NHS digital standards. Not meeting the NHS digital standards could mean the Trust incurs significant financial penalties (>£1m) and reputational damage to the trust. The risk is currently scored as a 15 on our risk register. There are a number of mitigations in place and the Trust has just agreed a £1.295m investment to move the organisation to Windows 10 and these upgrades will be in place by January 2020.

The Trust has not identified any principal risks to compliance with the NHS Provider licence and throughout the 2018-19 financial year, the Trust has achieved a score of 1 for use of resources and 1 for Governance, the best scores possible.

The Trust has a mature risk and quality management system as tested by the CQC in the 2018 inspection where outstanding was the outcome for both the core standards reviewed and the well led domain.

Board sub committees of Audit and Quality Assurance are wholly non-executive director led and have an annual work plan which also includes a review of the committee's effectiveness. There are strong reporting lines and the minutes of the meeting and any escalations are formally reviewed at the Board of Directors meeting. Executives are only in attendance at these Board subcommittees.

The reports provided to the audit and quality assurance committees are in the main audits that have been carried out by the internal audit function and this provides the Board with independent assurance.

The Board of Directors on a monthly basis receive at the public meeting the integrated performance and quality report and this is discussed in detail.

Through the risk management systems, all business cases and policies have an equality impact assessment (EIA) and will not be approved without the EIA being reviewed by the approving committee.

The Trust has a workforce plan that is updated annually and is signed off by the Board of Directors. Our workforce planning process has been developed in accordance with

'Developing workforce safeguards.' The approach includes:

- Undertaking a baseline assessment, to collect up to date workforce intelligence using a specifically designed workforce planning template and supported through engagement events
- Aligning this assessment with the annual planning round to ensure workforce planning is integrated with service and financial planning
- Analysing returns to identify workforce availability and key workforce challenges
- Developing short and medium term strategies
- Monitoring implementation through the Workforce Committee

The Board of Directors receives and approves every six months a review of the nurse and allied health professional safe staffing levels. The report meets the recommendations of the 'Developing Workforce Safeguards' recommendations. The safe staffing levels are published monthly in the integrated performance and quality report and where staffing levels fall below the accepted level an exception report is provided to the board members. The Board has engaged with NHS Improvement on their nursing retention improvement initiative and has developed an improvement plan to ensure that best practice on recruitment and retention are adopted.

The Trust's risk management strategy aims to control, manage and mitigate risk. It sets out a system for continuous improvement via risk management which extends to all areas of the organisation. It aims to reduce clinical and non-clinical risks. Risk management is integral to Trust business and is embedded in the culture of the Trust. Individual and organisational learning from incidents, mistakes, accidents and near misses is a key component of the Trust's risk management strategy to ensure continual improvement.

Risks are quantified based on the risk management standard ISO 31000:2009 which measures risk using a combination of consequence (also described as impact or severity) and the likelihood (or probability or frequency) of an event occurring. During 2018-19 there have been 12 high scoring corporate risks; all risks have been appropriately managed during the financial year using the Trust's risk management systems.

The Trust uses Datix to support its risk management and risk register processes. This database encompasses incidents, formal and informal complaints, litigation details and risks. All staff have a role in identifying risks and helping to reduce their impact.

Key risks for the organisation, corporate and divisional, are reported in the integrated performance and quality report and are reviewed formally by the risk and quality governance committee, management board and the board of directors at each of their meetings. Identified risks are reported using the Trust's integrated performance and quality reporting structures and are reviewed at divisional, management and board

meetings. Managers systematically assess risk in their areas of responsibility. All risk assessments are documented and risks recorded on the risk register. Once analysed the higher scoring risks are managed by higher level committees in the organisation. Risk control measures are identified and where resources may be required to control the risk a business case is developed; these are treated as a priority.

The risk and control framework is based on a board reporting process which ensures that information is presented to the board in a timely manner and in an appropriate format. The board assurance framework provides an immediate means of alerting the board to areas of concern or failures of control, enabling the board to ensure that the appropriate management resource is committed to resolving such issues. The reporting process includes the corporate plan which identifies the strategic objectives of The Christie. Progress towards their achievement is presented to the board twice a year. The board assurance framework is regularly reviewed and updated using the corporate risk register and corporate plan and is presented to the board at the start of the year and reviewed by the audit committee, quality assurance committee and the board of directors at each of their meetings. Each objective is allocated to either the audit or quality assurance committee. The presentation of the assurance framework has been improved to assist the board to judge the effectiveness of control measures intended to reduce the risks to the organisation in achieving its principal objectives. The audit and quality assurance committees examine issues at random and in depth to ensure that the system accurately describes risk and controls. The board has an agreed risk appetite statement which was reviewed and agreed during the development of the 2017-20 risk management strategy. The Christie works with a number of partner organisations as shown below, to ensure that risks to The Christie are identified, assessed and appropriate action is taken; these organisations include:

- NHS England specialised commissioning team (North) and Greater Manchester CCGs
- The University of Manchester and The University of Salford and a number of other academic institutes and professional bodies to ensure training and education is delivered in line with national standards and the academic expectations of relevant bodies
- Manchester Academic Health Science Centre (MAHSC), a partnership between The University of Manchester and six NHS organisations, uniting leading healthcare providers with world-class academics and researchers.
- Other acute trusts and CCGs as part of Greater Manchester Cancer Board
- Our private patient joint venture partner Health Corporation of America to continually develop private patient services at The Christie;
- Our wholly owned subsidiary pharmacy service - the trust took the decision to create its own wholly owned subsidiary non-hospital pharmacy company which

replaced Alcura Healthcare Ltd at the end of its five year contract. The new pharmacy company commenced on 11th December 2017 and offers both outpatient and inpatient dispensing services.
- Our pathology services partner Synlab UK Ltd to improve turnaround times for our patients and maintain delivery of high quality results.
- Our contract partners Alliance Medical Limited in the delivery of PET-CT services which includes clinical leadership, training & education and research co-ordination

The organisation's response to national alerts and governance action is managed through the patient safety committee and management board and reported to the board of directors.

The Christie also engages with the public and NHS stakeholders in the following way:
- public: council of governors and committees of governors, members' meetings, local public engagement meetings, and patient surveys (both internal and external), suggestion schemes and the patient comment system
- NHS: The Christie Commissioning Group Board (currently led by NHS England specialised commissioning team (North) and Greater Manchester CCG's), Greater Manchester Cancer Board, CCG representation on the drugs management committee
- Local Authority: The Christie Neighbourhood forum which includes a representative from MCC and local residents for input into trust developments and our Green Travel Plan. Greater Manchester Combined Health Authority through the Greater Manchester Health and Social Care Partnership.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The foundation trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and

the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control to ensure that resources are used economically, efficiently and effectively. My review is informed by the work of the internal auditors, clinical audit and the executive directors within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. Divisional and corporate departments are responsible for the delivery of financial and other performance targets via our performance management framework which includes monthly performance reviews with each service.

Evidence is also shown in the strong track record we have of transforming our services to deliver service improvements and operational efficiencies. To ensure the patient is at the centre of our planning, we have configured our transformation programme to reflect the end to end clinical pathways for our patients. These Cost Improvement Plans are only approved once the Executive Medical Director and Chief Nurse and Executive Director of Quality sign off the proposals as having no detrimental impact upon the quality of care provided to our patients. The accepted transformational schemes are reported and monitored within the Integrated Quality and Performance Report and presented at the public Board of Directors meeting.

We continue to work with Model Hospital initiatives, noting that the information is increasingly available to enable improved benchmarking and target areas of improvement. We are working closely with other specialist oncology centres (Clatterbridge and The Royal Marsden) to identify and implement best practice across all Trusts to deliver efficiencies and commercial opportunities. We continue to collaborate through the Costing Transformation Programme so that we have access to improved patient level data from other providers which we use to assess our use of resources and address any areas of variation.

We are highly engaged in the Greater Manchester Health and Social Care Partnership transformation programme which has key work-streams aiming to deliver cost improvements across the health economy. GM has a large and varied programme of works and as these workstreams progress over the subsequent years, we will benefit from scheme implementation. Specific areas of opportunity include pharmacy and back-office functions.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, audit, quality assurance, risk and clinical governance

committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Information governance

Our current top 3 data security risks, as advised by an external specialist, are managed through compliance with the data security and protection toolkit which is mandated by NHS Digital. In addition to the toolkit, we are also working towards Cyber Essentials Plus accreditation and this is recorded in the corporate risk register. Data security and information governance incidents are managed in accordance with internal and external reporting requirements; for the year 2018–2019 the trust had one reportable data breach. This breach related to the loss of a small number of patient notes and was reported to the Information Commissioner's Office (ICO). The ICO's decision relating to this case was that no further action from them was required.

Information governance risks are managed as part of the risk management systems and processes and assessed using the Information Governance Toolkit. The Trust's risk register is updated with currently identified information risks including data quality and data security which are reviewed by the Risk and Quality Governance Committee. We have been actively working on the implications of the new GDPR legislation which came into effect on 25th May 2018. A Data Protection Officer (DPO) was appointed and an independent review was undertaken to assess our preparedness. Progress has been monitored through our risk management systems. In addition, independent assurance is provided as part of the NHS Improvement coding and costing assurance audit process, and the Information Governance Toolkit self-assessment review undertaken by internal audit which gained significant assurance.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Board of Directors has engaged the external auditors to provide assurance that the accuracy of the data provided in the quality report is stated accurately and that there are appropriate systems of internal control. The external auditors have reviewed data sets as prescribed by NHS Improvement. This data is reviewed by the Board throughout the financial year in the integrated performance and quality report.

The quality report presents a balanced view and is based on accurate data. The board of directors' is assured of this through the Trust's governance processes and leadership by the executive team. Systems are in place to collect, validate and analyse all data using the appropriately skilled team. This may be the information or performance team, infection

control team, internal audit team, the quality & standards team or the NHS England cancer waiting times team. Our annual quality reports are a bringing together of reports on the quality of care contained in the quality accounts section of our monthly integrated performance and quality report. The monthly reports are considered by the senior clinicians and managers of the organisation at monthly management board meetings and by the board of directors. The quality report has been received by the quality assurance committee and has been approved by the management board. The preparation of the quality accounts has been led by the chief nurse & executive director of quality.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, the executive and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, audit committee, quality assurance committee and the risk & quality governance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

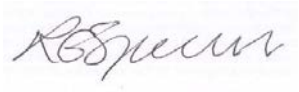
The Board Assurance Framework provides me with evidence that the effectiveness of controls to manage risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- Assessment of financial reports submitted to NHS Improvement, the Independent Regulator of NHS Foundation Trusts
- The CQC comprehensive inspection in May 2016
- Opinions and reports made by external auditors
- Opinions and reports made by internal auditors
- NHS Litigation Authority claims profile and other external inspections, accreditations and reviews.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control has been reviewed by:

- The Board; through consideration of key objectives and the management of principal risks to those objectives within the Assurance Framework, which is presented at board meetings
- The Audit Committee by reviewing and monitoring the opinions and reports provided by both internal and external audit
- The Quality Committee; by reviewing and monitoring the opinions and reports provided by both internal and external audit

- The Risk and Quality Governance Committee by implementing and reviewing clinical governance and risk management arrangements and receiving reports from the sub risk committees
- External assessments of services



Roger Spencer
Chief Executive
23rd May 2019

The Modern Slavery Act 2015

The Modern Slavery Act 2015 establishes a duty for commercial organisations to prepare an annual slavery and human trafficking statement. This is a board approved statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business.

Our statement can be found in the trust publications section of our website.

NHS Emergency Preparedness, Resilience and Response (EPRR) assurance process

The trust participates in an annual self-assessment process against the NHS Core Standards for EPRR. The outcome of the self-assessment for 2018-19 was that the trust declared substantial compliance with the Core Standards. Evidence of compliance, supported by a Board-approved Statement of EPRR Conformity, was submitted to the commissioners.

Conclusion

As accounting officer and based on the information provided above I am assured that no significant internal control issues have been identified.

Independent auditor's report to the Council of Governors of The Christie NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of The Christie NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Group Statement of Changes in Taxpayers' Equity, the Trust Statement of Changes in Taxpayers' Equity, the Cash Flow Statement and notes to the financial statements, including the accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Health Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2019 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Grant Thornton

Overview of our audit approach

Financial statements audit

- Overall materiality: £6,081,000 which represents 2% of the group's operating expenses

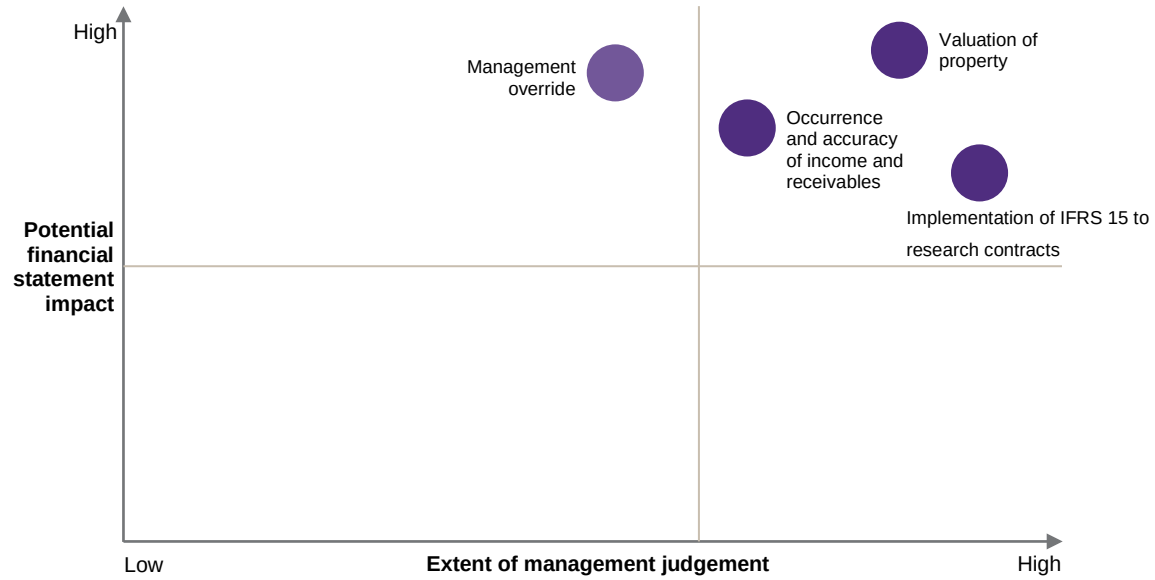
- Key audit matters were identified as:
  - Occurrence and accuracy of patient care income from contract variations and other operating revenues and existence of associated receivable balances
  - Valuation of land and buildings
  - Implementation of IFRS 15 to research contracts
- The group consists of six components – the Christie NHS Foundation Trust, two wholly owned subsidiaries and three joint ventures.
- We performed a full scope audit of the Christie NHS Foundation Trust and audit testing on classes of transactions, account balances, or disclosures relating to the subsidiaries and joint ventures which were material to the group position or included a likely significant risk of material misstatement to the group financial statements.
- We did not issue group instructions to the auditor of The Christie Clinic as we did in 2017/18

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- We identified two significant risks in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources relating to use of The Christie Pharmacy Company Ltd to improve dispensary services and achievement of the 62-day cancer waiting time from GP referral target (see Report on other legal and regulatory requirements section).

