

Annual Plan

2009-2010

Full version – for publication



CONTENTS

INTRODUCTION	4
1 PAST YEAR'S PERFORMANCE	4
1.1 Chief executive's summary of the year	
1.2 Summary of financial performance 2007/08	
1.3 Review of other major financial or non-financial issues	
2 FUTURE BUSINESS PLANS	12
2.1 Overall vision	
2.2 Strategic overview	
3 OPERATING RESOURCES REQUIRED TO DELIVER SERVICES 2009/10 – 20011/12 ...18	
3.1 Planning process	
3.2 Impact of IFRS	
3.3 Key financial assumptions	
3.4 Phasing	
3.5 Investment and disposal strategy	
3.6 Financing and working capital strategy	
3.7 Summary of key assumptions	
4 RISK ANALYSIS	27
4.1 Governance risk	
4.2 Mandatory services risks	
4.3 Financial risk	
4.4 Risk of any other non-compliance with the terms of authorisation	
5 DECLARATIONS AND SELF CERTIFICATION	32
5.1 Self-certification	
5.2 Board statements	
6. MEMBERSHIP	34
6.1 Membership commentary	

Introduction

The Christie was approved as a Foundation Trust in April 2007. This annual plan outlines performance during our second year as a foundation trust and sets out our priorities for the coming year. It identifies the key risks to the delivery of the Plan and how we are addressing those risks.

1 Past year's performance

1.1 Chief executive's summary of the year

During 2008/09 we have continued to make significant progress in delivering against our three key objectives: improving clinical outcomes, developing networked services and enhancing our world-class research.

Over the last twelve months we have moved from business case to building with the start of construction work on our £72m capital programme designed to improve patient access to services across our network.

As well as building for future services we are pleased with the endorsements we have received for our existing services. We received an 'excellent' for quality of services and 'excellent' for use of resources from the Healthcare Commission in the annual Health Check results. We were also rated as the fourth best hospital in the country in the national inpatient survey. This was supported by over 90% of patients consistently rating our services as 'excellent' or 'good' in our monthly patient satisfaction surveys.

We are also aware that alongside the highest-quality care and treatment, our patients want a clean and safe environment. Our infection rates remained below expected levels this year and we passed in all areas our unannounced Hygiene Code inspection by the Healthcare Commission.

Our success has been achieved based on both attention to operational performance and the development of strong strategic relationships with, for example, commissioners, the University of Manchester, local authorities, the Department of Health and other cancer centres in the UK, Europe and the USA. Most importantly however it has been achieved by ensuring that at the heart of everything we do is our vision of enabling every patient to have the best cancer care available.

Caroline Shaw
Chief Executive

1.2 Summary of financial performance 2008/09

The trust has achieved a surplus of £4.6m after exceptional items for the financial year ending 31st March 2009. Total activity during 2008/09 is within 0.5% of plan and the outturn financial position reflects strong operating performance across all divisions of the organisation.

This position includes an £0.5m impairment of cash assets held on deposit in Kaupthing Singer and Friedlander (KSF) which was taken into administration on 8th October 2008. This revaluation is in line with the administrator's indication on 20th April 2009 as to the floor creditors can expect for future payout. The total deposit held is £1m.

The actual net surplus varies to the budgeted plan as a result of increased cost per case treatments, additional PET and private patient activity and higher than planned levels of efficiency and productivity in delivering total activity.

The reported position also includes a £3.61m impairment of our assets. This is the impact of a revaluation of our assets to reflect current market conditions for which there is no positive revaluation reserve.

Table 1 summarises income and expenditure performance for the 12 month period to 31st March 2008. Comments on key issues are set out in the sections below.

Table 1 – Summarised income and expenditure 2008/09

<i>£ million</i>	<u>08/09 plan</u>	<u>08/09 actual</u>	<u>variance</u>
<u>Income</u>			
Clinical income	119.50	121.13	1.63
Non-clinical income	32.75	38.41	5.66
Total income	152.25	159.54	7.29
<u>Expenditure</u>			
Pay costs	(73.77)	(78.28)	(4.51)
Drugs	(35.74)	(33.03)	2.71
Other Non-pay (excl. depn.)	(27.40)	(29.74)	(2.34)
Total expenditure	(136.91)	(141.05)	(4.14)
EBITDA	15.34	18.49	3.15
Depreciation	(8.66)	(9.46)	(0.80)
Dividend	(4.02)	(4.02)	0.00
Interest	0.90	0.81	(0.09)
I&E (before exceptionals)	3.56	5.82	2.26
Exceptional Items	0.00	(1.24)	(1.24)
Net I&E	3.56	4.58	1.02

1.2.1 Activity and income

Activity plans for 2008/09 were significantly higher than those included within our foundation trust application as commissioners purchased previous years outturn activity plus a realistic forecast growth in demand.

At the corporate level delivery of actual activity during 2008/09 was within 0.5% of plan.

Total patient income was £121.13m which is £1.63m greater than plan. This figure includes an additional growth in demand for radiotherapy treatments, which confirms the planning assumptions used for our new satellite radiotherapy centres. It also includes a 1.7% reduction in chemotherapy income as a result of a change in treatment guidelines for breast patients and a movement from an in patient to an outpatient setting for two drugs regimes.

Other income increases include the reclassification of distinction awards, the reclassification to show all recharges to other NHS bodies gross and an increase in funding from the donated asset reserve to fund impairments on donated assets.

1.2.2 Expenditure

Total Pay costs are £4.51m higher than planned as a result of the increased cost of national pay awards, early achievement of European working time directives, a reduction in the level of vacancies across all staff groups and the timing of appointments to key developments. Costs are also higher than planned as a consequence of the reporting gross of all inter NHS recharges identified above.

Drug expenditure is lower than plan because of variable cost savings linked to treatment activity levels and to efficiency from price savings and waste reduction.

Total non pay costs are £2.34m above plan as a consequence of higher than planned costs of energy, volume driven growth in some consumables, one off legal fees and costs from restructuring back office functions.

1.2.3 Depreciation

Total depreciation of £9.46m includes accelerated depreciation of £0.5m on existing assets to be demolished as part of service development included in major business cases and the impact of the revaluation of land and buildings.

1.2.4 Interest

Despite higher cash balances than anticipated in the annual plan we have achieved lower than planned levels of interest receivable as a result of the reduction in interest rates during the last two quarters of the year.

1.2.5 Exceptional items

The Trust has incurred a £3.61 impairment charge in 2008/09 as a result of a reduction in the valuation of land and buildings, to reflect current market conditions, for assets where there is insufficient positive revaluation reserve. This is partly matched by transfer from donated asset reserve.

1.2.6 Cash flow

The closing cash balance of £23.78m was £9.23m ahead of plan. The higher cash balances are directly linked to the improved EBITDA position in year and the profile of cash expenditure against capital projects. In line with our plans we have not needed to use our working capital facility in year.

A summary cash flow is included in table 2 below.

Table 2 – cash flow

<i>£ million</i>	<u>08/09 plan</u>	<u>08/09 actual</u>	<u>variance</u>
EBITDA	15.34	18.49	3.15
Less non cash I&E	(4.08)	(5.07)	(0.99)
Movement in working capital	0.00	0.17	0.17
Cash flow from operations	11.26	13.59	2.33
Capital expenditure	(15.09)	(17.03)	(1.94)
Cash receipts from asset sales	1.50	0.00	(1.50)
Cash flow before financing	(2.33)	(3.44)	(1.11)
Movement in LT creditors	0.00	0.91	0.91
Interest received	0.90	0.81	(0.09)
Public dividend received	0.00	1.22	1.22
Other grants received	0.00	8.30	8.30
Dividends paid	(4.02)	(4.02)	0.00
Net cash (outflow) / inflow	(5.45)	3.78	9.23

Note – The planned cash outflow from capital expenditure is shown net of planned grants received of £15.3m

1.2.7 Balance sheet

Fixed assets are £29.49m lower than planned levels for 31st March 2009 as a result of the revaluation and impairments of trust fixed assets (£20.6m decrease in value) and reduced in year expenditure of £6.3m on the major capital projects.

The trust did not dispose of any protected, mixed use or unprotected fixed assets during 2008/09.

A summary balance sheet is included in table 3 below.