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those

that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter – Group and Trust	How the matter was addressed in the audit
Occurrence and accuracy of patient care income from contract variations and other operating revenues and existence of associated receivable balances Trusts are facing significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand and cost pressures. All the group's income from activities is derived from contracts with NHS commissioners. These contracts include the rates for, and level of, patient care activity to be undertaken by the Trust. The Trust recognises income from activities during the year based on the completion of these activities. This includes the block contract, which is agreed in advance at a fixed price, and patient care income from contract variations. Any patient care activities that are additional to those incorporated in these block contracts with commissioners (contract variations) are subject to verification and agreement by commissioners. As such, there is the risk that income is recognised in the accounts for these additional services that is not subsequently agreed to by the commissioners. Due to the nature of block contracts we have not identified a significant risk of material misstatement in relation to block contracts. 20% of the group's income is recorded as other operating revenues (excluding Education & Training income, and Provider Sustainability Funding income (PSF). The risk around other operating revenues is related to the improper recognition of revenues including contract liabilities (deferred income). Education & Training income and PSF income are income streams that are principally derived from contracts that are agreed in advance at a fixed price, or in the case of PSF agreed by NHS Improvement (NHSI). We have not identified a significant risk of material misstatement in relation to these elements of other operating revenue. We therefore identified the occurrence and accuracy of patient care income from contract variations and other operating revenues, and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement. .	Our audit work included, but was not restricted to: • Evaluating the group and Trust's accounting policy for recognition of income from activities and other operating revenues for appropriateness and compliance with the Department of Health and Social Care (DHSC) group accounting manual 2018-19; • Updating our understanding of the Group and Trust's system for accounting for income from activities and other operating revenues and evaluating the design of the associated controls. In respect of income from activities: • Using the DHSC mismatch report, investigating unmatched revenue and receivable balances over £300,000, corroborating the unmatched balances used by the Trust to supporting evidence; • Agreeing, on a sample basis, income from contract variations and year end receivables to supporting evidence; • Evaluating the judgements made by management in order to determine recognition of income from contract variations. In respect of other operating revenues: • Agreeing, on a sample basis, income and year end receivables from the group's other operating revenues to supporting evidence; • Testing, on a sample basis, additions to and releases from deferred research and development income in the current year to supporting evidence. The group's accounting policy on revenue recognition is shown in note 1.2 to the financial statements and related disclosures are included in note 3. **Key observations** We obtained sufficient audit evidence to conclude that: • the group and Trust's accounting policy for recognition of income from activities and other operating revenues complies with the DHSC group accounting manual 2018-9 and has been properly applied; and • Income from patient care activities and other operating revenues and the associated receivable balances, are not materially misstated.

Key Audit Matter –Trust	How the matter was addressed in the audit
Valuation of property The Trust revalues its land and buildings on a five-yearly basis to ensure the carrying value in the financial statements is not materially different from current value in use at the year-end date. In the intervening years, such as in 2018/19, the Trust requests a desktop valuation from its valuation expert. In addition, when a significant new building is brought	Our audit work included, but was not restricted to: • Evaluating management's processes and assumptions for the estimation of the value of property, the instructions issued to the valuation expert and the scope of their work; • Evaluating the competence, capabilities and

Key Audit Matter –Trust	How the matter was addressed in the audit
into use, as in the new proton beam and outpatient's department in 2018/19, the Trust requests a full valuation of that property from its valuation expert. The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions. These valuations represent significant estimates by management in the financial statements. We therefore identified valuation of land and buildings as a significant risk, which was one of the most significant assessed risks of material misstatement.	objectivity of the valuation expert; • Discussing with the valuer the basis on which the valuation was carried out; • Challenging the information and assumptions used by the valuer to assess completeness and consistency with our understanding; • Testing revaluations made during the year to see if they had been input correctly into the Trust's asset register; The group's accounting policy on valuation of property, including land and buildings, is shown in note 1.4.2 to the financial statements and related disclosures are included in note 10. The Audit Committee identified valuation of property as a significant issue in its report dated April 2019 referred to in the section of the Annual Report headed Committees of the Board. We obtained sufficient audit assurance to conclude that: • the basis of the valuation of land and buildings was appropriate, and the assumptions and processes used by management in determining the estimate of valuation of property were reasonable; • the valuation of land and buildings disclosed in the financial statements is reasonable.
Implementation of IFRS 15 to research contracts In 2018/19, a new accounting standard on accounting for revenue from contracts with customers (IFRS 15) was introduced. The standard requires entities to recognise such revenue as and when it has met the performance obligations in the contract. As at 31 March 2019 the Trust has deferred income of £14.592m. Of this, £7.207m relates to revenue from contracts with research and development customers (contract liabilities). The Trust manages research and development income and expenditure at a disease group level rather than on a contract by contract basis. It is therefore not possible to directly match contract liabilities at the year end with outstanding performance obligations on individual contracts. During the audit we identified this as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included but was not restricted to: • evaluating the group and Trust's accounting policy for recognition of revenue from contracts with research customers, including the recognition of contract liabilities. • obtaining an understanding of the process for assessing the impact of the new standard and evaluated the design of the associated controls. • challenging the assumptions made by management in relation to research contract liabilities. The Trust's accounting policy on recognition of income is shown in note 1.2.2 to the financial statements and related disclosures are at notes 15.2 and 15.3. We obtained sufficient audit assurance to conclude that: • the Trust has applied IFRS 15 appropriately to revenue from research contracts; • the assumptions used by management are reasonable

Our application of materiality

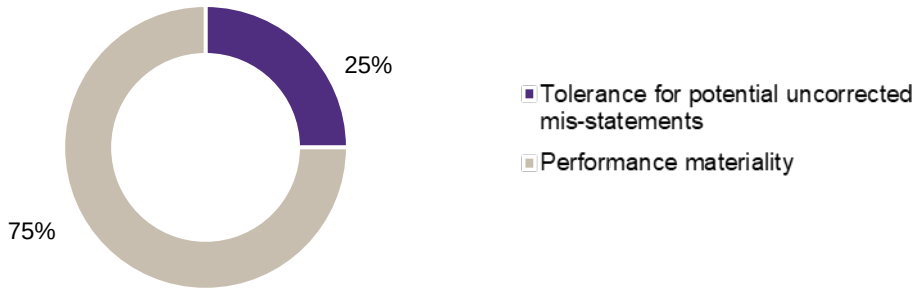
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Group	Trust
Financial statements as a whole	£ 6,081,000 which is 2% of the group's operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the group has expended its revenue and other funding. Materiality for the current year is at the same percentage level of operating expenses as we determined for the year ended 31 March 2018 as we did not identify any significant changes in the group or the environment in which it operates.	£ 6,080,000 which is 2% of the Trust's operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding. Materiality for the current year is at the same percentage level of operating expenses as we determined for the year ended 31 March 2018 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality	75% of financial statement materiality
Specific materiality		£20,000 for disclosure of senior manager remuneration in the Remuneration Report based on our view of the level of misstatement that would influence the views of the users of the accounts.
Communication of misstatements to the Audit Committee	£300,000 and misstatements below that threshold that warrant reporting on qualitative grounds	£300,000 and misstatements below that threshold that warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.

Overall materiality – Group and Trust



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the group's business, its environment and risk profile and in particular included:

- Evaluation of identified components to assess the significance of that component and to determine the planned audit response based on a measure of materiality. We determined a component to be individually significant if it represents 15% of the group's operating expenditure. This is a change in our audit approach from previous years where we used 5% of the Group's income, expenditure, gross or net assets;
- Identification of the Christie NHS Foundation Trust as the only significant component in the group. The Christie NHS Foundation Trust represents 96% of the group's operating income, 89% of its operating expenses and 83% of the group's total assets. We carried out a full scope audit in relation to the Trust.
- Identification of a further five non-significant components of the group – the Christie Charitable Fund, a wholly owned subsidiary, the Christie Pharmacy Ltd and three joint ventures, the Christie Clinic LLP, Christie Pathology Partnership LLP and CPP Facilities LLP.

- An interim visit in February 2019 to evaluate the group's internal control environment including its IT systems and controls over key financial systems and processes and a final visit in May 2019 to perform substantive tests on transactions and balances;
- For the Christie Charitable Fund performing analytical techniques on the figures consolidated into the group financial statements and substantive tests on donated income and the bank balance. The Christie Charitable Fund represents 4% of the group's operating income, less than 1% of its expenditure and 11% of the group's total assets;
- For the Christie Pharmacy Ltd performing analytical techniques on the figures consolidated into the group financial statements and tests of control and substantive tests on its operating expenses. The Christie Pharmacy Ltd represents 10% of the group's expenditure and less than 1% of the group's total assets;
- For the Christie Clinic LLP carrying out specific procedures on the Trust's share of the joint venture's profit. The Christie Clinic LLP represents 20% of the group's surplus for the year and 5% of the group's total assets. We performed analytical procedures on the group's share of the profits of its other two joint ventures. These bodies represent less than 1% of the group's surplus for the year and less than 1% of the group's total assets.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report**,** other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- The Audit Committee reporting in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance –the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2018/19 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2018/19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency**.**

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2018/19, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the Trust's services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019**.**

We have nothing to report in respect of the above matter.

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risks	How the matter was addressed in the audit
Risk 1 Use of The Christie Pharmacy Company Ltd to improve dispensary services In October 2017 the Christie NHS Foundation Trust set up a wholly owned subsidiary company, The Christie Pharmacy Company Ltd (TCP) to run its pharmacy dispensing services when the contract with the previous provider ended. In planning our 2017/18 audit we identified significant inherent risks in the Trust's arrangements for securing economy, efficiency, and effectiveness in its use of resources associated with any such significant new ventures. On the basis of the work we carried out as part of our 2017/18 audit, we were satisfied that the Trust had put adequate arrangements in place to secure economy, efficiency, and effectiveness in relation to the creation of TCP. However, we also noted that, at that time, it was too soon to assess the arrangements for improvement of dispensing times, one of the key objectives for setting up the company. The risk is whether the Trust has adequate arrangements in place to ensure sustainable resource deployment in that TCP delivers the improvements in dispensing times it was set up to achieve.	Our audit work included, but was not restricted to: • Evaluating key monitoring documentation and discussions with key staff to assess the arrangements in place to improve dispensing times following the creation of TCP **Key findings** The Trust's arrangements for improving dispensing times include: • setting and monitoring key performance indicators for TCP, and • requiring TCP to report on progress to the Trust's Risk and Governance Committee. These arrangements have led to an overall improvement in the number of months the dispensing time target has been met in 2018/19.
Risk 2 Achievement of the 62-day cancer waiting time from GP referral target As a specialist cancer centre, the national cancer targets are of particular relevance to The Christie NHS Foundation Trust. Because it is a tertiary centre, patients referred by GPs are seen by one or two other trusts before being referred on to The Christie. In 2018/19 the method for apportioning any breach of the target across trusts in the pathway was changed. The Trust expected that the new approach would mean its reported performance would fall below target. The potential adverse impact on patient experience and the Trust's reputation from non-achievement of the target following implementation of the new breach allocation policy led to the Trust assessing this one of its biggest risks for 2018/19. The risk is whether the Trust has adequate arrangements in place to ensure sustainable resource	Our audit work included, but was not restricted to: • Evaluating key monitoring documentation and discussions with key staff to assess the arrangements in place to improve achievement of the 62-day cancer waiting time target **Key findings** The Trust has put a number of arrangements in place to improve its reported performance against the 62-day cancer waiting time target including: • setting up focused task and finish groups on various aspects of the process • extending radiotherapy times The Trust's reported performance for the year was 79.1% against a target of 85%. However, statistics published by NHS England show that the Trust's

Significant risks	How the matter was addressed in the audit
deployment in the achievement of its 62-day cancer waiting time target.	performance was equal to the national average.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of The Christie NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Sarah Howard

Sarah Howard, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Manchester

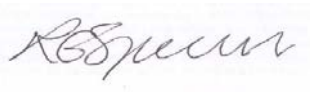
24 May 2019

Consolidated Accounts of The Christie NHS Foundation Trust 2018-2019

FOREWORD TO THE ACCOUNTS

THE CHRISTIE NHS FOUNDATION TRUST

The Annual Accounts of The Christie NHS Foundation Trust for the year ended 31 March 2019 have been prepared in accordance with paragraphs 24 and 25 Schedule 7 within the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.



Roger Spencer
Chief Executive
23 May 2019

Consolidated Accounts of The Christie NHS Foundation Trust 2018-2019

Statement of Comprehensive Income for the Year Ending 31 March 2019

	Note	**Group 2018-2019**	**NHS Foundation Trust 2018-2019**	Group 2017-2018	NHS Foundation Trust 2017-2018
		£000	**£000**	£000	£000
Operating income	3	**336,814**	**335,829**	343,358	341,325
Operating expenses	4	**(304,085)**	**(304,429)**	(269,655)	(269,691)
Operating surplus/ (deficit)		**32,729**	**31,400**	73,703	71,634
Finance income	8.1	**848**	**543**	242	101
Finance costs - financial liabilities	8.2	**(1,470)**	**(1,470)**	(945)	(945)
Finance costs - unwinding of discount on provisions	17	**(23)**	**(23)**	(17)	(17)
PDC dividends payable		**(7,362)**	**(7,362)**	(7,150)	(7,150)
Gains/(Loss) on disposal of assets		**(181)**	**(181)**	0	0
Gains/(Loss) on revaluation and disposal of investment assets	11.3	**(1,841)**	**0**	8	0
Corporation tax expense		**(70)**	**0**	0	0
Net finance costs		**(10,099)**	**(8,493)**	(7,862)	(8,011)
Share of profit of joint venture accounted for using the equity method	11.1	**5,871**	**5,871**	5,113	5,113
Surplus/ (deficit) for the year		**28,501**	**28,778**	70,954	68,736
Other comprehensive income					
Revaluation gains/ (losses) on Property, Plant and Equipment		**639**	**639**	5,385	5,385
Revaluation gains/ (losses) on intangible assets		**0**	**0**	0	0
Fair value gains/ (losses) on available for sale financial investments		**0**	**0**	0	0
Actuarial gains/ (losses) on defined benefit pension schemes		**0**	**0**	0	0
Other recognised gains and losses		**0**	**0**	0	0
Other Reserve Movements		**0**	**0**	0	0
Total comprehensive income for the year		**29,140**	**29,417**	76,339	74,121

The Group position includes The Christie NHS Foundation Trust, The Christie Pharmacy Limited and The Christie Charitable Fund. The 2017-18 Group position also included The Christie Charity Trading Company (note 1.1.3).

The notes on pages 232 to 277 form part of these accounts.

Consolidated Accounts of The Christie NHS Foundation Trust 2018-2019

Statement of Financial Position as at 31 March 2019

	Note	**Group** **31 March 2019** **£000**	**NHS Foundation Trust** **31 March 2019** **£000**	Group 31 March 2018 £000	NHS Foundation Trust 31 March 2018 £000
Non- Current Assets					
Intangible assets	9	**255**	**255**	811	811
Property, Plant and Equipment	10	**329,066**	**329,066**	320,159	320,159
Investments in joint ventures	11.1	**25,362**	**25,362**	26,641	26,641
Investment assets	11.3	**538**	**0**	517	0
Investment property	11.4	**850**	**0**		
Trade and other receivables	13.1	**0**	**1,119**	0	1,515
Total non-current assets		**356,071**	**355,802**	348,128	349,126
Current assets					
Inventories	12	**2,567**	**537**	2,511	578
Trade and other receivables	13.1	**58,048**	**60,187**	81,295	88,858
Other financial assets	13.4	**60**	**8**	57	8
Non current assets held for sale and assets in disposal groups	10.6	**0**	**0**	0	0
Cash and cash equivalents	14.1	**158,078**	**103,918**	94,283	35,413
Total current assets		**218,754**	**164,650**	178,146	124,857
Current Liabilities					
Trade and other payables	15.1	**(29,090)**	**(26,290)**	(30,404)	(29,957)
Borrowings	16	**(3,740)**	**(3,740)**	(1,829)	(1,829)
Provisions for liabilities and charges	17	**(524)**	**(524)**	(107)	(107)
Other liabilities	15.2	**(3,504)**	**(3,504)**	(2,095)	(2,095)
Tax payable	15.1	**(2,667)**	**(2,647)**	(2,490)	(2,475)
Total current liabilities		**(39,525)**	**(36,705)**	(36,925)	(36,463)
Total assets less current liabilities		**535,300**	**483,747**	489,349	437,520
Non-current liabilities					
Trade and other payables	15.1	**0**	**0**	0	0
Borrowings	16	**(59,486)**	**(59,486)**	(44,527)	(44,527)
Provisions for liabilities and charges	17	**(636)**	**(636)**	(653)	(653)
Other liabilities	15.2	**(11,088)**	**(11,088)**	(10,571)	(10,571)
Total non-current liabilities		**(71,210)**	**(71,210)**	(55,751)	(55,751)
Total assets employed		**464,089**	**412,537**	433,598	381,769
Financed by taxpayers' equity					
Public dividend capital	24	**142,934**	**142,934**	141,966	141,966
Revaluation reserve		**42,145**	**42,145**	41,545	41,545
Income and expenditure reserve		**227,458**	**227,458**	198,258	198,258
Financed by others' equity					
Charity Reserves	27	**51,252**	0	51,783	0
Pharmacy subsidiary reserves	29	**300**	0	46	0
Total Taxpayers' and Others' Equity:		**464,089**	**412,537**	433,598	381,769

The Group position includes The Christie NHS Foundation Trust, The Christie Pharmacy Limited and The Christie Charitable Fund. The 2017-18 Group position also included The Christie Charity Trading Company (note 1.1.3).

The accounts on pages 226 to 277 were approved by the Board of Directors on 23 May 2019 and signed on its behalf by:

Roger Spencer
Chief Executive

Date: 23 May 2019

Consolidated Accounts of The Christie NHS Foundation Trust 2018-2019

Statement of changes in taxpayers' equity for the year ended 31 March 2019

	Group						
	Minority interest	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charity Reserves	The Christie Pharmacy Limited Reserves	Total taxpayers' equity
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018	**0**	**141,966**	**41,545**	**198,258**	**51,783**	**46**	**433,598**
Impact of implementing IFRS 15 on opening reserves	**0**	**0**	**0**	**750**	**0**	**0**	**750**
Impact of implementing IFRS 9 on opening reserves	**0**	**0**	**0**	**(367)**	**0**	**0**	**(367)**
							0
Retained surplus/(deficit) for the year	**0**	**0**	**0**	**28,778**	**(531)**	**254**	**28,501**
Revaluation gains/(impairment losses) on Property, Plant and Equipment	**0**	**0**	**639**	**0**	**0**	**0**	**639**
Transfer from revaluation reserve to Income and Expenditure Reserve for impairments arising fro the consumption of economic benefits	**0**	**0**	**(39)**	**39**	**0**	**0**	**0**
Public dividend capital received	**0**	**968**	**0**	**0**	**0**	**0**	**968**
Taxpayers' equity at 31 March 2019	**0**	**142,934**	**42,145**	**227,458**	**51,252**	**300**	**464,089**
Taxpayers' equity at 1 April 2017	**0**	**126,746**	**41,223**	**124,459**	**49,611**	**0**	**342,039**
Retained surplus/(deficit) for the year	**0**	**0**	**0**	**68,736**	**2,172**	**46**	**70,954**
Revaluation gains/(impairment losses) on Property, Plant and Equipment	**0**	**0**	**5,385**	**0**	**0**	**0**	**5,385**
Transfer from revaluation reserve to Income and Expenditure Reserve for			**(5,053)**	**5,053**			**0**
Transfer to retained earnings on disposal of assets			**(10)**	**10**			**0**
Public dividend capital received	**0**	**15,220**	**0**	**0**	**0**	**0**	**15,220**
Taxpayers' equity at 31 March 2018	**0**	**141,966**	**41,545**	**198,258**	**51,783**	**46**	**433,598**

The notes on pages 232 to 277 form part of these accounts.

Consolidated Accounts of The Christie NHS Foundation Trust 2018-2019

Statement of changes in taxpayers' equity for the year ended 31 March 2019

	NHS Foundation Trust				
	Minority interest	**Public dividend capital**	**Revaluation reserve**	**Income and expenditure reserve**	**Total taxpayers' equity**
	£000	**£000**	**£000**	**£000**	**£000**
Taxpayers' equity at 1 April 2018	**0**	**141,966**	**41,545**	**198,258**	**381,769**
Impact of implementing IFRS 15 on opening reserves	**0**	**0**	**0**	**750**	**750**
Impact of implementing IFRS 9 on opening reserves	**0**	**0**	**0**	**(367)**	**(367)**
Total comprehensive income for the year					
Retained surplus/(deficit) for the year	**0**	**0**	**0**	**28,778**	**28,778**
Revaluation gains/(impairment losses) on Property, Plant and Equipment	**0**	**0**	**639**	**0**	**639**
Transfer from revaluation reserve to Income and Expenditure Reserve for impairments arising fro the consumption of economic benefits	**0**	**0**	**(39)**	**39**	**0**
Transfer to retained earnings on disposal of assets	**0**	**0**	**0**	**0**	**0**
Public dividend capital received	**0**	**968**	**0**	**0**	**968**
Taxpayers' equity at 31 March 2019	**0**	**142,934**	**42,145**	**227,458**	**412,537**
Taxpayers' equity at 1 April 2017	0	126,746	41,223	124,459	292,428
Total comprehensive income for the year					
Retained surplus/(deficit) for the year	0	0	0	68,736	68,736
Revaluation gains/(impairment losses) on Property, Plant and Equipment	0	0	5,385	0	5,385
Transfer from revaluation reserve to Income and Expenditure Reserve for impairments arising fro the consumption of economic benefits	0	0	(5,053)	5,053	0
Transfer to retained earnings on disposal of assets	0	0	(10)	10	0
Public dividend capital received	0	15,220	0	0	15,220
Taxpayers' equity at 31 March 2018	**0**	**141,966**	**41,545**	**198,258**	**381,769**

The notes on pages 232 to 277 form part of these accounts.

Consolidated Accounts of The Christie NHS Foundation Trust 2018-2019

Cash Flow Statement for the Year Ending 31 March 2019

	Note	**Group**	**NHS Foundation Trust**	Group	NHS Foundation Trust
		2018-2019	**2018-2019**	2017-2018	2017-2018
		£000	**£000**	£000	£000
Cash flows from operating activities					
Operating surplus/ (deficit)		**32,729**	**31,400**	**73,703**	**71,634**
Depreciation and Amortisation	4.1	**14,227**	**14,227**	**11,525**	**11,525**
Net Impairments	4.1	**18,005**	**18,005**	**7,675**	**7,675**
(Increase)/decrease in trade and other receivables		**23,384**	**29,434**	**(47,567)**	**(47,154)**
(Increase)/decrease in inventories		**(56)**	**41**	**(1,916)**	**(21)**
Increase/(decrease) in trade and other payables		**1,279**	**(488)**	**1,858**	**1,525**
Increase/(decrease) in other liabilities		**2,677**	**1,926**	**(6,842)**	**(6,842)**
Increase/(decrease) in provisions		**376**	**376**	**(230)**	**(230)**
Corporation tax paid		**0**	**0**	**0**	**0**
Net cash inflow/(outflow) from operating activities		**92,621**	**94,921**	**38,206**	**38,112**
Cash flows from investing activities					
Interest received		**842**	**543**	**242**	**101**
Cash from drawdown of profit from joint ventures	11.1	**7,150**	**7,150**	**0**	**0**
Purchase of Financial Assets		**(18)**	**0**	**(37)**	**0**
Proceeds from sale of property, plant and equipment		**10**	**10**	**0**	**0**
Sales of financial assets		**9**	**0**	**168**	**75**
Purchase of investment property		**(2,700)**	**0**		
Purchase of Property and Plant and Equipment		**(42,395)**	**(42,395)**	**(69,825)**	**(69,825)**
Net cash inflow/(outflow) from investing activities		**(37,102)**	**(34,692)**	**(69,452)**	**(69,649)**
Cash flows from financing activities					
Public dividend capital received	24	**968**	**968**	**15,220**	**15,220**
Loans received	16	**18,562**	**18,562**	**31,589**	**31,589**
Loans Repaid		**(1,926)**	**(1,926)**	**(912)**	**(912)**
Capital element of PFI obligations		**(147)**	**(147)**	**(157)**	**(157)**
Interest paid		**(1,318)**	**(1,318)**	**(724)**	**(724)**
Interest element of PFI obligations	8.2	**(6)**	**(6)**	**(15)**	**(15)**
PDC Dividend paid		**(7,857)**	**(7,857)**	**(7,118)**	**(7,118)**
Net cash inflow/ (outflow) from financing activities		**8,276**	**8,276**	**37,883**	**37,883**
Net increase/(decrease) in cash and cash equivalents	14.1	**63,795**	**68,505**	**6,637**	**6,346**
Cash and cash equivalents at 1 April	14.1	**94,283**	**35,413**	**87,646**	**29,067**
Cash and cash equivalents at 31 March	14.1	**158,078**	**103,918**	**94,283**	**35,413**

The Group position includes The Christie NHS Foundation Trust, The Christie Pharmacy Limited and The Christie Charitable Fund. The 2017-18 Group position also included The Christie Charity Trading Company (note 1.1.3).

The notes on pages 232 to 277 form part of these accounts.

Consolidated Accounts of The Christie NHS Foundation Trust 2018-19
Notes to the Accounts

1. Accounting Policies

NHS Improvement, in exercising the statutory conventions conferred on Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DH GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2018-19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to NHS foundation trusts, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DH GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS foundation trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Conventions

These accounts have been prepared on a going concern basis, under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and certain financial assets and financial liabilities.

1.1.1 Acquisitions and Discontinued Operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one NHS body to another.

1.1.2.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimates (see below) that management has made in the process of applying accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

(a) For each Research and Development contract, the Trust transfers control of goods and services over time and therefore, satisfies performance obligations and recognises revenue over time. This may be over several financial years. Research and Development income recognised is in equal value to the cost in the financial year of satisfying the performance obligations. See note 15.

(b) As part of our critical assessment of the impact of the IFRS 15 revenue recognition standard the Trust has determined that there are overarching implicit promises in relation to our contracted agreements with strategic partners which require us to have adequate and sufficient infrastructure in place which is appropriately maintained throughout the full length of contractual agreements. As a result of these promises and mutual understandings, the Trust has not absorbed all of the income in relation to these contracts but created a contract liability which is in place to cover the overall maintenance and sustainability of all required infrastructure.

(c) In 2017-18, the basis upon which the Modern Equivalent Asset Valuation was assessed for land by the external valuer was changed from the existing site to an alternative theoretical site.

1.1.2.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in material adjustment to the carrying amounts of assets and liabilities within the next financial year.

(a) Non-current Property, Plant and Equipment asset valuation relating to land and buildings are based on the District Valuers valuation - see note 10.

The uncertainty over future changes to estimations of the carrying amount of land and buildings is mitigated by the annual independent valuation of these assets. The estimation methods used by the independent valuer draw upon, but are not limited to, industry recognised building construction indices and relevant or comparable transactions in the market place. A simple sensitivity analysis indicates that a 3% movement in these estimations would increase or decrease the valuation of assets by £7.4m.

(b) Calculation of provisions - see note 1.12 and 17.

1.1.3 Consolidation

The Consolidated Accounts of The Christie NHS Foundation Trust show both the NHS Foundation Trust and the Group balances. The Group balances comprise The Christie NHS Foundation Trust, The Christie Charitable Fund and The Christie Pharmacy Limited which are consolidated on a line-by-line basis. The Group balances in 2017-18 also included The Christie Charity Trading Company (TCCTC). TCCTC was dissolved in 2017-18 and is therefore not part of the 2018-19 Consolidated Accounts.

The Christie Charitable Fund and The Christie Charity Trading Company

The Foundation Trust is the corporate trustee to The Christie Charitable Fund. The Foundation Trust has assessed its relationship to The Christie Charitable Fund and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The Christie Charity Trading Company (TCCTC) is consolidated into The Christie Charitable Fund accounts as TCCTC is deemed to be a subsidiary of The Christie Charitable Fund as its purpose was to carry on business as a general commercial company to procure profits and gains for the purpose of paying them to The Christie Charitable Fund. The Christie Charitable Fund holds 10 ordinary £1 shares in TCCTC which is 100% of the available shares.

TCCTC was incorporated on 27 April 2009 and ceased trading on 31August 2017. An application to strike off the company was made to Companies House in February 2018 and the company was struck off in May 2018.

The Charitable Fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on Financial Reporting Standards (FRS) 102.

On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The Charitable Reserves are comprised of the following Fund types:

(a) Restricted Funds - where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund.

(b) Endowment Funds - Funds where the capital is held to generate income for charitable purposes, and which cannot be spent, are accounted for as endowment funds. Income credited to endowment funds is transferred to designated funds to be utilised in line with the terms of the endowment.

(c) Unrestricted Funds - These include those funds which the trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds which the trustee has chosen to earmark for set purposes. The major funds held within these categories are disclosed in Note 27.2

The Christie Pharmacy Limited

The Trust has one wholly owned subsidiary - The Christie Pharmacy Limited (company number: 11-27496). The Christie Pharmacy was incorporated on 23 October 2017 and The Christie NHS Foundation Trust holds 1 ordinary £1 share in The Christie Pharmacy Limited which is 100% of the available shares.

Subsidiary entities are those over which the Trust is exposed to, or has rights to variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines.

On consolidation, necessary adjustments are made to the company's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trusts' accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The Christie Pharmacy Limited's statutory accounts will be prepared for the period from 23 October 2017 to 31 March 2019 in accordance with Financial Reporting Standards (FRS) 102. For consolidation at 31 March 2019, accounts will be prepared for the period 1 April 2018 to 31 March 2019.

The Christie Pharmacy Limited is accounted for using the cost method in the Trust accounts.

1.1.4 Consolidation - Joint ventures

Joint ventures are separate entities over which the Trust has joint control with one or more other parties and where it has the rights to the net assets of the arrangement. The meaning of control is to exercise control or power to influence so as to gain economic or other benefits. Joint ventures are accounted for using the equity method.

Valuation of the investment in the Joint Venture is recognised at cost and the carrying amount increased or decreased to recognise The Christie's share of its profit or loss.

The Trust has the following joint ventures:

- The Christie Clinic LLP - trading as The Christie Private Care (TCPC)
- The Christie Pathology Partnership LLP (CPP)
- CPP Facilities LLP (CPPFAC)

The figures in the accounts as disclosed in note 11 for the above are based on audited accounts to 31 December 2018 and management accounts for the period to 31 March 2019.

1.2 Income

1.2.1 Trust Income

The main source of revenue for the Trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised in accordance with IFRS 15 when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the Trust accrues income relating to performance obligations satisfied in that year.

DHSC has mandated that NHS bodies must adopt IFRS 15 using the partial retrospective or cumulative catch-up approach. This means that the effect of applying the new standard at the date of initial application is recognised within the opening income and expenditure reserve. The 2017-18 comparatives are therefore not restated. The 2017-18 accounting policy, prior to the introduction of IFRS 15, is stated below:

Income in respect of services provided is recognised when and to the extent that performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific performance obligation (treating Research & Development as one activity) that is to be satisfied in the following year, that income is deferred.

1.2.2 Revenue from Research Contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For research trial contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

1.2.3 Income from the sale of non-current assets

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

1.2.4 Charitable Income

a) Legacies
- Pecuniary legacies are recognised as they are received or where the receipt of the legacy is probable.
- Residuary legacies are included in the accounts at the earlier of receipt or agreement of the estate accounts.
- Finalisation of the estate accounts is assumed when notification of this is received from the personal representatives.
- Reversionary interests, involving a life tenant, are not recognised in the accounts due to the inherent uncertainties involved.
- Legacies to which the charity is entitled and for which notification has been received but uncertainty over measurement remains, are disclosed, if material, as contingent income.

b) Gifts in Kind
The amount at which gifts in kind are recognised is either a reasonable estimate of their value to the funds or the amount actually realised. Where applicable the basis of valuation would be disclosed in the Notes to the Accounts.

Donations of investments listed on the Alternative Investments Market (AIM) and other secondary markets are not recognised until the shares are sold. This is due to the AIM donated shares typically having a time restriction placed upon them which prevents their sale for a minimum period after the donation is made and the difficulty of attributing a value in advance of the sale of the shares listed on such exchanges.

c) Intangible Income
Assistance in the form of donated facilities, beneficial loan arrangements, donated services or services from volunteers is only recorded when they are provided at a financial cost to a third party and the benefit is quantifiable and measurable. Volunteers do bear costs however these are regarded as personal and are not quantified.

1.2.5 The Christie Pharmacy Limited Income

Income in respect of services provided is recognised when and to the extent that performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transactions prices allocated to that performance obligation. The main source of income for The Christie Pharmacy Limited is the dispensing of drugs to The Christie NHS Foundation Trust.

1.3 Expenditure on employee benefits

1.3.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial accounts to the extent that employees are permitted to carry-forward leave into the following period.

1.3.2 Pension costs - NHS Pension scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the HM Treasury's Financial Reporting Manual (FReM) requires that 'the period between formal valuations shall be four years, with approximate assessments in intervening years'.