Table 3 – balance sheet

<i>£ million</i>	<u>08/09 planned closing</u>	<u>08/09 actual closing</u>	<u>variance</u>
Total fixed assets	168.62	139.13	29.49
Current assets:			
Stock	1.14	1.34	(0.20)
Debtors	12.15	12.46	(0.31)
Cash	14.53	23.78	(9.25)
Total current assets	27.82	37.58	(9.76)
Total current liabilities	(21.58)	(23.97)	2.39
Total assets less current liabilities	6.24	13.61	(7.37)
Creditors greater than 1 year	(3.95)	(4.86)	0.91
Provisions for liabilities and charges	(1.03)	(0.26)	(0.77)
Total assets deployed	169.88	147.62	22.26
Taxpayers equity			
Public dividend capital	52.48	53.71	(1.23)
I&E reserve	10.84	12.43	(1.59)
Revaluation reserve	39.40	26.35	13.05
Donated asset reserve	67.16	55.13	12.03
Other reserve	0.0	0.0	0.0
Total taxpayers equity	169.88	147.62	22.26

1.2.8 Financial risk rating

We have maintained a financial risk rating of 4 or better during 2008/9 which is consistent with our self assessment submitted in our 2008/09 annual plan.

1.3 Review of other major financial or non-financial issues

Radiotherapy

Construction for our new radiotherapy centre at the Royal Oldham Hospital is underway and is due to open for patients in early 2010. In September 2008 a second Christie radiotherapy centre at Salford Royal hospital was approved by the board which is due to open by January 2011. The centre at Salford Royal will also be equipped to deliver stereotactic radiosurgery, a highly specialised neurosurgical technique, which will complement existing conventional neurosurgery offered by the Greater Manchester Neuroscience Centre at Salford Royal.

We have been successful in achieving support from our commissioners to provide a high dose rate prostate brachytherapy service. We have also been successful in the award of three national survivorship testing projects from NHS Improvement.

Chemotherapy

Building work started in spring 2009 on our new £35 million patient treatment centre at our main site in Withington. This will be home to the largest early clinical trials unit in the world, an expanded chemotherapy department and a new private patients unit. Over the last 12 months staff, patients and governors have worked with the architects to finalise the design, which incorporates the latest cutting edge technology and natural materials to ensure the building achieves an excellent rating in terms of its environmental credentials.

The new design will mean we can integrate chemotherapy and clinical trials to bring greater benefits to patients, including a speedier treatment process and improved environment. A lean review of the whole service, conducted during 2008 as part of the planning process, has identified £1.2m of productivity and efficiency gains that will be delivered by this project.

Surgical oncology

All network surgical service transfers are complete in line with Improving Outcomes Guidance. Operations being carried out on the Christie site are clinically appropriate, either because of the clinical need for a multidisciplinary team for complex level 2 surgery, or because of the availability of level 3 technologies on the Christie site.

Surgical developments on the Christie site are in line with National directives for investment in Specialist services and the Network Cancer Plan these include the introduction of Robotic and Laparoscopic Colorectal Cancer surgery. We have agreed further expansion of the number of pseudomyxoma patients treated, from the National commissioning group. We are awaiting a commissioner decision on the introduction of NICE approved cyto-reductive surgery

Research

This has been a very successful year with cancer research in Manchester ranked as the best in the UK in the Research Assessment Exercise, an independent review of research. Building on this we have continued to strengthen our research capacity further and over the last twelve months have successfully opened one of the first UK tissue banks in partnership with the University of Manchester – Patterson Institute and our Clinical Trials Unit has been successfully accredited by the MHRA.

We have also partnered with other teaching hospitals in Manchester and the University to form the Manchester Academic Health Science Centre which was one of only five applicants in March 2009 to be accredited by the Department of Health. These academic centres are planned to speed up the process of applying breakthroughs in research to the care of patients and it is envisaged that they will compete globally with established centres such as those in the United States, Canada, Singapore, Sweden, and the Netherlands.

Education

During 2008/09 we have taken the first steps towards our vision of establishing a Christie School of Oncology. We have appointed our first Director of Education, restructured to integrate all educational services within an established education directorate structure and the board of directors has approved a ten year education strategy. As a first milestone in this strategy the last year has seen the implementation of a highly successful medical undergraduate oncology programme for final year students, which culminated in almost 400 medical undergraduates receiving oncology training and education at The Christie.

Service performance

We have achieved the required performance for the introduction of 18 week referral to treatment targets for the three months in quarter 4. Measures that we have put in place to manage these patients have proved successful and will be continued for 2009/10. We have also achieved the required target threshold for expanded cancer waiting times for 31 day subsequent treatment patients. We are confident that we will be able to continue to do this throughout 2009/10. Following DH changes required in measuring cancer waiting times from 1st January 2009, we have continued to achieve a comparative 62 day performance which when assessed using the DH impact assessment, or the National Cancer Directors methodology is comparable to our 93% target for quarters 1-3 2008/09. This also includes the introduction of screening and consultant upgrade patients on the pathway. As we have no indication of target thresholds for this pathway for 2009/10, we plan to maintain this comparative performance.

Safety

Following the Healthcare Associated Infection Inspection on 11th and 12th February 2009 by the Healthcare Commission we received confirmation that we were rated as green against all of the duties of the hygiene code that we were assessed on. The summary report was published on the Healthcare Commission's website in March 2009.

In line with our commitment to improve safety we have reduced MRSA and Clostridium Difficile infection rates below our targets and have implemented MRSA screening for 100% of relevant elective patients.

Europe - Organisation of European Cancer Institutes

The OECI represents the leading cancer centres across Europe. The Christie was invited to join (the first UK centre to be given this accolade) in 2007 and was chosen to host the annual general meeting and conference in 2009. This conference brings together the leaders in cancer services across Europe. The OECI is implementing an accreditation programme for cancer services. The Christie is represented on the steering group by the Medical Director. Our membership of the OECI and associated activities is recognition of our status as a leading cancer centre.

Charity

Our charity has continued to enable us to provide enhanced services and facilities to our patients over and above those that are affordable within NHS tariffs. In particular during 2008 as well as continuing to support a range of additional patient services they have invested in new facilities for haematology transplant patients and radio immunotherapy treatments.

Awards

During 2008/09 the excellence of our staff in education, research and clinical care has been recognised in the following awards:

- Highly commended for 'Acute Healthcare Organisation of the Year' award at the Health Service Journal awards. The Christie was the only hospital in the North to be highly commended by the Health Service Journal for its exceptional performance over the last financial year and implementing major new plans to develop patient services. The Christie was also shortlisted for the Improving health with NICE guidance award for its female fertility oncology project. This was a joint submission with the Greater Manchester and Cheshire Cancer Network.
- Steve Hill, procedure nursing specialist won the new NHS 247's 'Employee of the Month' award for December 2008. The national award follows Steve's Christie staff award for 'making a difference to patients' for setting up a new service for abdominal drainage as a day case procedure.
- Highly commended for 'Career Progression in Health and Social Care' for NICE North West Health and Social Care Adult Learners week 2008
- Christie Crew were winners at the BT Seen and Heard Awards
- Awarded silver for 'check yours' integrated campaign, silver for 'check yours' direct marketing campaign and bronze for 'don't be a cancer chancer' website at the IPA Best of Health Awards 2008
- Runner up as 'Star Trust' at the Stand up to the Mic awards

Governor appointments

During 2008/09 elections were required in five public areas - Bolton, Bury, Oldham, Tameside & Glossop and Vale Royal, Crewe & Nantwich and in the "registered medical practitioners" staff class.

The governors for the Oldham public area and the "registered medical practitioners" staff class were unopposed and were re-appointed. The governor for Bury stood for election and was re-appointed. New governors were appointed after elections in Bolton and Tameside & Glossop and unopposed in Vale Royal, Crewe & Nantwich.

In 2009 elections are due in five public areas – Macclesfield & Congleton, Rochdale, Salford, Stockport and Wigan and two staff classes – "other professional clinical staff" (the governor retired in January 2009) and "volunteers". Elections are also required in two additional public areas following the death of the governor for Vale Royal, Crewe & Nantwich and the resignation due to ill health of the governor for Oldham.

Elections will take place and the results will be announced in advance of the annual members' meeting which is scheduled for 26th September, 2009.

2 Future business plans

2.1 Overall vision

2.1.1. Vision statement

The Christie is committed to delivering top quality cancer care, accessible to all, alongside excellent education and world class research.