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department (GAD)) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as at 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

c) Scheme provisions

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase Additional Voluntary Contributions (AVCs) run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

1.3.3 Pension costs - other schemes

The employees of The Christie Pharmacy Limited have access to two pension schemes. These are a Legal and General defined contribution scheme, and the National Employment Savings Trust (NEST) defined contribution pension scheme.

1.3.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as Property, Plant and Equipment.

1.4 Property, Plant and Equipment

1.4.1 Recognition

Property, Plant and Equipment is capitalised where:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- individually has a cost of at least £5,000; or
- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

1.4.2 Valuation

Property, Plant and Equipment assets are stated at the lower of replacement cost and recoverable amount. On initial recognition the assets are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. The carrying values of Property, Plant and Equipment assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are restated to current value using professional valuations in accordance with IAS16 every five years, with an interim valuation every three years. The Trust may also value its land and buildings annually by an independent professional valuer. If the fair value of a revalued asset differs materially from its carrying amount, an independent valuation is carried out for that class of asset.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. This year's valuation was undertaken by Mrs S Hall (MRICS) of the Valuation Office Agency. A full valuation was carried out on 31 March 2019. The next full valuation will be carried out in 2023-24.

The valuations are carried out primarily on the basis of Depreciated Replacement Cost of a Modern Equivalent Asset for specialised operational property and Market Value for Existing Use for non-specialised operational property. The value of land for existing use purposes is assessed on the alternative site basis. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Plant and equipment assets in the course of construction are valued at cost. The Trust does not revalue this class of assets. Costs include borrowing costs where capitalised under circumstances as defined under IAS 23.

Operational equipment is valued at depreciated historic cost.

An item of Property, Plant and Equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

1.4.3 Subsequent expenditure

Subsequent expenditure relating to an item of Property, Plant and Equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.4.4 Depreciation

Property, Plant and Equipment assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

No depreciation is provided on freehold land and assets surplus to requirements.

Assets in the course of construction are not depreciated until the asset is brought into operational use. Residual interests in on-Statement of Financial Position PFI contract assets are not depreciated until the asset reverts to the Trust.

Equipment is depreciated on historic cost for low value and/or short life assets and on current cost for other equipment assets evenly over the estimated life of the asset.

1.4.5 Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are reversed in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

In accordance with the DH GAM, impairments that are due to a loss of economic benefit or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses: and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

1.4.6 De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met;

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, Plant and Equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.4.7 Investment Properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of plant, property and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

1.5 Intangible Assets

1.5.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Expenditure on research activities is recognised as an operating expense in the period in which it is incurred.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Intangible assets acquired separately are initially recognised at historical cost. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to use the intangible asset;
- how the intangible asset will generate probable future economic benefits;
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it;
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of Property, Plant and Equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

1.5.2 Measurement

Intangible non-current assets held for operational use are valued at historical cost less accumulated amortisation. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating.

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is charged to the Statement of Comprehensive Income (SOCI) in the period in which it is incurred.

1.5.3 Amortisation

Intangible assets are amortised on a straight line basis over their expected useful economic lives or, in the case of software licences, over the term of the licence where this is shorter.

1.6 Donated assets

Donated and grant funded Property, Plant and Equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of Property, Plant and Equipment.

1.7 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as PPE at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the effective interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the SOCI.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI payments are recorded as an operating expense. Where the Trust has contributed land and buildings, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the SOCI. Where, at the end of the PFI contract, a property reverts to the Trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible non current asset.

1.8 Government grants

Government grants are grants from Government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.9 Research

The revenue cost of personnel, consumables, etc. engaged in research and development activities is shown as direct expenditure of the Trust. Some of these activities are funded through charitable sources and therefore an amount corresponding to the expenditure charged to the SOCI is included in operating income from charitable and other contributions to expenditure.

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a monthly basis.

Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible NHS foundation trusts disclose the total amount of research and development expenditure charged in the SOCI separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease. Thereafter the asset is accounted for as an item of property, plant or equipment. The lease liability is de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the SOCI.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.10.2 The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.11 Financial Instruments and Financial Liabilities

1.11.1 Financial Assets

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

DHSC has mandated that NHS bodies must adopt IFRS 9 using the partial retrospective or cumulative catch-up approach. This means that the effect of applying the new standard at the date of initial application is recognised within the opening income and expenditure. The 2017-18 comparatives are therefore not restated. The 2017-18 accounting policy, prior to the introduction of IFRS 9, is stated below:

Recognition

Financial assets and financial liabilities arising from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the NHS Foundation Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.
Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as loans and receivables.

1.11.2 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities) and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.11.3 Financial liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

Financial liabilities at fair value through profit and loss

Derivatives that are liabilities are subsequently measured at fair value through profit or loss. Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

1.12 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: 0.10%) in real terms.

Clinical negligence costs

NHS Resolution (formerly NHS Litigation Authority) operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 17 but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust and which represents the Department of Health and Social Care's investment in the Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable as PDC dividend. The charge is calculated at the rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) donated assets (including lottery funded assets),

(ii) plus the value of any deferred income balance that funds a donated asset (to avoid the potential to double count donated assets as a reduction in relevant net assets where a donated asset is associated with a deferred income balance),

(iii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility,
(iv) any PDC dividend balance receivable or payable, and
(v) Provider Sustainability Funding (PSF) incentive and bonus elements.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.16 Non Current Asset Investments

1.16.1 Recognition and Measurement
Non current asset investments are stated at fair value at the balance sheet date.

1.16.2 Realised and unrealised gains and losses
All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening fair value (or cost if purchased since the previous period end). Unrealised gains and losses are calculated as the difference between fair value at the year end and the opening fair value (or cost if purchased since the previous period end).

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 18, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

● possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

● present obligations arising from past events but for which it is not probable that a transfer of economic benefit will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Corporation tax

Under s519A ICTA 1988 the Trust is regarded as a Health Service body and is, therefore, exempt from taxation on its income and capital gains. Section 148 of the 2004 Finance Act provided the HM Treasury with powers to disapply this exemption. Accordingly the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare and where the profits exceed £50,000 per annum. Activities such as staff and patient car parking and sales of food are considered to be ancillary to the core healthcare objectives of the Trust (and not entrepreneurial) and therefore not subject to corporation tax. Any tax liability will be accounted for within the relevant tax year.

The Christie Pharmacy Limited, a subsidiary of the Trust, is subject to corporation tax on commercial activities. Corporation tax and deferred tax liabilities have arisen in the period to 31 March 2019.

1.19 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

● monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;

● non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and

● non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.21 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and Special Payments are charged to the relevant functional headings in the SOCI on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure). Note 21 is compiled directly from the losses and compensations register which is prepared on an accrual basis with the exception of provisions for future losses.

1.22 Third party assets

Assets belong to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 14.3 to the accounts.

1.23 Accounting standards issued but not yet adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

(a) IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by FReM: early adoption is not therefore permitted.

(b) IFRS17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021 but not yet adopted by FReM; early adoption is not therefore permitted.

(c) IFRS 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

No accounting standards in issue have been adopted early.
The implementation of IFRS 17 and IFRS 23 will have no impact on the Trust. The impact of IFRS 16 will be assessed following the publication of DHSC guidance on the implementation of the accounting standard.

2. Operating segments

Under IFRS 8 'Operating Segments', the Trust is required to disclose financial information across significant operating segments which reflect the way the management runs the Trust.

The Trust's core activities fall under the remit of the Chief Operating Decision Maker ("CODM") as defined by IFRS 8 'Operating Segments', which has been determined to be the Management Board, a sub-committee of the Board of Directors. These core activities are primarily the provision of specialist NHS healthcare, the income for which is received through contracts with commissioners. The planned level of activity is agreed with our main commissioners for the year, and are listed in the related party disclosure (see Note 22).

The Trust manages the delivery of healthcare services across clinical divisions. Certain aspects of performance are reported at a divisional level to the Management Board, although this is not the primary way in which financial matters are considered.

The Trust has applied the aggregation criteria from IFRS 8 Operating Segments because the clinical divisions provide similar services, have homogenous customers, common production processes and a common regulatory environment. The overlapping activities and interrelation between the divisions also suggests that aggregation is appropriate. The divisions report to the CODM, and it is the CODM that ultimately makes decisions about the allocation of budgets, capital funding and other financial decisions.

3. Operating income

		Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
		2018-2019	**2018-2019**	2017-2018	2017-2018
		£000	**£000**	£000	£000
Income from activities	3.1.1	**238,324**	**238,324**	217,681	217,681
Other operating income	3.2	**98,490**	**97,505**	125,677	123,644
		336,814	**335,829**	343,358	341,325

3.1.1 Income from activities by type

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
			Restated	Restated
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
Elective income	**43,890**	**43,890**	44,920	44,920
Non Elective income	**18,895**	**18,895**	18,606	18,606
Outpatient income*	**127,070**	**127,070**	125,654	125,654
Other types of activity income				
NICE drugs	**24,290**	**24,290**	15,992	15,992
CDF drugs	**8,161**	**8,161**	7,395	7,395
Growth Hormone drugs	**2,553**	**2,553**	1,743	1,743
Proton Beam Therapy	**4,012**	**4,012**	0	0
Agenda for Change pay award	**1,632**	**1,632**	0	0
Other**	**7,821**	**7,821**	3,371	3,371
Total	**238,324**	**238,324**	217,681	217,681

Income from activities relates to income arising from mandatory services. Growth in activity relates to increased patient treatments.
Due to the specialist nature of the Trust, increased income also relates to the complexity of patient treatments undertaken during the year.

* Outpatient income includes radiotherapy and chemotherapy ambulatory treatments and diagnostic imaging and tests.

** Other includes income from CQUIN, Multi disciplinary temas (MDTs) and any other clinical activity.

3.1.2 Income from activities by source

	Group 2018-2019	**NHS Foundation Trust 2018-2019**	Group 2017-2018	NHS Foundation Trust 2017-2018
	£000	**£000**	£000	£000
NHS Foundation Trusts	**1,364**	**1,364**	1,172	1,172
NHS Trusts	**402**	**402**	449	449
Clinical Commissioning Groups (CCGs) and NHS England	**230,567**	**230,567**	212,299	212,299
Department of Health and Social Care*	**1,632**	**1,632**	0	0
NHS other	**3,762**	**3,762**	3,002	3,002
Non English NHS Bodies	**597**	**597**	759	759
Total	**238,324**	**238,324**	217,681	217,681

* Department of Health and Social Care funding for the Agenda for Change (AfC) pay award.

3.2 Other Operating Income

	Group 2018-2019	**NHS Foundation Trust 2018-2019**	Group 2017-2018	NHS Foundation Trust 2017-2018
	£000	**£000**	£000	£000
Other operating income from contracts with customers:				
Research and development	**17,983**	**17,983**	21,459	21,459
Education and training	**6,000**	**6,000**	5,054	5,054
Non-patient care services to other bodies	**643**	**810**	635	627
Christie Medical Physics & Engineering	**7,897**	**7,897**	7,579	7,579
Joint venture - The Christie Clinic LLP*	**6,803**	**6,803**	6,093	6,093
Joint venture - The Christie Pathology Partnership LLP*	**1,187**	**1,187**	1,237	1,237
Joint venture - CPP Facilities LLP*	**770**	**770**	687	687
Provider sustainability fund (PSF) income**				
Core	**3,787**	**3,787**	1,495	1,495
Incentive	**20,866**	**20,866**	31,345	31,345
Bonus	**947**	**947**	1,627	1,627
General distribution	**961**	**961**	481	481
Income in respect of staff costs	**3,129**	**3,129**	1,965	1,965
Proton beam therapy***	**8,167**	**8,167**	5,090	5,090
Transformation monies****	**0**	**0**	2,649	2,649
Clinical excellence awards	**1,268**	**1,268**	1,205	1,205
Catering and other commercial income	**1,154**	**1,154**	1,154	1,154
Creche services	**737**	**737**	739	739
Property rentals	**255**	**255**	759	760
Car parking	**362**	**362**	366	366
Pharmacy sales	**(3)**	**(3)**	11	12
Other contract income	**2,025**	**2,025**	2,142	2,176
Other non-contract operating income:				
Charitable and other contributions to capital expenditure	**0**	**4,416**	0	2,986
Charitable and other contributions to revenue expenditure	**0**	**7,984**	0	10,259
Donations, legacies and grants	**13,552**	**0**	15,306	0
Insurance*****	**0**	**0**	16,599	16,599
Total	**98,490**	**97,505**	125,677	123,644

* Joint venture income relates to services provided to The Christie Clinic LLP, The Christie Pathology Partnership LLP and The Christie Pathology Partnership Facilities LLP via Service Level Agreements, property rental income and other contractual payments.

** The Trust receives core, incentive and bonus funding from NHS England in relation to the Provider sustainability fund Income (2017-18: Sustainability and Transformation Fund). The PSF is to enable the transformation of services to ensure continued delivery of excellent patient care, efficiencies and improvements.

*** Funding from NHS England in relation to Proton Beam Therapy costs incurred to date.

**** 2017-18 funding from the National Cancer Vanguard Programme from NHS England to transform cancer services.

***** Insurance - On 26th April 2017 a fire occurred on the hospital site. The fire caused significant damage to the Paterson building , which was occupied by the University of Manchester and Cancer Research UK. A commerical settlement has been agreed with the insurers as the Trust and its partners plan is to redevelop the building rather than replace the damaged property . The amount contained within note 3.2 above reflects the commercial settlement reached in 2017-18.

3.3 Additional information on contract revenue (IFRS 15) recognised in the period

	Group	NHS Foundation Trust
	2018-2019	2018-2019
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	0	0
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0	0
Total	0	0

3.4 Transaction price allocated to remaining performance obligations

	Group	NHS Foundation Trust
	2018-2019	2018-2019
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	1,839	1,839
after one year, not later than five years	8,511	8,511
after five years	0	0
Total revenue allocated to remainig performance obligations	10,350	10,350

4. Operating Expenses

4.1 Operating expenses comprise:

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	Restated 2017-2018	Restated 2017-2018
	£000	**£000**	£000	£000
Services from Foundation Trusts	**6,041**	**6,041**	5,610	5,610
Services from NHS Trusts	**817**	**817**	0	0
Services from other NHS and DHSC bodies	**2,664**	**2,664**	3,415	3,415
Services from non-NHS and non-DHSC bodies***	**7,788**	**7,788**	7,546	7,546
Executive directors' costs	**1,208**	**1,209**	1,132	1,132
Non-executive directors' costs	**143**	**143**	139	140
Staff costs	**131,336**	**130,431**	120,348	120,095
Drug costs	**73,336**	**74,880**	68,659	69,031
Supplies and Services- clinical	**20,429**	**20,415**	17,987	17,978
Supplies and services - general***	**2,682**	**2,679**	3,248	3,245
Establishment	**5,790**	**5,771**	6,115	6,103
Research & Development	**2,636**	**2,636**	1,626	1,626
Transport	**1,386**	**1,386**	1,269	1,267
Premises	**9,706**	**9,706**	6,972	6,969
Increase / (decrease) in provision for impairment of receivables	**(95)**	**(95)**	12	12
Increase / (decrease) in other provisions	**17**	**17**	(199)	(199)
Change in provisions discount rate	**(12)**	**(12)**	10	10
Depreciation of Property, Plant and Equipment	**13,671**	**13,671**	10,789	10,789
Amortisation of intangibles	**556**	**556**	736	736
Net impairments of property, plant and equipment*	**18,005**	**18,005**	7,675	7,675
Audit fees	**88**	**56**	69	58
Other auditors' remuneration	**5**	**5**	10	10
Internal audit costs	**130**	**109**	114	114
Training, courses and conferences	**982**	**966**	900	898
Insurance and clinical negligence	**1,156**	**1,148**	874	874
Legal fees	**56**	**56**	225	225
Publishing	**485**	**485**	349	349
Consultancy costs	**1,443**	**1,443**	1,860	1,855
Other services	**104**	**100**	261	259
Redundancy and termination benefits	**615**	**615**	654	654
Losses, ex gratia and special payments**	**9**	**9**	61	61
Other	**908**	**729**	1,189	1,154
Total	**304,085**	**304,429**	269,655	269,691

* Following an independent valuation of the Trust's land and buildings, a net impairment change has arisen. This reflects impairments due to the bringing in to use the new Proton building and Outpatients department. Other properties have, in the main, fallen in value.