2.1.2 Formation

During the first quarter of 2008/09 we have updated our five year strategy in the light of our experience since authorisation, our updated assessment of the national and local market and the major business cases approved by the board of directors since October 2007. Included within this process was a decision to change the name of the organisation to better reflect the research and educational components of our business and the fact that we are operating from more than a single hospital site.

The updated strategy was widely consulted and incorporated the views of governors, staff, members, lead commissioners and partner organisations. In particular the document takes account of

- the new national standards, targets, and performance assessment framework
- the 2009-10 NHS Operating Framework.
- the Darzi report
- the cancer reform strategy
- the North West cancer plan
- the changes to the compliance framework for foundation trusts

A full copy of our refreshed five year strategy was presented to our public board meeting in May 2008

2.2 Strategic overview

We have set ourselves nine strategic objectives. These will be achieved through a series of priority projects which together constitute our annual corporate plan for achieving our vision.

Our strategic objectives for the next five years are:

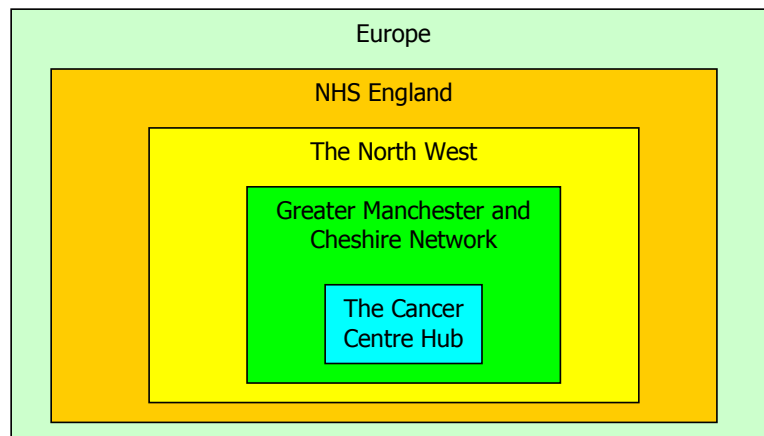
1. To improve clinical outcomes
2. To develop a network of services
3. To develop an ambitious programme of cancer research
4. To strengthen our image and reputation as a leading comprehensive cancer centre
5. To ensure the best possible patient experience
6. To be an excellent employer and recruit excellent employees
7. To demonstrate excellent clinical quality, and financial and operational management
8. To protect and enhance the environment and local community
9. To develop a nationally recognised programme of cancer education

Details of our 2009/10 milestones against these objectives are set out in our 2009/10 corporate plan which was presented in public to the board of directors in March 2009.

Our strategic objectives are supported by a series of key projects which together constitute a practical annual work programme. Each project contributes to several of the objectives. We have grouped our strategic projects into five categories according to whether they relate to developments at our flagship site, across the Greater Manchester and Cheshire Network, across the North West, across England or internationally.

Describing the projects in this way emphasises the different scope of activities across different geographies. It shows how we need the base of good quality services for our local population if we are to establish networks on a wider field. Equally it shows how establishing our reputation and activities at a national and international level enables us, by attracting additional resources and world leading scientists and clinicians, to provide a better service for our local population.

The different domains of our activities are shown in the diagram.



2.2.1 National and local challenges

There have been significant changes over the last twelve months in the external economic and political environment which have significantly impacted on the 2009/10 annual plan.

Nationally and internationally the affects of the global banking crisis have had a detrimental impact on the health of the public finances and our future projections in respect of growth, price inflation, interest rates and efficiency have all been revised to take account of this.

The 2009/10 operating framework confirmed the movement to the new healthcare resource groupings (HRG version 4) and revisions to the market forces factor. Both of these changes have had a significant effect on the price structure of our activity which has had to be mitigated in our financial planning. More details are contained in section 3.

As well as price changes there are a number of changes to the compliance and regulatory framework, including key access targets, the European Working Time Directive and registration with the Care Quality Commission, which have required us to reassess our revenue investments. Further details are included in section 3.

During 2008 we have seen an increase nationally in the level of participation by the private sector in non-surgical oncology. In particular one independent sector organisation has announced its intention to develop up to five private patient facilities across the country. Our forward plan acknowledges the risks and opportunities this creates.

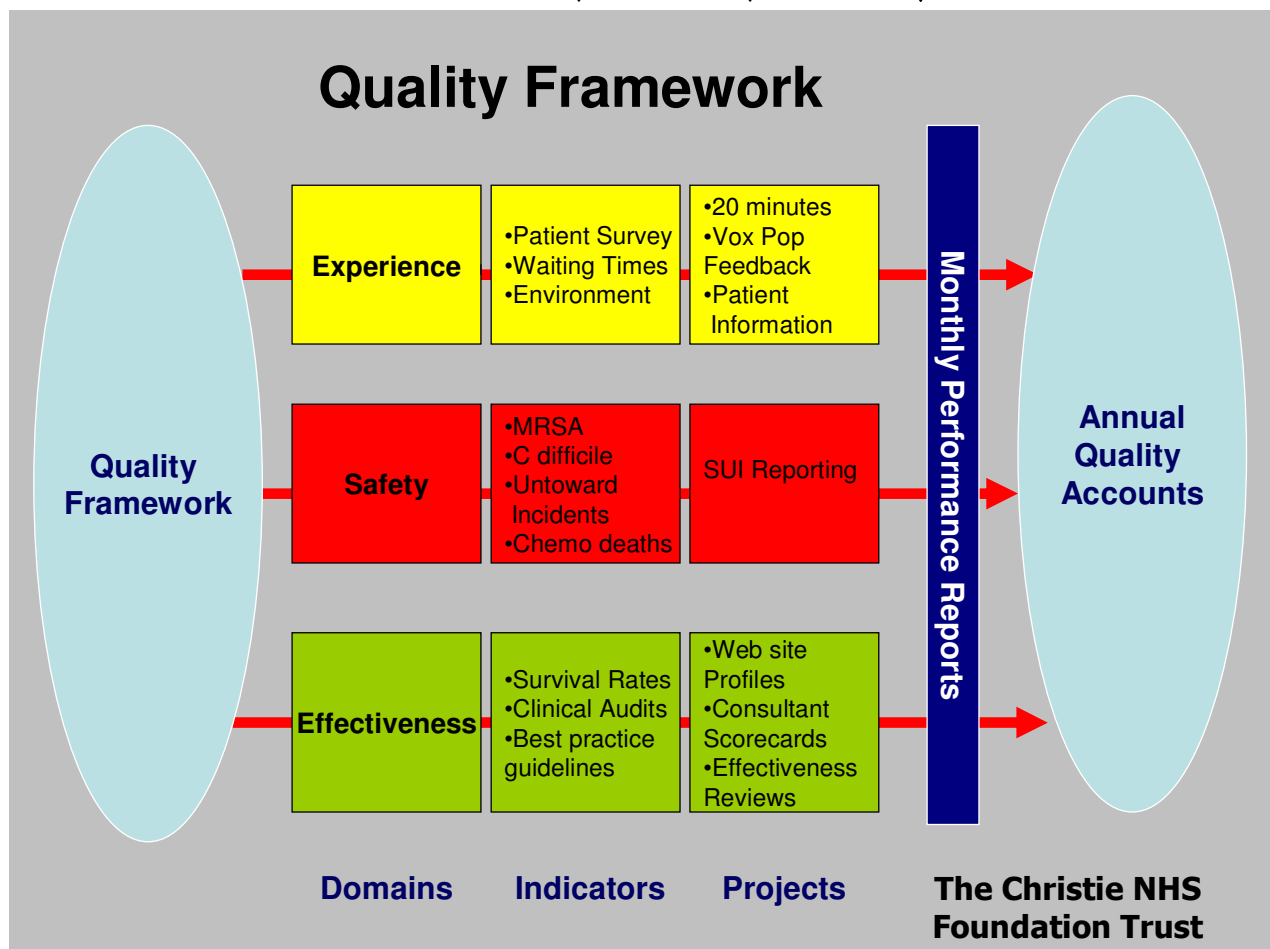
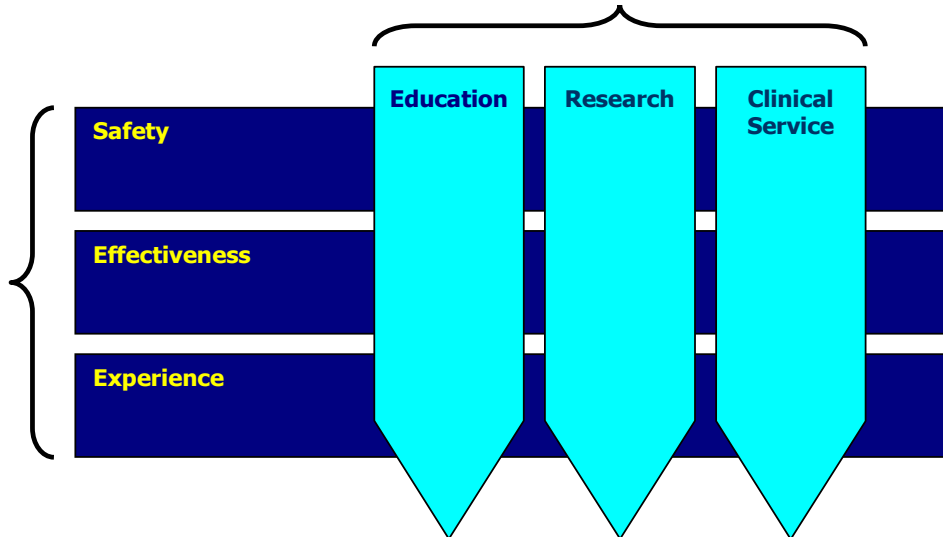
The economic recession has increased the importance of our role in the local community. Through our procurement and workforce strategies we are working to increase the contribution we make to the health of our population.

2.2.2 Quality

During 2008/09 the board of directors adopted a new strategic framework for quality. The way in which this covers our three areas of business (research, education and clinical services) and addresses the key Darzi themes of effectiveness, safety and experience are illustrated in the diagrams. The framework was developed in consultation with our clinicians and governors.

Quality Across The Christie's Activities

Components of Comprehensive Cancer Centre



The quality framework is the basis for our measurement of quality and will form the basis of our quality reporting in our annual report for 2008/09. It shows how the themes are linked to key projects and metrics. This will be developed further during 2009/10 leading to publication of quality accounts in 2010. The quality accounts will identify indicators to measure performance against the three Darzi themes.

Patient experience

To improve the patient experience for patients that come to The Christie by reducing waits on the day. We aim to achieve 85% of patients waiting no longer than 20 minutes between time of appointment and being seen by March 2010.

Patient safety

Our current MRSA and Clostridium difficile rates are below expected levels and very low for our group of patients. Maintaining low levels of infection is a top priority for the organisation. Our aim is to maintain very low levels of MRSA and Clostridium difficile infection and reduce these levels in line with agreed trajectories.

Clinical effectiveness

In order for us to develop our clinical outcome reporting measures and provide accurate and meaningful outcome data we need to ensure complete collection of staging data for our patients. We aim to increase the percentage of our patients with recorded (reported) stage in line with the National Cancer reform Strategy. The importance of achieving this target for future improvements in clinical outcomes has been acknowledged by our local commissioners and this target is specifically supported through their quality premium.

2.2.3 Key actions

Our annual plan has been prepared against the following objectives:

- To achieve a financial risk rating of not less than 4.
- To achieve all national standards.
- To achieve a green risk rating for governance.
- To comply with all other legal obligations e.g. hygiene code.
- To deliver the 2009/10 milestones in our five year strategy
- To recover all relevant activity and costs associated with the major business cases approved by the Board of Directors during 2007/08 and 2008/09.
- To deliver cost efficiencies that meet or exceed the targets set by the DOH

Key actions included within our 2009/10 annual corporate plan to achieve these objectives include:

- delivery to time and budget of our major capital investments designed to improve patient access to services,
- improving the patient experience by reducing waiting and ensuring all facilities utilised by The Christie conform to our set standards on quality and image,
- achieving formal accreditation as a European comprehensive cancer centre,
- improving the quality of comparative information on cancer services and outcomes
- continuing to develop the reporting and assurance framework available from the board to the ward
- developing proposals to work with others to secure additional value from research and private patient services within legislative constraints
- continuing our leadership of the Manchester versus cancer initiative which promotes measures to prevent cancer and public awareness of the symptoms of cancer and early detection and screening services.

2.2.4 Service development plans

Chemotherapy

Growth in chemotherapy treatments has been agreed with commissioners at 3% above 2008/09 outturn. This reflects the increasing treatment needs from both growth in new patient referrals and further treatment required as a result of improved outcomes. This growth will be managed in existing facilities and planned incremental workforce expansion and by delivering more of our activity off site in line with our plans.

Radiotherapy

Growth in radiotherapy treatments has been agreed with commissioners at 7%. This also reflects the increasing treatment needs from both growth in new patient referrals and the further treatment requirements that result from improved outcomes. This growth will be managed through the implementation of our satellite radiotherapy centre development in Oldham.

Both chemotherapy and radiotherapy growth reflects the implementation of our strategy and corporate objectives which have been consulted on and supported by our commissioners, Governors, members, stakeholders and the wider local health economy.

Details of the development of facilities for both chemotherapy and radiotherapy have been described in our review of major financial issues in section 1.3.

In addition to the growth in existing services we have also submitted proposals to commissioners to support key developments that we believe will improve outcomes for patients in a number of treatment areas. These proposals will be evaluated by commissioners during quarter 1:

Intensity Modulated Radiotherapy (IMRT)

This development will provide state of the art radiotherapy treatment as well as meeting the clinical need and NICE requirements for patients at The Christie and its satellite centres. This enables us to maintain our position as a leader in the UK for delivery of conformal radiotherapy and further our image and reputation as a leading comprehensive cancer centre.

Extension of robotic surgery

An additional 29 procedures have been requested on top of the 32 already commissioned in 2008/09. This enables an expansion of the cohort of patients able to benefit from the clinical skills and technology available at The Christie and offers significant benefit for patients requiring complex pelvic surgery in the future.

Psycho oncology

The current provision of psychological therapies will expand to cover additional sessions for psychologists and an accredited psychosexual counsellor to provide sensate focus therapy. It will also provide a more comprehensive programme for education and supervision to staff within the Trust.

We are not planning any material changes to mandatory services. Detailed income assumptions are set out in the following sections.

Summary of key service developments

Initiative	Activity included in 2009/10 contract	Financial and activity implications in annual plan 2009/10		Financial and activity implications excluded from annual plan 2009/10	
		Capital £	Revenue £	Activity	Revenue £
IMRT	0	267,500	0	1,008	214,000
Expansion of Robotic Surgery	0	0	0	49	211,000
Psycho oncology	0	0	0	276	70,000
Total	0	267,500	0	1,333	495,000

2.2.5 Summary of future business plans

Our assessment is that the strategic position from which we can deliver against these objectives remains strong:

- Financial projections indicate a risk rating for 2009/10 of four and compliance with the private patient cap and prudential borrowing limit
- Governance green – our projections are that we will achieve all key targets including 18 weeks
- The competitive situation remains consistent with the conclusions drawn 12 months ago
- National policy, in particular Darzi and the Cancer Reform Strategy have supported and strengthened the case for the short to medium developments identified in our original application
- The Trust has continued to work on strengthening its relationships with key stakeholders including PCTs, specialised commissioning groups, referring trusts, the University of Manchester and other key research partners.

3 Operating resources required to deliver services 2009/10 – 20011/12

3.1 Planning process

Planning for 2009/10 began in July 2008 with service line horizon scanning and prioritising key developments for submission to commissioners. Management board approved the internal prioritisation in October 2008. These proposals, along with supporting evidence, were presented to commissioners by senior clinicians at a seminar day in December 2008.

Projected growth in existing services has been discussed with commissioners since quarter 3, using six month outturn activity for 2008/09 and has been refreshed using January 2009 data.

As well as discussions on activity volume changes there have been detailed negotiations on the terms and conditions of the contract and the implications of moving to new health care resource groupings and a revised market forces factor through the monthly commissioning meeting and its working group since October 2008. In line with previous years these have been guided by the overarching principle of fair balance of risk and reward which is agreed annually with commissioners prior to the commencement of detailed negotiations.

Initial assessment of the impact of price changes on our budgets have been updated to account for details released in December 2008 in the operating framework and subsequent iterations of the national tariff and grouper.