** Total losses reported in this note are prepared on an accruals basis and therefore do not compare to note 21.

***Expenses for 2017-18 have been re-categorised to reflect the revised analysis of expenditure in 2018-19:

	2017-18	**Re-categorisation**	**Restated**
	£000s	**£000s**	**£000s**
Services from non-NHS and non-DHSC bodies***	0	7,546	7,546
Supplies and services - clinical	25,533	(7,546)	17,987
Supplies and services - general	3,149	99	3,248
Establishment	3,292	2,823	6,115
Premises	9,894	(2,922)	6,972
	41,868	0	41,868

4.2 Audit fees

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
Audit services - statutory audit	**88**	**56**	69	58
Total	**88**	**56**	69	58

Group statutory audit fees include £8k for the Charity and £24k for The Christie Pharmacy Limited. The Trust and Charity audit fees are stated gross of VAT. The Christie Pharmacy Limited audit fees are stated net.

The auditors' total liability (including interest) for all claims connected with the services or the agreement with the Trust (including but not limited to negligence) is limited to £500k.

4.3 Other auditors' remuneration

The fees paid or payable to the external auditors for other services are made up as follows;

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
Audit services - audit related regulatory reporting	**5**	**5**	5	5
Additional Reporting - Joint Ventures (Ernst Young)	**0**	**0**	5	5
Total	**5**	**5**	10	10

5. Operating leases

5.1 NHS FT as lessee

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
Payments recognised as an expense				
Minimum lease payments	**32**	**32**	36	36
	32	**32**	36	36
Total future minimum lease payments				
Payable:				
Not later than 1 year	**6**	**6**	5	5
Later than 1 year not later than 5 years	**0**	**0**	0	0
Later than 5 years	**0**	**0**	0	0
Total	**6**	**6**	5	5

The Trust commenced a lease arrangement in June 2016 for the lease of car park spaces at Christie Fields for the Park & Ride Scheme. The lease ended in May 2018.

The Trust commenced a lease arrangement in June 2018 for the lease of car park spaces at Withington Hospital for the Park & Ride Scheme. The lease ends in June 2019.

5.2 NHS FT as lessor

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
Recognised as income				
Rents	**2,091**	**2,091**	2,566	2,566
Contingent Rents	**0**	**0**	0	0
Total	**2,091**	**2,091**	2,566	2,566
Receivable:				
Not later than 1 year	**1,926**	**1,926**	1,879	1,879
Later than 1 year not later than 5 years	**8,103**	**8,103**	7,645	7,645
Later than 5 years	**16,843**	**16,843**	18,259	18,259
Total	**26,872**	**26,872**	27,783	27,783

The Trust has granted a number of leases to the University of Manchester at the Withington site.

The Trust entered into an agreement with The Christie Clinic LLP whereby the joint venture leases from the Trust part of the new patient treatment centre for 20 years, effective from 15 September 2010.

The Trust granted a 5 year lease to the NHS Blood Transfusion Service for use of the Photophoresis Unit which expired on 30 November 2016. A lease was granted for a further 5 years on 1 December 2016.

The Trust granted a 10 year lease to The Christie Pathology Partnership LLP on 1 June 2014. The lease was novated to CPP Facilities LLP on 1 June 2016.

6. Employee costs

The Christie Charitable Fund do not employ any staff directly. The Christie NHS Foundation Trust recharges the Christie Charitable Fund for staff undertaking fundraising, management, finance and administration duties and for the staff undertaking the charitable activities of research, clinical care and other activities. These include the staff costs related to The Christie Charitable Fund Trading Company Limited.

The Group figures include employee expenses arising from the employment of staff by The Christie Pharmacy Limited.

In line with HM Treasury requirements, accounts disclosures relating to staff costs are now included in the Annual Report.

6.1 Employee expenses

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-19 £000s	**2018-19 £000s**	2017-18 £000s	2017-18 £000s
Salaries and wages	**108,762**	**108,013**	99,436	99,218
Social security costs	**9,592**	**9,530**	8,888	8,870
Apprenticeship Levy	**479**	**479**	444	444
Employers contributions to NHS Pensions	**12,583**	**12,583**	11,643	11,643
Pension costs - other contributions	**58**	**10**	19	4
Termination benefits	**54**	**54**	46	46
Agency / contract staff	**1,070**	**1,023**	1,050	1,048
Total	**132,598**	**131,692**	121,526	121,273

Capitalised staff costs are excluded from this note and total £550k (2017-18 £1,009k).

6.2 Early Retirements due to ill-health

During 2018-19 there were no early retirements (1 - 2017-18) from the Trust on the grounds of ill-health. The estimated additional pension liabilities of ill-health retirements are £50k (£50k - 2017-18). The cost of these ill-health retirements will be borne wholly by NHS Pensions.

6.3 Directors' Remuneration and Other Benefits

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019 £000	**2018-19 £000**	2017-18 £000	2017-18 £000
Executive Directors' Remuneration	**965**	**965**	895	895
Employer contributions for national insurance	**132**	**132**	129	129
Employer contributions to the pension scheme	**111**	**111**	108	108

There is a total of 5 Executive Directors to whom benefits are accruing under defined benefit pension schemes.

Full details of Directors' remuneration and other benefits are set out in the Trust's remuneration report which is included in the annual report.

During 2018-19 no remuneration was made to the Trustees of The Christie Charitable Fund (2017-18 £nil).

7.1 Better Payment Practice Code - measure of compliance

	Group		Group	
	2018-2019		2017-2018	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**31,956**	**185,528**	32,006	212,826
Total Non-NHS trade invoices paid within target	**29,989**	**178,255**	30,353	205,849
Percentage of Non-NHS trade invoices paid within target	**94%**	**96%**	95%	97%
Total NHS trade invoices in the year	**1,747**	**17,555**	1,881	23,182
Total NHS trade invoices paid within target	**1,283**	**14,651**	1,410	20,708
Percentage of NHS trade invoices paid within target	**73%**	**83%**	75%	89%

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

There is also a further requirement for all NHS Foundation Trusts to pay all small local businesses within 10 days from date of invoice or receipt of goods. The Trust has paid 91% within this target (2017-18: 87%).

7.2. The Late Payment of Commercial Debts (Interest) Act 1998

	Group	Group
	2018-2019	2017-2018
	£000	£000
Amounts included within other interest payable arising from claims made under this legislation from claims made by small businesses.	**3**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0

8. Finance costs and finance revenue

8.1 Finance income

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
Bank interest receivable	**811**	**500**	227	87
Interest on loans and receivables	**16**	**43**	6	14
Interest on held-to-maturity financial assets	**21**	**0**	9	0
Total	**848**	**543**	242	101

8.2 Finance costs - financial liabilities

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
Interest on loans and overdrafts	**1,461**	**1,461**	929	929
Interest on late payment of commercial debt	**3**	**3**	1	1
Interest on obligations under PFI contracts	**6**	**6**	15	15
Total	**1,470**	**1,470**	945	945

9. Intangible assets

All Intangible Assets of The Christie NHS Foundation Trust Group are held by The Christie NHS Foundation Trust. Neither The Christie Charitable Fund nor The Christie Pharmacy Limited hold any Intangible Assets.

9.1 Intangible assets 2018-2019

	Group					
	Software purchased	**Software Internally generated**	**Licences and trademarks**	**Patents**	**Development Expenditure**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Gross cost at 1 April 2018	**3,025**	**0**	**0**	**0**	**0**	**3,025**
Additions - purchased	**0**	**0**	**0**	**0**	**0**	**0**
Additions - leased	**0**	**0**	**0**	**0**	**0**	**0**
Additions - purchased from The Christie Charitable Fund contributions	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications as held for sale	**0**	**0**	**0**	**0**	**0**	**0**
Transfers (to)/from NHS bodies	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**0**	**0**	**0**	**0**	**0**	**0**
Revaluations	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**
Reversals of impairments	**0**	**0**	**0**	**0**	**0**	**0**
Gross cost at 31 March 2019	**3,025**	**0**	**0**	**0**	**0**	**3,025**
Accumulated Amortisation						
Accumulated amortisation at 1 April 2018	**2,214**	**0**	**0**	**0**	**0**	**2,214**
Charged during the year	**556**	**0**	**0**	**0**	**0**	**556**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**
Transfers to NHS bodies	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**0**	**0**	**0**	**0**	**0**	**0**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**
Accumulated amortisation at 31 March 2019	**2,770**	**0**	**0**	**0**	**0**	**2,770**
Net book value at 31 March 2019	255	0	0	0	0	255
Net book value - purchased at 31 March 2019	**255**	**0**	**0**	**0**	**0**	**255**
Net book value - PFI lease at 31 March 2019	**0**	**0**	**0**	**0**	**0**	**0**
Net book value - Purchased from the Christie Charitable Fund Contributions at 31 March 2019	**0**	**0**	**0**	**0**	**0**	**0**
Net book value at 31 March 2019	**255**	**0**	**0**	**0**	**0**	**255**

9.2 Intangible assets 2017-2018

	Group					
	Software purchased	Software Internally generated	Licences and trademarks	Patents	Development Expenditure	Total
	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2017	3,025	0	0	0	0	3,025
Additions - purchased	0	0	0	0	0	0
Additions - leased	0	0	0	0	0	0
Additions - purchased from The Christie Charitable Fund contributions	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassifications as held for sale	0	0	0	0	0	0
Transfers (to)/from NHS bodies	0	0	0	0	0	0
Disposals	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0
Gross cost at 31 March 2018	3,025	0	0	0	0	3,025
Accumulated Amortisation						
Accumulated amortisation at 1 April 2017	1,478	0	0	0	0	1,478
Charged during the year	736	0	0	0	0	736
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Transfers to NHS bodies	0	0	0	0	0	0
Disposals	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Accumulated amortisation at 31 March 2018	2,214	0	0	0	0	2,214
Net book value at 31 March 2018	811	0	0	0	0	811
Net book value - purchased at 31 March 2018	811	0	0	0	0	811
Net book value - PFI lease at 31 March 2018	0	0	0	0	0	0
Net book value - Purchased from the Christie Charitable Fund Contributions at 31 March 2018	0	0	0	0	0	0
Net book value at 31 March 2018	811	0	0	0	0	811

10. Property, Plant and Equipment

All Property, Plant and Equipment of The Christie NHS Foundation Trust Group are held by The Christie NHS Foundation Trust. The Christie Charitable Fund and The Christie Pharmacy Limited do not hold any Property, Plant and Equipment Assets.

10.1 Property, Plant and Equipment 2018-2019

	Group								
	Land	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction and payments on account**	**Plant and machinery**	**Transport equipment**	**Information technology**	**Furniture and fittings**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Cost or Valuation at 1 April 2018	**6,045**	**212,847**	**0**	**128,443**	**52,724**	**33**	**7,493**	**0**	**407,585**
Additions - purchased	**0**	**0**	**0**	**29,888**	**5,831**	**0**	**0**	**0**	**35,719**
Additions - purchased from The Christie Charitable Fund contributions	**0**	**0**	**0**	**4,393**	**23**	**0**	**0**	**0**	**4,416**
Impairments charged to Operating Expenses	**0**	**(18,225)**	**0**	**0**	**0**	**0**	**0**	**0**	**(18,225)**
Impairments charged to Revaluation Reserve	**0**	**(1,976)**	**0**	**0**	**0**	**0**	**0**	**0**	**(1,976)**
Reversal of impairments credited to operating expenses	**175**	**45**	**0**	**0**	**0**	**0**	**0**	**0**	**220**
Reversal of impairments credited to the revaluation reserve	**0**	**2,615**	**0**	**0**	**0**	**0**	**0**	**0**	**2,615**
Reclassifications	**0**	**106,864**	**0**	**(149,437)**	**37,528**	**0**	**5,045**	**0**	**0**
Revaluation	**0**	**(59,541)**	**0**	**0**	**0**	**0**	**0**	**0**	**(59,541)**
Transferred to disposal group as asset held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**0**	**(82)**	**0**	**0**	**(2,818)**	**0**	**0**	**0**	**(2,900)**
Gross cost at 31 March 2019	**6,220**	**242,547**	**0**	**13,287**	**93,288**	**33**	**12,538**	**0**	**367,913**
Accumulated Depreciation									
Accumulated depreciation at 1 April 2018	**0**	**53,060**	**0**	**0**	**29,856**	**30**	**4,480**	**0**	**87,426**
Charged during the year	**0**	**6,563**	**0**	**0**	**5,596**	**3**	**1,509**	**0**	**13,671**
Impairment Reversals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments charged to Operating Expenses	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments charged to Revaluation Reserve	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Revaluation	**0**	**(59,541)**	**0**	**0**	**0**	**0**	**0**	**0**	**(59,541)**
Transferred to disposal group as asset held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**0**	**(82)**	**0**	**0**	**(2,627)**	**0**	**0**	**0**	**(2,709)**
Accumulated depreciation at 31 March 2019	**0**	**0**	**0**	**0**	**32,825**	**33**	**5,989**	**0**	**38,847**
Net book value at 31 March 2019	**6,220**	**242,547**	**0**	**13,287**	**60,463**	**0**	**6,549**	**0**	**329,066**
NBV - purchased at 31 March 2019	**6,030**	**170,260**	**0**	**12,287**	**55,689**	**0**	**6,095**	**0**	**250,361**
NBV -purchased finance lease at 31 March 2019	**0**	**9,049**	**0**	**0**	**0**	**0**	**0**	**0**	**9,049**
NBV- Charity Funded Finance Lease at 31 March 2019	**0**	**11,504**	**0**	**0**	**0**	**0**	**0**	**0**	**11,504**
Net book value - PFI lease at 31 March 2019	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net book value - Purchased from the Christie Charitable Fund 31 March 2019	**190**	**51,734**	**0**	**1,000**	**4,774**	**0**	**454**	**0**	**58,152**
Net book value at 31 March 2019	**6,220**	**242,547**	**0**	**13,287**	**60,463**	**0**	**6,549**	**0**	**329,066**

Land and buildings were revalued as at 31 March 2019 (previously revalued at 31 March 2018). The valuation exercise was carried out by an independent professional valuer. Independent valuations have not been undertaken for the remaining classes of Property, Plant and Equipment as their carrying amount is deemed to be the fair value.

The Christie Charitable Fund has provided funding to purchase assets. There are no restrictions placed on the use of these assets as part of the offer of funding and as such the Trust has full ownership of these assets.

Purchased finance leases are comprised of the Salford satellite centre £7,750k (2017-18 £8,139k) and the Manchester Cancer Research Centre (MCRC) of £1,299k (2017-18 £1,363k).

Finance leases funded from The Christie Charitable Fund contributions are comprised of the Oldham satellite centre £10,777k (2017-18 £11,313k) and the Manchester Cancer Research Centre (MCRC) of £727k (2017-18 £746k).

The Trust holds a 40 year lease for the Oldham satellite centre for use of part of the building located on land owned by Pennine Acute NHS Trust which was paid for up front and in full in March 2010. For the Salford satellite centre the Trust holds a 60 year lease with Salford Royal NHS Foundation Trust which was similarly paid for up front and in full in June 2011. The MCRC building located on the Withington site was paid for by the University of Manchester. The Trust holds a 125 year sublease for part occupancy of this building, which has been paid for upfront.