Whilst the economic conditions and the uncertainties created by changes to key pricing structures have complicated this years planning process the opening contract for 2009/10 was signed by the national deadline and opening budgets for 2009/10 have been approved by the management board and board of directors during March committee meetings.

3.2 Impact of IFRS

The organisation has undertaken a detailed assessment of the impact of IFRS and the changes needed to internal management structures and processes supported by external experts who were commissioned in February 2008.

In common with all organisations there are a number of minor impacts related to the treatment of leases, accrued holiday and the treatment of fixed assets. This includes two small PFI schemes for energy supply and provision of the electronic patient record system.

The major implication of IFRS however arises from the potential accounting treatment of charitable funds. There is currently a one year exemption from the requirement for consolidation under IAS26. A review of the corporate trustee structure of our charity is being undertaken in line with the extended timetable agreed by the regulator to evaluate the impact of consolidation of charity accounts. External advice on the accounting treatment for consolidation is being sought in particular on the treatment of Capital assets purchased from the charity funds and the consequent impact on donated asset reserve.

The trust has included the impact of accrued holiday pay within the 2008/09 accounts and the two small PFI schemes are shown in the fixed asset section of the trusts balance sheet as at 31st March 2009. The impact on the trusts opening balance sheet as at 1st April 2009 and the in year revenue impact of these two schemes is set out below:

Table 4 – IFRS impact

£m	1st April 2009
Fixed Assets	
UK GAAP	139.13
PFI contracts	1.55
IFRS	<u>140.68</u>
Current Liabilities	
UK GAAP	(23.97)
PFI contracts	(0.40)
IFRS	<u>(24.37)</u>
Liabilities over 12 months	
UK GAAP	(5.12)
PFI contracts	(1.21)
IFRS	<u>(6.33)</u>
I & E Reserve	
UK GAAP	12.43
PFI contracts	(0.06)
IFRS	<u>12.37</u>
£m	2009/10
EBITDA	
UK GAAP	15.98
Medway PFI contract	0.25
Dalkia PFI contract	0.11
IFRS	<u>16.33</u>
£m	
Surplus	
UK GAAP	4.69
Medway PFI contract	(0.01)
Dalkia PFI contract	0.01
IFRS	<u>4.69</u>

3.3 Key financial assumptions

3.3.1 Income

The Trust's Financial Plan shows clinical income increasing from £111.48m in 2008/09 to £119.21m in 2009/10 and total turnover increasing to £157.10m. The income estimate is summarised in Table 5 and the key assumptions are set out below

Table 5 – Income

£m	Plan	Actual	Current Plan		
	2008/09	2008/09	2009/10	2010/11	2011/12
NHS Clinical	110.65	111.48	119.21	126.13	133.52
Non-NHS Clinical	8.85	9.65	9.09	10.20	12.32
Sub-Total	119.50	121.13	128.30	136.33	145.84
R&D	4.48	5.31	7.62	7.62	7.62
Education	3.09	3.68	3.17	3.20	3.24
Other	25.18	29.42	18.01	18.94	19.35
Total	152.25	159.54	157.10	166.09	176.06

Clinical income price movement

Whilst not mandated nationally we have secured a 1.7% inflationary uplift for non payment by results (PbR) activity such as outpatient chemotherapy and radiotherapy treatments. This provides parity with national tariff uplifts.

Changes to the market forces factor (MFF) element of tariff have had a significant impact on baseline revenues. The uplift applied to our activity under this mechanism has fallen from 14.96% to 9.04%, with a further reduction to 7.38% in 2010/11. The impact of this is to decrease revenues by £1m in 2009/10.

The introduction of a new set of healthcare resource groupings (HRG version4) has had a significant number of impacts on the price structure of baseline activity.

- inpatient chemotherapy delivery has moved from a local tariff to a national one
- top up premiums for undertaking specialist procedures have disappeared as a consequence of the increased complexity of the tariff structure under the new groupings
- radiology income streams have become unbundled from inpatient tariffs
- a new tariff has been introduced for a range of our outpatient procedures

In line with our guiding principle of fair balance of risk and reward we have sought with commissioners to mitigate the risk for the health economy from the limited time to quantify and plan for the consequences of MFF and grouper changes by restricting the unanticipated loss or gain to one percent of relevant contract value. This one year agreement includes fully implementing all of the proposed changes to allow both organisations to clearly size the impact and to make the necessary changes to reporting systems.

In addition the operating framework identified funding for the commissioning of quality and innovation (CQUIN) equivalent to 0.5% of contract income. To secure this funding we have an agreed set of indicators with the commissioners which will be monitored throughout the year. Paid in advance failure to achieve the indicators will result in the 0.5% funding being withdrawn.

For 2010/11 and 2011/12 we are anticipating price inflation at a lower level than current year. Forward plans assume a rate of 1.2%.

Clinical income volume variation

The contract with our NHS commissioners was signed on the 13th March and includes growth of £2m above 2008/09 planned levels.

For radiotherapy the plan reflects current activity levels plus the activity assumptions contained within the satellite business cases approved by the board of directors during 2007 and 2008. For surgical activity the plan reflects forecast outturn adjusted for previous commitments. Chemotherapy treatment activity has grown in 2008/09 but lower than forecast and the activity plan maintains the current target.

A range of additional developments including growth in HIPEC, HDR, robotic laparoscopic prostatectomy, new NICE drugs, SIRT, IMRT, robotic laparoscopic hysterectomies and the development of psycho – oncology service are still being considered as part of phase 2 decisions. We expect firm decisions on these schemes during June 2009. Successful developments will be incorporated into the service agreement via contract variations.

Private patient income for 2008/09 and forward estimates have been set in line with business case approved by the board of directors during 2007.

Education

The contract offer for 2009/10 has not yet been agreed. The proposed plan for 2009/10 assumes recurrent levels plus inflation at 1.7%.

R&D

Planned R&D income accounts for the final reduction in NHS levy funding and assumes that we can continue to attract equivalent replacement income as achieved during 2008/09. The increase on previous years reflects the transfer of the Cancer Research Network into the trusts research division

Other

Other baseline income consists of charitable contribution, commercial and non patient care income, and cancer network funding. This is reduced in 2009/10 to reflect the transfer of the cancer network to Oldham PCT that took place on 1st October 2008 and the movement of PET CT to clinical income. The plan assumes zero margin on charitable and inflation of 1.7% on commercial and non patient care income.

3.3.2 Expenditure

The Trust's Financial Plan, approved by the Board of Directors, sets out the forecast increases in expenditure required to deliver the agreed activity targets after taking account of service development, pay and price inflation and the cost of compliance with national targets and core standards.

The main planning assumptions can be summarised as follows:

- **Pay inflation and national pay reform costs: £2.57m**
 - 2.4% in line with national tariff expectation of national pay review body awards
 - Incremental costs of the Consultant Contract and Agenda for Change

- **Specific non-pay inflation: £1.10m**
 - Inflation 1% non pay excluding drugs
 - Inflation 0% drugs
 - Inflation 1.7% services from other NHS providers

- **Revenue targeted investment: £0.54m**
 - Achievement of national targets
 - Hygiene code
 - Patient safety
 - Data security
- **Cost of delivering growth: £1.58m**
 - Pay drugs and non pay costs to deliver agreed growth
- **Other operating costs: £2.22m**
 - Other cost pressures identified through the bottom up financial planning process
 - Increase premium of CNST £0.17m
 - one off costs linked primarily to the implementation of the major capital developments and action plans considered by the board during 2007/08.
 - One off costs to assist in delivering future CIP
- **Efficiency savings: -£6.00m**
 - Cost improvements as detailed in section 3.3.3 below
- **Depreciation / Dividend: -£2.96m**
 - Reduced depreciation costs due to reductions in asset values in 2008/09
 - One off costs in 2008/09 due to accelerated depreciation DCU £0.5m
 - Reduction in dividend payment due to depositing cash with PGO
- **One off costs incurred in 08/09: -£1.60m**
 - Cancer network transferred to Oldham PCT
 - Development of major business cases
 - Environmental improvements

The 2008/09 planned and actual expenditure and our expenditure estimates for 2009/10 to 2011/12 are set out in the table below:

Table 6 –Expenditure

£m	Plan	Actual	Current Plan		
	2008/09	2008/09	2009/10	2010/11	2011/12
Pay Costs	(73.77)	(78.28)	(74.67)	(78.64)	(82.69)
Drug Costs	(35.74)	(33.03)	(32.22)	(32.91)	(33.55)
Other costs	(27.40)	(29.74)	(33.88)	(35.43)	(38.11)
Sub-Total	(136.91)	(141.05)	(140.77)	(146.97)	(154.36)
Depreciation	(8.66)	(9.46)	(7.70)	(9.46)	(11.00)
Dividend	(4.02)	(4.02)	(2.73)	(3.14)	(3.31)
Interest	0.90	0.81	0.11	(0.40)	(0.63)
Exceptional Items	0.00	(1.24)	(1.33)	(1.33)	(1.83)
Total	(148.69)	(154.96)	(152.41)	(161.30)	(171.12)

3.3.3 Efficiency savings

The Trust's financial plan assumes delivery of a cost improvement programme in each year in order to offset the efficiency target embedded within tariff and address internal cost pressures. For 2009/10 the cost improvement programme requires planned productivity and efficiency savings of £3.5m plus a further £2.5m to manage risk associated with changes to the tariff structure and the market forces factor.