10.2 Property, Plant and Equipment 2017-2018

	Group								
	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or Valuation at 1 April 2017	12,455	184,659	0	91,991	50,554	33	6,612	0	346,304
Additions - purchased	0	1,530	0	48,562	2,777	0	881	0	53,750
Additions - purchased from The Christie Charitable Fund contributions	0	0	0	2,846	140	0	0	0	2,986
Impairments charged to Operating Expenses	(1,225)	(2,338)	0	0	0	0	0	0	(3,563)
Impairments charged to Revaluation Reserve	(5,185)	(1,805)	0	0	0	0	0	0	(6,990)
Reversal of impairments credited to operating expenses	0	5,793	0	0	0	0	0	0	5,793
Reclassifications	0	12,830	0	(14,956)	2,126	0	0	0	0
Revaluation	0	12,375	0	0	0	0	0	0	12,375
Transferred to disposal group as asset held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(197)	0	0	(2,873)	0	0	0	(3,070)
Gross cost at 31 March 2018	6,045	212,847	0	128,443	52,724	33	7,493	0	407,585
Accumulated Depreciation									
Accumulated depreciation at 1 April 2017	0	38,145	0	0	28,245	23	3,389	0	69,802
Charged during the year	0	5,207	0	0	4,484	7	1,091	0	10,789
Impairment Reversals	0	0	0	0	0	0	0	0	0
Impairments charged to Operating Expenses	0	9,905	0	0	0	0	0	0	9,905
Impairments charged to Revaluation Reserve	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(197)	0	0	(2,873)	0	0	0	(3,070)
Accumulated depreciation at 31 March 2018	0	53,060	0	0	29,856	30	4,480	0	87,426
Net book value at 31 March 2018	6,045	159,787	0	128,443	22,868	3	3,013	0	320,159
NBV - purchased at 31 March 2018	5,855	92,252	0	121,538	17,687	0	2,856	0	240,188
NBV -purchased finance lease at 31 March 2018	0	9,502	0	0	0	0	0	0	9,502
NBV- Charity Funded Finance Lease at 31 March 2018	0	12,077	0	0	0	0	0	0	12,077
Net book value - PFI lease at 31 March 2018	0	0	0	0	118	0	0	0	118
Net book value - Purchased from the Christie Charitable Fund 31 March 2018	190	45,956	0	6,905	5,063	3	157	0	58,274
Net book value at 31 March 2018	6,045	159,787	0	128,443	22,868	3	3,013	0	320,159

10.3 Property, Plant and Equipment (continued)

The net book value of land and buildings at 31 March comprises:

	Group 2018-2019 £000	Group 2017-2018 £000
Freehold	**228,215**	144,253
Long leasehold	**20,553**	21,579
Short leasehold	**0**	0
Total	**248,768**	165,832

10.4 Economic Lives of Non-current Assets

	Group	
	Min Life Years	**Max Life Years**
Intangible assets		
Software purchased	**1**	**5**
Property, Plant and Equipment		
Buildings excluding dwellings	**9**	**75**
Plant and machinery	**1**	**20**
Transport equipment	**1**	**5**
Information technology	**1**	**10**

10.5 Impairments

Impairments charged in the year to the Statement of Comprehensive Income

	Group 2018-2019		Group 2017-2018	
	Property, plant and equipment £000	**Intangible assets £000**	Property, plant and equipment £000	Intangible assets £000
Impairments arose from:				
Loss or damage from normal operations	**0**	**0**	0	0
Loss as a result of catastrophe	**0**	**0**	9,905	0
Over-specification of assets	**0**	**0**	0	0
Other (specify)	**18,225**	**0**	3,563	0
Reversal of impairments	**(220)**	**0**	(5,793)	0
Total	**18,005**	**0**	7,675	0

Other impairments of £18,225k reflect the drop in value on the completion of new buildings on the site which have been revalued below the construction cost. The lower value reflects complexities in construction on a restricted site which needs to maintain operational healthcare activities and, as a consequence, will not achieve a construction cost of a greenfield site unencumbered by such needs. The existing buildings have also been revalued and changes reflect movements in general market prices.

10.6 Non-current assets held for sale and assets in disposal groups

The Trust has no non-current assets held for sale or in disposal groups.

10.7 Net book value of assets held under finance leases 2018-2019

	Group									
	Land	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction and payments on account**	**Plant and machinery**	**Transport equipment**	**Information technology**	**Furniture and fittings**	**PFI arrangements**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Cost or Valuation at 1 April 2018	**0**	**25,902**	**0**	**0**	**0**	**0**	**0**	**0**	**2,573**	**28,475**
Additions - purchased	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions - purchased from The Christie Charitable Fund contributions	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**(265)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(265)**
Reversal of impairments credited to operating expenses	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Revaluation	**0**	**(285)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(285)**
Disposals										
Gross cost at 31 March 2019	**0**	**25,352**	**0**	**0**	**0**	**0**	**0**	**0**	**2,573**	**27,925**
Accumulated Depreciation										
Accumulated depreciation at 1 April 2018	**0**	**4,323**	**0**	**0**	**0**	**0**	**0**	**0**	**2,455**	**6,778**
Charged during the year	**0**	**476**	**0**	**0**	**0**	**0**	**0**	**0**	**118**	**594**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals										
Accumulated depreciation at 31 March 2019	**0**	**4,799**	**0**	**0**	**0**	**0**	**0**	**0**	**2,573**	**7,372**
Net book value at 31 March 2019	0	20,553	0	0	0	0	0	0	0	20,553
Net book value - purchased at 31 March 2019	**0**	**9,049**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**9,049**
Net book value - Charity funded at 31 March 2019	**0**	**11,504**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**11,504**
Net book value at 31 March 2019	**0**	**20,553**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**20,553**

The Finance Leases for Buildings consist of:

	Net Book value
	£000
Salford Satellite	7,750
Oldham Satellite	10,777
MCRC Exchequer funded	1,299
MCRC Charity funded	727
Net book value at 31 March 2019	**20,553**

10.8 Net book value of assets held under finance leases 2017-2018

	Group									
	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	PFI arrangements	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or Valuation at 1 April 2017	0	23,950	0	0	0	0	0	0	2,573	26,523
Additions - purchased	0	0	0	0	0	0	0	0	0	0
Additions - purchased from The Christie Charitable Fund contributions	0	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0	0
Reversal of impairment credited to operating expenses	0	706	0	0	0	0	0	0	0	706
Reclassifications	0	0	0	0	0	0	0	0	0	0
Revaluation	0	1,246	0	0	0	0	0	0	0	1,246
Disposals	0	0	0	0	0	0	0	0	0	0
Gross cost at 31 March 2018	0	23,950	0	0	0	0	0	0	2,573	28,475
Accumulated Depreciation										
Accumulated depreciation at 1 April 2017	0	3,890	0	0	0	0	0	0	2,337	6,227
Charged during the year	0	433	0	0	0	0	0	0	118	551
Impairments	0	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2018	0	4,323	0	0	0	0	0	0	2,455	6,778
Net book value at 31 March 2018	0	21,579	0	0	0	0	0	0	118	21,697
Net book value - purchased at 31 March 2018	0	9,502	0	0	0	0	0	0	118	9,620
Net book value - Charity funded at 31 March 2018	0	12,077	0	0	0	0	0	0	0	12,077
Net book value at 31 March 2018	0	21,579	0	0	0	0	0	0	118	21,697

11. Investments

11.1 Investment in joint ventures

All investments in joint ventures by The Christie NHS Foundation Trust Group have been entered into by The Christie NHS Foundation Trust.

	2018-2019			
	TCPC	**CPP**	**CPPFAC**	**Total**
	£000	**£000**	**£000**	**£000**
Carrying value at 1 April 2018	**26,081**	**442**	**119**	**26,641**
Acquisitions in year	**0**	**0**	**0**	**0**
Share of profit/ (loss)	**5,743**	**27**	**101**	**5,871**
Impairments	**0**	**0**	**0**	**0**
Disposals	**0**	**0**	**0**	**0**
Less distributions	**(7,150)**	**0**	**0**	**(7,150)**
Carrying value at 31 March 2019	**24,674**	**469**	**220**	**25,362**

	2017-2018			
	TCPC	CPP	CPPFAC	Total
	£000	£000	£000	£000
Carrying value at 1 April 2017	21,285	445	99	21,828
Acquisitions in year	0	0	0	0
Share of profit/ (loss)	4,796	(3)	320	5,113
Impairments	0	0	0	0
Disposals	0	0	0	0
Less distributions	0	0	(300)	(300)
Carrying value at 31 March 2018	26,081	442	119	26,641

On 15 September 2010 the Trust entered into an LLP agreement with HCA International Limited to establish The Christie Clinic LLP - trading as The Christie Private Care (TCPC). The carrying value and profits represent the contractual arrangements of The Christie Clinic LLP.

On 1st July 2012, TCPC entered into an agreement with practicing consultants to establish LOC@The Christie LLP. LOC is an abbreviation for Leaders in Oncology Care. The partnership provides outpatient chemotherapy services. The TCPC figures above include LOC@The Christie LLP.

On 1 June 2014 the Trust entered into an LLP agreement with Synlab UK Limited to establish The Christie Pathology Partnership LLP (CPP). The carrying value represents the value of non-current assets transferred from The Christie NHS Foundation Trust Group to The Christie Pathology Partnership LLP as part of the initial setup with Synlab investing working capital equal to the value of the non-current assets and the profits.

On 1 June 2016 the Trust entered into an LLP agreement with Synlab UK Limited to establish CPP Facilities LLP (CPPFAC). The carrying value represents the value and profits represent the contractual arrangements of CPP Facilities LLP.

11.2 Disclosure of aggregate amounts for assets of joint ventures

All investments in joint ventures by The Christie NHS Foundation Trust Group have been entered into by The Christie NHS Foundation Trust.

	TCPC	**CPP**	**CPP Facilities**
Proportion of ownership interests held by The Christie NHS Foundation Trust	**49.0%**	**49.9%**	**49.9%**
Proportion of voting rights held by The Christie NHS Foundation Trust	**50.0%**	**50.0%**	**50.0%**

For The Christie Clinic LLP the residual proportions of ownership interests and voting rights are held by HCA International Limited and for The Christie Pathology Partnership LLP and CPP Facilities LLP by Synlab UK Limited.

For The Christie Clinic LLP, The Christie Pathology Partnership LLP and CPP Facilities LLP the figures in the note below are based on the draft accounts to the end of December 2018 and the Quarter 1 management accounts to the end of March 2019 but are not adjusted for share of profits attributable but not distributed to The Christie NHS Foundation Trust.

	2018-2019		
	Gross Assets As at 31 March 2019	**Net Assets As at 31 March 2019**	**Total Profit/(Loss) 2018-19**
	£000	**£000**	**£000**
The Christie Clinic LLP (TCPC)	37,442	35,813	12,941
The Christie Pathology Partnership LLP (CPP)	1,531	914	182
CPP Facilities LLP (CPPFAC)	1,788	457	219
Total	**40,761**	**37,184**	**13,342**

	2017-2018		
	Gross Assets As at 31 March 2018	Net Assets As at 31 March 2018	Total Profit/(Loss) 2018-19
	£000	£000	£000
The Christie Clinic LLP (TCPC)	53,353	51,446	11,178
The Christie Pathology Partnership LLP (CPP)	1,995	734	219
CPP Facilities LLP (CPPFAC)	1,961	238	401
Total	57,309	52,418	11,798

11.3 Investment assets

All of the Investments assets are held by The Christie Charitable Fund.

	Unrestricted	Endowment	Total 2018-2019	2017-2018
	£000	£000	£000	£000
Market value at 1 April	**0**	**517**	**517**	500
Less: disposals at carrying value	**0**	**(26)**	**(26)**	(40)
Add: acquisitions at cost	**2,700**	**18**	**2,718**	37
Movement in cash held as investment assets:	**0**	**14**	**14**	12
Arising from disposals, income received and distributions	**0**	**0**	**0**	0
Unrealised gain/ (loss) on revaluation	**(1,850)**	**15**	**(1,835)**	8
Market value at 31 March	**850**	**538**	**1,388**	517
Unrealised gain/ (loss) on revaluation as above	**(1,850)**	**15**	**(1,835)**	8
Realised gain / (loss) on disposal	**0**	**(6)**	**(6)**	0
Total gain/(loss) on revaluation and disposal of investment assets	**(1,850)**	**9**	**(1,841)**	8

Analysis of non current asset investments

Market value at 31 March		Unrestricted	Endowment	2018-2019 Total	2017-2018 Total
		£000	£000	£000	£000
Investments listed on Stock Exchange		**0**	**470**	**470**	463
Cash held as part of the investment portfolio		**0**	**68**	**68**	54
Investment property	11.4	**850**	**0**	**850**	0
		850	**538**	**1,388**	517

The non current asset investments held at 31 March 2019 related to the endowment funds which were all invested in the UK.

The investment portfolio is managed by Castlefield Partners Limited and consists of unit trusts, open ended investment company funds, exchange traded funds and gilts. Those which exceed 5% of the portfolio as at 31 March 2019 or 31 March 2018 are:

	2018-2019	2017-2018
Premier Portfolio Conbrio UK Opps Charity	**52%**	51%
I Shares III FTSE UK Gilts	**6%**	6%
Premier Portfolio Conbrio Managed Multi Asset	**0%**	6%
Powershares Global FTSE RAFI US	**7%**	6%

11.4 Investment Property

	Group	NHS Foundation Trust	Group	NHS Foundation Trust
	2018-2019	2018-2019	2017-2018	2017-2018
	£000	£000	£000	£000
At 1 April 2018	**0**	**0**	0	0
Additions	**2,700**	**0**	0	0
Fair value losses (impairment)	**(1,850)**	**0**	0	0
Total	**850**	**0**	0	0

The Charity purchased an investment property in January 2019. Investment properties are measured at their fair value as at the balance sheet date. The first professional valuation of investment properties took place in April 2019 and the fair value of the assets is reflected in these statements. The purchase price of the investment property reflected the value of the building and surrounding land, as well as the going concern value of the business operating on the premises prior to the purchase. This business ceased operating once the property was purchased and so the property has been valued solely on the fair value of the building and land in its current condition and without taking into account any future income flows arising from the use of the asset. As such, an impairment of £1.85m appears as an item of expenditure in these statements.

12. Inventories

Inventories	Group 2018-2019 £000	NHS Foundation Trust 2018-2019 £000	Group 2017-2018 £000	NHS Foundation Trust 2017-2018 £000
Raw materials and Consumables	**2,567**	**537**	2,511	578
Work in progress	**0**	**0**	0	0
Finished goods	**0**	**0**	0	0
Total	**2,567**	**537**	2,511	578
Inventories recognised in expenses	**32,340**	**3,894**	13,361	4,179
Write down of inventories recognised as an expense	**0**	**0**	0	0
Reversal of any write down of inventories resulting in a reduction of recognised expenses	**0**	**0**	0	0
Total	**32,340**	**3,894**	13,361	4,179

Inventories include raw materials and consumables held by The Christie Pharmacy Limited.

13. Trade and Other Receivables and Financial Assets

13.1 Trade and Other Receivables

	Group			
	Current		Non-current	
	2018-2019	2017-2018	**2018-2019**	2017-2018
	£000	£000	**£000**	£000
NHS contract receivables*	**13,319**		**0**	0
Non- NHS contract receivables*	**6,496**		**0**	0
NHS contract receivables not yet invoiced*	**5,437**		**0**	0
NHS contract receivables not yet invoiced - PSF**	**25,195**		**0**	0
Non-NHS contract receivables not yet invoiced*	**1,705**		**0**	0
Contract assets*	**0**		**0**	0
Trade receivables - NHS		14,792	**0**	0
Trade receivables - related parties		1,246	**0**	0
Trade receivables - non-NHS		4,411	**0**	0
Accrued income			**0**	0
Sustainability and Transformation Fund income		32,926	**0**	0
Insurance claims		16,400	**0**	0
Other accrued income		6,828	**0**	0
Provision for impairment of receivables	**(303)**	(33)	**0**	0
Prepayments	**2,652**	2,353	**0**	0
PDC dividend refund accrual	**777**	282	**0**	0
VAT receivable***	**1,139**	1,539	**0**	0
Charitable fund receivables	**799**	548	**0**	0
Other receivables	**832**	3	**0**	0
Trade and other receivables	**58,048**	81,295	**0**	0

	NHS Foundation Trust			
	Current		Non-current	
	2018-2019	2017-2018	**2018-2019**	2017-2018
	£000	£000	**£000**	£000
NHS contract receivables*	**13,327**		**0**	0
Non- NHS contract receivables*	**6,487**		**0**	0
NHS contract receivables not yet invoiced*	**5,435**		**0**	0
NHS contract receivables not yet invoiced - PSF**	**25,195**		**0**	0
Non-NHS contract receivables not yet invoiced*	**1,715**		**0**	
Contract assets*	**0**		**0**	
Trade receivables - NHS		14,792		0
Trade receivables - related parties		1,246		0
Trade receivables - non-NHS		6,336		0
Accrued income				
Sustainability and Transformation Fund income		32,926		
Insurance claims		16,400		
Other accrued income		6,808		
Provision for impairment of receivables	**(303)**	(33)	**0**	0
Prepayments	**2,637**	2,353	**0**	0
PDC dividend refund accrual	**777**	282	**0**	0
VAT receivable	**280**	321	**0**	0
Charitable fund receivables	**3,407**	7,035	**0**	0
Other receivables****	**1,231**	392	**1,119**	1,515
Trade and other receivables	**60,187**	88,858	**1,119**	1,515

***** IFRS 15 requires that contract assets and contract receivables are separately disclosed. A contract asset is where the right to consideration is dependent on a factor other than the passage of time or an administrative process. A contract receivable is where the right to consideration is unconditional. Comparatives have not been re-stated.