Expectations are that the greater efficiencies will be required in future years and this year's target is set in the context of a minimum of 11% over the next 3 years that will be required to address the consequence of the current financial climate.

As noted above we have secured transitional arrangements to manage the impact of tariff and MFF. The resources resulting from this mitigation will be used to manage in year risks and pump prime schemes that will result in future savings. This will enable us to have some future proofing for the difficult years ahead.

The Trust has a good track record of delivering cost improvements. During 2008/09 planned savings of over £3.6m have been delivered plus a further £1.3m to manage in year cost pressures linked to fuel price rises. Good progress has been made in planning and implementing schemes for 2009/10 and the main initiatives are shown in the table below:

Table 7 – Cost Improvement Programme

Theme	2009/10 £000's	2010/11 £000's	2011/12 £000's
Service redesign	1,261	841	946
Increased productivity	1,214	809	910
Improved procurement	1,786	1,191	1,339
Increased efficiency	1,161	774	871
Effective budgetary control	578	385	433
Total CIP in year	6,000	4,000	4,500
Pay	2,731	1,821	2,048
Non pay/productivity	3,268	2,179	2,451
Total CIP in year	6,000	4,000	4,500

3.3.4 Exceptional costs

Within the plan is an estimate for the potential impairments of new building values as projects are completed. The trust is currently assessing exceptional costs associated with moving to modern equivalent valuation for land and buildings.

3.3.5 Summary income and expenditure

The table below summarises the current income and expenditure plans of the Trust. This shows that a £4.6m surplus is forecast in 2009/10.

Table 8 – Summary income and expenditure

£ million	<u>09/10 plan</u>	<u>10/11 plan</u>	<u>11/12 plan</u>
Income	157.10	166.09	176.06
Expenditure	(140.77)	(146.97)	(154.36)
EBITDA	16.33	19.12	21.70
Depreciation	(7.70)	(9.46)	(11.00)
Dividend	(2.73)	(3.14)	(3.31)
Interest	0.11	(0.40)	(0.63)
I&E (before exceptionals)	6.02	6.13	6.76
Exceptional Items	(1.33)	(1.33)	(1.83)
Net I&E	4.69	4.80	4.94

3.4 Phasing

In line with 2008/09 for the purpose of monitoring performance on a monthly and quarterly basis the annual activity plan is phased based on working days which is the key driver for our activity profiles.

3.5 Investment and disposal strategy

Our capital investment strategy continues to be based on the following key drivers:

1. To deliver the expansion in off site radiotherapy capacity required to treat the projected growth in demand and to develop a network of local services in line with our strategic objectives
2. To deliver an expansion in clinical trials capacity that will enable us to be amongst the worlds leading researchers
3. To improve the quality and capacity of our chemotherapy facilities by investing in our main hospital site and at other sites across the network
4. To improve the quality and capacity of our private patient facilities
5. To improve patient access to the site by expanding car parking facilities on our main site
6. To renew the existing equipment and IT asset base in a planned way to ensure patient safety and maintain service continuity.
7. To invest in efficiency improvement and modernisation.
8. To deliver environmental improvements that put us in the upper quartile of healthcare providers.

For 2009/10 we are on plan to complete the building of the first radiotherapy satellite centre in the UK, an integrated patient treatment centre for clinical trial, chemotherapy and private patients and a 200 space multi story car park.

In line with our original integrated business plan we also planning to invest up to £3.8 in the retained estate to comply with statutory standards and ensure operational continuity. In addition the projected spend includes slippage of £0.5m against some schemes in 2008/09 which continue into 2009/10.

Our capital investment programme is to be funded by a mixture of our existing cash balances, generated specifically for this purpose over the last three years, a £21m loan approved by the from the foundation trust financing facility and support from our charity. Details of the planned programme are set out in table 9 below.

Table 9 – Capital Investment Programme

£m	Plan	Actual	Current Plan		
	2008/09	2008/09	2009/10	2010/11	2011/12
Radiotherapy satellite(o)	6.00	3.99	13.15	0.00	0.00
Radiotherapy satellite(s)	0.00	0.59	4.50	12.97	0.00
Oak Road development	13.00	3.99	16.43	14.50	0.00
Multi storey car park	2.90	1.83	1.79	0.00	0.00
Other business cases	4.30	2.49	2.82	4.50	2.60
Maintaining asset base	4.20	4.95	3.80	7.40	5.40
Total Capital Investment	30.40	17.84	42.49	39.37	8.00

£m	Plan	Actual	Current Plan		
	2008/09	2008/09	2009/10	2010/11	2011/12
Financed by:					
Trust cash	13.60	9.54	17.08	11.72	7.50
Loans	0.00	0.00	5.00	16.00	0.00
Capital receipts	1.50	0.00	0.00	0.00	0.00
Charitable funds	15.30	8.30	20.41	11.66	0.50
Total Capital Investment	30.40	17.84	42.49	39.37	8.00

3.6 Financing and working capital strategy

Our current target for average debtor days is 15 days. From 1st April 2009 it is proposed to measure debtor day performance against the following targets: -

- NHS bodies 10 days
- Private patients 30 days
- Miscellaneous debtors 30 days

Based on current average balances the target for total average debtor days will be 12 days.

During 2008/09 we have made changes to our procurement processes to ensure that we not only achieve a public sector payment target of 95% but that we achieve the target of 10 working days for all non public sector organisations.

Our financing plans for the capital investment strategy include utilising our existing cash balances and as a consequence we expect monthly cash balances to reduce during 2008/09. We expect to maintain sufficient cash balance to maintain a liquidity risk ratio of 4 and we would not require use of our working capital facility which has been maintained at £10m.

3.7 Summary of key assumptions

Our future financial plans are based on volume growth in turnover in line with agreed business cases and contracted commissioner activity plans. Price changes either reflect nationally agreed uplifts to NHS tariffs and pay costs, known cost pressures or are linked to relevant price indices.

Revenue investments are planned either to deliver activity growth, to ensure achievement of core and national standards or to manage risk; in particular to protect against contract penalties for non compliance.

Our 2009/10 planned surplus of £4.6m is set to ensure we achieve a financial risk rating of 4 and to generate sufficient cash surplus to meet future capital investment needs. This will be achieved by generating efficiencies of £6.0m (6.0%).

4 Risk analysis

4.1 Governance risk

4.1.1 Governance commentary

Our self assessment against key governance standards indicates a green rating. We have achieved all our 2008/09 targets, have set operational plans and made investments to ensure we continue to deliver all targets during 2009/10 and have declared compliance with Standards for Better Health. In particular we have noted the following:

Legality of constitution: There are no significant risks relating to the legality of The Christie NHS Foundation Trust.

Growing a representative membership: We are actively planning to expand our membership and have set a target to achieve 20,000 by March 2011. Through our governors we will ensure that this growth is representative of our population.

Appropriate board roles and structures: There are currently four non-executive board committees. These are the Remuneration Committee, Audit Committee, Governance Committee and Charitable Funds Committee. The Audit, Governance and Charitable Funds Committees address all aspects of assurance to the board. The board reviewed its committee structure at its February 2009 meeting as part of its annual self assessment and from the 1st April 2009 has approved the introduction of a finance and investment committee.

Service performance: We have achieved all known key targets during 2008/09. We have not been set a target threshold for the Cancer Waiting Time targets for quarter 4. Based on current trajectories and planned revenue investments we are planning to achieve all known national targets during 2009/10.

Clinical quality: the trust is not under a Healthcare Commission investigation or any other external investigation of significance to our Terms of Authorisation. Following our self assessment process we have declared compliance with the Standards for Better Health. In addition we have attained 4 green ratings against the duties assessed in the Healthcare Commission inspection to assess compliance with the hygiene code.

Risk and performance management: Our processes for the continued strong management and reporting of risk and performance have been further improved over the last 12 months. Our balanced scorecard approach has been reviewed and key performance indicators updated to reflect more demanding internal targets. We have made significant progress towards the implementation of a service line reporting approach including the development of a data warehouse and the introduction of initial monthly reports for service and clinical teams. Our monthly performance reports to the Board of Directors now include enhanced information and metrics on quality under the headings of clinical effectiveness, patient safety and patient experience.

Co-operation with NHS bodies and local authorities: During 2008/09 we have continued to recognise our role with both the health economy and our local community and have strengthened the board links to key organisations through regular meetings and improved reporting. We have continued our process of 306 degree stakeholder audits to measure how key partners perceive us and a detailed action plan has been approved for implementation during 2009/10.

4.1.2 Significant risks

The directors wish to state the following risks which relate to compliance with national targets and external assessments.

Risk	Potential impact	Likelihood	Mitigating action	Residual risk
Non compliance with key access targets (31 and 62 day cancer waiting times) because of unknown threshold for the new targets	4	4	Internal target set based on Department of Health modelling of the impact of the new method of measurement. Concerns and unexpected consequences outlined to the National Cancer Action Team / SHA / Monitor / HCC. Compilation of extenuating circumstances application to the HCC. Daily monitoring by internal delivery group; weekly monitoring by executive team; monthly report to trust CEOs. Management of network waiting list. Monitoring performance review of FT partner organisations. Timely referral from partner trust required	16
Fail to meet 18 week target	4	2	Ensuring that patients are being treated in a timely fashion once they are referred to the Christie; patient pathway trackers obtain the initial referral date; the 18 week status of all patients currently in the hospital has been identified. An 18 week PTL is in place and is being monitored.	8
Failure to comply with national monitoring of clinical outcomes	3	3	<p>The Somerset database is in place and will be rolled out. This is being overseen by peer review and the cancer centre services performance meeting. Submissions have been made to all national clinical audits that are due and clinical audit and information are collaborating to find the means to improve completeness of datasets dependent on information from other hospitals. A letter has been sent to the Chair of DAHNO regarding the means by which data submissions could be improved if some flexibility was employed regarding the core dataset.</p> <p>The impact of the new information structure under a Chief Informatics Officer and bringing together information assets will increase the available resources to further improve performance and this risk will reduce over the year (reduced from 16 09/10).</p>	6

4.1.3 HCAI targets

Fail to meet C Difficile target	4	3	Action plan in place monitored by the Director of Infection Prevention and Control. Action plan includes - use of antibiotics / leadership / focus on root causes & high risk areas and environment. Antibiotic pharmacist employed to lead on the action plan and monitor antibiotic prescribing. Audits of prescribing. Active surveillance and root cause analysis for every new case. Increased level of cleaning. Weekly report to trust executive on new infections. Regular environmental audits with results reported to divisions. Weekly antimicrobial meetings.	8
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Target		Q1	Q2	Q3	Q4
MRSA	2008/09 target	3	3	3	3
	2008/09 actual	1	1	1	1
	2009/10 target	3	3	2	2
Clostridium difficile	2008/09 target	27	27	27	27
	2008/09 actual	13	24	17	14
	2009/10 target	15	15	15	15

4.2 Mandatory services risks

4.2.1 Mandatory services

The trust is planning no changes to the mandatory services as set out in our Terms of Authorisation.

4.2.2 Significant risks

The directors wish to state the following risks which relate to our key clinical mandatory service delivery

Risk	Potential impact	Likelihood	Mitigating action	Residual risk
Technical failure (serious untoward incident) or management failure (missed target) within clinical services provided (Radiotherapy, Nuclear Medicine and Medical Engineering)	5	3	Rigorous application of documented procedures particularly in relation fitness to practice as recorded in training records. Prioritisation of work to minimise impact on safety	5
Major failure in radiopharmaceutical production	4	3	Trained and experienced staff working to set procedures	8

4.3 Financial risk

4.3.1 Commentary on financial risk rating

Self assessment of our financial plan indicates achievement of a financial risk rating of 4.30 during 2009/10. Based on the current financial plan the model also indicates that the trust would maintain a rating of 4 or greater during 2010/11 and 2011/12.

Table 10 –Financial Risk Rating 2008/09

Financial Criteria	Weight	Metric	Score	Rating	Weighted
Underlying Performance	0.25	EBITDA margin	10.40%	4	1.00
Achievement of Plan	0.10	EBITDA achieved	100.00%	5	0.50
Financial Efficiency	0.20	Return on Assets	5.40%	4	0.60
	0.20	I&E Surplus Margin	3.80%	5	1.00
Liquidity	0.25	Liquidity Ratio	42 days	4	1.00
Total	1.00				4.30

4.3.2 Significant risks

The trust proactively manages known financial risks in order to minimise the likelihood and consequence. Key areas for 2009/10 include:

Risk	Potential impact	Likelihood	Mitigating action	Residual risk
Failure to deliver cost improvement programme	5	3	Detailed plans for 2009/10 Performance monitoring regime Historic achievement	5
Actual activity levels below planned level of growth commissioned	5	3	Additional capacity secured by 09/10 revenue investments, weekly activity profiles,	10
Controlling drug expenditure within available resources	5	3	Drug management committee, introduction of electronic prescribing, cost per case contracts for new high cost drugs	5
Financial penalties contained with national contract	4	3	Detailed performance reporting systems, revenue investments as part of the 09/10 financial plan	4

4.3.3 Service line reporting

We have invested significantly during 2008/09 in our capability to produce patient level information and have implemented a bespoke reporting system during the second half of 2008/09. We are working with clinical champions to improve the quality of this information.

We are now regularly producing profit and loss contribution statements by service line and are utilising these to vary budgetary resources within the organisation with actual performance.

4.4 Risk of any other non-compliance with the terms of authorisation

Our self assessment gives us a Green (low risk) rating. In all other respects the trust plans to comply fully with its Terms of Authorisation.

5 Declarations and self certification

5.1 Self certification

The 2009/10 annual plan has been produced in consultation with key stakeholders including governors and lead commissioners and has been reviewed and recommended by the trust management board and audit committee prior to formal approval by the board of directors. Board approval for the declarations has been made with reference to a number of documents reviewed by the board which have provided supporting evidence to the statements.

So far no thresholds have been set for cancer targets (2 weeks, 31 and 62 day waits) and therefore the board statements below exclude any assessment of the impact of these. We continue to monitor performance against these targets and have systems and processes in place to assess the implication of thresholds once set.

5.2 Board statements

The Board of Directors of The Christie NHS Foundation Trust confirms that the following statements are true:

5.2.1 Clinical quality

- The board is satisfied that, to the best of its knowledge and using its own processes (supported by Healthcare Commission metrics and including any further metrics it chooses to adopt), The Christie NHS Foundation Trust has and will keep in place effective arrangement for the purpose of monitoring and continually improving the quality of healthcare provided to our patients.
- The board can confirm that The Christie NHS Foundation Trust has met and will continue to meet the requirements for registration with the Care Quality Commission in accordance with the Health and Social Care Act 2008.

5.2.2 Service performance

- The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and national core standards and with all known targets going forwards
- The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the *Code of Practice for the Prevention and Control of Healthcare Associated Infections* (including the Hygiene Code)

5.2.3 Risk management processes

- Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;
- All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;
- The necessary planning, performance management and risk management processes are in place to deliver the annual plan;
- A Statement of Internal Control (“SIC”) is in place, and The Christie NHS Foundation Trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to most up to date guidance from HM Treasury and
- All key risks to compliance with the authorisation have been identified and addressed.
- The target and thresholds for 62 day cancer pathways is not yet known. Therefore the board is unable to self certify ongoing compliance with this target.