** Provider Sustainability Fund (PSF) income is funding from NHS England. In 2017-18, this is disclosed as Sustainability and Transformation Fund income.

***VAT receivable includes £858k (2017-18 £1,217k) VAT owing to The Christie Pharmacy Limited.

****Other receivables include due payments that relate to a £2,000k loan made to The Christie Pharmacy Limited. The loan was for initial drug stock purchases and was issued in January 2018, to be repaid monthly, with the final payment due December 2022. The interest rate is fixed at 1.56%. The balance at 31 March 2019 is £1,515k (31st March 2018 £1,904k).

13.2 Allowances for credit losses 2018-19

	Group	**Group**	**NHS Foundation Trust**	**NHS Foundation Trust**
	Receivables and contract assets	**All other receivables**	**Receivables and contract assets**	**All other receivables**
	2018-2019	**2018-2019**	**2018-2019**	**2018-2019**
	£000	**£000**	£000	£000
At 1 April 2018	**0**	**34**	**0**	**34**
Impact of IFRS 9 (and IFRS 15) implementation on 1 April 2018	**401**	**(34)**	**401**	**(34)**
New allowances arising				
Changes in existing allowances	**(95)**	**0**	**(95)**	**0**
Reversals of allowances	**(3)**	**0**	**(3)**	**0**
At 31 March 2019	**303**	**0**	**303**	**0**

13.3 Allowances for credit losses 2017-18

	Group	**NHS Foundation Trust**
	All other receivables	**All other receivables**
	2017-18	**2017-18**
	£000	£000
At 1 April 2017	22	22
New allowances arising	18	18
Reversals of allowances	(6)	(6)
At 31 March 2018	34	34

13.4 Other financial assets

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
Other financial assets at 31 March	**60**	**8**	57	8

The Trust invested £1,000k and The Christie Charitable Fund invested £6,500k in a term deposit account with Kaupthing Singer & Friedlander in 2008, prior to the bank being put into administration. Based on the Administrator's assessment in 2008-09 these assets were initially impaired to £500k and £3,250k respectively (50p in the £ recovery) at 31 March 2009.

The Administrator has since improved his assessment of the potential recovery and at 31 March 2019 this stood at £865k and £5,623k respectively (86.5p in the £ recovery). The total of declared and received dividends at 31 March 2019 amounts to £857k and £5,572k respectively (85.75p in the £).

The Administrator's assessment of the outstanding valuation yet to be received via dividends is £8k and £52k respectively. As at 31 March 2019 the Administrator has not declared any further dividends

14.1 Cash and cash equivalents

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
Balance at 1 April	**94,283**	**35,413**	87,646	29,067
Net change in the year	**63,795**	**68,505**	6,637	6,346
Balance at 31 March	**158,078**	**103,918**	94,283	35,413
Broken down into:				
Cash at commercial banks and in hand	**3,633**	**75**	3,425	203
Cash with the Government Banking Service	**124,445**	**73,843**	90,858	35,210
National Loans Fund	**30,000**	**30,000**		
Cash and Cash Equivalents as in Statement of Financial Position	**158,078**	**103,918**	94,283	35,413

14.2 Analysis of changes in net (debt)/ funds

	Group		
	1 April 2018	**Movement in year**	**31 March 2019**
	£000	**£000**	**£000**
Cash at bank and in hand	**94,283**	**63,795**	**158,078**
Debt due within one year	**(1,829)**	**(1,911)**	**(3,740)**
Debt due after one year	**(44,527)**	**(14,959)**	**(59,486)**
Total net funds	**47,927**	**46,925**	**94,852**

	NHS Foundation Trust		
	1 April 2018	**Movement in year**	**31 March 2019**
	£000	**£000**	**£000**
Cash at bank and in hand	**35,413**	**68,505**	**103,918**
Debt due within one year	**(1,829)**	**(1,911)**	**(3,740)**
Debt due after one year	**(44,527)**	**(14,959)**	**(59,486)**
Total net funds	**(10,943)**	**51,635**	**40,692**

14.3 Third party assets held by the Trust

The Christie NHS Foundation Trust held cash at bank and in hand of £nil at 31 March 2019 (£19,978 31 March 2018) which relate to monies held by the Foundation Trust on behalf of patients and other parties. This has been excluded from the cash and cash equivalents figures reported in the accounts.

15.1 Trade and other payables

	Group			
	Current		Non-current	
	2018-2019	2017-2018	**2018-2019**	2017-2018
	£000	£000	**£000**	£000
NHS payables revenue	**5,979**	3,573	**0**	0
Amounts due to related parties	**120**	383	**0**	0
Trade payables capital	**8,418**	10,678	**0**	0
Other payables	**10,578**	7,530	**0**	0
Other taxes payable	**70**	0	**0**	
Accruals	**3,925**	8,240	**0**	0
	29,090	30,404	**0**	0
				0
Taxes payable	**2,667**	2,490	**0**	0
				0
Total Trade and Other Payables	**31,757**	32,894	**0**	0

Other payables includes £1,786k (2017-18: £1,671k) outstanding pension contributions at 31 March 2019.

	NHS Foundation Trust			
	Current		Non-current	
	2018-2019	2017-2018	**2018-2019**	2017-2018
	£000	£000	**£000**	£000
NHS payables revenue	**5,979**	3,573	**0**	0
Amounts due to related parties	**120**	383	**0**	0
Trade payables capital	**8,418**	10,678	**0**	0
Other payables	**8,326**	8,189	**0**	0
Accruals	**3,448**	7,134	**0**	0
	26,290	29,957	**0**	0
Taxes payable	**2,647**	2,475	**0**	0
Total Trade and Other Payables	**28,937**	32,432	**0**	0

Other payables includes £1,779k (2017-18: £1,665k) outstanding pension contributions at 31 March 2019.

15.2 Other liabilities

	Group			
	Current		Non-current	
	2018-2019	2017-2018	**2018-2019**	2017-2018
	£000	£000	**£000**	£000
Deferred Income: contract liabilities (Research and Development)	**204**	694	**7,003**	8,635
Deferred Income: contract liabilities (Other)	**1,643**		**1,476**	
Deferred grants	**1,635**	1,385	**0**	0
Deferred income: other (non-IFRS 15)	**22**	16	**2,609**	1,936
Total Other Liabilities	**3,504**	2,095	**11,088**	10,571

	NHS Foundation Trust			
	Current		Non-current	
	2018-2019	2017-2018	**2018-2019**	2017-2018
	£000	£000	**£000**	£000
Deferred Income: contract liabilities (Research and Development)	**204**	694	**7,003**	8,635
Deferred Income: contract liabilities (Other)	**1,643**		**1,476**	
Deferred grants	**1,635**	1,385	**0**	0
Deferred income: Other (non-IFRS 15)	**22**	16	**2,609**	1,936
Total Other Liabilities	**3,504**	2,095	**11,088**	10,571

Non-current deferred income includes income related to research and development funds received to undertake clinical trials and other research projects which last in excess of one year and a 125 year lease of land to the University of Manchester on which the MCRC building is situated £2,609k (2017-18 £1,936k).
£694k of revenue included in the contract liability balance as at 1 April 2018 was recognised in 2018-19.

16. Borrowings

All Borrowings of The Christie NHS Foundation Trust Group are by The Christie NHS Foundation Trust. The Christie Charitable Fund does not have any Borrowings.

The Christie Pharmacy Limited has a £2m interest bearing loan from The Christie NHS Foundation Trust which is repayable over 5 years.

16.1 Borrowings

	Group			
	Current		Non-current	
	2018-2019	2017-2018	**2018-2019**	2017-2018
	£000	£000	**£000**	£000
Loan from ITFF	**936**	911	**12,797**	13,709
Loan from ITFF - Proton Beam Therapy Unit	**2,804**	771	**46,689**	30,818
Obligations Under PFI contracts	**0**	147	**0**	0
Total	**3,740**	1,829	**59,486**	44,527

Loans from Independent Trust Financing Facility (ITFF)

16.1.1 The Trust had an application for a £21m loan to support its investment in new buildings to improve patient access to services approved by the Foundation Trust Financing Facility.

Repayment of the loan principle commenced from 15 September 2011 on a bi-annual basis. The loan is charged at a fixed interest rate of 4.2% per annum. The final repayment date is 15 March 2034.

16.1.2 The Trust had an application for a £52.5m loan to support its investment in the Proton Beam Therapy Unit approved by the Independent Trust Financing Facility.

The Trust had drawn down £50.151m of the loan as at 31 March 2019. Repayment of the loan commenced in November 2018 and is on a bi-annual basis. The loan is charged at a fixed interest rate of 2.14% per annum.

16.2 Reconciliation of liabilities arising from financing activities

	Group		
	DHSC Loans	**PFI contract**	**Total**
	£000	**£000**	**£000**
Carrying value at 1 April 2018	46,209	147	46,356
Impact of implementing IFRS 9 on 1 April 2018	236	0	236
Cash movements:			
Financing cash flows - payments and receipts of principal	16,636	(147)	16,489
Financing cash flows - payements of interest	(1,315)	(6)	(1,321)
Non-cash movements:			
Interest charge arising in year	1,460	6	1,466
Carrying value at 31 March 2019	**63,226**	**0**	**63,226**

17. Provisions for liabilities and charges

All Provisions for liabilities and charges of The Christie NHS Foundation Trust Group are by The Christie NHS Foundation Trust. The Christie Charitable Fund and The Christie Pharmacy Limited do not have any Provisions.

	Group			
	Current		Non-current	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Pensions - ill health retirement	**26**	25	**488**	504
Pensions - early departure costs	**14**	14	**100**	106
Personal injury claims	**24**	47	**0**	0
Other	**460**	21	**48**	43
Total	**524**	107	**636**	653

	Pensions Ill health retirement	**Pensions relating to other staff**	**Personal injury claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2018	**529**	**120**	**47**	**64**	**760**
Change in discount rate	**(11)**	**(1)**			**(12)**
Arising during the year	**0**		**27**	**444**	**471**
Utilised during the year	**(20)**	**(12)**	**(34)**		**(66)**
Reversed unused			**(16)**		**(16)**
Unwinding of discount	**16**	**7**			**23**
At 31 March 2019	**514**	**114**	**24**	**508**	**1,160**
Expected timing of cash-flows:					
Not later than 1 year	**26**	**14**	**24**	**460**	**524**
Later than 1 year not later than 5 years	**103**	**47**		**48**	**198**
Later than 5 years	**385**	**53**			**438**
	514	**114**	**24**	**508**	**1,160**

The above provision for personal injury is based upon information supplied by the NHS Litigation Authority. The associated contingent liability is shown under note 18.1.

Other provisions are the cost of pseudomyxoma peritonei complications of £70k and a VAT provision for £436k. The pseudomyxoma peritonei provision is based on the average cost of complications per operation over the preceding 3 years, linked to the number of operations undertaken within a 3 year period. The VAT provision is an estimate of VAT due to HMRC as a result of changes in NHS VAT guidance and an ongoing review by HMRC.

£6,668k is included in the provisions of the NHS Litigation Authority as at 31 March 2019 in respect of the clinical negligence liabilities of the Trust (£6,689k at 31 March 2018).

18. Contingencies at 31 March

18.1 Contingent Liabilities

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
Personal injury claim	**(17)**	**(17)**	(20)	(20)
Indemnities	**(184)**	**0**	(159)	0
	(201)	**(17)**	(179)	(20)

The personal injury claims liability is based upon information supplied by the NHS Litigation Authority.

For the Indemnities liability, The Christie Charitable Fund has a policy of accepting unclaimed legacy funds whilst offering indemnities to Solicitors for these funds. The repayment of these funds is classified as possible and not probable and therefore a contingent liability is recognised for all gifts where an indemnity is given. These are held for five years from the date of the gift.

18.2 Contingent Assets

The Group has no contingent assets at the balance sheet date.

19. Commitments

19.1 Capital commitments

During the year, the Trust completed the major investment relating to the construction and equipping of the new Proton Beam Therapy centre at Withington, with a consequential significant reduction in capital commitments. The Trust still has contractual arrangements for the purchase of high value medical treatment and research equipment and has a contractual commitment to demolish a building. As at 31 March 2019 the capital commitments contracted amounted to £0.6m (£30.9m contracted at 31 March 2018).

19.2 Other financial commitments

The Trust has entered into contractual arrangements with the University of Manchester regarding the Manchester Academic Health Science Centre Clinical Trial Unit (MAHSC-CTU), a unit dedicated to data processing of grant-funded studies. The unit was set up by The Christie in 2010 to provide a service both for The Christie and the North-West. In the year, it was decided that the unit would transfer over to the University of Manchester with the Trust agreeing to fund the trials already in operation as part of the handover agreement. As at 31 March 2019 the contracted commitment in relation to the MAHSC-CTU is £1.6m.

20. Lease obligations

20.1 Finance lease obligations

All Finance Leases held by The Christie NHS Foundation Trust Group are held by The Christie NHS Foundation Trust. The Christie Charitable Fund and The Christe Pharmacy Limited do not hold any Finance Leases.

Amounts payable under finance leases:

	Group			
	Minimum lease payments		Present value of minimum lease payments	
	31 March 2019 £000	31 March 2018 £000	**31 March 2019 £000**	31 March 2018 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**0**	0
Present value of minimum lease payments	**0**	0	**0**	0
Included in:				
Current borrowings	**0**	0		
Non-current borrowings	**0**	0		
	0	0		

The Trust holds Finance leases for three buildings but all of these were paid in a single upfront payment and there are no annual ongoing payments. See note 10.1 for details of the leases.

20.2 Private Finance Initiative lease obligations

All PFI Assets held by The Christie NHS Foundation Trust Group are held by The Christie NHS Foundation Trust. The Christie Charitable Fund and The Christie Pharmacy Limited do not hold any PFI Assets.

Amounts payable under PFI leases:

	Group			
	Minimum lease payments		Present value of minimum lease payments	
	31 March 2019 £000	31 March 2018 £000	**31 March 2019 £000**	31 March 2018 £000
Within one year	**0**	154	**0**	147
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	(7)	**0**	0
Present value of minimum lease payments	**0**	147	**0**	147
Included in:				
Current borrowings	**0**	147		
Non-current borrowings	**0**	0		
	0	147		

The finance lease obligations relate to the following private finance initiative scheme;

PFI 1. Provision of an Energy Management Service

Contract Start date: February 2004
Contract End date: February 2019

20.3 The Trust is committed to make the following payments for the service element of on-SOFP PFI's obligations until the commitment expires:

	Group	
	31 March 2019 £000	31 March 2018 £000
	Total	Total
Not later than one year	**0**	1,388
Later than one year and not later than five years	**0**	0
Later than five years	**0**	0
	0	1,388

20.4 The Trust is committed to make the following total payments of on-SOFP PFI's obligations until the commitment expires:

	Group	
	31 March 2019 £000	31 March 2018 £000
	Total	Total
Not later than one year	**0**	1,542
Later than one year and not later than five years	**0**	0
Later than five years	**0**	0
	0	1,542

21. Losses and special payments

	Group			
	2018-2019 Number of Cases	**2018-2019 Amount £000**	2017-2018 Number of Cases	2017-2018 Amount £000
Bad Debts	**59**	**9**	11	3
Stores losses - pharmaceuticals	**2**	**7**	1	9
Stores losses - other	**0**	**0**	1	0
Ex gratia payments - staff/patients loss of personal effects	**2**	**1**	2	1
Insurance Excess	**0**	**0**	3	60
	63	**17**	**18**	73

22. Related Party Transactions

The Christie NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with The Christie NHS Foundation Trust, The Christie Pharmacy Limited or The Christie Charitable Fund. See note 6.3 for details of Directors' remuneration and other benefits.