5.2.4 Compliance with authorisation

- The board will ensure that The Christie NHS Foundation Trust remains compliant with their Authorisation and relevant legislation at all times;
- The board has considered all likely future risks to compliance with the authorisation, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks; and
- The board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance with its authorisation.

5.2.5 Board roles, structures, and capacity

- The board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the board;
- The board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability;
- The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills;
- The management team have the capability and experience necessary to deliver the annual plan; and
- The management structure in place is adequate to deliver the annual plan objectives for the next three years.

6. Membership

6.1 Membership commentary

At the beginning of April 2008 our public membership was 8352. Public membership has grown by 45% during the year and at the end of March 2009 was 12,104. This growth has enabled us to meet the target required to reach a total staff and public membership of 20,000 by 2011. We have achieved this by undertaking a number of recruitment activities including;

- actively recruiting patients and visitors in the waiting areas of the hospital
- attending fundraising and membership events
- encouraging existing members to recruit a member
- encouraging our charity supporters to become members
- encouraging staff to raise membership at events or meetings they attend

Some 703 people have been removed from membership during the year due to death and failure to contact/ address change.

6.1.1 Membership profile

Our membership consists of a public and a staff constituency.

The public constituency is open to everyone living in England and Wales who is over the age of 16 and operates on an 'opt in' basis. There are 13 classes within this constituency, 12 based on local government electoral boundaries within our network with the other covering the rest of England & Wales.

A staff constituency operating on an 'opt out' basis for staff employed at the trust over 12 months and all volunteers.

Membership representation

We produce reports on a regular basis which monitor membership representation, by comparing the respective ethnicity, age and gender information with the eligible membership population.

A key objective is to consider ways in which we could encourage a more diverse membership. Our public meetings and Oldham 2010 campaign will impact on ethnic mix as the catchment area has a high population of British Asians.

Table 11 - analysis of current membership

Membership size and movements		
Public constituency	Last year (2008/09)	Next year (estimated) (2009/10)
At year start (April 1)	8,352	12,104
New members	4,455	3835
Members leaving	703	875
At year end (March 31)	12,104	15,064
Staff constituency	Last year	Next year (estimated) (2009/10)
At year start (April 1)	2,387	2,560
New members	657	687
Members leaving	484	516
At year end (March 31)	2,560	2,731
Analysis of current membership		
Public constituency		
Age (years):	Number of members	Eligible membership
0-16	0	668,365
17-21	118	187,275
22+	7,651	2,132,889
Not stated	4,335	n/a
Total Public Constituency	12,104	2,988,529
Ethnicity	Number of members	Eligible membership
White	7,361	2,758,661
Mixed	36	35,746
Asian or Asian British	185	142,454
Black or Black British	72	30,698
Chinese/Other Ethnic group	134	21,196
Not stated	4,316	n/a
Total Public Constituency	12,104	2,988,755
Socio-economic groupings:	Number of members	Eligible membership
ABC1	9,199	1,134,206
C2	217	349,878
D	1,375	441,674
E	1,247	390,796
Not assigned	66	n/a
Total Public Constituency	12,104	2,316,554
Gender analysis:	Number of members	Eligible membership
Female	5,845	1,533,250
Male	3,871	1,455,279
Unknown	2,388	n/a
Total Public Constituency	12,104	2,988,529

Note

The total eligible population result from a combination of the differing data sources used to populate information on age, ethnicity, gender and socio-economic status.

Census data is used to provide age, gender and ethnicity information, however in the case of ethnicity the data does not split ethnic groups into age bands and the report does not exclude members of the population under 16 years of age.

The socio-economic analysis is sourced for a different data sets hence the variance in the total eligible population figures.

Age

The public membership is only available to people over the age of 16 living in England & Wales therefore, as illustrated in table 11, our age group analysis begins at 16. It is apparent from the data that a large proportion of our membership is over the age of 21. We recognise the need to engage with the younger age groups and are planning to do this by maximizing the opportunity to reach them through younger activity based fundraising events and by attending community events that attract a younger demographic, such as Manchester Pride. We have attended a number of meetings with the Christie Crew, a group of young people who have been treated on the Young Oncology Unit at the Christie. This relationship will also be maintained to ensure better engagement with younger people. The Membership and Community Engagement sub group is actively considering proposing a change to the constitution to allow a stakeholder governor representing younger service users.

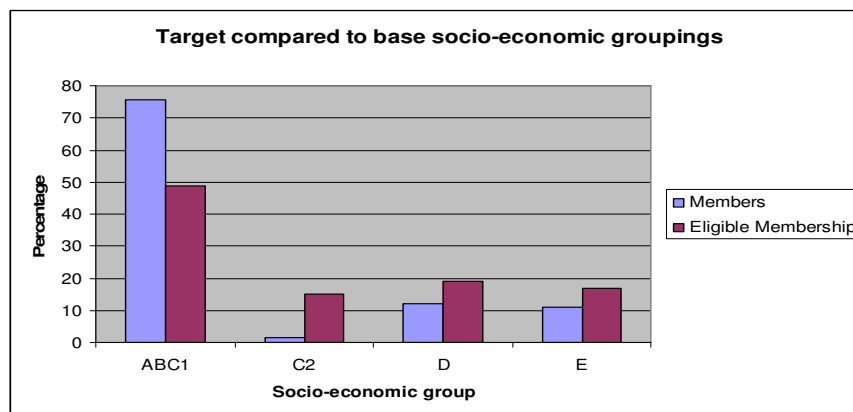
Ethnic groups

Many of our members have chosen not to share their ethnicity with us however table 11 shows attention is required to ensure a representative membership in all ethnic groups. We have held public engagement meetings throughout 2008 in all of the public constituency areas and we identified the ethnic community groups in each area and invited them to attend. We offered interpretation services if required. We will continue to invite ethnic community groups to membership engagement meetings, and actively pursue recruitment through targeted events such as the Oldham 2010 project and community melas, which are local family fun days targeted to ethnic minority communities.

Socio-economic groupings

Social grade analysis was carried out on the public membership data for the Greater Manchester and Cheshire classes. The provision of a socio-economic analysis on the class covering the Rest of England & Wales has been deemed of limited value and has not been undertaken.

The graph below illustrates that although we are over performing in comparison to the ABC1 groupings. Attention is required to increase the membership of skilled working class (C2) working class (D) and those at the lowest levels of subsistence (E). The Oldham 2010 project will also assist with this.



6.1.2 Future membership

We plan to continue to grow our membership and reach a target of 20,000 total members by March 2011. The Oldham 2010 and Salford 2011 projects, which are based on our new radiotherapy developments, will provide 4000 of the expected 6000 total with other members coming from mainstream methods.

6.1.3 Engagement

We have built our relationship with members through active involvement opportunities and regular communication through newsletters and our website. The Headlines magazine was sent to all members in the spring and autumn. A membership survey was included in the autumn edition and has provided valuable feedback and support.

Other activities included invitations to our on site open day when 350 members and friends attended and our annual members' meeting. We have involved members in;

- The trust name change consultation and vote.
- Changes to the constitution.
- Participation in surveys, sharing opinions and feedback.
- Improving patient experience through participating in observations, trust committees and events such as the annual Patient Environment Action Team (PEAT) survey of the hospital environment.

All members were invited, along with local community groups to local public engagement events. This gave members the opportunity to meet with their governor and staff from The Christie, hear about our news and developments and raise any questions they have. We plan to carry out public engagement events again in the local authority areas in 2009. In March we held an event for LINK's and have formally advised local governor contacts to these important new organisations.

6.1.4 Election of governors

A cycle of elections is in place that will result in approximately one third of governors seeking election/re-election every year.

During 2008, five area seats were due for election, along with one staff class seat. As a result of the election process, three seats were contested, with election turnout rates as below;

Constituency Area	Election turnout (%)
Tameside & Glossop	35.2
Bury	35
Bolton	29.6

We will continue to raise the profile of our governors, and the role of a governor, to ensure that they are engaged with our members, which will enhance the election process in terms of nominations received and election turnout.

Five public area seats, along with two staff class seats are due for election in 2009 and two public area seats have become vacant. The election process is due to commence in the summer.

All elections to the Council of Governors will continue to be held in accordance with the model rules for election as stated in the constitution. The election process last year was carried out by the Electoral Reform Service (ERS) who will undertake this again in 2009 following a market test of other providers.

There have been no electoral ward boundary changes since authorisation in April 2007.

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