The Department of Health is regarded as a related party. During the year The Christie NHS Foundation Trust Group has had a significant number of material transactions totalling £2.3m (2017-18: £1.9m) with the Department. In addition The Group had significant transactions (£1.5m and greater) with other entities for which the Department is regarded as the parent. These entities are listed below:

Mid Cheshire Hospitals NHS Foundation Trust
Manchester University NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Foundation Trust
East Cheshire NHS Trust
Health Education England
NHS Bolton CCG
NHS Bury CCG
NHS Eastern Cheshire CCG
NHS Manchester CCG
NHS Oldham CCG
NHS Salford CCG
NHS Stockport CCG
NHS Tameside and Glossop CCG
NHS Trafford CCG
NHS Wigan Borough CCG
Health Education England
NHS England - Core
NHS England - North East Specialised Commissioning Hub
NHS England - North West Specialised Commissioning Hub
NHS England - Central Specialised Commissioning Hub

Other bodies within the Whole Government Accounts (WGA) boundary the Group has had material transactions with are listed below:

	2018-2019 Receivables £000	**2018-2019 Payables £000**	2017-2018 Receivables £000	2017-2018 Payables £000
HM Revenue & Customs	**0**	**2,738**	1,626	2,490
NHS Pension Scheme	**0**	**0**	0	0
Welsh Health Bodies	**0**	**0**	331	0
NHS Blood & Transplant	**0**	**130**	13	133
National Loans Fund	**30,000**	**0**	0	0

	2018-2019 Income £000	**2018-2019 Expenditure £000**	2017-2018 Income £000	2017-2018 Expenditure £000
HM Revenue & Customs	**0**	**10,142**	0	9,314
NHS Pension Scheme	**0**	**12,583**	0	11,643
Welsh Health Bodies	**3,738**	**0**	3,018	0
NHS Blood & Transplant	**13**	**2,663**	13	2,637

The Group has had material transactions with the following joint ventures:

	2018-2019 Receivables £000	**2018-2019 Payables £000**	2017-2018 Receivables £000	2017-2018 Payables £000
The Christie Clinic LLP	**979**	**91**	279	131
The Christie Pathology Partnership LLP	**377**	**0**	392	8
CPP Facilities LLP	**202**	**0**	477	0

	2018-2019 Income £000	**2018-2019 Expenditure £000**	2017-2018 Income £000	2017-2018 Expenditure £000
The Christie Clinic LLP	**8,112**	**636**	5,914	661
The Christie Pathology Partnership LLP	**1,302**	**5,812**	1,230	5,129
CPP Facilities LLP	**1,427**	**3,024**	664	2,883

The Trust has had material transactions with the following:

	2018-2019 Receivables £000	**2018-2019 Payables £000**	2017-2018 Receivables £000	2017-2018 Payables £000
The Christie Pharmacy Limited	**0**	**0**	1,915	0
The Christie Charitable Fund	**4,286**	**0**	8,960	0

	2018-2019 Income £000	**2018-2019 Expenditure £000**	2017-2018 Income £000	2017-2018 Expenditure £000
The Christie Pharmacy Limited	**119**	**34,236**	28	9,562
The Christie Charitable Fund	**12,574**	**0**	13,245	0

23. Financial instruments

IFRS 9 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities. Under the NHS financial regime the service provider relationship that the Trust has with its commissioners and the way they are funded, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 9 mainly applies. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Market risk
Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. The Trust's transactions are almost all undertaken in sterling and so it is not exposed to foreign exchange risk. It holds no significant investments other than short-term bank deposits. Other than cash balance, the Trust's financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cash-flows are substantially independent of changes in market interest rates.

Liquidity risk
Liquidity risk is the possibility that the Trust might not have the funds available to meet it's commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities.

The Trust's net operating costs were incurred under annual service agreements primarily with NHS England, which are financed from resources voted annually by Parliament. The Trust has achieved a risk ratio for liquidity of 1 (lowest risk) as defined by NHS Improvement's compliance framework. This illustrates the liquidity risk to the Trust is low.

Interest-Rate Risk
All of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest, the Trust is not, therefore, exposed to significant interest-rate risk.

Foreign Currency Risk
The Trust has negligible foreign currency income or expenditure.

23.1 Fair value measurement of financial assets

Financial assets and financial liabilities measured at fair value in the Statement of Financial Position are grouped into three levels of a fair value hierarchy. The three levels are defined based on the observability of significant inputs to the measurement as follows:

Level 1: quoted prices (unadjusted) in active markets for identical assets or liabilities

Level 2: inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly

Level 3: unobservable inputs for the asset of liability

The following table shows the levels within the hierarchy of financial assets measured at fair value on a recurring basis:

As at 31 March 2019	**Level 1**	**Level 2**	**Level 3**	**Total**
	£000	**£000**	**£000**	**£000**
Financial assets				
Investments listed on the Stock Exchange - note 11.3	**470**	**0**	**0**	**470**
Investments in Joint Ventures - note 11.1	**0**	**0**	**25,362**	**25,362**
Other financial assets - note 13.4	**0**	**0**	**60**	**60**

As at 31 March 2018	**Level 1**	**Level 2**	**Level 3**	**Total**
	£000	**£000**	**£000**	**£000**
Financial assets				
Investments listed on the Stock Exchange - note 11.3	463	0	0	463
Investments in Joint Ventures - note 11.1	0	0	26,641	26,641
Other financial assets - note 13.4	0	0	57	57

The level 3 valuation for investments in joint ventures is recognised at cost the carrying amount increased or decreased to recognise The Christie's share of its profit or loss.
The level 3 valuation for other financial assets is based on the Administrator's assessment of potential recovery.

23.2 Fair value measurement of non financial assets

The following table shows the levels within the hierarchy of non-financial assets measured as detailed in note 1.4.2:

As at 31 March 2019	**Level 1**	**Level 2**	**Level 3**	**Total**
	£000	**£000**	**£000**	**£000**
Investment property - note 11.4	**0**	**850**	**0**	**850**

As at 31 March 2018	**Level 1**	**Level 2**	**Level 3**	**Total**
	£000	**£000**	**£000**	**£000**
Investment property - note 11.4	0	0	0	0

23.3 Financial Assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses. There is no material difference requiring disclosure.

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
NHS receivables	**43,951**	43,948	53,900	53,900
Non-NHS receivables	**9,530**	8,744	22,674	31,613
Other financial assets	**0**	1,515	0	1,904
Cash at bank and in hand	**158,078**	103,918	94,283	35,413
Other investments	**538**	0	517	0
Current assets	**60**	8	57	8
Total at 31 March 2019	**212,157**	**158,133**	171,431	122,838

Financial assets are stated at amortised cost.

23.4 Financial Liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses. There is no material difference requiring disclosure.

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
NHS payables	**5,977**	**5,977**	3,573	3,573
Non-NHS payables	**23,026**	**20,331**	29,320	31,058
Borrowings - loans from the Department of Health and Social Care	**63,226**	**63,226**	46,209	46,209
Private Finance Initiative and finance lease obligations	**0**	**0**	147	147
Total at 31 March	**92,229**	**89,534**	79,249	80,987

Financial liabilities are stated at amortised cost.

23.5 Maturity of financial liabilities

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
In one year or less	**32,743**	**30,048**	34,723	36,461
In more than one year but not more than five years	**14,960**	**14,960**	6,730	6,730
In more than five years	**44,526**	**44,526**	37,796	37,796
Total	**92,229**	**89,534**	79,249	80,987

24. Public Dividend Capital

	Group	**NHS Foundation Trust**	Group	NHS Foundation Trust
	2018-2019	**2018-2019**	2017-2018	2017-2018
	£000	**£000**	£000	£000
Public dividend capital at start of year	**141,966**	**141,966**	126,746	126,746
New public dividend capital received	**968**	**968**	15,220	15,220
	142,934	**142,934**	141,966	141,966

25. Prior Year Adjustments

There are no prior year adjustments relating to the year.

26. Events after the reporting year

There were no post balance sheet events requiring disclosure.

27. Charity reserves

	31 March 2019	31 March 2018
	£000	£000
Endowment funds	**541**	519
Unrestricted funds	**49,747**	51,264
Restricted funds	**964**	0
	51,252	51,783

27.1 Endowment funds

	Balance 1 April 2018	**Incoming Resources**	**Resources Expended**	**Transfers**	**Gains and Losses**	**Balance 31 March 2019**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Edith and Hiram Tagg and Samuel Fidler Gregson Memorial Fund	**517**	**8**	**(2)**	**0**	**16**	**539**
Minor Legacies	**2**	**0**	**0**	**0**	**0**	**2**
Total	**519**	**8**	**(2)**	**0**	**16**	**541**

The purpose of the Edith and Hiram Tagg and Samuel Fidler Gregson endowment fund is to benefit children and elderly patients at the Christie Hospital.

The terms of the minor legacies were for the capital of £2,000 to be invested and the income applied for the general purposes of the charity.

27.2 Restricted funds

	Balance 1 April 2018	**Incoming Resources**	**Resources Expended**	**Transfers**	**Gains and Losses**	**Balance 31 March 2019**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Cancer appeal fund	**0**	**481**	**(481)**	**0**	**0**	**0**
General research	**0**	**980**	**0**	**(300)**	**0**	**680**
Medical equipment	**0**	**0**	**(16)**	**300**	**0**	**284**
Total	**0**	**1,461**	**(497)**	**0**	**0**	**964**

27.2 Unrestricted funds

	Balance 1 April 2018	**Incoming Resources**	**Resources Expended**	**Transfers**	**Gains and Losses**	**Balance 31 March 2019**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Cancer appeal fund	**30,407**	9,897	(9,575)	238	(1,850)	**29,117**
General research	**4,584**	426	(477)	107	0	**4,640**
GI DOG research	**1,197**	179	(242)	(50)	0	**1,084**
GU DOG research	**1,588**	39	(157)	1	0	**1,471**
Leukaemia research	**1,032**	23	(65)	(69)	0	**921**
Medical equipment fund	**1,460**	143	(7)	(282)	0	**1,314**
Melanoma and kidney research	**1,506**	85	(120)	0	0	**1,471**
Paediatric oncology unit	**1,561**	402	(388)	0	0	**1,575**
Surgical Research	**933**	0	(25)	(839)	0	**69**
Lymphoma Research	**894**	0	0	(447)	0	**447**
Adult Leukaemia Unit	**1,147**	127	(215)	0	0	**1,059**
Medical Oncology Research	**826**	0	(43)	0	0	**783**
Other	**4,129**	1,092	(761)	1,341	(5)	**5,796**
	51,264	**12,413**	**(12,075)**	**0**	**(1,855)**	**49,747**
Total funds	**51,783**	**13,882**	**(12,574)**	**0**	**(1,839)**	**51,252**

The movements on the larger funds (balance over £750,000 at the beginning or close of the year) are disclosed above.

Transfers between funds relate to grant applications approved by the Charitable Fund Committee where funds are requested from different unrestricted funds.

The fund names are self-explanatory in most cases but further information is given below:-

The Cancer Appeal Fund is the general fund for the charity. The other funds are designated funds. In accordance with the guidance of the Charity Commission, the charity uses designated funds to acknowledge general provisions for expenditure and future potential liabilities where these do not constitute current obligations under FRS12.

28. The Christie Charitable Fund

The Christie Charitable Fund statutory accounts are prepared in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on Financial Reporting Standards (FRS 102).

The Trustees Report and Audited Accounts for the Christie Charitable Fund will be available from 31 August 2019 and can be obtained from the Finance Department on 0161 446 8091 or via the Charity Commission website at www.charity-commission.gov.uk.

The Statement of Financial Activities and Balance Sheet for The Christie Charitable Fund presented in notes 28.1 and 28.2 have been prepared on the above basis and then necessary adjustments made for consolidation purposes.

28.1 Statement of Financial Activities for the year ended 31 March 2019

	Restricted Funds £000	Unrestricted Funds £000	Endowment Funds £000	**2018-19 Total £000**	2017-18 Total £000
Incoming resources					
Income and endowments from:					
Donations and legacies	1,461	12,014	0	**13,475**	15,270
Other trading activities	0	77	0	**77**	20
Investments	0	326	6	**332**	149
Total incoming resources	**1,461**	**12,417**	**6**	**13,884**	15,439
Expenditure on:					
Raising funds		2,675		**2,675**	2,653
Charitable activities					
Clinical care	0	280		**280**	303
Research	0	2,556		**2,556**	2,097
Purchase of new equipment	16	199		**215**	185
New buildings, refurbishment and major projects	481	4,050		**4,531**	2,910
Other including staff and patient welfare	0	2,317		**2,317**	5,143
Subtotal expenditure on charitable activities	**497**	**9,402**	**0**	**9,899**	10,638
Total expenditure	**497**	**12,077**	**0**	**12,574**	13,291
Net gains / (losses) on investments	0	(1,857)	16	**(1,841)**	24
Net income / (expenditure)	964	(1,517)	22	**(531)**	2,172
Transfers between funds				**0**	0
Net movement in funds	**964**	**(1,517)**	**22**	**(531)**	2,172
Reconciliation of funds:					
Total funds brought forward at 01 April 2018	0	51,264	519	**51,783**	49,611
Total funds carried forward at 31 March 2019	**964**	**49,747**	**541**	**51,252**	51,783

28. The Christie Charitable Fund (continued)

28.2 Balance Sheets as at 31 March 2019

	Restricted Funds	Unrestricted Funds	Endowment Funds	31 March 2019	31 March 2018
	£000	£000	£000	£000	£000
Fixed assets:					
Investments	**0**	**0**	**538**	**538**	517
Investment property	**0**	**850**	**0**	**850**	
Total Fixed assets	**0**	**850**	**538**	**1,388**	517
Current assets:					
Stocks	**0**	**21**		**21**	20
Debtors	**0**	**796**	**3**	**799**	548
Investments	**0**	**52**		**52**	49
Cash at bank and in hand	**964**	**51,665**	**2**	**52,631**	57,871
Total Current assets	**964**	**52,534**	**5**	**53,503**	58,488
Liabilities:					
Creditors: Amounts falling due within one year	**0**	**3,637**	**2**	**3,639**	7,222
Net Current assets	**964**	**48,897**	**3**	**49,864**	51,266
Total assets less current liabilities	**964**	**49,747**	**541**	**51,252**	51,783
Creditors: Amounts falling due after more than one year	**0**	**0**	**0**	**0**	0
Total Net assets	**964**	**49,747**	**541**	**51,252**	51,783
The Funds of the charity:					
Restiricted funds	**964**	**0**	**0**	**964**	
Endowment funds	**0**	**49,747**	**0**	**49,747**	519
Unrestricted funds	**0**	**0**	**541**	**541**	51,264
Total Charity funds	**964**	**49,747**	**541**	**51,252**	51,783

29. The Christie Pharmacy Limited

The Christie Pharmacy Limited statutory accounts are prepared in accordance with Financial Reporting Standards (FRS 102) for the period 23 October 2017 to 31 March 2019.
The Statement of Financial Position and the Statement of Comprehensive Income for The Christie Pharmacy Limited presented in notes 29.1 and 29.2 are based on the draft accounts.

29.1 The Christie Pharmacy Limited Statement of Financial Position as at 31 March 2019

	31 March 2019
	£000
Current assets:	
Inventories	**2,008**
Trade and other receivables	**518**
Cash and cash equivalents	**1,529**
Other receivables	**856**
Total current assets	**4,911**
Current Liabilities	
Trade and other payables	**(3,097)**
Loan from parent company	**(395)**
Total current liabilities	**(3,492)**
Net Current assets	**1,419**
Total assets less current liabilities	**1,419**
Non current liabilities	
Loan from parent company	**(1,119)**
Total Net assets	**300**
Equity	
Share holding	**0**
Income and Expenditure reserve	**300**
	300

29.2 The Christie Pharmacy Limited Statement of Comprehensive Income for the period to 31 March 2019

For consolidation purposes, a Statement of Comprehensive income has been prepared for the period 1 April 2018 to 31 March 2019.

	Draft Accounts 2018-19 £000	Period from 1 April 2018 - 31 March 2019 £000	Period from 23 October 2017 - 31 March 2018 £000
Turnover	**42,395**	32,833	9,562
Cost of sales	**(40,500)**	(31,311)	(9,189)
Gross profit	**1,895**	1,522	373
Administrative expenses	**(1,490)**	(1,171)	(319)
Operating profit	**405**	351	54
Interest payable	**(35)**	(27)	(8)
Corporation tax	**(70)**	(70)	0
Surplus/ (deficit) for the period	**300**	254	46

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